Action Plan – Mr Damian Rzeszowski at HMP Full Sutton – Self-Inflicted Death on 31/03/2018				
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 held in the segregation unit in line with national guidelines, including ensuring that they: •Do not hold prisoners on open ACCT plans or those in post-closure unless all other options have been considered and excluded and the exceptional circumstances are fully documented and explained; •Hold an ACCT review within 24 hours of segregation for prisoners on an open ACCT or in the post-closure phase; •Complete Initial Segregation Health Screens accurately and fully; •Hold Segregation Review Boards every 14 days; •Consider a prisoner's mental health during a Segregation Review Board;	Accepted	Prisoners on an open ACCT or ACCTs in the post closure phase have defensible decision documentation completed by a Governor on location and this is reviewed daily. During each review, alternative locations are considered and reasons for and against a move are clearly documented. ACCT reviews are carried out within 24hrs when a prisoner is located in the segregation unit and algorithms are completed by healthcare and signed by Governors. The Safer Custody team now quality checks ACCT documents daily for prisoners located in the segregation unit to ensure that reviews are being carried out within the timeframes and that appropriate actions are set and completed. Since November 2018 the Safer Custody team have been appointed as Key Workers for any complex prisoners including those at a higher risk of suicide or self-harm, this will often include prisoners who are located in the segregation unit. The Safer Custody function now has a better understanding and improved relationships with higher risk prisoners and Key Workers are able to engage and support prisoners through meaningful actions such as increased time out of cells as members of the cleaning party. A weekly multi-disciplinary safety meeting was introduced in November 2018 providing an opportunity to discuss the care of all complex prisoners including those located in the segregation unit, prisoners on an ACCT or those being managed on a Challenge, Support and Intervention Plan (CSIP). The meeting provides an opportunity to work with colleagues from healthcare to share information on how to best support and manage	Governor and Head of Healthcare Completed

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	•Complete mental health care plans for prisoners who have been segregated for longer than 30 days; •Encourage prisoners to attend Segregation Review Boards and record the reasons for non-attendance if applicable; •Set realistic, specific and time-bound behaviour targets at Segregation Review Boards; and •Consider whether it is necessary to plan for the return to normal location when prisoners have been in segregation for a long period.		prisoners. Any long term segregation prisoners are discussed at the safety meeting to ensure that their needs and concerns have been addressed and suitable alternatives to segregation considered. This might include referral to specialist units at other establishments. 72hr and 14 day reviews are held for every prisoner on Rule 45 as per PSO 1700 and the mental health of a prisoner is discussed and documented during these boards. Prisoners are encouraged to attend Rule 45 boards with non-attendance recorded. Since November 2018 there has been an increased emphasis on multidisciplinary attendance, including IMB, psychology, and healthcare to improve the quality of discussions and ways of supporting a prisoner to return to normal location whilst also considering their concerns and risks. Pathways to progression are discussed and scrutinised during the review and healthcare algorithms are also updated. Targets are set during Rule 45 review boards and all prisoners have a segregation care plan which is reviewed monthly by the Segregation Governor for quality assurance purposes to ensure that progression pathways are being followed and appropriate targets set. Any issues identified are followed up by the Segregation Governor. All prisoners located in the segregation unit are visited daily by a registered health practitioner. If concerns are raised about a prisoner's mental health a care plan is produced and any risks identified are shared at the weekly safety meeting and at the daily safety huddle which takes place in the healthcare unit. Any issues are circulated to relevant	

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			operational staff and whilst medical care plans are not available to operational staff any relevant elements of the care plan are shared for safety reasons.	
2	The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that they: •Complete an Immediate Action Plan within one hour of the ACCT being opened; •Review the level of risk and frequency of observations immediately if the prisoner's circumstances and/or presentation change, rather than waiting for the next ACCT review; •Do not close ACCTs until the caremap actions have been completed; and •Adhere to the frequency of observations set out in the ACCT document.	Accepted	To ensure that Immediate Action Plans are completed within an hour of an ACCT being opened the Wing Manager or ACCT Case Manger are now responsible for completing the action plan, with the Orderly Officer completing it in their absence. Since November 2018 the Safer Custody team have been responsible for carrying out daily checks on all ACCT documents to ensure compliance and any issues or discrepancies are reported to the Case Manager and Safer Custody Manager. As part of the Safer Custody team's quality assurance checks on ACCT procedures a member of the team now attends every ACCT review to ensure that the level of risk and frequency of observations have been considered, particularly when there is a change of circumstances. Safer Custody attendance at case reviews also ensures that ACCTs are not closed until all caremap actions have been completed. This is documented on NOMIS and the Safer Custody manager carries out checks on ACCT documents to ensure compliance. In November 2018 a weekly safety meeting was introduced and is attended by prison and healthcare colleagues, including representatives from mental health and psychology. The meeting provides an opportunity to discuss all prisoners on open ACCTs, ACCTs in post-closure, those on CSIP, and any other complex cases and enables staff to share risk	Head of Safer Custody Completed

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			information and updates on individuals to improve the care and support that they receive.	
3	The Governor and Head of Healthcare should ensure that staff inform the substance misuse team when prisoners admit to using drugs or refuse mandatory drug tests so that it can provide prompt substance misuse support.	Accepted	When a prisoner is placed on report for a charge involving substance misuse the adjudications clerk informs the substance misuse team via email, the adjudicating Governor ensures that this has been done at the hearing. All prisoners who are found guilty of misuse of substances, refuse or fail a mandatory drugs test are referred to the substance misuse team and are offered the opportunity to receive a suspended award in the first instance. Through engaging with the substance misuse team by attending a drugs awareness course prisoners can avoid adjudication for substance misuse. This now forms part of the local drugs strategy and is also highlighted in the adjudication awards tariff.	Head of Segregation and Head of Drug Strategy Completed
4	The Governor should ensure that control room staff call an ambulance as soon as a medical emergency code is called.	Accepted	In November 2018 a Standard Operating Procedure (SOP) was introduced and all staff have been briefed on the correct process to follow once a code blue has been called. This has improved communication with the ambulance control room and reduced delays as triage questions are now completed once the control room have requested an ambulance instead of in advance of calling for one. Healthcare staff have developed a training package to raise awareness of emergency codes. All healthcare staff have been briefed regarding the new SOP and it has been incorporated into the induction process for new starters since November 2018. Code blue and red cards which detail the process to follow once an emergency code has been raised were issued to all staff in November	Head of Operations Completed

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			2018 and healthcare have carried out training sessions with officers on the wings to ensure the correct process is understood and followed for completing triage questions.	
5	The Governor should ensure that staff use appropriate interpretation services when contacting the next of kin of a foreign national prisoner.	Accepted	Following Mr Rzeszowski's death telephone numbers of interpretation services have been made available in the contingency plans for ease of access to ensure that information can be shared with the next of kin as quickly as possible following a death.	Head of Safer Custody Completed
6	The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that they: •Following a death in custody of a foreign national prisoner, the prison offers up to £3,000 towards reasonable funeral expenses and a separate amount for reasonable repatriation costs; and •The prison now offers to pay reasonable funeral expenses to Mr Rzeszowski's family.	Accepted	The prison will make a further contribution to Mr Rzeszowski's family for funeral expenses.	Head of Safer Custody Completed
7	The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report	Accepted	Staff named in the report were contacted by the Head of Safer Custody and a copy of the report has been shared with them.	Head of Safer Custody Completed

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	at the draft stage in line with paragraph 1.11 of PSI 58/2010.			