Action Plan – Mr Robert Ginn at HMP Pentonville– Self-Inflicted Death on 29/11/2018				
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**
1	The Governor and the Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that they: Consider all risk factors, including suicidal statements, apparent planning and previous suicide attempts, when assessing a prisoner's risk; Schedule case reviews at appropriate intervals, in line with the prisoner's level of risk. Hold multidisciplinary case reviews, attended by all relevant people involved in a prisoner's care. Adhere to the frequency of observations set out in the ACCT document and that observations take place at unpredictable times. Record details of protective factors and potential triggers in the ACCT document. Involve the	Accepted	Guidance will be published reminding all staff including healthcare staff, that prisoners at risk of suicide and self-harm must be managed in line with national guidelines. The guidance will include that staff should consider all risk factors including suicidal statements, apparent planning and previous suicide attempts. Case managers will be reminded within the guidance that case reviews should be scheduled in line with management of risk and that reviews should be multidisciplinary attended by all relevant people involved in the prisoner's care. Staff will be reminded within the guidance that they must adhere to the frequency of observations set out in the ACCT document and that observations take place at unpredictable times. Case managers will be reminded within the guidance that family involvement should be explored when appropriate and clearly document this within the ACCT. The prison will implement a system of internal assurance to ensure ACCT processes correspond to the required standards and identify examples of good practice or where improvement is required. Where standards fall below that expected a requirement to instigate remedial action will be communicated to the individual's line manager. This assurance system will report to the Good Order and Safety Committee who will drive remedial action where identified.	01/08/2019 Head of Safety Custody

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	prisoner's family when that would be appropriate.			
2	The Governor and the Head of Healthcare should ensure that reception staff examine all available documentation about a prisoner and consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm. When they decide not to begin ACCT procedures for prisoners with significant risk factors, or who arrive with documents detailing a risk of suicide and self-harm, they should clearly record the reasons.	Accepted	The prison will publish guidance reminding all reception-based staff, including healthcare, that they should examine all available documentation about a prisoner, including suicide and self-harm warning forms, person escort records and medical records when determining their risk of suicide or self-harm. Staff are to consider and record all the known risk factors of newly arrived prisoners and, where there are any concerns about self-harm, either open an ACCT document immediately or discuss with a manager as to whether this is necessary. Any decision not to open an ACCT must be recorded on NOMIS. The prison will implement a system of internal assurance to ensure reception assessments correspond to the standards identified above and provide examples of good practice or highlight where improvement is required. Where standards fall below what is expected a requirement to instigate remedial action will be communicated to the individual's line manager. This assurance system will report to the Good Order and Safety Committee who will drive remedial action where identified.	01/08/2019 Head of Safer Custody Head of Healthcare 01/09/2019 Head of Safety Custody
3	The Head of Healthcare should ensure that there is effective and clear liaison between the primary care mental health team and the mental health in-reach team, which allows a prisoner's	Accepted	Healthcare have made key policy changes in April 2019 to ensure that there is a direct pathway for communication and escalation between Primary Care Mental Health (Well-being) and Secondary Care Mental Health (Psychiatrist Team). These changes have been reflected in both Operational policies for Primary Care and Mental health and In-reach services. This allows a senior clinician from the Health & Well-being model to directly refer a case for psychiatry	Completed Head of Healthcare

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	suitability for each mental health team to be promptly reassessed.		review without needing to access in-reach services in the first instance. This will allow a far quicker and measured approach for patients who do not fit clearly into either service.	
4	The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that: • Staff enter cells as quickly as possible in a life-threatening situation. • Staff radio an appropriate emergency code. • Control room staff call an ambulance as soon as an emergency code is called.	Accepted	The prison will publish guidance reminding staff of their responsibilities during medical emergencies and the need to immediately communicate medical emergencies using the appropriate emergency codes and that control room staff must make immediate contact with the emergency services in the event of an emergency code being called over the radio net. The prison will implement a system of internal assurance to ensure emergency processes correspond to the standards identified above and identify examples of good practice or where improvement is required. Where standards fall below that expected a requirement to instigate remedial action will be communicated to the individual's line manager. This assurance system will report to the Good Order and Safety Committee who will drive remedial action where identified.	01/08/2019 Head of Safer Custody 01/09/2019 Head of Safer Custody
5	The Governor should ensure, in line with PSI 64/2011, that • When a prisoner changes their next of kin, staff update the prisoner's NOMIS prison record promptly; and • A family liaison officer breaks the news of a death to a next of kin in	Accepted	The prison will publish guidance informing staff that where a prisoner indicates that they wish to nominate a next of kin for the first time or where they change an existing next of kin, the NOMIS record should be updated to reflect this. The prison acknowledges that, in line with policy, the death of a prisoner should always be given by a family liaison officer unless exceptional circumstances prevail and contingency plans will be clearly updated to ensure reflect this requirement	01/10/2019 Head of Safer Custody

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	person as soon as possible.			
6	The Governor should ensure that, following a death in custody, staff receive adequate support and that a manager, not involved in the death, leads a hot debrief and records who attends.	Accepted	The prison will publish guidance to all senior managers responsible for managing the immediate period following a death in custody that staff should receive appropriate support and that a hot debrief will be held immediately led by a senior manager with the care team in attendance documenting those attending. A review of the contingency plans will be completed to ensure it reflects the published guidance.	01/10/2019 Head of Safer Custody