

Action Plan – Mr Trevor Oakley at HMP Winchester – Self-Inflicted on 22/10/2018

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Governor and Head of Healthcare should ensure that reception staff start ACCT procedures whenever a prisoner has significant risk factors, regardless of the prisoner's stated intentions.	Accepted	<p>All reception staff at HMP Winchester have been reminded via daily and weekly team briefings and supervision of the need to consider all available risk-related information when considering a prisoner's risk factors and the need to open an ACCT, and not rely solely on the prisoner's presentation. Staff have been reminded of the need to review all documentation including the Suicide and Self-Harm warning form (SASH), the Person Escort Record (PER), NOMIS, and the Police National Computer (PNC) before interviewing the prisoner to ensure that all risks are identified.</p> <p>The PER and SASH sheets are now integrated, and these are checked and signed by reception managers during the handover from escort staff. A red flag page alerts reception staff to any risks or concerns. Safer custody are sent copies of such documentation on a daily basis so that risks are widely shared and identified.</p>	Completed Head of Safety Custody.
2	<p>The Governor and Head of Healthcare should ensure that staff manage ACCT procedures in line with the guidance in PSI 64/2011, including that:</p> <ul style="list-style-type: none"> • healthcare staff always attend the first case review; and • staff hold post-closure reviews within seven days of the ACCT being closed, and complete the post-closure review paperwork fully and 	Accepted	<p>HMP Winchester's ACCT case manager/review booking system will be reviewed to ensure that consistent case management and multi-disciplinary attendance occurs.</p> <p>ACCT documents are now returned to the Safer Custody department upon closure. The Safer Custody team then redistribute the ACCT to the relevant case managers within 7 days for a post closure interview to take place, with assurance checks undertaken by Safer Custody.</p>	July 2019 Head of Safer Custody.

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	accurately.			
3	The Governor and Head of Healthcare should develop a system to identify and record dates that might be triggers for suicide and self-harm, such as court dates, and ensure wing and healthcare staff are made aware.	Accepted	<p>The keyworker element of OMIC (Offender Management in Custody) sets out a mandated 45 minute session per week for each prisoner with their nominated keyworker. These sessions improve the flow of information around risks and triggers/significant court dates, and in addition an alert is being added to the prison NOMIS database for dates that will automatically raise an alert closer to that time.</p> <p>The keyworker is able to contact the healthcare department via telephone and email referral or by attending the weekly safety information meeting and raising the concern in this forum.</p>	Head of Residence June 2019.
4	The Governor and Head of Healthcare should ensure that prisoners passing through reception on return to the prison after a court appearance, 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	All prisoners returning from court are seen by reception staff. HMP Winchester is currently embedding a 'change of status' document in reception that will flag risks associated with ongoing court appearances, change of status from remand through to trial, conviction and sentencing so that decisions around ongoing care and possible support via the ACCT process are made at this early point. Consideration will be given to opening an ACCT where risks have been identified, and to ensure that any relevant information and documentation is shared with healthcare.	Head of Operations June 2019.
5	The Governor should ensure that where a member of staff cannot see a prisoner in their cell, and they consider it unsafe to enter the cell alone to check on the prisoner, they request assistance immediately.	Accepted.	A notice to staff was issued in April 2019 reminding staff of the requirement that, when they consider it unsafe to enter a cell alone, they must raise the alarm either by calling for assistance or via a radio message at the scene and remain at the cell door until help arrives. As soon as a second member of staff has arrived the cell will be entered and the occupant checked.	Completed. Governor

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			In the event that the situation is deemed life-threatening, staff are expected to enter the cell to render immediate assistance once they have raised the alarm.	
6	The Governor should ensure all staff, irrespective of status, position or experience, are offered formal support from the prison, following a death in custody.	Accepted	Hot debriefs now take place at HMP Winchester following any serious incident and include all staff affected. There is also a newly established care team on site to provide staff with support as well as the staff support services available via the intranet.	Completed Head of Safer Custody