Action Plan in response to the PPO Report into the death of

Lewis Jeffers on 25/11/2020 at HMP Stocken

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with policy guidance and, in particular, they: • invite healthcare staff to the first case review and obtain a written contribution if they are unable to attend; • set caremap actions that are meaningful and individualised to address risk and sign them off as completed only once the issue identified has been fully addressed; • make clear, readable and accurate records on the ACCT paperwork.	Accepted	HMP Stocken continue to follow PSI 64/2011 'Management of prisoners at risk of harm to self, to others and from others' and the requirements of ACCT version 6. A notice to staff has been issued reminding staff that it is mandatory for healthcare to be invited to all first ACCT case reviews, and that a legible contribution must be obtained should healthcare be unable to attend. To assist with healthcare's availability to attend reviews a shared database has been created that details when healthcare are available so they can be booked to attend ACCT reviews. HMP Stocken intends to deliver refresher training throughout 2022 with the assistance of the Regional Safety Team. This training will provide ACCT case co-ordinators with best practice reminders, including the need for meaningful and individualised Care Plan actions that should be recorded as completed only when the issue identified has been addressed. It will also	Head of Safety HMPPS Head of Safety & Regional Safety Team HMPPS	Completed May 2022

			reinforce the importance of accurate and legible entries within the ACCT paperwork. Oversight of the ACCT process is conducted using the ACCT version 6 quality assurance (QA) tool to ensure prisoners at risk of suicide and self-harm are being managed effectively. The initial QA checks are completed by the Custodial Managers within 72 hours of an ACCT document being opened, and covers information gathering, the risk assessment and care planning. Learning from the QA checks is shared and discussed at the monthly safety meetings.	 Head of Safety HMPPS	 Completed
2	The Governor should share this report with SO A, SO B and SO C so they are aware of the Ombudsman's findings, and should arrange for them to have refresher ACCT training.	Accepted	This report has been shared with the named individuals and they will be attending the refresher ACCT training detailed in the previous recommendation. The recommendations will also be shared with the wider ACCT Case Co-ordinator group.	Head of Safety HMPPS	Completed
3	The Governor should ensure that prisoners are given timely access to Listeners when requested.	Accepted	A monthly rota has produced detailing the location of all the Listeners and highlights the duty Listener on each day of the month. If a Listener is required at any point during a 24hr period the request goes through the Orderly Officer to facilitate. During night state and dependent of risk level, the Orderly Officer may allocate two listeners and utilise the care suite. In addition, prisoners are able to access the Samaritans as all cells now contain in-cell telephony.	Head of Safety HMPPS	Completed

4	The Governor should ensure that all staff are aware of the local policy on responding to blocked observation panels.	Accepted	As detailed in the PPO report a notice to staff was issued in February 2021 covering blocked observation panels. This notice was reissued in March 2022 and the dangers of blocked observation panels will be discussed in staff meetings. Further reminders will be added to daily briefing sheets and incorporated into safety briefings. Additionally, the prison's process on blocked observation panels is incorporated in the Local Security Strategy which is available to all staff, and has been highlighted on the daily safety brief sent to all members of staff individually.	Head of Safety HMPPS	Completed
5	The Governor and Head of Healthcare should work with Safer Custody to establish joint information sharing from, and to, the counselling service to ensure that any relevant findings are available to key members of staff.	Accepted	Counsellors will be instructed to feedback relevant findings from sessions to the Safer Custody team, and ensure pertinent risks are recorded onto prison and healthcare systems, as appropriate. This way more relevant information will be available in preparation for prisoner ACCT reviews. The Safer Custody team can then generate the relevant IR/CSIP/ACCT dependant on the circumstances.	Head of Safety HMPPS	March 2022
6	The Governor and Head of Healthcare should ensure all staff who had significant involvement with any prisoner who dies in custody are offered support.	Accepted	Managers will be reminded to invite all those involved in a death in custody to any hot/cold debriefs and to offer support to those who may have been working with or caring for the prisoner prior to their death. There are a range of staff support initiatives available which are well publicised throughout the prison. These include the Post Incident Care Team (PICT) and the TRiM (Trauma Risk	Head of Safety HMPPS	March 2022

			Management) package. The duty practitioners for both can be found listed on the daily briefing sheets.		
7	The Governor should ensure that a family liaison officer is appointed as soon as possible after a death in custody and that decisions around how and when the family should be notified are properly recorded.	Accepted	HMP Stocken's death in custody contingency plan requires the appointment of a family liaison officer (FLO) at the earliest opportunity. The FLO will notify the family of the death as soon as possible. The only exception to this is during the night when local police are tasked with notifying the family, and contact is followed up by the FLO in the morning. The contingency paperwork records who from the family has been notified, when they were notified and where they were notified. When the police complete the notification they report the details to the Custodial Manager in charge of the prison (Orderly Officer) who is then responsible for relaying this information to the FLO. Custodial Managers will be reminded of the need to relay information from overnight deaths in custody to appointed FLOs upon commencement of their duties.	Head of Safety HMPPS	March 2022