

Action Plan – Mr Liam Murray at HMP Durham – Self-Inflicted death on 14/01/2020

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
			<p>competency assessments for clinical staff operating within the reception process. This will be inclusive of working with Liaison and Diversion services to support with the sharing of risk information at an early opportunity to help men during their initial days in custody.</p> <p>A defensible decision-making training session will be rolled out across the healthcare service and will include professional responsibility, accountability and record keeping.</p>	
2	The Governor should ensure that key workers are aware of what is expected of them in their key working role and that key workers take proactive steps to help resolve issues prisoners raise with them.	Accepted	All prison officers have now undertaken Keyworker and Five Minute Intervention (FMI) training. This now forms part of Prison Officer Entry Level Training (POELT) for newly recruited staff. Those staff at Durham who were already employed have received the training on site. This training ensures that staff are fully aware of the expectations of the keyworker role in encouraging prisoners to make the best of the opportunities available to them and help them build confidence with a sense of self-awareness, as well as to provide support on an individual basis with issues beyond a prisoner's control.	Head of Residence Completed
3	The Governor should share this report with the Officer and ensure that a senior manager discusses the Ombudsman's findings with him.		The named officer has been spoken to by the Head of Safer Custody and the contents of the PPO report discussed.	Head of Safer Custody Completed
4	The Head of Healthcare should ensure all prisoners are offered a Secondary Reception Screen	Accepted	A baseline audit will be completed to assess the uptake of secondary screenings and establish any root cause for patients not having or being offered second reception screens. Service user feedback will also be sourced.	Head of Transformation January 2021

Action Plan – Mr Liam Murray at HMP Durham – Self-Inflicted death on 14/01/2020

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
	in line with Nice Guidance NG57.		An action plan will be generated on established lessons to be learnt.	
5	The Manager for Mental Health Services should review the assessment process to ensure that staff review the prisoner's medical record prior to assessment and that care plans are documented following assessment.	Accepted	<p>The mental health triage and assessment processes have been reviewed. A Mental Health or Learning Disability Nurse is now based in reception and all patients referred into the team are offered a face to face triage within 24 hours, which includes a discussion on current and previous engagement with services. A formal process is also in place to allow both regional community mental health trusts to review each system, with information being reviewed and returned within 24 hours.</p> <p>Following triage and where required, comprehensive assessments are undertaken and care planning is completed in line with organisational policy for patients taken onto the caseload.</p> <p>Where urgent assessments are required, the review of available records is undertaken through SystemOne/GP summary prior to attending and requests for community mental health records are made as urgent business.</p>	Mental Health Manager (TEWV) Completed