

**Action Plan – Mr Michael Harris at HMP Doncaster – Self-Inflicted Death on 21/11/2019**

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
1	<p>The Executive Director of Custodial Contracts should:</p> <ul style="list-style-type: none"> <li>• satisfy himself that processes are in place at Doncaster to ensure that the PPO's recommendations are being implemented and embedded; and</li> <li>• report his findings to the Ombudsman.</li> </ul>	Accepted	<p>A letter will be sent from the Executive Director of Custodial Contracts to the Ombudsman, setting out what will be done to ensure that processes have been put in place at HMP Doncaster, in order to implement and embed PPO recommendations.</p>	<p>Executive Director of Custodial Contracts December 2020</p>
2	<p>The Director should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:</p> <ul style="list-style-type: none"> <li>• assessing a prisoner's level of risk on the basis of recognised risk factors and not just on the prisoner's presentation or what he says;</li> <li>• recording the reasons for decisions;</li> <li>• carrying out and recording conversations and observations, as required; and</li> </ul>	Accepted	<p>In April 2020, following a management restructure, HMP Doncaster introduced a new Head of Safer Custody and a new Safer Custody Custodial Operations Manager (COM). Resources within the Safer Custody team have also been increased by the addition of a Safer Custody Analyst, four Prison Custody Officers, with additional ACCT Assessors being trained.</p> <p>All new operational staff receive Suicide and Self-Harm Training (SASH) as part of their initial prison officer or COM training. This is a national prison service package designed to ensure that staff understand the risks factors which must be considered when assessing a prisoner's risk of suicide and self-harm. An ongoing programme of refresher training for all existing staff is also being delivered as part of the establishment's training plan.</p> <p>The Yorkshire Prison Group Safety team will also deliver additional ACCT case management training to all Band 4 and Band 5 case managers to enhance their existing knowledge and skill levels, and to ensure staff conduct ACCT</p>	<p>Director January 2021</p>

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	<ul style="list-style-type: none"> <li>only closing an ACCT when all caremap actions have been completed.</li> </ul>		<p>reviews in line with national guidance. The training will reiterate the importance of considering all risk factors when assessing a prisoner's risk of suicide and self-harm and that decisions must not be based on presentation alone. Staff will also be reminded that ACCTs must not be closed before all caremap actions have been completed and that reviews should be multidisciplinary. Where a prisoner has been identified as having a mental health issue, the attendance of the Mental Health team is also requested to ensure that any caremap actions in relation to Healthcare have been completed, where consideration is being given to the closure of an ACCT.</p> <p>Defensible Decision Making training will also be delivered to all COMs and ACCT case managers. Training will refresh learning for current staff and highlight the importance of recording any decisions made.</p> <p>In June 2020 a new process of ACCT assurance was also introduced. Duty Directors now carry out assurance checks of documents throughout the week, as well as a 10% quality check at weekends. Night Duty Managers also now conduct sample checks of documents during night duties to assure the quality of the process and documentation. Lessons learned and advice or guidance is taken forward by the Safer Custody COM.</p> <p>In addition, the Safer Custody COM now carries out a post-closure quality review on 10% of ACCT plans. Any identified shortfalls are raised with the case manager as points of learning and highlighted to the relevant COM or Duty Director as appropriate.</p>	

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			HMP Doncaster will continue to be supported by the Yorkshire Prison Group Safety team, who will provide regular independent assurance visits and feedback on any areas where performance is not to the required standard.	
3	<p>The Head of Healthcare should:</p> <ul style="list-style-type: none"> <li>• confirm to the Ombudsman that a revised mental health triage process is now in place;</li> <li>• ensure that all relevant information and actions from the previous day's mental health response nurse is shared at the daily handover; and</li> <li>• ensure that healthcare staff prepare for ACCT reviews by reading the prisoner's SystemOne notes.</li> </ul>	Accepted	<p>The process for referral to Mental Health (MH) has been reviewed and a new system implemented. Following receipt of a referral, the dedicated MH administrator documents on the MH tracker. The triage is then completed by a registered MH Nurse within 48 hours, if urgent and 5 days if routine. Once the triage is complete, if required, the patient is then referred for a full mental health assessment and booked for the next available appointment. This is then added to the SystemOne appointment ledger. Ledgers are routinely audited by the MH Clinical Matron. Any patients who are identified at risk during ACCT reviews are triaged at the time and referred for a full MH assessment, if clinically appropriate.</p> <p>An integrated Substance Misuse and MH handover is held daily at 8am. All assessments identified as urgent are discussed at this handover and then allocated appropriately. A member of staff also attends the daily multi-disciplinary Healthcare Handover. Additionally, all complex cases are discussed at the Multi Professional Complex Case Clinic and MDT meeting as appropriate.</p> <p>Each member of the MH team also receives the At-Risk report at 8am from the Safer Custody Team. ACCTs are allocated to the appropriate MH Duty Worker. The patient's SystemOne records must then be reviewed at this time prior to attending the ACCT review.</p>	Head of Healthcare Completed

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4	The Director should ensure that the key drug issues at Doncaster are identified and addressed in the prison's local drugs strategy.	Accepted	<p>HMP Doncaster have a dedicated Drug Strategy manager in post and a review of the local Substance Misuse Strategy was undertaken in June 2020. The findings have been used to identify and address key issues and inform changes and improvements in line with the published National Drugs Strategy.</p> <p>A review of the Health Needs Analysis was last carried out in 2019, and assisted in the development of the Substance Misuse Strategy. A further review will take place in 2021, at a date to be confirmed. The 2021-2022 Drug Strategy is expected to be produced in the first quarter of 2021.</p> <p>To ensure a multi-disciplinary approach, the Drug Strategy manager attends the Security meeting, Safer Custody meeting and Health Care Local Delivery Board, which includes the Drug and Alcohol Recovery team (DART), where issues relating to substance misuse are discussed and addressed on a monthly basis.</p> <p>Prisoners with substance misuse concerns and addiction receive support in the form of both clinical and psychosocial interventions.</p>	Drug Strategy Manager March 2021
5	The Director should share this report with COM A and COM B and discuss the Ombudsman's findings with them.	Accepted	The named members of staff will be issued with a copy of this report electronically and spoken to individually by the Head of Safer Custody to ensure they are aware of the findings.	Head of Safer Custody January 2021

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6	The Director should ensure that this report is shared with PCO A and that a senior manager discusses the Ombudsman's findings with him.	Accepted	The identified member of staff will be issued with a copy of this report electronically and spoken to by the Head of Safer Custody to ensure they are aware of the findings.	Head of Safer Custody January 2021
7	The Head of Healthcare should share this report with Nurse A and Nurse B and discuss the Ombudsman's findings with them.	Accepted	This report has been shared with both named nurses and the findings of this and the clinical review will be discussed with them at a full Mental Health team meeting. The report will also be discussed with the Regional Mental Health Lead for S&W Yorkshire.	Head of Healthcare December 2020