

Action Plan – Mr Gary Sheehan at HMP Hull – Self- Inflicted Death on 21/06/2020

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
1	The Governor at Full Sutton should ensure that, where a decision is made not to implement a Parole Board recommendation, this decision is clearly communicated to the prisoner and appropriately recorded.	Accepted	<p>In December 2020 a new process was introduced to ensure that Parole Board decisions are clearly communicated to the prisoner and are also properly recorded. Administration staff are now responsible for printing a copy of any Parole Board decision received, which is then passed to the Prison Offender Manager who will visit the wing to discuss the outcome with the prisoner in person. An email has been issued to all Offender Management Unit staff setting out this new process and detailing staffs' responsibilities. This also highlighted the importance of prisoners being kept informed at every stage of their progression following a Parole Board outcome, so that they are fully aware of the reason for decisions being made including those around transfers to other establishments. The need for detailed case notes to be recorded on NOMIS was also reiterated.</p> <p>A four monthly audit check will be conducted by the Head of Offender Management Delivery on all parole decisions, to ensure compliance with this process. The results will be reported back to the Senior Management team by the Head of Function as part of managing performance and quality.</p>	Head of Offender Manager Delivery Completed
2	The Heads of Healthcare at Full Sutton and Hull should ensure that staff monitor prisoners' compliance with medication, particularly mental health medication, by those self-isolating.	Accepted	<p>HMP Full Sutton</p> <p>Changes have been made to the current medication compliance regime. If medication is not collected at the weekly allocated timescale then a task will be sent by the Pharmacy team to Primary Care and Mental Health team so that the issue can be addressed at the daily safety huddle and a solution gained through multi-disciplinary team (MDT) discussion.</p> <p>Missed daily supervised medication is also addressed at the safety huddle on</p>	Head of Healthcare January 2021

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			<p>a daily basis, with a solution sought by MDT discussion following three consecutive days of medication not being collected. This includes discussion with the service user to ascertain the reasoning behind non collection of medication.</p> <p>HMP Hull</p> <p>The in-possession medication policy has been reviewed and is currently awaiting ratification. This includes a patient non-attendance pathway which staff must follow should a patient not attend to collect medication for 48 hours, as well as the follow up actions to be taken by clinicians.</p> <p>Communication and liaison requirements with prison staff and engagement with the mental health team, should mental health medication be involved are also set out.</p> <p>Improved integration within HMP Hull Healthcare (Primary Care, Drug and Alcohol Recovery team and Mental Health) including combined MDT and handover meetings have further contributed to reducing the risk by improved sharing of information across the service.</p>	<p>Head of Healthcare January 2021</p>