

Action Plan: Jamie Osborne, HMP Lewes, death on 12/02/2016

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"> • All known risk factors of newly-arrived prisoners should be considered and recorded when determining risk of suicide and self-harm, using all available information such as that from Person Escort Records. • They should set effective caremap objectives which are specific, time bound and meaningful, aimed at reducing risk and updated at each case review. • Case reviews should record and take into account all known risk factors and triggers and set a level of observations which appropriately reflects 	Accepted	<p>A local notice to staff will be issued to remind reception staff of the need to ensure that all known risk factors are considered for newly-arrived prisoners. Relevant risk factors will be documented on the prisoner's NOMIS record (electronic prisoner record) giving clear indication of the consideration given to these risk factors in determining the course of action, including for example an ACCT being opened or referrals made. Guidance will be circulated to increase staff knowledge about when family involvement in ACCT processes may be beneficial.</p> <p>All Custodial Managers, Supervising Officers and Healthcare staff will receive refresher ACCT Case Manager training. Two local notices to staff have also been circulated to raise awareness and increase capability in completing ACCT reviews, including recording known risks and triggers to aid decisions on the frequency of observations, and effective use of the Caremap to ensure that specific and meaningful objectives are set which are considered at each ACCT case review.</p> <p>The Safer Custody Team carry out regular quality assurance checks on ACCT documents, and improvement notices are issued as advice and guidance where required.</p> <p>All healthcare staff will be reminded of the need to ensure they re-familiarise themselves with the Trust observation policy known as The Observation and Therapeutic Engagement Policy. This will be monitored by the ward manager who will review the relevant paperwork and steps will be taken to address non-compliance.</p>	<p>31/12/2016 Heads of Safer Custody and Reception</p> <p>Completed Head of Safer Custody</p> <p>Ongoing Head of Safer Custody</p> <p>Ongoing through supervision. Head of Healthcare</p>

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	<p>that risk.</p> <ul style="list-style-type: none"> • ACCT observations should be at irregular, unpredictable intervals. • Staff should review risk and consider whether to hold a case review whenever an event occurs which indicates an increase in risk. • They should ensure that there is no confusion between ACCT observations and routine healthcare observations. • They should involve the prisoner's family when it would be beneficial. 		<p>All healthcare staff have been reminded of the need to familiarise themselves with and follow both the required ACCT observations and conversations, and the routine healthcare observations.</p> <p>All staff will be reminded by way of notice to staff of the importance of undertaking ACCT observations at irregular intervals. In addition, staff will be reminded of the need to consider the level of risk and whether an ACCT case review should be held when an event occurs which indicates an increase in risk.</p>	<p>Ongoing through supervision. Training by 31/12/2016 Head of Healthcare</p> <p>31/12/2016 Head of Safer Custody</p>
2	<p>The Governor and Head of Healthcare should ensure that staff are aware of and appropriately use the enhanced case management approach for suicidal prisoners with complex needs.</p>	Accepted	<p>All Custodial Managers, Supervising Officers and appropriate Healthcare staff will receive ACCT Case Manager training which addresses when to consider the use of enhanced case management, as set out in national safer custody policy.</p>	<p>31/12/2016 Head of Safer Custody and Training</p>

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3	The Governor and Head of Healthcare should ensure that healthcare staff understand the process for transferring prisoners under the Mental Health Act and that they inform NHS England and the Ministry of Justice Mental Health Casework Section promptly when a prisoner is assessed as requiring such a transfer	Accepted	<p>All Healthcare staff have been briefed on the process for transferring prisoners under the Mental Health Act, and where they can find the best-practice guide and tracker which, in line with the Department of Health guidance on mental health transfers, records when the Ministry of Justice casework section is contacted to indicate that a prisoner will be requiring transfer. As NHS England purchase a number of mental health inpatient hospital spaces from the Trust, staff are aware that they only need to inform NHS England where more beds are required.</p> <p>Since 30 August 2016, a dedicated member of administrative staff has been in place to facilitate a more robust process including ensuring the tracker is completed comprehensively.</p>	Completed Head of Healthcare
4	The Governor and Head of Healthcare should ensure prisoners at risk of suicide or self-harm are not placed on the basic level of the IEP scheme unless all other options have been considered and excluded, and there are fully documented reasons to explain the exceptional circumstances.	Accepted	<p>Alongside the ongoing ACCT refresher training, a notice to staff will be issued to remind ACCT Case Managers that the ACCT case review team must consider the impact that placing a prisoner on the Basic IEP level may have.</p> <p>Managers will be reminded of the need to consider whether the prisoner is on an ACCT when deciding whether they will be placed on Basic IEP level, and in these circumstances this sanction will be imposed only as a last resort and the reasons for doing so will be documented.</p> <p>In line with national policy on prison discipline procedures, where the outcome of a disciplinary hearing raises safer custody concerns, all staff will be reminded of the need to inform the safer custody team and the relevant residential staff to ensure appropriate support is in place.</p>	31/12/2016 Head of Safer Custody

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			Staff will be reminded of the need to formally record the outcome of each IEP review on NOMIS.	
5	The Governor and Head of Healthcare should ensure that staff use an appropriate code to communicate a medical emergency, even when a prisoner is in healthcare, so the control room know to call an ambulance immediately.	Accepted	All Healthcare staff have been provided with a copy of the national policy contained within relevant Prison Service Instruction (PSI) concerning Emergency Response Codes, and have been verbally briefed on the use of the codes by their manager. There are visual prompts in the clinical areas to remind staff of the requirement to use the appropriate emergency code.	Completed Head of Healthcare