

Action Plan – Mr Daniel Akam at HMP Lindholme – Self-Inflicted Death on 13/10/2018

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Governor should provide the Ombudsman with a copy of the report of the disciplinary investigation into Officer B's failure to carry out the ACCT check, Including the reasons why it was decided to take no further action.	Accepted	A copy of the report has been shared with the Ombudsman.	Governing Governor Completed
2	The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidance, including that: <ul style="list-style-type: none"> • healthcare staff attend all first case reviews; • staff review the level of risk and frequency of observations immediately if the prisoner's circumstances change, and do not wait for the next ACCT review; • staff hold multidisciplinary 	Accepted	<p>All new operational staff receive Suicide and Self Harm (SASH) training as part of the induction process. This is a national training package made up of six modules focusing on areas of specific need and is designed to ensure that staff understand the risks factors which must be considered when assessing a prisoner's risk of suicide and self-harm. SASH training for all staff in modules 1-6 has been scheduled to take place up until 2021. The Safer Custody team also regularly publishes learning and staff information notices reminding staff of national guidelines on the management of prisoners at risk of suicide and self-harm in line with PSI 64/2011.</p> <p>A Notice to Staff (NTS) was issued in November 2018 reminding staff of the need for Healthcare to attend all first case reviews and that subsequent ACCT reviews must be multidisciplinary. Additionally, Mental Health staff are aware that they should attend or make a verbal contribution at ACCT reviews and other staff such as chaplains and workshop instructors are also aware that they should attend if there is a need. The NTS also reiterated the requirement</p>	Head of Safety Completed

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	<p>case reviews; and</p> <ul style="list-style-type: none"> • staff adhere to the frequency of observations set out in the ACCT document and conduct observations at unpredictable times. 		<p>for staff to adhere to the level of observations set out in the ACCT document and to ensure these are carried out at unpredictable times. Staff were also reminded of the importance of reviewing the frequency of observations outside of the ACCT review, should there be a change in circumstances or concerns raised.</p> <p>72 hour and fortnightly quality assurance checks are conducted by the Safer Custody team and Residential Managers to ensure compliance, with an additional check made by the Safer Custody team once the ACCT is closed. There is also a review undertaken on two ACCTs per month, whereby CCTV is viewed, to ensure observations during the night have been recorded correctly. Any evidence of non-compliance is challenged through the line management hierarchy and warning letters issued where appropriate. Repeat non-compliance will be challenged through performance measures.</p> <p>The Local Operating Policy (LOP) for Healthcare attendance at ACCT reviews was reviewed in December 2018 and re-issued to Healthcare staff at that time. This reiterates the importance of Healthcare’s involvement in the ACCT process and reinforces the requirement for Healthcare to be in attendance at a first case review. A Mental Health duty worker is also contactable via radio, so that they can be invited to a first case review. Data regarding attendance at a first case review is also reported to Care UK via the PROTECT audit, which is undertaken every three months. If Healthcare staff have not been able to attend a first review, it is raised at the daily morning briefing.</p>	<p>Head of Healthcare Completed</p>
3	<p>The Governor should ensure that investigations into acts and threats of violence are</p>	<p>Accepted</p>	<p>All acts of violence are referred to the Safer Custody team through the CSIP process. All incidents are now triangulated every morning at the residential briefing using IR, IRS and wing observation books, to ensure all incidents have</p>	<p>Head of Safety Completed</p>

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	conducted and completed in accordance with the prison's violence reduction policy.		<p>been captured. Since Mr Akam's death staff have been ring fenced within the Safer Custody team to ensure that a full investigation is completed within the required 72 hours timescale. All outcomes are passed to Residential Custodial Managers for further action, as deemed appropriate. A CSIP quality assurance process was introduced in June 2019 and is currently being embedded.</p> <p>Prisoners assessed as presenting a high level of risk to others are warned at Reception about consequences of continued anti-social behaviour, and problematic prisoners are discussed at the weekly SIM meeting.</p>	
4	The Head of Healthcare should ensure that healthcare staff know the criteria for referring prisoners to GPs and prison psychiatrists to ensure that tasks are actioned promptly by the appropriate personnel.	Accepted	<p>Referrals to the GP and Psychiatrist can be made via SystemOne task. The Task LOP instructs Healthcare staff to task to groups, as opposed to individuals, so that referrals and requests can be actioned promptly. Tasks are audited monthly by the Practice Manager and any concerns or issues are raised with the member of staff sending the task.</p> <p>All Healthcare staff are aware of the criteria for referral to the GP or the Psychiatrist and this has been discussed in the daily team handover and in team meetings. Inappropriate tasks are raised, by the GP or Psychiatrist, with the Head of Healthcare in order to identify training and knowledge gaps which need addressing with healthcare staff.</p>	Head of Healthcare Completed
5	The Governor should ensure that following a death in custody direct contact is made with the nominated next of kin and or other immediate family members	Accepted	Under the Offender Management in Custody (OMIC) model introduced in 2018, keyworkers will, as part of their weekly interactions with prisoners, update next of kin (NOK) details at periodic intervals to ensure the correct information is held on file. In addition, any time a prisoner goes through Reception, (new transfer in, transfer out, external escort, bed watch) their NOK details are refreshed as part of that process.	Head of Safety Completed

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	wherever possible, in line with Prison Service Instruction 64/2011.		All Family Liaison Officers (FLO) have been sent an email to remind them of the need to visit the next of kin or other family members in person, wherever possible, to break the news of any death in custody.	