

**Action Plan –Mr Tom Piggott at HMP High Down - Self-inflicted on 27 May 2018**

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 or self-harm in line with national guidelines, including in particular that:</p> <ul style="list-style-type: none"> <li>• all known risk factors are considered when determining the level of risk of suicide and self-harm;</li> <li>• ACCT caremap actions are specific and meaningful, aimed at reducing a prisoner’s risk and identify who is responsible for them;</li> <li>• observations are carried out at unpredictable intervals;</li> <li>• ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk, and</li> <li>• all case reviews are included in the ACCT documentation.</li> </ul>	Accepted	<p>The Governor will ensure that all relevant staff have had Case Manager training. The establishment also will revise the Suicide and Self Harm Training (SASH) training delivery plan to ensure that all staff are trained in modules 1-6 as soon as possible. SASH includes a module on recognising triggers and risk in vulnerable prisoners.</p> <p>The establishment has implemented a robust three-tier management check of ACCT documents. A Custodial Manager and Duty Governor complete assurance checks daily on all ACCT documents, and all findings are referred to the Safety Team who take action to address them. The Safety Team collate the findings highlighting any procedural failings and this is addressed by the Safety Team and line managers. The assurance checks include a focus on caremaps, ensuring that the actions are relevant to the individual, that they support them and reduce the risk of self harm, and that there is a named person on the caremap responsible for each action.</p> <p>The checks also consider case reviews, ensuring they are of good quality, multi-disciplinary, and that they are held in a timely manner after any event that could increase the prisoner’s risk of self harm. Briefing sessions form part of the training schedule. Case Management training sessions will take place in April 2019</p> <p>In relation to observations, staff will have briefing sessions in March and April to improve the quality of ACCT entries and ensure that observations are being recorded correctly. This again will be checked through the three-tier check, and if there is any unacceptable practises found staff will be spoken to by the Safety Team as a one-to-one initially and then referred to their line</p>	<p>April 2019 Head of Safety and Head of Healthcare</p>

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			management.	
2	The Governor and Head of Healthcare should ensure that there is a clearly agreed protocol for the management of prisoners with complex and/or deteriorating mental health which includes decisions around level of observations and crisis management.	Accepted	<p>The Head of Healthcare and Head of Safety will produce a protocol for managing prisoners with complex needs. In addition, a flowchart included in the duty governor log, will detail how prisoners in crisis are managed via a multi-disciplinary process. Out of hours contacts for healthcare will also be provided.</p> <p>The protocol will be communicated to the Senior Leadership Team and included in the Safety Meeting.</p>	April 2019 Head of Healthcare and Head of Safety
3	The Governor and Head of Healthcare should ensure that there is a clear protocol for the management of prisoners in the healthcare unit, including an admission and discharge pathway, plans for dealing with disruptive patients and that staff are supported when working in this difficult environment.	Accepted	<p>The current protocol for managing prisoners in Healthcare will be reviewed together with the current admissions policy. This will ensure there is a clear pathway for admissions and discharges and care plans agreed for dealing with challenging patients.</p> <p>Following the review there will be an agreed practice for the support of staff working in this area between the Healthcare provider and the prison management. This will be communicated to all Healthcare staff and to Senior Leaders Team. Assurance checks by Head of Safety and Head of Healthcare will be introduced to ensure appropriate admissions and discharges to Healthcare.</p>	April 2019 Head of Healthcare and Deputy Governor
4	The Head of Healthcare should ensure that healthcare staff assure	Accepted	The Head of Healthcare will ensure that all Healthcare staff undertake annual Self-Harm and Suicide Prevention in Criminal Justice Setting training. This will reiterate to staff the importance of observations and will highlight some of the	April 2019 Head of Healthcare

