

Action Plan - Mr Shaun Dewey - HMP Bristol – Self Inflicted on 13th April 2018

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 and for managing and supporting them. In particular, this should ensure that all staff who assess risk:</p> <ul style="list-style-type: none"> • have a clear understanding of their responsibilities and the need to share all relevant information about risk; • consider and record all known risk factors for a prisoner when determining his risk of suicide and self-harm; • document the information considered and the reasons for the decisions taken; and • start ACCT procedures whenever a prisoner has significant risk factors, irrespective of their stated intentions. 	Accepted	<p>A notice to staff was published in February 2019 reminding staff to communicate concerns to the Residential Manager and open an ACCT if they receive information or observe changes in the risk that an individual may pose to themselves. The identification and management of prisoners at risk of suicide and / or self-harm is the responsibility of all members of staff.</p> <p>Multi-disciplinary ACCT case reviews ensure the people involved in a prisoner’s care are invited where relevant. All known risk factors are considered when determining the level of risk of self-harm and appropriate levels of observations and conversations are set to reflect the identified risk This is documented within the ACCT.</p> <p>Weekly Safer Custody Quick Time Learning bulletins have been sent by email to remind all staff of the following; ACCT handover, Listeners scheme, effective caremap guidance, observations and conversations guidance, opening an ACCT and attendance at ACCT reviews, In addition National Safety Bulletins are shared with all staff.</p> <p>The Safety newsletter was published in July 2018 covering guidance about sharing information in relation to wing observation books.</p> <p>All ACCT case managers have attended the mandatory ACCT case manager training, which reminds staff of the need to ensure all known risk factors are considered and recorded and all staff have attended the mandatory suicide and self-harm (SASH)</p>	Safer Custody / Head of Healthcare Completed

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			<p>training. This is delivered by national trainers ensuring a consistent approach and quality of delivery throughout the Service.</p> <p>Healthcare ensure that all staff are briefed on the ACCT requirements at induction and are required to attend the prison SASH training within 3 months of starting their role.</p> <p>The Mental Health team will endeavour to attend all first ACCT case reviews, share all relevant information about risk, document their input on the ACCT record and make a contemporaneous note on the Healthcare medical records system (SystemOne).</p> <p>An ACCT learning booklet for healthcare staff has been developed and is due to be implemented across the service. The booklet includes guidance on areas to consider when determining the risks of self-harm or suicide and documentation requirements for healthcare staff.</p> <p>Safer custody provide a supervisory approach to all case managers to give support, critical friend analysis and honest reflection on their ACCT case management and where issues are identified additional support is given in the form of advice and guidance or one to one mentoring until case management is considered to be up to the required standard.</p>	
2	The Governor should ensure that staff record behaviour that is out of character or unusual for a prisoner and	Accepted	A Local Notice to Staff was published in February 2019 reminding staff that if they receive information, or observe changes in a prisoner's behaviour, which indicates a change in the risk they may	Safer Custody completed

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	that it is discussed at the next shift handover.		<p>pose to themselves, they must communicate their concerns immediately to the Residential Manager and open an ACCT.</p> <p>A Quick Time Learning bulletin was also sent to all staff in February 2019 reminding them about the importance of recording out of character or unusual behaviour so that this can be discussed at handover. Observation books are used to record pertinent information and to brief staff at each shift handover.</p> <p>In instances when an ACCT is not opened this must be documented in NOMIS case notes and the wing observation book, which ensures that this information is discussed as part of the handover procedure.</p> <p>Safer Custody carried out weekly staff briefings during February and March 2019 to promote understanding about the importance of identifying and recording information about changes in behaviour.</p>	
3	The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of a prisoner's safety and welfare and that there are no matters that need immediate attention.	Accepted	<p>A local notice to staff was re-published in February 2019 reminding staff of their responsibilities to check the wellbeing of men when cell doors are unlocked and that there are no immediate issues that require attention.</p> <p>A Quick Time Learning Bulletin covering welfare checks was also issued in February 2019 to all staff and will be re-published regularly as a reminder.</p>	Safer Custody May 2019

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			<p>Regular briefings are used to reinforce staff responsibilities when unlocking prisoners to satisfy themselves of the prisoner's safety and welfare.</p> <p>The frequency of roll checks is being reviewed in May 2019 to explore if they need to be increased.</p> <p>The Safety newsletter will maintain a focus on staff responsibilities for checking welfare when unlocking cell doors. A safety newsletter was issued in July 2018 covering this issue.</p>	
4	<p>The Governor and Head of Healthcare should ensure that when a mental health referral is received, a member of the mental health team assesses the prisoner and where they decide not to accept a prisoner on to their caseload, their reasons are clearly documented.</p>	Accepted	<p>A standard referral process has been put in place to manage all referrals into the Mental Health service.</p> <p>All incoming referrals are screened by the Mental Health co-ordinator and allocated according to priority. An assessment is undertaken where appropriate and the Healthcare medical records system (SystemOne) is updated to document the assessment undertaken and the outcome of the referral. The referrer is notified of the outcome of the referral.</p> <p>A notice to prison staff informing them of the referral process has been issued.</p>	Head of Healthcare Complete
5	<p>The Governor and Head of Healthcare should ensure that staff explore why prisoners have not collected their medication and that alternative measures for them to receive their</p>	Accepted	<p>There is a standard operating procedure (management of missed doses/ did not attend SOP) in place to follow up on prisoners that have not collected their medications and this has been issued to all staff involved in the administration of medications.</p>	Head of Healthcare Complete

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	<p>medication are put in place, where necessary.</p>		<p>An audit has been undertaken to assure compliance, and the outcomes and learning from it have been shared with staff. We will continue to audit this on a regular basis.</p> <p>In order to ensure the safe administration and management of medications within the prison environment, the standard process is to encourage prisoners to attend the medication hatch for collection of their medication. Where prisoners have expressed difficulties/ vulnerabilities, healthcare will make an arrangement with the prison to enable collection at the beginning or the end of the medication round.</p>	