

Action Plan – Mr Darren Pallas at HMP Leeds– Self Inflicted Death on 31/01/2020

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	<p>The Governor and Head of Healthcare should ensure that:</p> <ul style="list-style-type: none"> • prison, healthcare and mental health team staff work jointly to manage prisoners at risk of suicide and self-harm; and • Staff do not end ACCT monitoring until all the risks noted in a prisoner's caremap have been adequately addressed and the caremap actions completed. 	Accepted	<p>Case managers have been tasked with ensuring a multidisciplinary approach is maintained at all ACCT case reviews. They ensure that all key stakeholders, including Healthcare have been made aware of all ACCT reviews taking place each day. Where mental health issues have been identified, they must also make sure that Healthcare provide verbal or written input if attendance cannot be facilitated. Case managers have also been made fully aware that ACCTs must not be closed without Healthcare in attendance.</p> <p>The Safer Custody function will deliver bespoke ACCT case manager training specific to caremaps and what constitutes a completed action to all Band 4 case managers, Band 5 enhanced case managers and the Senior Management Team, who are responsible for complex case management. Staff will be reminded of the requirement to ensure that risks have been fully addressed before caremap actions are marked as completed. The training will also reiterate the need to consult with the mental health team prior to closure to confirm that there are no caremap actions specific to healthcare that remain outstanding and must ensure that these have been documented by a named Mental Health nurse.</p> <p>A new quality assurance (QA) process will also be introduced to strengthen current practice, which will include a daily residential check of the ongoing record to ensure compliance with the required level of observations and conversations, a 72 hour QA check to ensure the ACCT has been opened and documented correctly, as well as a case manager QA check at every review. Once the ACCT is closed and the post closure review completed, a further check will be conducted by the Safety team to ensure all post closure reviews</p>	Head of Safer Custody/Head of Healthcare October 2020

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			evidence input from mental health. This will ensure that a consistent approach is being taken towards the quality of ACCT documents and caremaps. This new process will include checks to ensure that caremap actions have been dealt with appropriately, with a requirement to cross reference with SystmOne, to ensure healthcare specific caremap actions have been completed.	
2	The Governor and Head of Healthcare should ensure that staff are given clear guidance and check their understanding about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.	Accepted	<p>All Healthcare staff receive Immediate Life Support training on an annual basis to ensure that they are aware of and understand the European Resuscitation Council Guidelines.</p> <p>The Safety team will also re-distribute these guidelines to all staff at HMP Leeds via email. The guidelines make clear the circumstances in which resuscitation is considered to be inappropriate. The guidance will be issued on an annual basis and line managers will be asked to discuss with staff to check their understanding.</p>	Head of Healthcare/ Head of Safer Custody October 2020
3	The Governor should ensure that: <ul style="list-style-type: none"> • prisoners' next of kin details are kept up to date; and • when a prisoner dies in custody, a deputy family liaison officer is appointed and all contact with a next of kin is recorded to provide continuity of support in absence of the 	Accepted	<p>A Prisoner Information Notice will be issued on a six monthly basis requesting that prisoners provide up to date next of kin (NOK) details to so that records can be maintained.</p> <p>A Staff Information Notice will also be issued to encourage staff to check NOK details as part of their conversations during keyworker sessions and update these as appropriate on NOMIS.</p> <p>Reception processes will continue to include requests for NOK details. These measures will ensure that the prison are able to contact families quickly in cases of emergency.</p>	Head of Safer Custody October 2020

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	designated family liaison officer.		<p>The Safer Custody function will also continue to ensure that NOK details are collected as part of the ACCT process. A requirement that these are cross referenced with NOMIS and relevant updates made will form part of the new QA process for ACCT.</p> <p>The local contingency plans for deaths in custody have been updated to make clear that a named deputy family liaison officer (FLO) should be nominated at all times, so that they can provide appropriate support to the family in the absence of the designated FLO.</p>	Head of Operations Completed