Action Plan - Callum Stephenson - HMP Northumberland - Self- Inflicted - DOD 08/01/2016				
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**
1	The Director should ensure that all information about bullying and intimidation is fully coordinated and investigated; that those suspected of involvement are appropriately challenged and monitored; that staff consider whether victims are at increased risk of suicide or self-harm; and that apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situation.	Accepted	A notice to staff will be issued to remind staff of the importance of appropriate recording, investigation and management of acts or allegations of bullying, and the processes in place to tackle this behaviour. Staff have been reminded of the importance of submitting Information Reports (IR) where there are concerns regarding bullying. These reports are received by the Security Department, and the information disseminated in the daily briefings to the Senior Prison Custody Officers (SPCOs) who manage the residential units. Sharing this information ensures that the relevant SPCO can brief their unit staff to make them aware of any issues and follow it up through formal processes where appropriate. Where victims and perpetrators of bullying have been identified, the InSight process is used to set the actions, outcomes and measurements needed to support, manage and monitor these prisoners. Any member of staff who has concerns about a prisoner can raise an InSight referral, following which the Houseblock SPCO will interview the prisoner and make a decision whether to open an InSight plan. The InSight plan is tailored to challenge, support and manage the individual concerned, with consideration given to their individual needs, any increased risk of suicide and self-harm that the situation presents, and long-term solutions. In addition, every incident of violence is fully investigated by a unit manager, and a Violence Reduction Information Report form (VRIR)	Head of Residence August 2016

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			completed. This form contains information about the background of individuals concerned, a summary of the incident, issues arising, learns learned, areas of good practice identified and recommendations. The completed investigations are standard checked by the Director and all learning points are added to the safer custody continuous improvement plan which is reviewed in the monthly multi-disciplinary Safer Prison Strategy Meeting. In all instances alongside the above forms, the wing observation book and case-notes on PNOMIS will be completed and handovers will be given to in coming staff to ensure effective information sharing, and that staff are aware of situations that may potentially lead to an increased risk of suicide and or self-harm.	
2	The Director should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidance, including that: ▪ Staff appropriately assess, identify, consider and record all relevant risk factors when determining a prisoner's risk of suicide or self-harm, and begin ACCT procedures when indicated. ▪ ACCT case reviews are multidisciplinary where possible and include all relevant people involved in the prisoner's care, with healthcare staff attending all first case reviews.	Accepted	A new case manager training programme for all SPCOs and Senior Operational Managers will be designed and implemented during September 2016 to ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidance. This training will cover the need to identify and record risk factors, ensure case reviews are multidisciplinary, the need for reviews to consider factors around bullying where this is relevant, and the effective use of caremaps. Introduction to Safer Custody training is delivered to all new employed staff in the establishment as part of their training/induction and annual refresher training is mandatory for all staff.	Learning and Development Manager September 2016

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	▪ ACCT case reviews fully consider and record the implications for managing the risks of prisoners suspected of being bullied and intimidated ▪ ACCT care-map actions are specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated as necessary and that all actions are completed before an ACCT is closed.		All open ACCT documents are currently audit standard checked each week by the Safer Custody Manager and immediate feedback is given to the relevant staff and/or case-manager. 10% of all closed ACCT documents are audit standard checked each week by the Safer Custody Manager. A summary of feedback is given monthly to all case-managers in the establishment.	
3	The Head of Healthcare should ensure that all important information about prisoners' health and appointments is entered in SystmOne and that nurses adequately review newly arrived prisoners' SystmOne records to ensure appropriate continuity of care.	Accepted	All prisoners entering the establishment receive a full health screen in reception, which will include a review of SystmOne records where available. Any appointments required are made in reception and are entered onto SystmOne. These appointments include virtual clinics for the GP to do medication reviews on all new prisoners and a virtual clinic for all prisoners with long term conditions. This will be reviewed by the practice nurse and the prisoner will be referred appropriately should they need continuing care Reception screening is continually reviewed with all providers to ensure appropriate continuity of care. All staff are made aware of the process during their induction, and new staff will shadow experienced staff in reception until they feel confident in the process.	Head of Healthcare August 2015

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4	The Director should ensure, in line with PSI 64/ 2011, that a manager debriefs all the staff involved in a death at the prison immediately after the emergency response, and offers appropriate support.	Accepted	The Head of Residence will issue a staff information notice (SIN) to all staff regarding incident debriefs and their individual responsibilities post incident. Specific guidance will be issued to orderly officers and operational senior managers detailing their responsibilities to ensure that staff are debriefed immediately after the emergency response following a death in custody to ensure they are offered the appropriate support.	Head of Residence August 2016