Action Plan – Mr Jonathan Crooks at HMP Altcourse – Self Inflicted Death on 29/02/2020				
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**
1	The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff: • consider the most appropriate location for prisoners coming off constant watch and record their decision in the ACCT record. • set effective caremap actions that are specific and meaningful, aimed at reducing risk, and update them at each review; and • accurately record details of case reviews in the ACCT record**.**	Accepted	Since Mr Crook's death all Case Managers have been reminded of their responsibility to ensure that prisoners supported on ACCT are managed in line with national guidelines. This information has been communicated through emails, management meetings, further staff training and awareness sessions, including one to one training where required. Case Managers have also been advised to ensure that all considerations and decisions regarding the appropriate location of prisoners being removed from constant supervision are recorded on the ACCT document. Any learning or examples of best practice identified from the ACCT Quality Assurance (QA) process, including the setting of effective caremap actions is fed back as part of the monthly Safer Custody meetings. This learning is also disseminated to Case Managers on a regular basis to ensure staff are aware of the importance of ensuring that all caremap actions are specific, meaningful, aimed at reducing risk and that they must be updated at each review. All ACCT case reviews, care map actions and post closure review documentation are checked by Unit managers on a regular basis and by Safer Custody managers on an ad-hoc basis to assure both compliance and quality. This process ensures ACCT reviews accurately record details of how the person is being supported.	Head of Safety Completed
2	The Head of Healthcare should: • ensure healthcare staff offer all prisoners a full general	Accepted	A process is in place to ensure that all prisoners arriving into the establishment receive a first reception health screen and subsequently a secondary health screen, in line with PSO 3050. There is also an audit process in place that allows for the completion of both of the screenings to be monitored. Any	Head of Healthcare March 2021

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	health assessment within a week of their arrival, in line with PSO 3050; and • accurately record actions and decisions about prisoners' care in their ongoing record.		prisoner identified as not having had a screening is flagged to the Healthcare management team so that arrangements can be made for this to be completed as soon as possible. Staff are aware that refusals and non-attendance (DNAs) must be recorded, however the importance of accurately recording actions and decisions about a prisoner's care will be reiterated to all Healthcare staff.	
3	The Head of Healthcare should review the contingency arrangements if the prison's electronic medical record is not accessible to ensure that medication is prescribed promptly.	Accepted	A Business Continuity Plan is now in place to assist in the event of a SystmOne failure. In addition, allocated laptops have been issued to some of the Healthcare management team to allow for remote SystmOne access. These measures will ensure medication can be prescribed promptly should there be difficulties in accessing the electronic medical record.	Head of Healthcare Completed