Action Plan – Mr Trevor Green at HMP Durham – Self Inflicted on 21/07/2020				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
1	The Governor should ensure that staff manage newly arrived prisoners in line with national guidelines, including ensuring that they: • assess all prisoners arriving in reception and check all accompanying documents to identify any immediate needs and risks; • provide all accompanying documents for any interviews or assessments taking place outside reception; and • base their assessment of a prisoner's risk of suicide and self-harm on the prisoner's known risk factors rather than their presentation or what they say.	Accepted	During November 2020, a number of measures were introduced to ensure that Reception staff are aware of their responsibilities when assessing a newly arrived prisoner's risk of suicide and self-harm and that they understand the importance of considering all available documentation as part of that process. A Suicide and Self-Harm (SASH) monitoring log has been introduced to record all those prisoners arriving into custody with a SASH warning form, including a log of the time of reception, whether an ACCT was opened and healthcare screenings. In all cases where a prisoner has arrived into custody with a SASH warning form, the Senior Officer (SO) must make a defensible decision as to whether they open an ACCT or not and record the outcome. This is to ensure that decisions take account of all available information and are not made on presentation alone. The Reception Custodial Manager (CM) also conducts a triangulated assurance process to ensure that all prisoners arriving with information to suggest they are at increased risk are supported appropriately. The Person Escort Record (PER), initial Cell Sharing Risk Assessment (CSRA), SASH forms and the vulnerabilities assessment carried out on arrival are now kept together in a file and handed on to anyone who is required to interview the individual, ensuring consistency regarding the sharing of information. Hard copies of PSI 64/2011 have been made easily accessible to all staff working in reception so that they can reference the list of risks and triggers it contains, as required. Excerpts from Chapter 3 - Risks and Triggers are also displayed in the Reception SO's office to assist with the identification of risk of suicide and self-harm during that part of the reception process.	Head of Operations/ Head of Healthcare Completed

Action Plan – Mr Trevor Green at HMP Durham – Self Inflicted on 21/07/2020				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
			The Reception SOs have been provided with a link that allows them to access the Safety Bulletins published by the National Safety team that highlight those who are deemed to be a heightened risk of self-harm and suicide in relation to those men who are received into HMP Durham. This includes transgender prisoners, licence recalls, foreign national prisoners who are, or are about to be held on an IS91 a form issued by Immigration Enforcement to prison authorities authorising detention under Immigration Act powers and those close to deportation. In order to help with the reduction of risk and assist with the settling-in period a welfare check has been introduced which now forms part of the Reception process. This check makes sure that prisoners have been issued with all necessary items to ensure decency, have had an opportunity to go through property and are able to maintain contact with their family. Information needed to help with adjustment to custody is also provided, including details of support available and how to access Listeners, Samaritans and staff.	
2	The Governor should share a copy of this report with SO X and ensure that a senior manager discusses the Ombudsman's findings with her.	Accepted	The member of staff has received a copy of the PPO report and a meeting has been held with the Head of Safer Prisons to discuss the findings.	Head of Safer Prisons Completed
3	The Prisons Group Director for Tees and Wear should write personally to the Ombudsman	Accepted	A letter has been sent from the Prison Group Director for Tees and Wear to the Ombudsman, setting out what is being done to improve staff understanding of	Prison Group Director Tees and Weir

Action Plan – Mr Trevor Green at HMP Durham – Self Inflicted on 21/07/2020				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
	setting out what he is doing to ensure that staff at Durham have a better understanding of the principles of risk assessment for suicide and self-harm.		their responsibilities when assessing the risk of suicide and self-harm at HMP Durham.	Completed
4	The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that: • a prison manager talks to a prisoner within an hour of the ACCT being opened; • the ACCT plan follows the prisoner around the establishment; • staff adhere to the frequency of observations set out in the ACCT document; and • staff in contact with prisoners receive appropriate ACCT training.		In December 2020 an urgent request was submitted to the Learning and Development team asking for case manager training to be delivered to those CMs and SOs that had not undertaken the most recent version of case manager training. This was delivered with the support of Tees and Wear Group Safety team. Case managers that had been identified as requiring additional support in improving quality were also provided with a one day refresher. In addition to focusing on risks and triggers for suicide and self-harm and the support management of the person in crisis, there was a greater emphasis on the process management of the document, including that concern and keep safe forms and immediate action plans should include time-bound actions. The need for the prisoner to be spoken to by a prison manager within an hour of the ACCT being opened and the importance of staff to adhering to the set frequency of observations as stated in the ACCT was also reiterated. To ensure that the ACCT document follows the prisoner wherever they go both internally and externally, all residential areas have a prominent roll board which highlights any prisoner who is subject to ACCT or Challenge and Support Intervention Plan (CSIP) support and a designated area for those documents	Head of Safer Prisons Completed

