

Action Plan – Mr Nigel Coomber at HMP Winchester – Self-Inflicted Death on 17/03/2019

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure that healthcare staff attending ACCT reviews have familiarised themselves with the prisoners' relevant medical history prior to attending.	Accepted	<p>The system for monitoring ACCT reviews was updated in January 2020 and staff are now alerted to all upcoming reviews. This enables staff to review individual cases in advance to ensure they are aware of all key information.</p> <p>Staff are reminded during the weekly healthcare team meeting of the importance of reviewing the medical records prior to all individual reviews. The Nursing and Midwifery Council (NMC) code of conduct was also shared with clinical staff in February 2020 to remind them of their responsibility to maintain and review clinical records in line with the professional standards.</p> <p>The senior healthcare managers reviewed the ACCT process in January 2020 and assessed the mental health team staffing levels and the number of ACCT reviews that should be scheduled each week. The number of reviews that should be held were agreed and added to the local operating procedure (LOP).</p>	<p>Completed Head of Healthcare</p> <p>Completed Head of Healthcare and the Mental Health Team</p>
2	<p>The Head of Healthcare should ensure that:</p> <ul style="list-style-type: none"> • where it is suspected that a prisoner has a personality disorder, a full assessment is undertaken and a care plan put in place. Healthcare staff should consider whether to pursue a diagnosis and, where necessary, record their reasons for not doing so; • the risks associated with 	Accepted	<p>The screening process was reviewed in January 2020 to ensure that all prisoners are screened by the mental health team within 72 hours of arrival and any mental health needs are identified and a care plan is initiated at the first opportunity.</p> <p>Where a personality disorder is suspected, the mental health team initiate the appropriate care plan and hold individual assessments in order to consider whether a formal diagnosis is appropriate. Staff were reminded during briefings in January 2020 to record the reasons for any decisions that are made during all reviews within the patient records.</p> <p>The mental health team share key risk information, including the risks</p>	Completed Head of Healthcare

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	<p>certain mental health conditions, such as EUPD, should be shared with prison staff and taken into account in risk assessments.</p>		<p>associated with EUPD and other mental health conditions, with prison staff during the safety intervention meeting (SIM) where individual cases are discussed and any decisions made are recorded in the patient records and documented in the minutes of the meeting.</p> <p>The mental health team also hold mental health training sessions for all staff which were on hold due to Covid-19 but are due to recommence in 2021.</p>	
3	<p>The Governor and Head of Healthcare should ensure that:</p> <ul style="list-style-type: none"> • complex case meetings are made aware when a prisoner is being managed under ACCT; • complex case meeting discussions are clearly recorded; and • all information relating to risk that is discussed at such meetings is made available to relevant staff. 	Accepted	<p>The complex case meetings were reviewed in January 2020 and were renamed the safety intervention meeting (SIM). These are held weekly and are multi-disciplinary with attendance from every operational function within the prison in order to ensure that all key information, including whether a prisoner is on an ACCT, is discussed with a wider range of staff.</p> <p>Administrative staff that are responsible for taking the minutes during the SIM attended a minute taking course in August 2019. The SIM agenda was also updated to include the open ACCT caseload which ensures that all cases are discussed during the SIM.</p> <p>The minutes of the SIM are shared directly with all attendees following the meeting and are also attached to the weekly invites to ensure that all attendees have read the minutes from the previous meeting. The minutes are also held on the public drive that prison staff can access, staff were notified of their location on the shared drive in February 2020.</p>	<p>Completed Senior Managers</p> <p>Completed Head of Operations</p>

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4	The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular that evidence of risk should be fully considered and balanced against how the prisoner presents himself.	Accepted	<p>Suicide and Self-Harm (SASH) training is delivered to all staff on a rolling basis. The SASH training provides guidance on the ACCT process and includes the requirements for assessing risk. The SASH training was suspended due to the COVID-19 restrictions in 2020 and is due to recommence in 2021.</p> <p>A full review of the ACCT process took place in September 2019 and ACCT assessors are now multi-disciplinary. Staff also received focused training on the key risk factors and triggers and how to recognise these, including the importance of asking probing questions and the physical signs to look for.</p> <p>A monthly ACCT case manager training programme was introduced in October 2019 to give ongoing training to all case managers. This is attended by senior officers and custodial managers and includes information on risk assessments and the importance of considering the prisoner's presentation when assessing risk.</p>	<p>Head of Safer Custody August 2021</p> <p>Completed Head of Safer Custody</p>
5	The Governor should remind staff of the importance of using the correct medical emergency codes as soon as possible in an emergency, and the potential consequences of not doing so.	Accepted	<p>The Governor re-issued a notice to staff in January 2020, to remind staff of the importance of using the correct emergency codes immediately, in line with PSI 03/2013. This also outlined the potential consequences of any delays in calling the appropriate emergency code.</p> <p>Staff are regularly briefed on the importance of following the correct emergency process, including using the correct codes, to ensure that the emergency services attend as soon as possible.</p>	Completed Governor and Duty Managers

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6	The Prison Group Director for South Central should write personally to the Ombudsman to set out what he is doing to achieve improvements in risk assessment at Winchester.	Accepted	The Prison Group Director wrote to the Ombudsman on 26 February 2020.	Completed Prison Group Director