Action Plan – Mr Roy Glassford at HMP Leeds – Self-Inflicted on 26/08/2018

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular, staff should: • assess the level of a prisoner's risk of suicide and self-harm based on all available information and known risk factors and not on a prisoner's own presentation; and • set Care Map actions that are specific, meaningful and time-bound, aimed at reducing a prisoner's risks to themselves, and update them if additional needs are	Accepted	A revision of the 'Single Case Manager' (SCM) model of ACCT case management took place in February 2019, with three dedicated Supervising Officers (SOs) being responsible for the end-to-end case management of all prisoners that are supported through ACCT processes. National guidelines advocate the SCM model as best practice for supporting those prisoners at risk of self-harm or suicide. Through appointing a single case manager, prisoners receive seamless and regular support throughout their time on the ACCT and this has improved consistency, transparency and legitimacy of the process. All ACCT case managers have received safety training and are closely monitored through the line management hierarchy within the Safer Custody team. The focus is on minimising self-harm and suicide through the improvement of ACCT procedures. The training reinforces the need to consider and make decisions based on all available information and known risk factors rather than presentation alone. Staff are also reminded that caremap actions should be specific, meaningful and time-bound and aimed at reducing a prisoners' risk and that when additional needs have been identified these are added to the Care Map. Existing processes to assess the quality of ACCT documents will also be refined and improved. Training for authors of quality assurance documents will be undertaken to ensure they fully understand what is required, identify	Head of Safer Custody April 2019

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	identified.		deficiencies and take action to rectify. Where necessary, case managers will be offered further line management support and guidance, including written feedback. Development plans will also be used to strengthen learning if required.	
2	The Governor and Head of Healthcare should ensure that prisoners passing through reception on return to the prison after a court appearance, police questioning or any other event that might increase their risk, are screened to assess their risk of suicide and self-harm and for potential health problems.	Accepted	A review of procedures will be undertaken to ensure that when prisoners arrive back to the prison following a court appearance, police production or any other circumstance that may affect their risk, they are screened for potential health problems and their risk of suicide and self-harm is assessed.	Head of Safer Custody June 2019
3	The Governor should ensure that arrangements are in place to identify prisoners who may be at increased risk of suicide and self-harm, or require a healthcare	Accepted	To identify prisoners who may be at risk of suicide and self-harm, or require a healthcare assessment following a court appearance by video link, there will be an addition to the 'Know Your Job Sheet' (KYJS) that is used by the video link officers. This will ensure that staff supervising video link procedures are aware of their responsibility to identify prisoners whose risk of suicide and self-harm may have increased as a result of their video link proceedings. The KYJS	Head of Safer Custody April 2019

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	assessment, following a court appearance by video link.		will also include actions to be taken following any such identification of increased risk.	
4	The Head of Healthcare should ensure mental health staff receive formal in-house risk assessment and management of mental health training.	Accepted	The mental health team have implemented the Functional Analysis of Care Environment (FACE) risk assessment in order to evaluate a prisoner's risk of suicide and self-harm and this is now completed for every prisoner who is on the caseload. Training was provided to the mental health staff in January 2019. An audit was carried out in February 2019 to ensure full compliance	Head of Healthcare Completed
5	The Head of Healthcare should ensure staff are aware of the Mental Capacity Act (2005) and how to use mental capacity assessments.	Accepted	All staff have been instructed to complete the Mental Capacity Act (MCA) training via e-learning. Compliance has been monitored as part of the statutory mandatory training target since January 2019. HMP Leeds has been 100% complaint in all statutory mandatory training since February 2019.	Head of Healthcare Completed
6	The Governor and Head of Healthcare should ensure that all staff are aware of the management of food refusal policy and audit its use.	Accepted	The Safeguarding Strategy for HMP Leeds which includes the management of food refusal policy was revised in January 2019. This strategy will be circulated to all staff electronically and hard copies will be printed and distributed to all areas of the establishment. A Staff Information Notice will be published reminding all staff of the importance in adhering to the management of food refusal policy.	Head of Safer Custody April 2019

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No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**
7	The Head of Healthcare should ensure that there is a robust system in place to identify when prisoners do not collect their medication and that healthcare staff take appropriate action.	Accepted	All missed medication of concern is discussed and documented on SystmOne at the daily service meeting. Pharmacy Technicians endeavour to contact a patient whenever they have missed medications to discuss any issues although prisoners do have a right to refuse medication.	Head of Healthcare Completed