Action Plan – Mr William McGeough at HMP Grendon –Self-Inflicted Death on 21/12/2019				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
1	The Governor, the Head of Healthcare and the Head of Chaplaincy of HMP Long Lartin should ensure that all staff have a clear understanding of the need to record and promptly share information about a prisoner's possible risk.	Accepted	The serious illness or death of a prisoner's relative (SIDPR) form was amended in 2020 to include instructions to chaplaincy staff to record all pastoral contact on the prison NOMIS database. The chaplaincy procedures book also includes instructions to all staff that an entry must be made on NOMIS when a SIDPR is opened and each time the prisoner is seen by a chaplain during the SIDPR process. A notice to all chaplaincy staff was sent in August 2020 to ensure that all risk information is shared appropriately and the importance of this was also explained at the August 2020 chaplaincy team meeting. Regular assurance checks will be carried out by the managing chaplain to ensure compliance. By July 2020, all healthcare staff had received training in the processes for sharing information which included documenting risk information on the security IR system, wing observation book and on all ACCT documents. Weekly meetings take place with the mental health services and multi-disciplinary staff from all areas to discuss complex cases, providing a further forum for information to be shared. A rolling programme of Suicide and Self Harm (SASH) training is delivered to all staff which provides guidance on the requirements of recording all risk information and the need to share this information accordingly. All staff will complete induction SASH training or refresher training by January 2021.	Completed Managing Chaplain Completed Head of Healthcare January 2021 Head of Safety
2	The Governor and the Head of Chaplaincy of HMP Long Lartin should ensure all chaplaincy	Accepted	From March 2020, all chaplaincy staff working in the prison had full access to NOMIS. The induction training for new volunteers recommenced in August 2020, and their visits will begin following completion of the training. The	Completed Managing Chaplain

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	staff have access to NOMIS and that they record their own contacts with prisoners as soon as practicable.		chaplaincy induction provides access and training on the prison NOMIS database and training on how to record information and the importance of doing so. The managing chaplain reminded all chaplaincy staff to record all contact with prisoners as soon as possible. This was also mentioned at the chaplaincy team meeting in August 2020.	
3	The Director General of Prisons should amend Prison Service Instruction 05/2016 to say that chaplaincy staff should pass on information to healthcare staff after breaking the news of a relative or friend's death to a prisoner.	Accepted	HMPPS Chaplaincy and Faith Services (CFS) are due to replace Prison Service Instruction 05/2016 Faith and Pastoral Care for Prisoners with a Policy Framework document by the end of 2020. This will include the requirement on chaplaincy staff to inform healthcare when a prisoner has received the news of a relative or friend's death. As an interim measure CFS will issue revised guidance to all managing chaplains informing them of this requirement.	December 2020 Chaplaincy and Faith Services Policy Lead
4	The Governors and the Heads of Healthcare of HMP Long Lartin and HMP Grendon should ensure that staff offer support to prisoners who self-isolate prior to and following a transfer.	Accepted	HMP Long Lartin: All healthcare patients that identify as self-isolating are referred to and assessed by the inclusion team which includes integrated mental health and substance misuse services. Each patient will be offered a full assessment and an agreed care plan to support their needs. The weekly safety intervention meeting agenda was updated in December 2019 to include an in-depth discussion of all self-isolators over all residential wings. The minutes from this meeting are sent out weekly to all attendees and functional heads. In addition to this, self-isolators are supported back into the normal location through multi-disciplinary segregation review boards both prior to and following a transfer.	Head of Healthcare Complete Completed Head of Safety

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			HMP Grendon: The process of sharing information between establishments prior to and during a transfer was reviewed in July 2020. The Head of Healthcare, induction wing manager and safer custody team worked together to identify ways to reduce the time delay between a resident being accepted to Grendon and the transfer taking place. The key focus was on further measures that should be in place when there is a change in behaviour prior to or following the transfer, such as extended periods of isolation or a recent bereavement. As a result, once a transfer is confirmed by the escort contractor, an individual's case will be reviewed again by Grendon. Where relevant information prior to a transfer is identified, a meeting must be held prior to the transfer with the sending establishment to decide if the transfer should be delayed. This meeting must include input from all stakeholders including the assessment unit, chaplaincy, security, safer custody and healthcare provider at both establishments. It was also agreed that key points identified during the meeting must be added to the case notes by the sending establishment so that all members of staff are aware of any risk factors and the measures put in place to mitigate the risk. Following the transfer, these concerns will be raised directly with the new resident and further support offered during the initial assessment.	Completed Head of Safer Custody and Head of Healthcare
5	The Governors and the Heads of Healthcare of HMP Bullingdon and HMP	Accepted	HMP Bullingdon: The induction and first night procedures were reviewed in February 2020 to ensure that all new receptions, including prisoners lodging overnight for onward transfer, go through the same procedures and that all	Completed Head of Safer Custody

