

Action Plan – Mr Jeffrey Shane Watkins at HMP Littlehey – Self-Inflicted on 24/10/2018

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Governor should ensure that staff consistently enforce Littlehey's noise reduction policy.	Accepted	The local Noise Reduction Policy which was introduced in 2014, it has been reviewed and it will be reissued. All staff will be informed when it has been updated and reminded via a Notice to Staff of the requirement to enforce the policy. This will be further enforced through staff briefings by wing managers.	August 2019 Head of Residence
2	The Governor should ensure that staff record what action they have taken in response to a 'sharing of risk' form, including the reasons why no action is considered necessary.	Accepted	A new process has been introduced, when a 'sharing of risk' form is issued this will be recorded by the Safer Custody Department, who will then inform the appropriate wing location and log it on NOMIS. The staff on the wing will then be required to update NOMIS with the action taken, including the reasons why, if no action was considered necessary. In addition, when a 'sharing of risk' form is issued, it will be reviewed at the weekly Safety Intervention Meeting, which will include the actions taken. A notice to staff will be issued to explain the process.	August 2019 Head of Safer Custody Head of Residence
3	The Governor should ensure that key workers are allocated sufficient time to engage with prisoners.	Accepted	Local policy ensures that all key workers are allocated appropriate time to speak to their allocated prisoners. The allocation of time and quality of key work is monitored by the key worker's line manager and the outcomes of these assurance checks are then reported to the Functional Head. The People Hub also monitor distribution of key worker time to ensure hours are detailed appropriately.	Completed OMIC lead
4	The Head of Healthcare should ensure that staff action referrals promptly and record all interactions and risk information in a prisoner's medical record.	Accepted	The Head of Healthcare will ensure that all healthcare staff action referrals promptly and that they record interactions with prisoners in the medical record. Healthcare staff will be reminded of these requirements during daily healthcare meetings.	August 2019 Head of Healthcare
5	The Governor should ensure that:	Accepted	The local Night Operating Instructions have been reviewed and include instructions to staff on the entering of cells during the night state. They remind	August 2019 Head of

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	<p><input type="checkbox"/> all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is a potential risk to life, and that local policies and instructions reflect this prominently; and</p> <p><input type="checkbox"/> all staff carry a torch during the hours of darkness.</p>		<p>staff that subject to personal risk assessment, they may enter a cell at night in order to preserve life. A Notice to Staff will be issued to remind staff of this.</p> <p>All staff who carry out night duties will be issued with a torch at the beginning of the night shift as part of their night equipment. The torch will be signed out at the beginning of the night shift and signed back in at the end.</p>	Security
6	The Governor should ensure that all prison staff are made aware of, and understand, their responsibilities during medical emergencies, including the need for the control room to telephone an ambulance immediately.	Accepted	The Governor will issue a Notice to Staff reminding all staff of their responsibilities during medical emergencies, which will include the need for the Control Room to call an ambulance immediately. A copy of the NTS will be made available on display in the Control Room. The Head of Operations will also remind Control Room staff of this requirement through staff briefings.	August 2019 Head of Operations
7	The Head of Healthcare should ensure that decisions to allow a prisoner to hold medication in possession should be reviewed if a prisoner expresses suicidal thoughts.	Accepted	The Head of Healthcare will ensure that in possession medication is reviewed for any prisoner who expresses suicidal thoughts. In addition, the healthcare department will ensure that this is communicated to the Safer Custody Department. Healthcare staff will be reminded of these requirements at the daily healthcare meetings.	August 2019 Head of Healthcare
8	The Governor and Head of Healthcare should give clear guidance to staff about	Accepted	Guidance as to when resuscitation is inappropriate is included in the local Suicide and Self-Harm Prevention Policy which has been recently reviewed to ensure it was up to date. The Governor and Head of Healthcare will issue a	August 2019 Head of Safer Custody

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	the circumstances in which resuscitation is inappropriate.		Notice to Staff reminding them of the circumstances in which resuscitation is inappropriate.	
	The Governor should ensure that prisoners are offered appropriate support following a death in custody or other traumatic event.	Accepted	The Governor will ensure that prisoners are offered appropriate support following a death in custody or other traumatic event. This will be included in the local Contingency Plans as a Post Incident Requirement following a death in custody or other traumatic event.	August 2019 Head of Security
10	The Governor and Head of Healthcare should ensure that a copy of this report is shared with the relevant members of staff so that they are aware of the Ombudsman's findings.	Accepted	A copy of the report has been shared with the relevant members of staff, this was completed on Monday 8 th July 2019.	Head of Safer Custody Completed