

Action Plan –Stephen Quinnell. HMP Northumberland. Self -Inflicted. 04/11/2016

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Director should ensure that staff understand the procedure for identifying, managing and supporting prisoners at risk of suicide and self-harm. In particular, they should ensure that staff assess the risk of suicide and self-harm based on all available information and known risk factors and not on a prisoner's own presentation	Accepted	<p>All newly recruited staff are required to complete suicide and self-harm training as part of their initial training course. In order to capture established staff a training plan has been devised, which projects all staff will have received at least part of the course by January 2019. The new training course will be prioritised for critical groups (including safer custody staff, reception, healthcare, care and separation unit and managers) so it is rolled out effectively.</p> <p>A staff information notice will be circulated highlighting the factors referred to in the PPO's thematic review of self-inflicted deaths, which was published in April 2014. Local guides outlining this information will also be devised and provided to all trained case managers. Newly trained case managers will be provided with this guide on completion of the training course. These steps will ensure case managers understand that they are required to identify whether any of the risk factors are relevant when carrying out each case review. For each identified risk factor the case manager is then required to assess the level of risk and identify support to reduce its impact. This information is recorded in the summary of the case review and the support element reflected in the caremap.</p> <p>Adherence to this approach will be monitored through ACCT quality assurance tests and through the self-harm improvement meetings. In addition, a monthly article on Safer Custody matters will be devised and published in the newsletter (Director's Huddle) edited by the Director. The Safer Custody article will focus on key messages with the first including information about risk factors.</p>	<p>January 2019 Learning & Development Manager</p> <p>September 2017 Head of Safer Custody</p>
2	The Director should ensure that staff on the house block, and in particular personal officers, are	Accepted	The weekly briefings between managers and front line staff will now include a prompt for all staff to check ACCT documents, both those open and those in post-closure, for key information such as trigger dates or events for residents	September 2017

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	made aware of potential triggers for suicide and self-harm, such as further charges and forthcoming court appearances, and that they take appropriate action to manage that risk, including starting ACCT procedures where appropriate		they have a particular interest in. For residential staff this will be for personal officers to check their cohort and for offender supervisors this will be residents in their case loads.	Head of Safer Custody
3	<p>The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:</p> <ul style="list-style-type: none"> • Case reviews are multi-disciplinary and include all relevant people involved in a prisoner’s care, including mental health staff where appropriate. • Staff set ACCT care map actions designed to reduce the prisoner’s risk of suicide and self-harm, review them at each case review and complete them all before closing an ACCT. • Staff vary the times of ACCT checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked. 	Accepted	<p>Multi-disciplinary ACCT case reviews will be consistently provided to achieve compliance with this recommendation and to ensure that information is consistently shared among those who come into contact with prisoners at risk of self-harm.</p> <p>All case managers were reminded in August 2017, through the issuing of Learning Bulletins, of the need to ensure that caremap actions are devised with the purpose of reducing the level of risk the prisoner presents to himself. Case managers were also reminded of the need to ensure the care map is reviewed at each case review and that an open ACCT should only be closed once all care map actions have been completed.</p> <p>A staff information notice will be circulated which provides all staff with advice on the timing of ACCT observations/conversations. This notice will also include advice on the quality of entries into ACCT ongoing records.</p> <p>The impact of our measures to deliver multi-disciplinary case reviews, that the caremap is used appropriately, and that observations are carried out at unpredictable times will be monitored by the Safer Custody team as well as through the weekly self-harm improvement and monthly Safer Prisons meetings.</p>	August 2017 Head of Safer Custody

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4	The Director should ensure that all staff understand the importance of entering a cell without delay when a prisoner's life is at risk, when it is safe to do so.	Accepted	All staff will be reminded through verbal briefings of the guidance previously issued surrounding the entering of a cell during night state in order to preserve life. This requirement will be included in the night state guidance pack which is used by night patrol staff.	September 2017 Head of Security