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

Mr Christopher Riley - 10/03/2022 - HMP Leeds

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Governor and Head of Healthcare should ensure that staff identify and manage newly arrived prisoners at risk of suicide and self-harm in line with PSI 64/2011 and PSI 07/2015. In particular, reception, healthcare, first night staff an all others who assess risk should: • recognise the additional vulnerabilities of newly arrived prisoners and have a clear understanding of their responsibilities and the need to review all relevant records, including the Person Escort Record; • start ACCT procedures whenever a prisoner has significant risk factors, regardless of the prisoner's stated intentions; and	Accepted	In April 2022, the National Safety team carried out a Bus to Bed review of the processes for identifying newly arrived prisoners who are at risk of suicide and self-harm to ensure they are managed in line with PSI 64/2011. As a result, both reception and first night procedures have been updated. All digital Person Escort Records (PERs) with a self-harm alert are printed prior to the interview with the Reception Officer to ensure they are aware of information relating to the prisoner's risk of suicide and self-harm. Reception staff also now complete a Custody Care Record (CCR) for newly arrived prisoners which prompts staff to check all relevant records, including the PER form, for previous incidents of self-harm and other significant risk factors. It also reminds staff that assessment of risk should not be solely based on what a prisoner says. The form also includes a section to document	Head of Safety HMPPS/ Head of Healthcare PPG	Completed

	• document the information considered when deciding whether or not to start ACCT procedures.		defensible decisions regarding why the opening of an ACCT was not required at the time. The CCR accompanies the prisoner to the First Night Unit where a further interview is undertaken with the prisoner to ensure any risk factors have been identified and appropriate action taken. The Reception Supervising Officer carries out a daily quality assurance check of the CCR forms, with a further 10% monthly check undertaken by the Reception Manager and Safety team. To assist with the introduction of the new practices staff were issued with updated guidance and a 'Know Your Job' sheet. Floor walkers were also present during the first week of the implementation to ensure any questions could be answered and that staff were aware of their individual responsibilities. The National Safety team has also provided risk and triggers training focusing on first night and reception staff. This training reiterated the importance of documenting any risk information and the need for an ACCT to be opened where significant risk factors are present. In June 2022, all healthcare staff received additional training covering suicide prevention and identification of risks and triggers during reception. This explored the key areas of risk to		

			consider, rather than relying on self-disclosed information. During May to August 2022, ACCT refresher training was also delivered to all healthcare staff by the Safer Custody team. This will continue bi-annually.		
2	The Governor should ensure that safety custody welfare checks take place as requested.	Accepted	In April 2022, the Safety Function reinstated a log of all prisoners requiring safer custody welfare checks. This includes a record of who is responsible for carrying out the check and what action has been taken as a result. The Safety Custodial Manager monitors the log on a daily basis to ensure all prisoners have received the required checks.	Head of Safety HMPPS	Completed
3	The Prison Group Director for Yorkshire should write to the Ombudsman to set out what action she has taken to satisfy herself that meaningful improvements have been made to the assessment and management of the risk of suicide and self-harm at HMP Leeds.	Accepted	A letter has been sent from the Prison Group Director for Yorkshire to the Ombudsman, setting out the measures that have been implemented at HMP Leeds to provide assurance that meaningful progress has been made with regard to the assessment and management of the risk of suicide and self-harm.	Prison Group Director for Yorkshire HMPPS	Completed
4	The Head of Healthcare should: • ensure that mental health referrals process are promptly identified, processed and acted upon; • ensure that mental health assessments take place in line with local guidelines; and	Accepted	All referrals to the mental health team are now made through a Threshold Assessment Grid (TAG) referral process. This is a scoring assessment tool, which allows for the better allocation of offenders as it assesses the severity of an individual's mental health problems. These referrals are monitored by the Mental Health Lead on a weekly basis to ensure they have been actioned in line with local guidelines.	Head of Healthcare PPG	Completed

	• ensure that substance misuse reviews take place as scheduled and that, when it is not possible, a reason is documented in the prisoner's medical record.		Further monthly monitoring is also undertaken by the Head of Healthcare and submitted to NHSE commissioners quarterly to ensure compliance. The issue identified with the initial referral being directed to the incorrect task box has also been addressed with the individuals concerned. In July 2022, the healthcare team received additional training on the completion of the TAG referrals to ensure all reviews, including substance misuse reviews, are undertaken in a timely fashion and documented in the prisoner's medical record to prevent any delays. This training will continue to be provided bi-annually.		
5	The Governor should ensure that staff do not conduct ACCT observations for prisoners who are unconscious and on life support in hospital.	Accepted	Escort risk assessment forms have been updated to make clear that staff should not conduct ACCT observations for prisoners who are unconscious or on life support whilst in hospital. This requirement has also been highlighted during staff security briefings. In addition, Duty Managers have been made aware that they must relay this information to staff when dispatching escorts.	Head Of Security HMPPS	Completed
6	The Governor should remind staff of the importance of retaining paperwork relating to a prisoner's risk of suicide and self-harm, so that it is available to the PPO if required.	Accepted	A Notice to Staff will be issued to remind staff of the importance of correctly storing any paperwork in relation to the assessment of a prisoner's risk of suicide and self-harm should further scrutiny be needed.	Head of Safety HMPPS	December 2022

7	The Governor and Head of Healthcare should ensure that a copy of this report is shared with the staff named in this report and that a senior manager discusses the Ombudsman's findings with them.	Accepted	The report has been shared and the Ombudsman's findings discussed with all named prison staff during individual and group sessions carried out by the Safety team. All PPO reports and recommendations are routinely shared and discussed with healthcare staff during lessons learnt sessions. A quality assurance process is also undertaken on a monthly basis to ensure changes have been implemented and the learning from the reports is embedded. Reports are also sent by email to any staff unable to attend these sessions.	Head of Safety HMPPS/Head of Healthcare PPG	Completed