Action Plan – Mr Azaz Sheikh at HMP Doncaster – Self Inflicted on 21/06/2020				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
1	The Director should initiate an investigation into CM A's actions in relation to the ACCT case review on 21 June with a view to considering whether disciplinary action is appropriate.	Accepted	An investigation will be commissioned into the events leading up to the death of Mr Sheikh and in relation to the ACCT case review chaired by CM A. A decision on whether disciplinary proceedings are appropriate will then be taken.	Director June 2021
2	The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with national policy, in particular staff should: • invite all relevant staff to ACCT case reviews, and obtain contributions from those unable to attend; • assess risk based on the prisoner's known risk factors, including any recent suicide attempts and incidents of self-harm, and set an appropriate level of observations based on the level of risk; • mark caremap actions as completed only once they	Accepted	All new operational staff receive Suicide and Self-Harm Training (SASH) as part of their initial prison officer or Custodial Operations Manager (COM) training. This is a national Prison Service package designed to ensure that staff understand the risks factors which must be considered when assessing a prisoner's risk of suicide and self-harm. An ongoing programme of refresher training for all existing staff is also being delivered as part of the establishment's training plan. In April 2020, a management restructure was undertaken at HMP Doncaster with the introduction of a new Head of Safer Custody and a new Safer Custody COM. Resources within the Safer Custody team were also increased by the addition of a Safer Custody Analyst, four Prison Custody Officers, with additional ACCT Assessors being trained. The Director continues to monitor the progress seen following the introduction of these measures and to ensure learning continues to be taken forward in order to drive up the quality of ACCT case management further. Additional ACCT case management training has also been delivered by the Yorkshire Prison Group Safety team to all Band 4 and Band 5 case managers	Head of Safer Custody Completed

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	have been actioned fully; and • keep accurate records of case reviews and who attended.		to enhance their existing knowledge and skill levels, and to ensure staff conduct ACCT reviews in line with national guidance. The training reiterates the need to consider all risk factors when assessing a prisoner's risk of suicide and self-harm and that decisions must not be based on presentation alone. Information regarding any recent suicide attempt or incident of self-harm must also be considered as part of the risk assessment process. Staff are also reminded of the importance of setting appropriate levels of observations based on the current level of risk. The requirement for all caremap actions to have been completed before an ACCT can be closed is reinforced, as well as the need for reviews to be multidisciplinary with contributions sought from relevant staff if attendance is not possible. Where a prisoner has been identified as having a mental health issue, the attendance of the Mental Health team is requested to ensure that any caremap actions in relation to Healthcare have been completed, where consideration is being given to the closure of an ACCT. Defensible Decision Making training has also been delivered to all COMs and ACCT case managers by the Group Safety team. This training aims to refresh learning for current staff and highlight the importance of recording decisions made. In June 2020, a new process of ACCT assurance was also introduced. Duty Directors now carry out assurance checks of documents throughout the week, as well as a 10% quality check at weekends. In addition, Night Duty Managers now conduct sample checks of documents during night duties to assure the quality of the process and documentation. Lessons learned and advice or	

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			guidance is taken forward by the Safer Custody COM. They also carry out a post-closure quality review on 10% of ACCT plans. Any identified shortfalls are raised with the case manager as points of learning and highlighted to the relevant COM or Duty Director as appropriate. HMP Doncaster will continue to be supported by the Group Safety team, who will provide regular independent assurance visits and feedback on any areas where performance is not to the required standard. Nationally, work is currently underway to roll out a revised version of the ACCT case management system during this year. Prior to going live, establishments will be supported with an awareness raising period in order to understand the changes made and the principles underpinning effective delivery of ACCT. Linked to the roll-out of the updated ACCT across the estate, HMPPS are also in the process of refreshing safety training. This includes modules on self-harm and suicide, and risks and triggers among other topics. Within this training, there will be an emphasis on the need for assessments of risk to consider all available information, rather than being reliant on presentation alone.	
3	The Head of Healthcare should review the task system on SystmOne to ensure that requests for continuation of medication are actioned appropriately.	Accepted	A Local Operating Procedure (LOP) is in place identifying the process that staff should follow to ensure the continuity of medication. However, a review of the task system is underway and a LOP regarding communication and management of tasks is awaiting ratification.	Head of Healthcare Feb 2021

