

**Action Plan – Mr Alan Doward at HMP Manchester – Self Inflicted on 19/01/2019**

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	<p>The Governor and Head of Healthcare should produce clear guidance about procedures for identifying prisoners at risk of suicide and self-harm. In particular, this should ensure that reception, healthcare, first night staff and all others who assess risk:</p> <ul style="list-style-type: none"> <li>•Have a clear understanding of their responsibilities and the need to share all relevant information about risk.</li> <li>•Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide and self-harm, including information from the Person Escort Record (PER) and other sources.</li> <li>•Document the information considered and the reasons for the decision on whether or not to open an ACCT.</li> </ul>	Accepted	<p>All staff have been reminded, via a Notice to Staff, of the requirements of PSI 64/2011(Management of prisoners at risk of harm to self, to others and from others) and PSI 07/2015 (Early days in Custody) in regard to decision making, information sharing and recording.</p> <p>Reception and First Night staff have received training in module one of the Suicide and Self Harm (SASH) awareness training package to enable them to identify risks and triggers for newly arrived prisoners.</p> <p>Signage that explains and identifies risks and triggers has been displayed across the establishment, including Reception and the First Night Centre.</p> <p>A new electronic ACCT assurance process has been implemented that requires managers to interrogate ACCT documents and highlight any poor quality practice. This will be quality assured by the Safer Custody manager and any remedial actions or further training needs will be identified and actioned.</p> <p>Healthcare staff are located in Reception throughout the period that prisoners return from court and all returning prisoners are seen by Healthcare before being relocated back onto the wings. Prisoners returning from court with a change of status form must be seen by Healthcare and a nurse's signature is required on the change of status form, a copy of the form is placed in the prisoner's wing file. Reception staff have been briefed on this requirement.</p> <p>A management check to give assurance around this process will be added to the Reception Manager's Check log.</p>	Completed Head of Safer Custody, Reception Manager and Head of Healthcare

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2	The Head of Healthcare should ensure that all prisoners with a history of mental ill health and/or self-harm are properly identified, reviewed and referred for a primary mental health assessment.	Accepted	<p>The Reception Screening Tool has been amended to reflect the recommendation that all prisoners with a history of mental ill health and / or self-harm are appropriately reviewed and referred to the Mental Health In-reach Team for assessment. The screening tool now includes a link to the list of risks and triggers for staff guidance.</p> <p>Staff have been informed that they must copy any paperwork that highlights risks to the screening tool, including Prisoner Escort Records.</p> <p>An e-mail has been sent to all staff reinforcing the need to adhere to the above actions.</p>	Completed Head of Healthcare
3	The Governor and Head of Healthcare should ensure that staff are given clear guidance and check their understanding about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.	Accepted	<p>A Notice to Staff has been issued giving guidance to staff regarding the appropriate use of CPR, and the circumstances where it is not appropriate.</p> <p>Training for all staff on resuscitation will be included in the regular 'Lock Down Training Mornings' and will be completed by December 2019.</p>	December 2019 Head of safer Custody and Training Manager
4	The Governor should ensure that all relevant staff, including healthcare staff, are invited to the debrief following a death in custody.	Accepted	<p>All managers have been advised of the requirement to complete a hot debrief promptly after a death in custody and make a note of the people attending.</p> <p>Guidance has been provided by the Long Term High Security Wellbeing Strategy Manager.</p>	Completed Head of Safer Custody

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			Two members of staff attended a training session for trainers in hot debrief in August 2019.	