

**Action Plan- Lee Martin Parish. HMP The Mount. Self – Inflicted. 21/06/2017.**

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Prisons Group Director for London and Thames Valley Prisons should assure himself that effective action is taken to implement recommendations from this and previous investigations into deaths at HMP The Mount.	Accepted	The Prison Group Director (PGD) for London and Thames Valley has commissioned the Regional Safer Custody team to review the actions taken to address PPO recommendations. A report will be provided to the PGD and Governor detailing the progress that has been made and recommending further action if necessary. This will be continuously monitored through further planned assurance visits.	Regional Safer Custody lead May 2018
2	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: <ul style="list-style-type: none"> <li>• Holding a multidisciplinary case review within 24 hours of an ACCT plan being opened and when there is evidence of significant change in risk.</li> <li>• Prison and healthcare staff working jointly to manage prisoners at risk of suicide and self-harm. Healthcare staff should be invited to and attend at least the first review</li> <li>• Holding multidisciplinary ACCT reviews, with continuity of case management and involving all</li> </ul>	Accepted	<p>The Safer Custody department are currently developing a local Suicide and Self Harm Prevention Policy to provide further guidance for staff and reflecting the national PSI. This is currently out for consultation and is intended for publication in May 2018, at which point it will be disseminated to staff.</p> <p>A Full Staff Briefing held on 3 January 2018 reminded staff of the importance of the effective management of ACCT procedures and highlighted the recommendations from the PPO Report, reaffirming the need for positive interactions and checks to be completed. A Staff Information Notice was also issued that contained the content of the presentations.</p> <p>In order to improve multidisciplinary attendances at case reviews, the Daily Briefing Sheet now details all the ACCT reviews due to take place that day. The Case Manager is responsible for ensuring that all key parties, including healthcare, are invited so that they can contribute to the prisoner's care and information can be appropriately shared. An email reminding Case Managers of this was sent from Head of Safer Custody in February 2018.</p>	<p>Head of Safer Prisons &amp; Equality May 2018</p> <p>Head of Safer Prisons &amp; Equality and Head of Healthcare Completed</p>

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	<p>staff who can contribute to a prisoner's care.</p> <ul style="list-style-type: none"> <li>• Case managers completing care-maps at the first ACCT case review, setting specific and meaningful care-map actions, identifying who is responsible for them and reviewing progress at each review.</li> <li>• All staff undertaking ACCT observations as directed and actively engaging with prisoners being monitored.</li> </ul>		<p>Management checks are undertaken weekly at senior management level to ensure that the reviews are multi-disciplinary. These checks also consider the timeliness of reviews, attendance at reviews, quality of caremaps, continuity of Case Manager and quality of entries in the ACCT. The Case Manager is responsible for ensuring staff complete the appropriate checks throughout the core day.</p> <p>ACCT Case Manager training has been completed by all Band 4 operational staff, and Suicide and Self Harm (SASH) training is provided to all staff, with a dedicated Wednesday morning lockdown period used to deliver essential training.</p> <p>The Five Minute Intervention (FMI) Training is also being rolled out across HMP The Mount and focusses on positive interactions. Since March 2018, 18 more staff have trained as ACCT Assessors.</p>	
3	<p>The Governor should ensure that when staffing on a unit is reduced, arrangements are in place to ensure that prisoners subject to ACCT procedures are appropriately and formally monitored.</p>	Accepted	<p>Following this incident, changes were introduced to the Daily Briefing Sheet so that these now identify the name and location of all prisoners who are subject to ACCT procedures and the number of ACCT observations that are required in each area for both the day and the night. This is used to assess the required level of staffing for each area to ensure that prisoners can be appropriately monitored.</p>	<p>Head of Safer Prisons &amp; Equalities</p> <p>Completed</p>
4	<p>The Governor should ensure that, when a cell door is unlocked, staff satisfy</p>	Accepted	<p>Shortly after the incident, the Governor met with all residential staff to reinforce the need for staff to undertake the required checks on prisoners when unlocking them. This has also been addressed by the Governor at full</p>	<p>Heads of Residence</p>

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	themselves of the prisoner's wellbeing and that there are no immediate issues that need attention.		<p>staff briefings, by a Staff Information Notice (SIN 3/18) and this requirement is reinforced by POELT mentors and line managers on an ongoing basis.</p> <p>Unit Custodial Managers dip test compliance by directly observing wing staff while they are unlocking, and their interactions with prisoners. Wing staff are held responsible by their wing managers and performance action and support is provided where necessary.</p>	Completed
5	The Governor should ensure that effective measures are in place to address public protection issues before allowing a prisoner access to all telephone numbers	Accepted	The Governor provided clear instructions to all staff at a full staff briefing on 3 January 2018, and on 4 January 2018 a SIN 3/18 was issued, to remind staff of the importance of being aware of public protection issues and that these issues must be considered before prisoners can access telephone numbers.	Governor Completed