

**Action Plan- Eugene Patrick O'Donnell - HMP Durham - Self-Inflicted - 16/02/2018**

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	<p>The Governor and Head of Healthcare should ensure that reception staff:</p> <ul style="list-style-type: none"> <li>• are aware of all known risk factors for suicide and self-harm;</li> <li>• identify prisoners' risk factors from the information and documents available to them; and</li> <li>• record the risk factors they have considered and the reasons for decisions.</li> </ul>	Accepted	<p>A new reception screening tool has been introduced and is used to identify any immediate health needs as well as focusing on identifying an individual's risk of harm to themselves. It also includes a list of the risk factors that must be considered when considering the risk of suicide and self-harm. The tool also prompts staff to make a NOMIS case note recording the reasons for any decisions made in relation to the ACCT process and the risk factors that have been taken into account, including any protective factors.</p>	Head of Healthcare Completed
2	<p>The Head of Healthcare should ensure that:</p> <ul style="list-style-type: none"> <li>• a process is put in place to ensure that a referral to the clinical monitoring team has been made when appropriate;</li> <li>• ongoing checks are made when specified, even if the prisoner fails to attend a clinic appointment; and</li> <li>• checks continue until the prisoner's condition has stabilised.</li> </ul>	Accepted	<p>All prisoners arriving at HMP Durham receive an assessment by reception nurses and those identified as having a drug or alcohol issue, are placed on the GP/ANP ledger to ensure that clinical monitoring can commence immediately. It is the responsibility of the GP/ANP to make a decision in relation to the level of monitoring required and add the prisoner to the clinical monitoring ledger. Night staff cross check the clinical monitoring ledger with GP/ANP ledger to ensure that all prisoners have been included. In the event of a late reception not seen by GP/ANP, the trained nurse allocated to nights will make the clinical decision in relation to the level of monitoring. This process also ensures that the clinical monitoring in place will continue even if a prisoner fails to attend a clinic appointment and until a prisoners condition has stabilised and they have been removed from the ledger.</p>	Head of Healthcare Completed

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3	<p>The Governor should:</p> <ul style="list-style-type: none"> <li>• review the current provision of radios to ensure it is sufficient to meet the needs of the prison; and</li> <li>• remind staff of the need to use their radio in the event of a medical emergency and to use the correct medical emergency code.</li> </ul>	Accepted	<p>A review of the provision of radios has been undertaken to ensure that every residential area has sufficient radios to raise an alarm throughout the day and night.</p> <p>A staff information notice reminding staff of their responsibilities during a medical emergency, including the need to use code red or code blue to communicate the nature of the emergency, via radio communication if possible, was re-issued in February 2019. Posters are also displayed in staff areas to highlight the correct emergency response process.</p> <p>Additional measures introduced include a training course developed by the Safer Custody Officer, which covers what to do in the event of a medical emergency, emergency response codes and how to recognise overdose. This training package has been added to the end of all SASH training sessions (which are mandatory for all those who have contact with prisoners).</p> <p>All new entry prison officers are now given a briefing regarding Emergency Response codes to ensure they understand their responsibilities in the event of medical emergencies. A practical test of what they have learned is carried out before any new member of staff 'goes live'. Guidance cards have been issued to radio holders which include details of when to call a code red/blue and what information to gather for the Ambulance Service.</p> <p>All control room staff have now been briefed that if they hear a member of staff shout for assistance for a particular medical problem (e.g. chest</p>	Head of Operations/Head of Safety

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			pains, ligature, blood loss) but without calling code red/blue, they must activate the relevant code red/blue procedure immediately, including calling an ambulance.	
4	The Governor should ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody, that all those involved in the incident are invited to attend, and that the list of attendees is accurately recorded.	Accepted	All operational governors have been reminded, both via email and through a briefing by the Governor at the monthly Senior Managers Team meeting in March 2018 of the importance of following the contingency plans for a death in custody and that all staff involved in major incident, are invited to a hot debrief and a list of attendees kept.	Governing Governor Completed