

Action Plan – Simon Mellors. HMP Manchester. Self-Inflicted. 25/02/2018

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	<p>The Governor of Nottingham should ensure that staff assess and manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular that:</p> <ul style="list-style-type: none"> • The assessment of risk takes account of all the prisoner's circumstances and risk factors and not just their personal presentation. • ACCTs are not closed where it is known a prisoner will be transferring. 	Accepted	<p>Since February 2018, the ACCT Case Management model has been introduced at HMP Nottingham and all staff who carry out ACCT case reviews have now received ACCT Case Manager training. This training focuses on how to assess risk in order to ensure that all of the prisoner's circumstances and risk factors are considered and that decisions are not based on personal presentation alone. The model also ensures a consistent approach and accountability for case reviews and the overall management of the ACCT process. It is overseen on a daily basis by the Orderly Officer.</p> <p>Under the ACCT Case Management model, the daily operational report lists all open and post-closure ACCTs. The Orderly Officer and the Safer Custody Team, will ensure that all scheduled reviews, including post-closures, have been carried out each day. The Safer Custody Team are also responsible for checking that when a prisoner on an open ACCT or within the post-closure review period transfers a full handover is provided to the receiving establishment and that a case review is carried out in reception prior to their transfer.</p>	Head of Safer Prisons and Equality Completed
2	<p>The Governor of Nottingham should review the operation and management of the ACCT process to ensure that information is accurately recorded and that staff share information to provide collaborative care.</p>	Accepted	<p>A review of the operation and management of the ACCT process at HMP Nottingham has been undertaken, and a review of the Case Management process carried out by the Regional Safer Custody team.</p> <p>Since 29 July 2018 specially trained Safer Custody staff interview every prisoner who arrives at HMP Nottingham in reception, to ensure effective sharing of relevant information and provision of collaborative care. The interview covers all relevant risk factors and also considers relevant health</p>	Head of Safer Prisons and Equality Completed

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			<p>information as well as self-harm warning forms. At this point, a risk-based decision is made whether or not to open an ACCT.</p> <p>The ACCT process as a whole is robustly managed and overseen by the Head of Safer Prisons and Equality and the Safer Custody Team. When a prisoner is due to transfer the Safer Custody team will also check NOMIS, the operations report and the ACCT register to determine the status of an ACCT and ensure that the information passed to the transfer prison is accurately recorded.</p>	
3	<p>The Governor of Nottingham should ensure that:</p> <ul style="list-style-type: none"> • ACCT caremaps have specific, meaningful and time bound actions, aimed at reducing prisoners' risks to themselves, progress should be considered at each review and the caremaps updated if additional needs are identified. • Case reviews assess the risk of suicide or self-harm based on all available information and known risk factors and set a level of observations which reflects that risk. 	Accepted	<p>The review of the ACCT Case Management process carried out by the Regional Safer Custody Team in June 2018 resulted in a number of recommendations being made in order to improve current practice. These recommendations will now be implemented and further guidance issued to Case Managers to provide assistance and support when completing caremaps and to ensure that actions are reflective of risk and updated at each review to record progress and any additional needs. There will also be a focus on Quality Assurance (QA) and additional guidance provided to individual case managers where required. Good practice examples will also be shared.</p> <p>All ACCT Case Managers have now also had Case Manager training, which includes how to properly assess risk based on all available information and how to set appropriate levels of observations and interactions for prisoners at risk of suicide or self-harm</p>	Head of Safer Prisons and Equality November 2018

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4	The Head of Healthcare at Nottingham should ensure mental health assessments take into account all relevant information, including any previous mental health diagnosis, use standard mental health assessment tools, and assessment and treatment are in line with NICE guidelines.	Accepted	<p>Both the PPO and Clinical Review reports will be shared/reviewed with the Mental Health team as part of a CPD (Continuous Professional Development) reflective session.</p> <p>The Head of Healthcare will also advise all team members of the recommendation, to remind staff of the need to ensure that mental health assessments take into account all relevant information, including any previous mental health diagnosis, use standard mental health assessment tools, and assessment and treatment are in line with NICE guidelines. This will be via a global team email and a face-to-face reiteration at the daily handover meeting.</p>	Head of Healthcare October 18
5	The Governor of Manchester and the Head of Healthcare should ensure that staff are aware of, consider and record all known risk factors and triggers for suicide and self-harm and open an ACCT where the prisoner has significant risk factors. When, exceptionally, they decide not to begin ACCT procedures for prisoners with significant risk factors, they should clearly record the reasons.	Accepted	<p>Suicide and Self- Harm training (SASH) is being delivered to all staff through an on-going programme of monthly training sessions and is due to be completed in September 2019. The SASH training includes information about the identification of risks and triggers for suicide and self-harm and guidance on when to open an ACCT. Staff are also reminded that decisions not to open an ACCT must be clearly recorded and the reasons for not doing so included. This training is also provided as part of the induction process for all new directly and non-directly employed members of staff.</p> <p>A Manchester information notice will also be issued to all staff highlighting how to appropriately identify triggers and alerts for suicide and self-harm and open an ACCT where prisoners have significant risk factors and decisions must be fully recorded.</p>	<p>Training Team September 2019</p> <p>Head of Safer Custody October 2018</p>

