

**Action Plan – Mr Vasile Nastase at HMP Forest Bank – Self-Inflicted Death on 01/09/2019**

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
1	The Director General of HMPPS should review PSO 3050 and PSI 07/2015 to ensure that prisoners who attend court by video link are assessed for their risk of suicide and self-harm and seen by healthcare staff in the same way as prisoners attending court in person.	Accepted	<p>In March 2021 the Director General wrote to all Governors and Directors requiring them to review local processes to ensure that, in line with the expectations of PSI 07/2015 and PSO 3050, similar health screening arrangements and the same processes for assessing risk of self-harm or suicide are followed after video link appearances as on reception following a physical appearance in court.</p> <p>The letter was sent out in a global bulletin to Executive Directors and Prison Group Directors as well as Governors and Directors and included a safety briefing for staff on assessing the risk of harm in prisoners attending court and other appointments by video link. The briefing reminds staff to stay alert to the risks and to engage with prisoners following video calls and video link appearances.</p> <p>A wall chart was also sent out in the bulletin to be displayed in prisons as a visual reminder of the actions to follow after a video call.</p> <p>As part of the HMPPS national policy update both these policies are due to be replaced by Policy Frameworks. The findings of this report will be used to inform the development of the new policies which will ensure that prisoners attending court by video link are appropriately risk assessed afterwards.</p>	Director General HMPPS Completed

**Action Plan – Mr Vasile Nastase at HMP Forest Bank – Self-Inflicted Death on 01/09/2019**

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
2	<p>The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular, staff should:</p> <ul style="list-style-type: none"> <li>• assess the level of a prisoner's risk of suicide and self-harm based on all available information and known risk factors, and not only on a prisoner's presentation or what he says;</li> <li>• set caremap actions that are specific, meaningful and time bound, aimed at reducing the prisoner's risk to themselves, and update the caremap actions if additional needs are identified;</li> <li>• consider if an additional case review is required, or the level of observations needs to be revised, if there is a change in behaviour or additional concerns; and</li> <li>• be reminded to record factual information on the ongoing</li> </ul>	Accepted	<p>A training programme is in place to ensure that all staff receive the two day mandatory Suicide and self-harm (SASH) training.</p> <p>The SASH training includes a module focused on improving staff understanding of the risk factors which must be considered when assessing a prisoner's risk of suicide and self-harm.</p> <p>Staff have also been issued with further guidance relating to the identification of risks and triggers, to reinforce the knowledge gained during SASH training and to remind them that decisions are not to be based on presentation alone.</p> <p>In addition a Notice to Colleagues has been issued on 1<sup>st</sup> June 2020 which promotes and reinforces the knowledge already gained about ACCT procedures. This, along with refresher training delivered to key staff in January 2020 and June 2020, includes the need to review ACCTs when new information about risk is received and that appropriate levels of observations are set according to the level of risk.</p>	

**Action Plan – Mr Vasile Nastase at HMP Forest Bank – Self-Inflicted Death on 01/09/2019**

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
	record, which is free from judgement or speculation.		<p>Staff have been reminded, by the Notice to Colleagues, to make entries in the ongoing record which are factual observations at the time of entry.</p> <p>ACCT case managers have been provided with additional training sessions focusing on the identification and mitigation of risk, based on all available information and known risk factors, including how to document such on caremaps to ensure they reflect the issues identified in the ACCT assessment.</p> <p>Further training will be delivered by the end of August 2020 to ensure all current Case Managers are aware of expectations in relation to ACCT Management.</p>	<p>Head of Safety &amp; Decency Completed Aug 2020</p>
3	<p>The Head of Healthcare should:</p> <ul style="list-style-type: none"> <li>• carry out an in-depth analysis of how workloads are prioritised to ensure that staff can attend immediately when prisoners are deemed to be in a mental health crisis; that;</li> <li>• review the Mental Health Care pathway and consider if any</li> </ul>	Not Accepted	<p>Workloads are prioritised in line with NHSE Service Specification for mental health in prisons. There is a robust system for MH assessment following self harm and for MH crisis which is in line with the service specification requirement. Within the service specification there is no requirement to attend immediately to an escalating concern as the mental health team does not provide 7 day / 24 hour cover.</p>	N/A

**Action Plan – Mr Vasile Nastase at HMP Forest Bank – Self-Inflicted Death on 01/09/2019**

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
	<p>revisions are necessary to enable staff to respond to a mental health crisis; and</p> <ul style="list-style-type: none"> <li>review the use of risk assessments during ACCT reviews to act as aide memoirs so that more thorough risk assessments are completed ensuring key risk indicators are not missed.</li> </ul>		<p>The system by which the service works allows review within 24hrs of the concern being raised. Review of the mental health care pathway was undertaken in line with the NHSE service specification and commissioning arrangements in November 2018. This is the care pathway in use today.</p> <p>All staff attending ACCT reviews check the health record prior to ACCT attendance in order for any existing risk assessments to be considered as part of the current risk management. In the absence of any previous risk assessments being in place, the nurse attending the review will undertake their own risk assessment and document accordingly.</p>	
4	<p>The Head of Healthcare should:</p> <ul style="list-style-type: none"> <li>commission an investigation into the decision by Nurse A not to complete an emergency mental health assessment on 31 August;</li> <li>implement any actions or learning deriving from this</li> </ul>	Not Accepted	<p>We will not be commissioning an investigation into Nurse A because she acted in line with the NHSE service specification guidance and, as such, did not meet the threshold for undertaking an investigation. Sodexo's investigation guidelines state that an investigation may be required for one of the following reasons:</p> <ul style="list-style-type: none"> <li>when misconduct is suspected;</li> <li>where performance related issues have arisen; or</li> <li>when an employee has raised a grievance.</li> </ul>	N/A