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4	The Head of Healthcare should review the mental health appointment system and ensure that all referrals are seen within the appropriate timescales.	Accepted	There is now a triage system in place for referrals to Mental Health (MH). Urgent referrals are seen within 48 hours and non-urgent within five days. All triages are recorded on a triage tracker which identifies the date referred, urgency, date seen and any further follow up required. If it is deemed appropriate for a full MH assessment to be carried out, then this is either booked by the clinician at the time, for the next available appointment with themselves for continuity, or a task sent to the administration team to book in the next available slot with another clinician. This is audited weekly by the MH matron and the tracker is updated daily by the administration team. Where a prisoner has self-harmed or been placed on an ACCT, a full MH assessment is routinely completed within 48 hours. These processes are regularly discussed in handovers, MDTs, and individual supervision to ensure staff are aware.	Head of Healthcare & Mental Health Matron Completed
5	The Director should ensure that: • the key worker scheme is effective at providing meaningful support to prisoners; • a named key worker is allocated to each prisoner and any changes in key worker allocation are kept to a minimum; and	Accepted	Key work was suspended on 24 March 2020 as extensive restrictions were introduced to manage the impact of COVID 19 in prisons. Prisons have since been working to an Exceptional Delivery Module seeking to deliver key work to identified groups of priority prisoners where it is safe and possible to do so. Although HMP Doncaster undertook to continue with keyworker sessions, Mr Sheikh did not fall into one of the priority groups. However, there is a commitment to ensuring that key work is reinstated fully across the estate when safe to do so. In preparation the Director has changed the management structure for the keyworker scheme with overall responsibility now sitting with the Head of Residence who has been tasked with ensuring that the scheme is effective at providing meaningful support and that contact takes place in line with national guidance.	Head of Residence

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	• contacts take place in accordance with the national policy framework.		Management checks at HMP Doncaster are currently in the process of being updated and implemented to ensure that there are no prisoners who have not been allocated a named key worker. Changes of keyworker will be kept to a minimum wherever possible and will only occur in exceptional circumstances and these management checks will highlight any unnecessary changes. Additional checks will also be introduced that focus on individual performance and which will evaluate key worker sessions with built in training/coaching for staff as required.	
6	The Executive Director of Custodial Contracts should: • satisfy himself that processes are in place at Doncaster to ensure that the PPO's recommendations are being implemented and embedded; and • write to the Ombudsman to report his findings.	Accepted	A letter will be sent from the Executive Director of Custodial Contracts to the Ombudsman, setting out what will be done to ensure that processes have been put in place at HMP Doncaster, in order to implement and embed PPO recommendations.	Executive Director of Custodial Contracts February 2021
7	The Director should ensure that control room staff call an ambulance immediately when a medical emergency code is called.	Accepted	The LOP for managing those at risk of harm has been revised and guidance issued to control room staff with regards to the importance of notifying emergency services immediately when a medical emergency code is called.	Head of Safer Custody Completed

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			It has also been noted within a recent Early Learning Review conducted by the Group Safety Team for a separate incident, that changes to this process are much improved and now embedded.	
8	The Director and Head of Healthcare should share this report with CM B and Officer A (when she returns to work) and arrange for a senior manager to discuss the Ombudsman's findings with them.	Accepted	The named members of staff will be issued with a copy of this report and spoken to individually by the Head of Safer Custody to ensure they are aware of the findings. Any further clarity required in relation to the Mental Health referral processes and medication management will see staff signposted to the Head or Deputy Head of Healthcare. This will enhance opportunities for partnership working.	Head of Safer Custody April 2021