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			This information is also sent out as a GSI email on a weekly basis by the Safer Custody department.	
6	The Governor of Manchester should ensure that ACCT post-closure reviews are conducted in line with Prison Service instructions and should be held to check the prisoner's progress and to decide whether further monitoring is needed.	Accepted	<p>Guidance concerning post-closure reviews is being delivered as part of the on-going programme of SASH training and all staff will be detailed to attend during the next 12 month period.</p> <p>Assurance checks on post closure reviews will also be completed by a Band 5 member of the Safer Custody team to ensure that a 7 day review after initial closure is being completed in line with the requirements of the relevant PSI, and consideration has been given to further monitoring if required.</p>	<p>Training September 2019</p> <p>Safer Custody Completed</p>
7	The Governor and Head of Healthcare at Manchester should ensure that reception staff examine all available documentation about a prisoner and consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm.	Accepted	Training will be provided to all operational staff, reminding them of the need to examine all available documentation for any newly arrived prisoners on reception at HMP Manchester. This will ensure staff are aware of all known risk factors when considering the risk of suicide or self-harm. The requirement to record known risk factors will also be reinforced during the training.	Operational Governor Reception October 18

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8	The Head of Healthcare at Manchester should ensure that all healthcare staff are aware of the circumstances in which a mental health referral is appropriate, and make a referral when indicated.	Accepted	<p>All healthcare staff have been made fully aware of how to refer men to the mental health team.</p> <p>Inpatient staff now complete mental health assessments on all prisoners admitted to the inpatient unit.</p>	Head of Healthcare Completed
9	The Head of Healthcare at Manchester should ensure that all staff understand and are confident in using emergency call signs.	Accepted	<p>In May 2018 staff were issued with ERIC (Emergency Response In Custody) reminder cards. This card provides a prompt to staff regarding the use of either code red or code blue, in the event of a medical emergency. The ERIC card fits inside the housing of the staff ID cards so that they are accessible at all times.</p> <p>In September 2018 Governor's Order 11.2017 was reissued to all staff providing a reminder of the emergency response protocols to be used.</p>	The Governor. Completed
10	The Governor and Head of Healthcare at Manchester should ensure that a debrief is held promptly after the death of a prisoner and that all staff involved are offered effective support.	Accepted	<p>A Manchester information notice will be issued to staff about the appropriate times to complete relevant debriefs from incidents, particularly those involving the death of a prisoner.</p> <p>Senior Managers will have the information delivered in the operational meeting in September that after an incident where a death has occurred a hot debrief must be organised.</p> <p>Cold debriefs will be arranged by Safer Custody in collaboration with service providers in order to address issues from the incident.</p>	Head of Safer Custody Completed

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11	The Executive Director for the Long-Term and High Security Estate and the Prison Group Director for the East Midlands should assure themselves that meaningful action is taken to address our recommendations.		<p>Long Term and High Security The Group Safer Custody (GSC) team will work with the Safer Custody team at HMP Manchester in bi-monthly assurance and support visits. These visits will ensure that actions to address recommendations are implemented. Dip tests of archived actions will also be carried out to gain assurances around these being embedded and to ensure ongoing learning, which will form part of the Band 5 visit logs, which will feed into GSC quarterly visit reports.</p> <p>East Midlands All recommendations and actions will be entered on to the group's central consolidated action plan INSIGHT. The prison's progression against action plans will be monitored through, Safer Custody meetings, the Bi Lat process and the Group Quarterly Performance and Assurance Review. Once actions have been closed, the establishment's Performance and Assurance Manager will test processes to ensure that they are embedded and remain so. The Group Business Change Manager will review progress and ensure meaningful action has taken place.</p>	<p>Executive Director Long Term and High Security</p> <p>Prison Group Director East Midlands</p>