Action Plan – Mr Matthew Lambert at HMP Wormwood Scrubs – Self-Inflicted Death on 13/11/2018				
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**
1	The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that Staff consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, person escort records and medical records Staff have a clear understanding of their responsibilities and the need to record and share relevant information about recognised risk. Prison and healthcare staff, including the mental health team, work together to manage prisoners at risk of	Accepted	To improve collaboration between discipline and healthcare staff, the healthcare team is routinely represented at the monthly Safety meetings and ACCT reviews. All reception staff will be reminded via e-mail of their responsibility to take into account any warning forms or information relating to self-harm on PERs or other documents. Additional training on the risks of self harm is also being arranged. The self harm warning forms and PERs are reviewed by healthcare staff on reception and documented in the medical record as part of the reception healthcare screening process. This ensures that information is discussed with the patient during screening to assess risk and if referrals to the mental health team are necessary. Patients with a history of self-harm will also be seen by the GP in reception. Any concerns about self harm will either result in an ACCT document being opened immediately or a discussion with a manager as to whether this is necessary, with any decision not to open an ACCT recorded on NOMIS. This will also be communicated via e-mail to all staff in Reception, including healthcare professionals. Reception staff will photocopy all warning forms and relevant PERs and these will be subject to random management checks twice a month to ensure risk of self-harm has then been considered either by opening an ACCT or making an entry on NOMIS. Suicide and Self-Harm (SASH) training is being delivered to all staff. New induction period training is also being delivered to staff working in non-	Head of Safer Custody October 2019

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	suicide and self-harm. Healthcare staff should be invited to and attend at least the first ACCT review, and subsequent reviews as necessary, and ensure they read a prisoner's SystmOne records in detail before attending ACCT and healthcare review meetings Staff hold multidisciplinary ACCT reviews, with the same case manager and involving staff who contribute to a prisoner's care. Case managers complete caremaps, setting specific and meaningful caremap actions, identifying who is responsible for them and reviewing progress at each review.		operational roles who work with prisoners, such as the mental health team and substance misuse staff. The next training will be prioritised for primary care and probation staff. The Head of Healthcare will liaise with the Head of Safer Custody to discuss improvements to the ACCT process, to ensure co-ordinated care and joint working should a prisoner be under the care of in-reach services, then a member of their team will attend the reviews. For all other subsequent reviews the wing based nurse will make daily contact with the officers on the wing to identify who is for review and then either assign a staff member or send relevant information to ensure appropriate information is shared. The system for arranging future reviews has changed to encourage other teams, such as the mental health team, to attend. Nurses attending scheduled reviews are expected to read the prisoner's medical record on SystmOne. Healthcare input in the ACCT review will be the same member of staff, where possible. If not, the member of healthcare staff attending will ensure they have up to date, relevant information regarding the patient from the patient's medical record. Where possible they are also expected to get a handover from the member of staff who attended the previous review. The system for arranging ACCT reviews has changed so that, for the main wings, there is a set day for reviews. This ensures greater predictability and therefore has made it much easier for other departments to attend. Scheduling of the reviews has been carried out to maximise attendance of key managers and consistent case manager involvement and oversight. The system will be reviewed at the end of June 2019 and any necessary changes made as a	

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			result of findings. Additional training for case managers was facilitated during April and May 2019 to ensure they are more confident in completing caremaps. Improved multi-disciplinary working and decision-making has already led to case managers being better able to focus their efforts on developing meaningful caremaps for those prisoners who need them. Local guidance on caremaps, with examples of good practice, will be developed and sent to all case managers by the end of September 2019. The quality assurance process for ACCT documents is being revised and refreshed, so that wing managers are more accountable for the quality of the overall document and to ensure that caremaps are meaningful and updated.	
2	The Head of Healthcare and the clinical leads for the Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) should ensure that the zoning guidance is reviewed so that there is a clear and explicit expectation that staff review records and contact new patients promptly.	Accepted	A review will be carried out to ensure that the zoning guidance is clear and explicit of the expectation that staff review records and contact new patients promptly. Prior to any assessment the team will ensure access to the clinical records and ensure that all relevant updates are captured and reviewed to ensure clear and concise updates for care planning.	Head of Healthcare, August 2019

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3	The Head of Healthcare should ensure that an effective system is in place to provide mental healthcare staff with appropriate oversight of prisoners' risks in line with the zoning guidance.	Accepted	The zoning process review will ensure that the process is effective to provide mental healthcare staff with an appropriate oversight of prisoners' risks. Zoning process will be added as an agenda item to the prison partnership meeting.	Head of Healthcare, August 2019