**Action Plan – Mr Vasile Nastase at HMP Forest Bank – Self-Inflicted Death on 01/09/2019**

<b>No</b>	<b>Recommendation</b>	<b>Accepted/ Not Accepted</b>	<b>Response</b>	<b>Target date for completion and function responsible</b>
	investigation as a matter of urgency; and  • provide a report to the Ombudsman.		None of these reasons apply in respect of Nurse A's actions.	
5	The Head of Healthcare should ensure that healthcare staff are transferred from Sodexo to GMMH as a matter of urgency to enable the Mental Health Manager to manage the mental health team in a seamless manner, developing staff where required.	Not Accepted	This is a commercially sensitive matter currently under review through contract review meetings with NHSE, Head of Healthcare and Sodexo Healthcare Corporate team.  The mental health team has management of the Sodexo healthcare staff with 50% of their salary paid by Sodexo to enable the governance for this process. The mental health manager completes all the Sodexo mental health staff 1-1s, clinical supervision, training bookings and absence management. The mental health manager has incorporated the Sodexo mental health nurses working alongside the GMMH nurses and has adjusted the shift patterns to integrate the team together accordingly.	N/A
6	The Director should ensure that: • a formal translation policy is produced for communicating with prisoners who do not speak or understand English well;	Accepted	The early days in custody policy makes reference to translation services.  Early days information is available in the most popular 5 languages. The top 5 languages within the	Head of Safety & Decency  Completed

**Action Plan – Mr Vasile Nastase at HMP Forest Bank – Self-Inflicted Death on 01/09/2019**

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
	<ul style="list-style-type: none"> <li>• accredited interpretation services are used by all members of staff, including healthcare staff, when interviewing or assessing such prisoners;</li> <li>• staff should explain sentencing decisions to such prisoners using interpretation services; and</li> <li>• staff are able to use interpretation services in cells and other non-office situations when required (for example, by means of a hand held portable telephone).</li> </ul>		<p>prison are reviewed in accordance with the population profile.</p> <p>All residents on entry to the prison are given a reception healthcare screen and translation services are available in this area.</p> <p>The prison processes behind the sentencing decisions of the court are explained by OMU (Offender Management Unit), within 7 days, as specified within the Lifer Manual, using translation services.</p> <p>Big Word is not compatible with portable phones due to the way it connects into the various languages required. However, we will conduct a feasibility study into the use of Big Word translation services with in-cell telephony.</p> <p>After conducting the feasibility study it was apparent the in-cell telephony does not support the Big Word translation services. There has been a marked increase in the use of Big Word across the establishment. Plus, with the recent appointment of a full time Foreign National Prisoner Coordinator there is an increase in resource dedicated to supporting our FNO population.</p>	<p>Head of Performance &amp; Administration</p> <p>Completed</p>

**Action Plan – Mr Vasile Nastase at HMP Forest Bank – Self-Inflicted Death on 01/09/2019**

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
7	The Director and the Head of Healthcare should agree a protocol with the local ambulance service to ensure they understand the prison context and that staff who request ambulances might not be able to provide detailed information about the patient immediately.	Accepted	<p>There is a protocol in place between North West prisons (which includes HMP Forest Bank) and North West Ambulance Service (NWAS).</p> <p>However, we acknowledge that communications staff should call an ambulance immediately and provide updates to the ambulance service as and when the information becomes available.</p> <p>Officers working in the Communications Room will be re-trained in emergency response practices and their training records will be updated to reflect this.</p>	<p>Head of Security and Operations</p> <p>Completed July 2020</p>
8	The Director and Head of Healthcare should ensure that: <ul style="list-style-type: none"> <li>• staff use an appropriate code to communicate a medical emergency; and</li> <li>• communication room staff call an ambulance immediately, and are provided with sufficient training.</li> </ul>	Accepted	<p>The correct code was used to communicate the medical emergency, however, a Director's Instruction was re-issued in September 2019 reminding all staff of the emergency response codes to be used in a medical emergency and the importance of following correct procedure, including the implications of any delay.</p> <p>Officers working in the Communications Room will be re-trained in emergency response practices and their training records will be updated to reflect this.</p>	<p>Head of Security and Operations</p> <p>Completed July 2020</p>

**Action Plan – Mr Vasile Nastase at HMP Forest Bank – Self-Inflicted Death on 01/09/2019**

<b>No</b>	<b>Recommendation</b>	<b>Accepted/ Not Accepted</b>	<b>Response</b>	<b>Target date for completion and function responsible</b>
9	The Director and Head of Healthcare should ensure that all relevant staff are able to attend a debrief following a death in custody.	Not Accepted	Three separate dates were arranged to try and accommodate a time when most staff, based on a 24hr operational shift, were available. In this instance most of the staff involved worked nights, and, as such, the de-briefs were attended as far as could be accommodated. There were 8 participants at the Hot De-brief and 5 participants at the Cold De-brief.	N/A