

**Action Plan – Mr Daryl Brimfield at HMP High Down – Self-Inflicted Death on 29/08/2019**

<b>No</b>	<b>Recommendation</b>	<b>Accepted/ Not Accepted</b>	<b>Response</b>	<b>Target date for completion and function responsible</b>
1	The Governor should ensure that Officer A receives refresher training in ACCT and safer custody procedures as a matter of urgency.	Accepted	Officer A has completed national Suicide and Self Harm (SASH) training and is due to receive refresher training that covers ACCT processes by July 2020. Officer A also completed further SASH training in May 2020.	Head of Safer Custody July 2020
2	The Governor and Head of Healthcare should ensure that staff conducting reception assessments always examine and consider the Person Escort Record, and any other documents that arrive with the prisoner, to assess whether the prisoner has any risk factors for suicide and self-harm.	Accepted	<p>A Governor Information Notice (GIN) will be issued in June 2020 to all staff giving instruction that the Prisoner Escort Record and other documentation must be viewed by both prison and healthcare staff working in the first night centre to assess any risk factors for suicide and self-harm. The Head of Operations and Head of Healthcare will carry out assurance checks that this is being done.</p> <p>A checklist has been introduced to be used by staff in reception. The checklist includes all documentation that should be checked at each stage and discipline and healthcare staff must sign to confirm that they have viewed the relevant document and any risk factors for suicide and self-harm have been considered at each stage of the reception process. The Head of Operations is responsible for quality checking the checklist and will feedback to Reception managers any concerns as well as any examples of good practice.</p>	Head of Operations and Head of Healthcare June 2020
3	<p>The Governor should review the current arrangements for induction to ensure:</p> <ul style="list-style-type: none"> <li>•There are sufficient numbers of trained staff to complete the BCS1;</li> <li>•Induction is managed more</li> </ul>	Accepted	<p>Following a review of induction processes additional staff have been trained and are now in place to complete the BCS1. There is also an additional manager to oversee induction processes and to ensure that prisoners can be inducted and located in a timely manner.</p> <p>The times for arriving into and leaving reception is noted on the reception paperwork and monitored by the Head of Operations who feeds back to the</p>	Head of Operations And Head of Offender Management Completed

**Action Plan – Mr Daryl Brimfield at HMP High Down – Self-Inflicted Death on 29/08/2019**

<b>No</b>	<b>Recommendation</b>	<b>Accepted/ Not Accepted</b>	<b>Response</b>	<b>Target date for completion and function responsible</b>
	efficiently to reduce time taken locating prisoners; •Assessors have easy access to computer systems; and •Assessors adopt 'best practice' and consult prisoners' records.		Senior Leadership team and reception managers.  Additional computer points have been installed in the Offender Management Unit (OMU) to make it easier for staff to access relevant documents and information. In November 2019 OMU staff were briefed via line management and in team meetings to consult all relevant documents when completing the BCS1.	
4	The Head of Healthcare should review: •Review the training of clinical staff in depression identification; •Introduce a brief checklist of questions and observations to exclude suicide risk; and •Ensure that prisoners with mental health concerns are assessed within the required timeframe.	Accepted	All clinical staff completed online training in depression identification in October 2019 and new clinical staff receive training as part of their induction process.  A checklist was introduced in August 2019 including questions relating to suicide and self-harm and this is quality assured by the healthcare performance lead  There is now a Duty Mental Health worker on site daily and all urgent mental health referrals are seen immediately.  A mental health pathway was implemented in October 2019 and assessments are carried out within 72 hours.	Head of Healthcare Completed
5	The Head of Healthcare should ensure that there are sufficient prescribers available during evening reception and that there are no unnecessary delays in prescribing	Accepted	There are additional nurse prescribers in addition to the duty doctor. A rota/on call system is being implemented to cover evening reception and should be embedded by July 2020.	Head of Healthcare July 2020

**Action Plan – Mr Daryl Brimfield at HMP High Down – Self-Inflicted Death on 29/08/2019**

<b>No</b>	<b>Recommendation</b>	<b>Accepted/ Not Accepted</b>	<b>Response</b>	<b>Target date for completion and function responsible</b>
	medications to new receptions.			
6	The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.	Accepted	A Governor's Information Notice (GIN) is due to be issued to all staff in June 2020 reminding them of the circumstances in which resuscitation is appropriate.	Head of Safer Custody and Head of Healthcare June 2020
7	The Governor should ensure that: <ul style="list-style-type: none"> <li>•Cell conditions are properly checked and documented;</li> <li>•Repairs are promptly reported and fully documented and that there is a clear audit trail showing when the fault has been reported and when it has been resolved;</li> <li>•Prisoners are not placed in cells that do not meet the minimum requirements, in accordance with PSI 17/2012; and</li> <li>•Staff always challenge</li> </ul>	Accepted	<p>Managerial decency checks were implemented in August 2019 to ensure that all cell conditions are decent. A visual check of cells is now carried out daily at unlock and Accommodation Fabric Checks are carried out weekly. The Deputy Head of Residence is responsible for overseeing this and checks all spaces including out of order and damaged cells to ensure that they have been reported and that work is completed as soon as possible.</p> <p>A GIN relating to cell decency will be published in June 2020 reminding staff to complete cell checks and promptly report and document any repairs. The notice will also remind staff to challenge prisoners about any items attached to cell doors. Staff challenge prisoners and request that any items attached to the cell door are removed, this is done through the Incentives and Earned Privilege process. If staff have any concerns over suicide/self-harm they should consider whether opening an ACCT is appropriate and can refer to the Safer Custody team if necessary.</p>	Head of Residence June 2020

**Action Plan – Mr Daryl Brimfield at HMP High Down – Self-Inflicted Death on 29/08/2019**

<b>No</b>	<b>Recommendation</b>	<b>Accepted/ Not Accepted</b>	<b>Response</b>	<b>Target date for completion and function responsible</b>
	prisoners about items attached to a cell door and remove them.			
8	The Governor should share this report with Officer A and B and arrange for a senior manager to discuss the Ombudsman's findings with them.	Accepted	The Head of Safer Custody has shared the report with Officer A and B and discussed the Ombudsman's findings.	Head Of Safer Custody Completed