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	themselves of a prisoner's well-being when completing nursing observations and are alert to behavioural changes.		<p>signs to watch out for if there are behavioural changes of concern. All Healthcare staff will also attend the SASH training as a priority.</p> <p>A review will take place at the Safety Meeting of staff attendance at the training. A monthly audit will be completed on observations and any concerns highlighted will be addressed via monthly staff supervision.</p>	
5	The Governor should ensure that all staff are made aware of and understand their responsibilities during medical emergencies, including opening cells when there is an immediate danger to life.	Accepted	<p>The Governor will remind staff of how to carry out a dynamic risk assessment when considering whether to enter a cell, and ensure they are aware of the importance of calling for assistance immediately in a medical emergency or a threat to life. This will be discussed at the full staff meeting in March and reinforced as a Governor's Order.</p> <p>A process will be implemented from March 2019 in which all night staff will receive a briefing on their key responsibilities at the start of their night shift.</p>	<p>Completed Governor</p> <p>Completed Head of Security</p>
6	The Governor and Head of Healthcare should ensure that signs of drug use are recorded in prisoners' records and all staff should submit intelligence reports when they are aware of suspected drug use.	Accepted	<p>The Governor will re-issue a notice to staff, reminding them of the importance of recording that a prisoner is suspected of using drugs correctly and in a timely manner.</p> <p>All staff must report all instances of suspected drug use via Mercury Intelligence Report and all incidents will be recorded on an Incident Statement and on IRS by the Orderly Officer. The notice to staff also reminds staff that they should also refer the prisoner to the relevant services.</p> <p>Guidance will be issued to all healthcare staff reminding them to record any concerns about drug use on SystemOne and Datix (healthcare equivalent of an</p>	April 2019 Governor and Head of Healthcare

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			incident report) as well as submitting a Mercury Intelligence Report.	
7	The Governor should ensure that, following a death in custody, family liaison is appropriate, including keeping in touch with the family, returning the deceased prisoner's possessions and contributing towards funeral expenses, in line with PSI 64/2011.	Accepted	<p>All Family Liaison Officers (FLOs) will receive reminders regarding the requirements of PSI 64/2011 following a death in custody, this will include returning property to the deceased family and offering to pay a contribution towards funeral costs. These reminders will be generated at the time of a death in custody and form part of the checklist by the Safety Team.</p> <p>The Safety Team will maintain a checklist of key FLO actions to provide assurance in the event of an FLO absence.</p>	April 2019 Deputy Governor
8	The Governor should ensure that following a death in custody all staff involved have the opportunity to attend a debrief, in line with PSI 64/2011.	Accepted	<p>All Duty Governors and Orderly Officers will be reminded of the importance of staff attending a debrief following a death in custody by a Notice to Staff.</p> <p>The Head of Safety and Deputy Governor will develop an administrative pack to include a standard debrief form in the event of a death in custody. Included in the pack will be a template attendance lists for debriefs, template letters of notification and a template for immediate lessons learned. A cover sheet will include details of key contacts and debrief requirements.</p> <p>The debrief admin pack will be completed as soon as possible after the incident and will be communicated to Senior Leadership Team and Orderly Officers as a briefing session by the Governor.</p>	April 2019 Governor  April 2019 Deputy Governor
9	The Chief Executive of HMPPS should provide the	Accepted	Tackling the misuse of drugs in prisons is a key priority for HMPPS to ensure that prisons are safe, secure and reduce reoffending. We have formed a Drugs	Chief Executive of

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	<p>Ombudsman with a revised date for issuing detailed national guidance on measures to reduce the supply and demand of drugs in prisons, and an assurance that this new date will be met.</p>		<p>Taskforce, working with law enforcement and health partners across government to restrict supply, reduce demand and build recovery. The Taskforce is in the final stages of drafting and publication of the Prison Drugs Strategy and Guidance. We hope to publish the Strategy shortly, which will provide overarching direction for HMPPS and key partners, while the Guidance will provide practical advice and examples of good practice and will be embedded across the prison estate.</p> <p>We shared the draft documents with the PPO and other stakeholders for feedback in November 2018 and would be very happy to discuss them further.</p>	<p>HMPPS Shortly</p>