Action Plan – Darren Adams. HMP Lindholme. Self- Inflicted. 13/11/2017				
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**
1	The Governor and the Head of Healthcare at HMP Lindholme should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that: • staff consider all risk factors, including suicidal statements and access to lethal methods, when assessing a prisoner's risk; • healthcare staff attend all first ACCT case reviews; • staff do not record ACCT care map actions as complete until a prisoner's risk has been reduced; and • staff adhere to the frequency of observations set out in the ACCT document and that observations take place at unpredictable times	Accepted	All staff were reminded in July 2018, through the issue of an operational order, of the need to manage prisoners at risk of suicide and self-harm in line with the PSI. The requirement to consider all risk factors when assessing risk and that reviews should be multi-disciplinary will be re-enforced. Staff will also be reminded they must adhere to the required frequency of observations set out in the individual ACCT document and that these should be undertaken at unpredictable times. The Local Operating Procedure (LOP) for healthcare attendance at ACCT reviews will be updated and reissued to all staff in October 2018. The LOP will ensure that primary care nursing staff will attend in the absence of Mental Health staff when they not available, and that all first ACCT case reviews include a healthcare representative. All ACCT case managers have now undertaken the Suicide and Self-Harm (SASH) case manager training, which includes the need to ensure that all risk factors are considered when risk is being assessed, and that care map actions are fully completed before being recorded as such.	Head of Healthcare Head of Safer Custody Completed
2	The Governor at HMP Lindholme should ensure that when prisoners say they have ligatures, staff search them and their cells as soon as	Accepted	A Notice to Staff was issued in June 2018 reminding staff that they must take immediate action when prisoners say that they have ligatures, and that this is fully recorded in the relevant documentation so that the action can be evidenced.	Head of Safer Custody Completed

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	possible and remove any ligature. Until this is done, staff should constantly observe them and be ready to intervene immediately if necessary			
3	The Governor at HMP Lindholme should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that: • staff enter cells as quickly as possible in a life-threatening situation; • staff radio an appropriate emergency code; and • control room staff call an ambulance as soon as an emergency code is called.	Accepted	Staff were reminded through a Notice to Staff in June 2018 of their responsibilities during medical emergencies. The Notice will include the need to enter a cell as quickly as possible during potentially life threatening situations, subject to a dynamic risk assessment. This will be re-issued in November 2018. Refresher training in ERIC (emergency response incident codes) has been carried out and cards for guidance regarding the use of code blue and code red have been provided to all staff. The protocol for phoning for an ambulance immediately in an emergency was reissued in April 2018. This will be reinforced through staff briefings, the issue of ERIC cards and included within induction training for all new starters.	Head of Safer Custody Completed
4	The Head of Healthcare at HMP Lindholme should ensure that staff are competent in assessing rigor mortis and conditions unequivocally associated with death	Accepted	Over last six months all clinical staff have undertaken Immediate Life Support (ILS) training or been allocated a date to attend. The RCN guidelines on when not to resuscitate have been issued to all staff. Information regarding the decision to commence CPR has been shared with all staff through a discussion event and a copy of the supporting documentation is located in the emergency response file in each	Head of Healthcare: Completed

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			treatment area. Staff are compliant with ILS training and are attending their annual refresher training.	
5	The Head of Healthcare at HMP Lindholme should ensure that healthcare staff complete medical records in line with the General Medical Council and Nursing and Midwifery Council's guidance, recording full details of care plans and referrals.	Accepted	All staff will be reminded of their responsibilities in line with the code of conduct. Record keeping training sessions will be provided to all clinical and administrative healthcare staff. Audits on record keeping are now part of Care UK's Protect Audit schedule and will be carried out to ensure compliance.	Head of Healthcare: October 2018
6	The Governor at HMP Lindholme should ensure that all managers follow the national guidelines for dealing with a death in custody or serious incident, including that: • all staff, including staff who are members of the care team, are offered appropriate and timely support from someone unconnected to the incident; and • a debrief is held promptly after the death of a prisoner and that all staff, including healthcare staff, are invited.	Accepted	A duty care team is in place in line with national guidelines, with a published rota which offers support to all staff at HMP Lindholme. Further recruitment will take place to ensure there is a wider pool of people to call upon, in the event that those on duty within the care team have been involved in the incident. A new monthly meeting for the Careteam and FLO will be introduced in November 2018. This will be led by the Head of Safety, who is also the Regional Lead for Careteam. This will ensure Careteam at Lindholme is well managed and developed Debriefs are held after an incident to which all staff, including healthcare are invited. The duty Careteam member also attends. However, if staff are unavailable due to being distressed and have	Head of Safer Custody Completed

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			gone home, the duty care team will follow this up. When they are next on duty the Head of Safety and Equality will contact them personally and provide support where required.	
7	HMPPS should ensure that when lost data contains information about a prisoner whom it may be possible to identify, and which may pose a risk to the prisoner's safety, the prison is advised to consider notifying the prisoner of the loss.	Accepted	The Safer Custody Casework Team (SCCT) are working with colleagues in data compliance to ensure that prisons are advised of the need to consider notifying a prisoner of a data loss where they could be identified and put at risk as a result. Progress against this recommendation will be monitored and the PPO update in September 2019.	Safer Custody Casework Team September 2019
8	The Governor at HMP Garth should ensure that all prison staff are made aware of and understand the local violence reduction policy and their responsibilities, including that: • staff support and protect victims; and • staff take appropriate measures against perpetrators to address violent or antisocial behaviour.	Accepted	A new safety framework is being introduced at HMP Garth, its basis will be the 5 P's, People, Physical, Population, Partnerships and Procedural. The main intervention for challenging violence will be the Challenge Support Intervention Plan (CSIP). This is a case management approach to addressing violent offenders, the emphasis is on setting targets for improvements in an offender's anti-social behaviour and supporting them to achieve this. These changes will be introduced with staff training/awareness sessions, team meetings and briefings and communication via the email and intranet systems. Victims of violence are now supported under the new Challenging Anti-social Behaviour Support (CAB) document which was introduced in February 2018.	Head of Safer Prisons and Equalities Completed

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9	The Governor at HMP Garth should ensure that when a prisoner expresses concerns about moving prisons, those concerns are identified and addressed before the transfer is completed.	Accepted	All Offender Management Unit staff have been briefed via email and through staff meetings that should a prisoner raise concerns about a pending or potential transfer, these concerns must be fully investigated prior to a transfer taking place, the aim being to mitigate or allay concerns wherever possible, up to and including the potential to rearrange or cancel the move should the concerns be proven to provide an insurmountable level of risk. Considerations and actions taken will be documented and communicated to the receiving prison and, where possible and safe to do so, to the prisoner himself.	Head of OMU Completed