

Action Plan – Mr Kieron Simpson. Self-Inflicted. HMP Manchester. 02/05/18

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	<p>The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, in particular that they:</p> <ul style="list-style-type: none"> • complete ACCT care maps to include specific, meaningful and time bound actions, aimed at reducing prisoners' risks to themselves, consider progress at each review and update the care maps if additional needs are identified; • assess and record risk at each review, especially when an ACCT is reopened, and clearly document the reasons for any change in risk; and • Hold a post-closure review within seven days of closing an ACCT. 	Accepted	<p>A review of the ACCT Case Management process was carried out by the Safer Custody functional head in October 2018. The recommendations made are now being implemented in order to improve current practice. Further guidance was emailed to all Case Managers in December 2018, to provide assistance and support to staff when managing the ACCT process and completing care maps. The guidance reminds staff that care map actions must be reflective of risk, specific, meaningful and time bound and must be updated at each review to ensure that progress is recorded and any additional needs identified.</p> <p>The step by step guide also outlines “what needs to happen” and “who needs to do what” to ensure that risk is assessed and recorded at each review, including when an ACCT is reopened and in relation to ACCT post closure reviews, stipulating that this must be held within seven days of closure.</p> <p>Assurance checks on post closure reviews have been introduced and are 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.</p> <p>There will also be a focus on Quality Assurance (QA) and additional guidance will be provided to individual case managers where required. Good practice examples will also be shared at quarterly meeting held with other establishments within the Long Term and High Security estate.</p>	<p>Head of Safer Custody February 2019</p>

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2	The Governor should ensure that all incidents of violence are investigated in accordance with PSI 64/2011 and Manchester's own Violence Reduction Policy, including providing feedback on the investigation to the victim and ensuring that details of the investigation are appropriately documented.	Accepted	<p>The local Violence Reduction policy has been updated, and details the way in which acts of violence should be investigated, in line with PSI 64/2011. The updated version of the policy was issued to all staff via email in December 2018.</p> <p>All incidents of violence are now reported via the Incident Reporting system and a Challenge Support and Intervention Plan (CSIP) referral is completed. The Band 5 manager in the area of where the violence took place will be responsible for ensuring that relevant evidence is gathered in order to complete the investigation and that this is fully documented. They will also be responsible for making a decision on what level of intervention is required and for providing feedback regarding the investigation, with appropriate support given to those who are victims.</p>	Head of Safer Custody December 2018
3	The Governor should ensure that all prisoners have a single named member of staff assigned to them who supports and encourages them to achieve their objectives.	Accepted	<p>The roll out of the Offender Management in Custody (OMIC) model is now underway. All prisoners within the establishment will receive a core service of basic screening, assessment and sentence planning and co-ordination, a key worker and access to appropriate interventions.</p> <p>The key worker will be an integral part of the prison officer role at HMP Manchester and they will be responsible for coaching and mentoring a small caseload of prisoners as they progress through their sentence. The scheme focuses on the mitigation of the negative effects of imprisonment and prisoners are encouraged to identify and resolve issues for themselves and engage in their rehabilitation. Regular one to one meetings will be held and relevant information will be shared with the Prison Offender Manager.</p>	Head of OMU Completed

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4	<p>The Head of Healthcare should ensure that:</p> <ul style="list-style-type: none"> • the appointment allocation system is robust and effective in facilitating GP interventions for patients subject to frequent cell movement around the prison; and • Prisoners have access to mental health services equivalent to those in the community. 	Accepted	<p>Clinics are now held centrally allowing prisoners from all areas to have access to them. The escorting member of staff will be provided with an up to date list of prisoners and their locations to ensure that prisoners moved to a different location can still keep their appointment. The Head of Healthcare has implemented an appointment system whereby if a prisoner misses a GP appointment through no fault of his own, the maximum length of time he will have to wait will be two weeks.</p> <p>Prisoners currently have emergency access to the mental health in reach team between Mondays and Fridays 0900 hours to 1700 hours. Outside of these hours access is restricted to the 24 hour cover provided by the Healthcare service. This service includes mental health nurses who are able to conduct an assessment of required</p> <p>To ensure that the mental health service provided are in line with those in the community, a new mental health service specification is to be implemented which will include the 'stepped care' model referred to within the clinical review. Revisited costings to provide the additional resources required have been submitted to NHS England for approval. Once such approval is agreed it is anticipated that recruitment of staff will take six months to achieve.</p>	Head of Healthcare June 2019
5	The Governor and Head of Healthcare should ensure that all staff are aware of the correct medical emergency codes and	Accepted	In September 2018, Governors order 11.2017 (Emergency response protocol) was reissued reminding staff of their responsibilities during a medical emergency, including the correct use of code red, code blue.	Head of Healthcare Completed

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	have appropriate training in the use of emergency call signs.		<p>An Emergency Response in Custody (ERIC) pocket sized card was issued to all staff in May 2018. The ERIC card provides a prompt on the actions required during a medical emergency.</p> <p>Emergency response training is also provided as part of the POELT course for all new prison officers.</p>	
6	The Governor should ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody, that all those involved in the incident are invited to attend, and that an accurate written record is kept.	Accepted	<p>Senior Managers were reminded during a staff operational meeting of the need to hold a hot debrief in accordance with PSI64/2011 following a death in custody and that all those involved in the incident must be invited to attend, with a record of those in attendance kept.</p> <p>An information notice will also be issued providing information about the appropriate times to complete relevant debriefs from incidents, particularly those involving the death of a prisoner.</p>	Head of Safer Custody February 2019