Action Plan – Mr Nuno da Cruz at HMP Chelmsford –Self- Inflicted on 16/09/2018				
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**
1	The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, in particular that they: • identify risk factors and assess a prisoner's risk based on their risk factors and not just personal presentation; and • share information to provide collaborative care and treatment, in particular ensuring effective communication between healthcare and prison staff when there are potential concerns about a prisoner's mental health.	Accepted	A one page guidance document has been produced on those risk factors which can increase prisoners' self-harm and suicide risk. This has been sent to all HMPPS staff electronically and is being distributed to every staff member including those employed by other providers. There is an assurance process in place whereby staff sign to confirm they have received the guidance. Following the change in Healthcare provider to Castle Rock Group (CRG), all healthcare staff will be allocated to attend and complete the mandatory self-harm and suicide training which draws on risk factors and the importance of information sharing. The weekly mental health multi-disciplinary meeting has been expanded to include the Prison Safety team. Within this meeting, information is shared around self-harm risk and mental health concerns, to enable a collaborative care plan to be produced. Where appropriate this information is then shared with the wider prison team.	Head of Safer Prisons Complete
2	The Head of Healthcare should review the mental health screening and assessment procedures to ensure a more robust and coordinated process to identify risk factors and	Accepted	From 1st April 2019 health services at HMP Chelmsford have been provided by CRG Medical Service. The Partnership Integration Manager will review all mental health pathways as part of CRG Medical Services mobilisation plan. This will include the re- introduction of the threshold assessment grid (TAG) referral process to identify risk and prioritise appointments.	Head of Healthcare 1st June 2019

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	triggers for suicide and self-harm.			
3	The Head of Healthcare should ensure that when an appointment does not go ahead, the prisoner's medical record is noted with the reason and a new appointment is arranged.	Accepted	The Partnership Integration Manager has created and appointed a new dedicated appointment administrator role. This role was introduced to ensure any cancelled appointments are followed up and a new appointment is made where required. Missed appointments are also highlighted in the daily operational meeting to ensure that the relevant wing managers are aware.	Head of Healthcare Complete
4	The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that: • staff enter cells as quickly as possible in a life-threatening situation; • Staff understand and use the appropriate emergency code when they discover a medical emergency.	Accepted	In May the Safety team will visit all areas in the prison, briefing staff on calling and responding to medical emergencies. This will include appropriate calling of medical codes and the importance of entering a cell to preserve life. Information regarding the dynamic risk assessment will be communicated through a one page targeted brief to staff in all key areas to reiterate the importance of these procedures.	Head of Safer Prisons Complete
5	The Head of Healthcare should ensure that, in accordance with European Resuscitation Council Guidelines, healthcare staff fully understand the	Accepted	The Partnership Integration Manager has re- issued the European Resuscitation Council Guidelines following the change in healthcare provider, to ensure that all new and existing staff are aware of the guidance.	Head of Healthcare Complete

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	circumstances in which resuscitation is inappropriate and are confident about applying the guidance on resuscitation appropriately.			
6	The Governor should ensure that following a death in custody appropriate contact is made and maintained with the nominated next of kin.	Accepted	All Governors and Family Liaisons Officers (FLO) have been reminded through written guidance that contact should be made with the nominated next of kin, and maintained with that person. This will be reiterated further on the FLO deployment guidance and the newly implemented risk assessment for FLO deployment.	Head of Safer Prisons Complete