Action Plan – Mr Wayne Boughen at HMP Leeds – Self-Inflicted Death on 17/11/2018				
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 or self-harm in line with national guidelines, including in particular that: • staff have a clear understanding of their responsibilities when conducting ACCT observations; • observations are carried out at unpredictable intervals and within the prescribed timeframe; • ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk; and • all case reviews are included in the ACCT documentation.	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 quality assurance system for ACCT documentation is in place. Any deficiencies identified are fed back at source to the staff member responsible and this includes checks around the irregularity and timeliness of observations. Repeat non-compliance is managed through formal performance processes. A revision of the SCM model was introduced in January 2019 bringing ACCT case managers under the remit of the Safer Custody department. Three operational staff were recruited into the ACCT case manager roles and this enabled application of specific training and close monitoring through the line management hierarchy. Further plans are to increase the number of ACCT case managers from 3 to 4 as this will ease caseloads and assist in adherence to national guidelines. Since Mr Boughen's death a staff training day dedicated to Safety and ACCT procedures was organised and attended by both operational and non-operational staff. This reiterated staff responsibilities when conducting ACCT observations and emphasised that observations must be at unpredictable intervals and within the specified timeframe. A further staff training day dedicated to Safety is being planned for November 2019 and this will emphasise the importance of conducting ACCT reviews whenever the prisoner	Head of Safety November 2019

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			is at increased risk as well as consolidating staff understanding their responsibilities around ACCT observations. Pocket sized cards highlighting correct procedures around the ACCT process have been distributed to all staff. All ACCT case managers will be reminded to ensure case reviews must be included in the ACCT document. This will be through verbal briefings and complemented via email to all ACCT case managers by the Head of Safety. Existing processes to assess the quality of ACCT documents have also been refined and improved. Training for authors of quality assurance documents has been delivered to ensure they fully understand what is required, identify deficiencies and take action to rectify. Where necessary, case managers are offered structured supervision and further line management support and guidance.	
3	The Head of Healthcare should ensure that the care provided for prisoners with severe and enduring mental health problems is delivered in line with NICE guidance NG66, including ensuring that the prisoner is allocated a care co-ordinator and detailed care plans are established.	Accepted	Patients with severe and enduring mental health problems are on a mental health caseload with appropriate care plans and allocated case manager/co-ordinator. Since December 2018, a monthly audit check is completed of all patients on a CPA to ensure that a care plan has been put in place and the annual review is booked. These patients are discussed in mental health MDT meetings on a regular basis and these meetings are attended by the Psychiatrist. Regular care plan audits are carried out by the mental health service manager. This is in line with NICE guidance NG66.	Head of Healthcare May 2019