Action Plan – Mr Trevor Green at HMP Durham – Self Inflicted on 21/07/2020				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
			to be kept to allow easy access to any escorting officer. Staff have been reminded during briefings that they must check to ensure whether any prisoner moving from a wing is subject to these measures and if so that the documentation accompanies him. An assurance process is in place to monitor the quality of ACCT documents, including observation levels. The night Orderly Officer is responsible for monitoring all ACCTs opened that day to ensure that all immediate actions have been taken and that observation levels are appropriate to risk. This is then filed as a report to the Safer Prisons department and allocated case manager. The wing SO also carries out daily checks to ensure observation and conversation levels are adhered to, with further ad hoc checks undertaken by the unit CM. The Duty Governor also conducts a full quality assurance on one ACCT per day covering risk and triggers identification, quality of reviews and assessments, continuity of observation levels and monitoring of the caremap to ensure all risks have been effectively identified and actions taken. All directly and non-directly employed staff who are required to make contact with prisoners are expected to completed SASH modules 1-5 as a minimum. To ensure that this continues during COVID restrictions approval has been granted by the Learning and Development team to deliver SASH modules to partners using a digital platform and which includes an element of supervision which will be provided by the partner agency. Nationally, work is currently underway to roll out a revised version of the ACCT case management system during this year. Prior to going live, establishments	

Action Plan – Mr Trevor Green at HMP Durham – Self Inflicted on 21/07/2020				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
			will be supported with an awareness raising period in order to understand the changes made and the principles underpinning effective delivery of ACCT. Linked to the roll-out of the updated ACCT across the estate, HMPPS are also in the process of refreshing safety training. This includes modules on self-harm and suicide, and risks and triggers among other topics. Within this training, there will be an emphasis on the need for assessments of risk to consider all available information, rather than being reliant on presentation alone.	
5	The Director General of Prisons should amend Prison Service Instruction 03/2013 to reflect the national guidelines agreed between HMPPS and the Association of Ambulance Chief Executives.	Accepted	PSI 03/2013 will be amended to reflect the national guidance document agreed with the Association of Ambulance Chief Executives, and we will remind all Governors of the need for local procedures to include the requirement for staff on the scene to provide relevant information to the control room as soon as possible.	Safety Group July 2021
6	The Governor should ensure that all managers follow the national guidelines for dealing with a death in custody or serious incident, including that: • a debrief is held promptly after the death of a prisoner and that all staff that are involved are invited;	Accepted	The requirement to hold a hot debrief following a death in custody is now embedded in prison practice and forms part of the contingency plan. The Duty Governor is responsible for ensuring that anyone involved in the incident is invited to the hot debrief so that any immediate needs can be addressed and appropriate support provided. In addition, the Group Staff Support Lead makes contact with all staff to offer a second line of support. It is the responsibility of the Orderly Officer to capture the names of all staff involved in the incident so that Incident Report Forms can be completed without delay. The Safer Prisons team then issue an adapted statement form	Head of Safer Prisons Completed

Action Plan – Mr Trevor Green at HMP Durham – Self Inflicted on 21/07/2020				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
	• all staff directly involved in an incident should complete Incident Report Forms as soon as possible; and • all documentation, including any evidential telephone recordings, is retained and securely stored.		with the required methodology to the individual and this forms part of the chain of evidence. In November 2020 the Head of Safer Prisons reviewed and amended the chain of evidence procedures following a death in custody. This now includes an introduction with guidance to anyone managing or handling evidence. A Single Point of Contact (SPOC) is identified, who is provided with a list of documents that must be seized, along with CCTV, Body Worn Camera footage and audible telephone logs. There is also an adjoining table to record any documents that are not available, which is then escalated to the Head of Safer Prisons without delay to allow them to address the issue. Once all documentation is recovered, it is scanned and reviewed by the SPOC in its new format to ensure it is legible and there are full copies. All discs are also immediately reviewed by the SPOC to ensure they are workable copies. A second line of assurance is conducted by the Head of Safer Prisons prior to discs being located in the security chain of evidence and prior to any dissemination to interested parties. A record is also kept of any requests to access discs or scanned documents, including the date of the request, who requested it, which member of staff was responsible for sending it, when it was delivered, the method it was sent, either post or email, and the special delivery number or email address and recipient.	
7	The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to	Accepted	A copy of the report has been sent by email to all staff named within the document. The Safer Prisons team will also provide a hard copy to each member of staff and discuss with the individual any issues that have been highlighted.	Head of Safer Prisons/Head of Healthcare Completed

Action Plan – Mr Trevor Green at HMP Durham – Self Inflicted on 21/07/2020				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
	read the report at the initial stage in line with paragraph 1.11 of PSI 58/2010.			