

Action Plan – Mr Charlie Edward March at HMP Bure – Self-Inflicted Death on 17/05/2020

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
1	The Governor and Head of Healthcare should ensure that all staff are aware that they should take account of a prisoner's risk factors and previous behaviour when assessing risk and should not rely on a prisoner's assertions that he has no thoughts of self-harm.	Accepted	<p>Suicide and Self-Harm (SASH) training is delivered to all staff on a rolling basis and provides guidance on the ACCT process, including the importance of reviewing a resident's risk factors and taking into account previous behaviour when assessing risk. The implementation of ACCT Version 6 is currently underway and the updated SASH training will be delivered to all staff from July 2021.</p> <p>Two SASH training sessions were held in April 2021 for healthcare staff which included guidance on the procedure for opening ACCTs and the need to take into account any risk factors and previous behaviour when assessing a resident's risk. Healthcare work closely with safer custody and attend all relevant meetings held by the prison to assist with assessing risks. The Mental Health team also attend all ACCT reviews and to ensure a multi-disciplinary approach.</p>	<p>December 2021 Head of Safety and Head of Business Assurance</p> <p>Completed Head of Healthcare</p>
2	The Governor should ensure that staff consider opening Enhanced ACCT Case Management procedures where there has been a pattern of serious self-harm.	Accepted	<p>Any residents that are thought to be at risk, or have complex needs, are discussed at the Multi-Professional Complex Case Clinics (MPCCC). Any decision to implement enhanced or complex case management procedures is subsequently discussed at the Safety Intervention Meeting (SIM) to ensure that all relevant information is shared. All Case Managers are aware of the process to escalate an ACCT to the SIM to discuss enhanced case management and clear instructions on this are delivered during the ACCT training and also through regular briefings.</p> <p>Staff were reminded through a notice to staff in December 2020 that residents who are presenting in crisis, displaying changes in behaviour, or where there</p>	Completed Head of Safety

Action Plan – Mr Charlie Edward March at HMP Bure – Self-Inflicted Death on 17/05/2020

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
			<p>has been serious self-harm, should be referred to the SIM where this will be discussed and the decision is made whether enhanced ACCT monitoring should be initiated.</p> <p>When a new ACCT is opened, the Safer Prisons Business Administrator (BA) compiles an analysis of all the individual's previous self-harm, any previous ACCT history, and other relevant risk information. This is then shared with the Case Manager to ensure that enhanced ACCT case management is considered where appropriate.</p>	
3	The Head of Healthcare should ensure that staff are aware that prisoners can continue to work when they are subject to ACCT monitoring.	Accepted	All healthcare staff were informed during two SASH training sessions held in April 2021 that residents may continue to work when they are subject to ACCT procedures. This was also discussed with individual staff during regular handovers by team leaders.	Completed Head of Healthcare
4	The Governor should share this report with SO A and arrange for a senior manager to discuss the Ombudsman's findings with him.	Accepted	The initial report was shared with the member of staff in November 2020 during meetings with both his line manager and the Head of Safer Prisons where the Ombudsman's findings were discussed.	Completed Head of Safer Prisons
5	The Head of Healthcare should share this report with Nurse A and discuss the	Accepted	This was shared and discussed with the staff member in November 2020 by the Mental Health Lead to ensure oversight and understanding. All PPO reports	Completed Mental Health Lead

Action Plan – Mr Charlie Edward March at HMP Bure – Self-Inflicted Death on 17/05/2020

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
	Ombudsman's findings with her.		and outcomes are now available to all healthcare staff to be able to view and to discuss, for learning purposes.	