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	Grendon should ensure that staff manage newly arrived prisoners in line with national guidelines, including ensuring that they: • examine all available documentation on the prisoner and consider and record all known risk factors for suicide and self-harm; and • interview the prisoner after examining all available documentation.		relevant documents are checked and completed including the early days in custody passport which documents the journey through reception. As part of this process it was agreed that the prisoner will be interviewed following the completion of the passport and the cell sharing risk assessment (CSRA). The Quality Assurance (QA) checks of the reception screening documents were introduced in January 2020 and this process has been further reviewed in August 2020. It was agreed that the custodial manager will now complete a weekly QA check of 10% of the new arrivals to ensure that paperwork is examined and all risk factors are recorded. Guidance on the complete reception process and requirements was sent to all first night and reception staff in August 2020. A staff briefing was also held to give staff further training on the need to follow the same procedures for prisoners who are staying for both short term and long term periods. <u>HMP Grendon:</u> The Secure Estate Assessment Template (SEAT) was introduced in January 2020 to support staff in identifying information gathered during previous reception screens. The SEAT also requires the clinician to record whether the PER has been seen. A training session was held for all healthcare staff in August 2020 to ensure staff are aware of the need to review all available information, interview the prisoner following this and to share information following a reception screening.	Completed Head of Healthcare
6	The Governor and the Head of Chaplaincy of HMP Grendon should ensure that the chaplaincy team offers support	Accepted	It was agreed in July 2020 that a member of the chaplaincy will attend all meetings where a new transfer is taking place to ensure that support is offered if there has been a bereavement.	Completed Head of Chaplaincy

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	to all prisoners who have recently suffered the death of a relative or friend.		All chaplaincy staff were reminded in August 2020 to ensure that they offer support to all prisoners when they have suffered a bereavement and to document this to ensure that all staff are aware.	
7	The Head of Healthcare of HMP Long Lartin should ensure that staff complete in-depth assessments when a prisoner makes statements that could suggest emerging psychosis.	Accepted	All inclusion staff were reminded during the clinical supervision in July 2020 of the need to report and share any concerns that they may have regarding change in presentation, behaviour, mental state and/or risk factors and all patients are continually assessed. Should any change be identified, this will be shared during the daily team handover meetings and if required, discussed at further multi-disciplinary team (MDT) meetings and assessed further with the psychiatric team. Training is delivered to staff annually by the consultant, in addition to this further training for staff has been offered through virtual platforms since January 2020 which includes key information and training on the mental health indicators of psychosis.	Completed Head of Healthcare Inclusion Team Manager
8	The Governor of HMP Grendon should review the processes when a prisoner has failed to return to their cell after using the sanitation system to ensure that control room staff immediately alert staff on the relevant wing and to minimise any delays finding the prisoner.	Accepted	Staff were be reminded in September 2020 through a notice to staff and at briefings that, should a resident fail to return to their room within eight minutes when sanitation is in operation, contact with the wing must be made using the radio network to minimise any delays. Control room staff will also be reminded that it is not acceptable to use the telephone, cell intercom or any other form of communication. The local operating procedure, including that of the sanitation system, will be reviewed in October 2020.	October 2020 Head of Safer Custody

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9	The Governor of HMP Grendon should ensure that control room staff call an ambulance as soon as an emergency code is called and that information about the prisoner's condition is obtained and promptly passed to the ambulance service.	Accepted	In November 2016, the prison and the South Central Ambulance Service introduced a joint emergency call out protocol to ensure a timely and appropriate response to medical emergencies. This protocol will be reviewed as part of the local operating procedure review in October 2020 to ensure that it is effective and staff will be reminded of the requirements following this. In accordance with the local security strategy, the role of the duty manger is to take the role of scene commander and be responsible for the management of any incident to its conclusion. All duty managers were briefed in August 2020 to ensure that they are confident in this role and the requirements to oversee the incident and ensure that the required information is given to the ambulance service as soon as possible. All control room staff have received full radio training and following the completion of the review of the operating procedures in October 2020, staff will be provided with specific guidance on the requirements to call an ambulance as soon as an emergency code is called and that information about the prisoner's condition is obtained and promptly passed to the ambulance service.	October 2020 Head of Operations
10	The Head of Healthcare at HMP Grendon should ensure that staff know when it is appropriate not to attempt to insert an I-gel airway.	Accepted	The decision not to attempt insertion of an I-gel airway during resuscitation and whether or not to deploy a piece of equipment is a clinical decision on the spot, providing this is logical and justifiable. Resuscitation Council UK Guidelines were shared with staff and advise that where rescue breaths are not possible chest compressions without airway management conform to the guidance requirements.	Competed Head of Healthcare January 2021 Head of Healthcare

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			A to E training provide intermediate life support (ILS) resuscitation training to all nurses. Included within this training is when it is advisable and clinically indicated to use an I-gel airway and airway insertion. All nurses have completed annual ILS resuscitation training. The healthcare management agreed with A to E training that a further scenario based annual training session specifically focusing on the management of patients who ligature, including airway management, will be added to the current training package. The first ligature specific scenario based training session will take place by January 2021.	