Action Plan – Mr Daniel Wilcock. Self-Inflicted. HMP Leeds. 03/04/18				
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, including ensuring that they: • hold a multidisciplinary case review within 24 hours of an ACCT being opened; • consider all risk factors, including suicidal statements, current self-harming behaviour and previous suicide attempts, when assessing a prisoner's risk; • do not record ACCT caremap actions as complete until they have been completed; • 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	The 'Single Case Manager' (SCM) model of ACCT case management was introduced at HMP Leeds in May 2018. 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 in line with national guidelines. A revision of the SCM model was introduced in January 2019 bringing ACCT case managers under the remit of the Safer Custody department. This will allow for specific training and close monitoring through the line management hierarchy. There will be a focus upon the improvement of ACCT documents to ensure multidisciplinary reviews are held within the first 24 hours of the ACCT being opened, that all risk factors including suicidal statements, current self-harming behaviour and previous suicide attempts are considered and that there is an adherence to the set frequency of observations. ACCT Case Managers will be reminded that all caremap actions must be completed before an ACCT document is closed and that actions should not be marked as complete unless the issue to which they relate has been resolved and the associated risk reduced. 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 deficiencies and take action to rectify. Where necessary, case managers will be offered further line management	Head of Safer Custody April 2019

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			support and guidance, including written feedback. Development plans will also be used to strengthen learning if required. Pocket sized cards highlighting correct procedures around the ACCT process will also be distributed to all staff. In addition in December 2018, a staff training day dedicated to Safety and ACCT procedures was attended by both operational and non-operational staff.	
2	The Governor should ensure that when prisoners say they have ligatures, staff search them and their cells as soon as possible and remove any ligature.	Accepted	A Governor's Order was published in December 2018 reminding staff of the action that should be taken when prisoners say they have ligatures, specifically that checks of the prisoner and their cells take place as soon as it is safe to do so, to ensure that any potential ligature is removed at the earliest opportunity.	Head of Safer Custody Completed
3	The Head of Healthcare should ensure that healthcare staff assess and treat all prisoners who have self-harmed, including those who report self-harm.	Accepted	A local operating procedure will be developed to give clear guidance to healthcare staff when a patient claims to have self-harmed and in particular to have swallowed razor blades. This will include the observations to be undertaken and appropriate escalation of any health concerns to hospital. This will be distributed to all staff and discussed at team meetings. The process will then be shared with prison colleges. The Primary Care Manager will randomly audit incidents to ensure compliance from the nursing team as part of Care UK scheduled audits.	Head of Healthcare March 2019
4	The Head of Healthcare should ensure that prisoners: • are seen within prescribed timescales; and	Accepted	A new mental health triage process was implemented in October 2018. Triage assessments are now wing based using an evidence based triage template. This has ensured the five day target is reached. Compliance is monitored through a tracker of all referrals including timescale and	Head of Healthcare Completed

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	• are not discharged from the mental health team without being assessed.		outcomes. In November 2018 all 203 referrals were assessed with 5 days. Quality Assurance is monitored through a monthly clinical lead meeting.	
5	The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that control room staff call an ambulance as soon as an emergency code is called.	Accepted	A Staff Information Notice reiterating staff responsibilities during medical emergencies was published in December 2018 and includes the need for control room staff to call an ambulance immediately in the event of an emergency. Global emails to all staff are also circulated every 6 months highlighting their responsibilities during medical emergencies. This was last circulated in March 2019.	Head of Safer Custody Completed
6	The Governor should ensure, in line with PSI 64/2011, that where it has not been possible for someone from the prison to inform the family about a death in custody, prison staff should arrange a visit as soon as possible afterwards.	Accepted	The Head of Safer Custody will provide a briefing to staff who undertake the role of Family Liaison Officer (FLO), to remind them that if the prison has not been able to inform the family of a death in custody directly, then a visit by prison staff should be arranged as soon as possible in line with PSI 64/2011. Any decisions should be fully documented within the FLO Log. It is recognised that staff undertaking family liaison work must be sensitive to the wishes of the family. PSI 64/2011 does not currently recognise the potential need for alternative forms of liaison if deemed to be more appropriate in individual circumstances. A review of PSI 64/2011 is being conducted, and the policy framework that is issued to replace it will include scope for FLOs to be more flexible in their response to sensitive situations such as this.	Head of Safer Custody March 2019 Safer Custody and Policy Team March 2020