

Action Plan – James Brown HMP Humber Self-Inflicted - 14/06/2016

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	<p>The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular:</p> <ul style="list-style-type: none"> • Enhanced case management procedures should be used to manage prisoners with complex behaviours; • Case reviews should be multi-disciplinary and involve the prisoner's family where it would be beneficial; • Care maps should contain actions that are specific, time bound and meaningful, tailored to the individual to reduce their risks and updated at each case review. 	Accepted	<p>A representative from the healthcare department will attend all ACCT reviews, they will be informed their attendance is required via the ACCT booking system. Dip tests are conducted on all ACCT reviews attended. Statistics recorded of attended ACCT reviews within the healthcare SMT minutes.</p> <p>The complex case identification continuum was disseminated to all case managers on 7 July 2017 by email from Regional Safer Custody team. This document highlights how to identify and what to consider in making reviews into enhanced cases.</p> <p>Staff Information Notices were issued in August 2017 informing staff of the Prison and Probation Ombudsmen's findings regarding SMART care-map targets and the need for a multidisciplinary approach to case reviews have been raised across the prison estate. A separate Staff Information Notice reminding staff of the importance of conversations and observations was also published in August 2017.</p>	Head of Healthcare Head of Safer Custody Completed
2	<p>NHS England Yorkshire and The Humber should ensure that the specialist commissioning of mental health and psychiatric services follow national guidance for s47/s48 assessments and transfer to mental health units. The healthcare provider should also ensure:</p>	Accepted	<p>Healthcare services at HMP Humber are now provided by City Healthcare Partnership (CHCP).</p> <p>CHCP introduced a new system in March 2017 to ensure the NICE guidance in regards to hospital transfer under a S47/48 is adhered to, including that prompt identification and referral is carried out, and full documentation is available within the patient records to support the process.</p> <p>Records of timelines are kept for all patients referred to hospital.</p>	Head of Healthcare Completed March 2017

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	<ul style="list-style-type: none"> • NHS England and the Ministry of Justice Mental Health Casework Section are promptly notified when a prisoner is assessed as requiring such a transfer • Healthcare staff work in partnership with community services to ensure continuity of care • Healthcare staff work in partnership with the prison to ensure an integrated care plan/behaviour modification plan is in place for prisoners with learning difficulties/disabilities. 		<p>Any patient identified as requiring a hospital transfer will be effectively care planned with a risk assessment and behavioural plan provided to support him whilst on the wing.</p>	
3	<p>The Governor should review decision-making procedures around the use of special accommodation and the location of prisoners at risk of suicide and self-harm in the segregation unit and ensure the segregation unit operates in line with the national policies set out in PSO 1700.</p>	Accepted	<p>HMP Humber completes a defensible decision log for all men located or being considered for location with the segregation unit. The defensible decision log is then forwarded to the Regional Safer Custody Team for assurance purposes and advice on management.</p> <p>All Senior Management Team members were made aware via briefings in June 2017 of the requirements of the defensible decision log and the requirements to notify the regional safer custody lead when locating a prisoner on an ACCT document in the segregation unit.</p>	Head of Safer Custody Completed

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			<p>If a move to normal location is feasible within a foreseeable timescale, the ACCT will remain open until the move has taken place and the prisoner has settled in their new accommodation. When a move from a Segregation Unit is planned, a pre-discharge case review will take place before a prisoner is returned to normal location.</p>	
4	<p>The Governor should remind staff that when an observation panel is covered and a prisoner fails to respond, arrangements should be made to enter the cell as quickly as possible, particularly in the case of prisoners being monitored under ACCT arrangements.</p>	Accepted	<p>A notice to staff originally issued in April 2017 will be re-issued in September 2017 to remind staff that they have a responsibility to preserve life, taking into consideration all security factors and that a dynamic risk assessment must be made by the staff on scene.</p> <p>All staff have been issued with Emergency Response In Custody card for attaching to ID badges to ensure immediate guidance is available.</p>	<p>Head of Safer Custody Completed April 17</p>
5	<p>The Head of Healthcare should ensure substance misuse services are effective and provide:</p> <ul style="list-style-type: none"> • Swift access to appropriate support • Improved communication with the mental health team, substance misuse service and prison staff about individuals' presentation and needs • Details of all interventions 	Accepted	<p>Since May 2017 the service offered is an integrated service, managed by one operations manager directly employed by City Healthcare Partnership, which has improved communications and service efficiency.</p> <p>All patient records are entered onto one system, SystemOne, which is accessible to all staff working within the healthcare department.</p> <p>All staff on duty attend a joint daily lunchtime handover to improve communications across the departments. Weekly clinical team meetings and a monthly communication full staff meeting have also been implemented, with an expectation that staff attend a minimum of one in three full staff meetings. Terms of Reference are in place and meetings are minuted.</p>	<p>Head of Safer Custody Completed</p>

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	from substance misuse services are fully recorded in prisoners' records.		All teams have service specific handovers daily also to provide focus to the patients on their caseload. The mental health and DART team attend a pathfinder meeting fortnightly.	
6	The Governor should ensure that a family liaison officer informs a prisoner's family quickly and in person of their death, in line with national guidance.	Accepted	<p>Information and guidance regarding informing families of deceased prisoners is present in contingency plans, which contain up to date information regarding contacting Family Liaison Officers (FLO).</p> <p>HMP Humber has five FLOs from a range of different functions who are kept up to date with all relevant information and whose contact details are available in the Communications Room and Command Suite.</p> <p>All Operational and Custodial Managers and FLOs were reminded in May 2016 through a staff briefing of the importance of informing the next of kin as soon as a prisoner becomes seriously ill and a Staff Information Notice on this topic was issued in July 2017. This Staff Information notice will be re issued every three months.</p>	Head of Safer Custody Completed March 2017
7	The Governor should ensure that prisoners who request additional support following a death in custody are responded to within 24 hours.	Accepted	Contingency plans for any death in custody include that a Notice to prisoners will be issued regarding the death and that the Samaritans are notified within 12 hours in order that a notice to prisoners can be published by the Samaritans on all wings indicating that additional support will be provided, including making themselves available on the wing. Any men on ACCT documents will be reviewed within the first 24 hours following the death.	Head of Safer Custody Completed March 2017
8	The Governor should ensure that, in line with PSI 58/2010, the Prison and Probation Ombudsman is promptly	Accepted	A Staff Information Notice was issued in August 2017 informing staff of the importance of adhering to PSO 58/2010, ensuring that information is provided promptly following a death in custody.	Head of Security Completed

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	provided with all requested documents following a death in custody			