Action Plan – Gareth Levi Frew. HMP Exeter. Self- Inflicted. 18/10/2017				
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**
1	The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular, that: a. Case reviews are multidisciplinary, include all those involved in a prisoner's care and that healthcare staff attend all first case reviews. b. Staff read the ACCT document and familiarise themselves with all relevant issues and known risk factors before holding reviews and ACCT case reviews should assess and record the level of risk, taking into account all risk factors. c. The frequency of observations reflects the prisoner's risk and is adjusted when that risk changes. d. There are procedures in place to check the quality of ACCT procedures, identify bad practice, learn lessons, and where appropriate, provide staff refresher training on suicide and self-harm prevention procedures e. All newly promoted supervising officers receive the national ACCT case manager training as soon as possible.	Accepted	All staff will be reminded of the importance of multi-disciplinary attendance at ACCT case reviews by those involved with the prisoner's care, and the need for healthcare attendance at the first case review and subsequent case reviews where appropriate, and that a written contribution should be provided where an attendee cannot be present. The Head of Residence and Safety will provide verbal briefings and electronic briefings, and review management check feedback. In addition, the Safer Custody database is shared daily by the safer custody team with all staff. The database records which prisoners require ACCT case reviews, and confirms that Healthcare attendance (or failing that, a contribution) is required for all first ACCT case reviews. The monthly Safer Custody data analysis report, shared with the Governor, analyses ACCT reviews and compliance with this requirement. Any first ACCT case reviews which do not appear to have healthcare contributions or attendance are explored further by the Head of Residence and Safety with the ACCT case manager. All Case Managers will be subject to regular supervision sessions which will conducted by the Head of Safety and the Safer Custody Custodial Managers (CMs). These supervision sessions will cover the case manger's understanding of the need to ensure all risks and issues are considered in determining the level of risk, and that this consideration must be documented. The sessions will also look at level of observations	Head of Safety September 2018. Head of Health Completed

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	f. Clinical staff review ACCT documentation frequently and in particular, that mental health staff consult and review ACCT documentation at each contact with a prisoner and make a detailed contemporaneous record of their consultation with the prisoner in both the medical records (SystmOne) and the ACCT document		set, and the need to adjust observations when there is any change to the risk presented. Additionally, a separate verbal and written briefings have been issued to all case managers by the Head of Safety to remind all of the importance of familiarising themselves with the known risks and the need to ensure observations reflect the prisoners risk. A daily ACCT management check process has been reintroduced. This management check process is multi-disciplinary and involves managers from across the functions. Feedback is given to the Safety team and any non-compliance will be challenged and actioned. Case Manager training has been delivered, with only one Case Manager now awaiting training, and will be delivered on an ongoing basis as and when required. Mental health staff will consult and review the ACCT record and record contemporaneous notes within the ACCT document summarising their interactions to inform colleagues as well as within the SystmOne notes.	
2	The Governor should ensure that the personal officer policy is effective in providing meaningful support to prisoners,		The Keyworker scheme is currently being rolled out, and at present all prisoners have an allocated keyworker. The key worker is a residential prison officer who provides regular one to	Head OMU March 2019

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	particularly in relation to the identification, discussion and recording of significant events, and that contacts take place at a frequency in line with the policy.		one engagement with a small prisoner caseload, to support, challenge and guide them through their sentence. Policy indicates that all prisoners should have 45 minutes per week contact time and that this is recorded accordingly. This scheme has replaced the personal officer role which is now obsolete.	
3	The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use the appropriate emergency medical code to communicate the nature of the emergency effectively.	Accepted	All staff have now been issued with a pocket guide to emergency response codes. A notice to staff has also been published to remind all staff about the need to use emergency medical codes in line with the national instruction and the local protocol, and that control room staff call an ambulance immediately when an emergency medical code is received, without waiting for further confirmation. This will be repeated in response to a number of new staff that have begun since this was last carried out.	Head of Residence / Safety October 2018
4	The Head of Healthcare should ensure that staff contact the prison's mental health team to request an urgent assessment if they identify that a new prisoner has significant mental health issues.	Accepted	A new referral template will be developed for staff to use on SystmOne that allows for urgent referrals to be identified, and for this process to be audited.	Head of Health July 2018
5	The Head of Healthcare and the Governor should review the provision of mental health services to ensure there is adequate cover throughout the week, including on	Accepted	A consultation process is currently underway into the provision of mental health services, including over the weekend, following which it is anticipated 7 day per week provision will be in place.	Head of Health August 2018

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	Sundays, and address the apparent anomaly that commissioned services are not available when they should be.			