

Action Plan – Mr Halo Hama-Rashid at HMP Pentonville – Self-Inflicted Death on 28/08/2019

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
1	<p>The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with PSI 64/2011, including that:</p> <ul style="list-style-type: none"> •The ACCT assessment interview and first ACCT case review are completed within 24 hours of the start of ACCT procedures; •First ACCT case reviews are multidisciplinary and always include a member of healthcare staff; •Staff read the ACCT document and familiarise themselves with all relevant issues and known risk factors before holding reviews; •ACCT case reviews assess and record the level of risk, considering all risk factors; •A multi-disciplinary review is held when there is evidence of a significant change in risk; 	Accepted	<p>Following two reviews into ACCT procedures in January 2019 and April 2020, along with a review of staffing levels, the Governing Governor has increased staffing within the Safer Custody department to allow for a greater focus on the improvement and quality of ACCTs. There is now a dedicated Safer Custody Custodial Manager (CM) to mentor and support ACCT case managers in the delivery of ACCT procedures.</p> <p>There is a process in place to ensure all case managers receive national case manager training and the Safer Custody CM is implementing a mentoring program which will include good practice for caremaps, risks and triggers awareness, and a focus on tailoring the frequency of observations to reflect the prisoner's risk. This will be rolled out from September 2020.</p> <p>In February 2020 the Safer Custody team introduced a process to track all new ACCTs. A discussion about case reviews scheduled for the day takes place each morning at the operational briefing to ensure that the assessment interview and first case review is carried out within the 24 hour period as set out in PSI 64/2011.</p> <p>In February 2020 The London Group Prison Safety Lead and senior managers at Pentonville carried out a review of the regime and the availability of healthcare colleagues to improve and support multidisciplinary attendance at ACCT case reviews. Following the review a dedicated special point of contact (SPOC) for health and wellbeing was appointed by Care UK. The SPOC liaises with ACCT case managers to agree times for case reviews to be held so that healthcare are able to attend and contribute. If attendance cannot be facilitated</p>	Head of Safer Custody Completed

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	<ul style="list-style-type: none"> •Case managers complete care maps at the first ACCT case review, set specific and meaningful care map actions, identify who is responsible for them and review progress at each review; •The frequency of observations reflects the prisoner’s risk and is adjusted when that risk changes; •ACCT procedures are not closed at the first case review, unless all issues identified at the assessment interview and in the care map have been resolved; and •There are procedures in place to check the quality of ACCT procedures, identify poor practice, learn lessons and, where appropriate, provide staff with refresher training. 		<p>contributions from healthcare are provided via email or telephone to the case manager and this is evidenced in the ACCT document. The Safer Custody CM oversees this process to ensure that any other relevant multi-disciplinary colleagues are invited to attend reviews.</p> <p>The Safer Custody CM is responsible for overseeing all ACCT documents. ACCTs are quality checked by managers on a weekly basis, including a review of ACCTs in the post closure stage. Findings are reported at the monthly safety meeting to ensure that any poor practice or training requirement is identified and actioned.</p>	

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2	<p>The Governor and Head of Healthcare should ensure that:</p> <ul style="list-style-type: none"> •Staff do not rely solely on a prisoner's presentation and denial of thoughts of suicide and self-harm; •Reception staff consider all risk factors of newly arrived prisoners, particularly those with a suicide and self-harm warning form; and •A healthcare professional assesses all prisoners who arrive in reception with a suicide and self-harm warning form. 	Accepted	<p>A review of reception processes has been scheduled to take place in September 2020. The review will consider how reception processes can better support those who are vulnerable and at risk of suicide and self-harm, as well as to help staff to better identify risk. This will also include healthcare professionals assessing all prisoners who arrive into reception with a suicide and self-harm warning form. Actions taken from the review will be overseen by the Head of Safer Custody and discussed at the monthly safety meeting.</p> <p>Reception staff will receive refresher training in the risks and triggers module of the national Suicide and Self Harm (SASH) training to ensure that all risk factors are considered when assessing newly arrived prisoners and that staff do not rely solely on a prisoner's presentation. This training will be delivered from September 2020.</p>	Head of Safer Custody October 2020
3	<p>The Prison Group Director for London should write to the Ombudsman setting out what she is doing to satisfy herself that effective action is being taken to improve the quality of ACCT assessments and reviews at Pentonville.</p>	Accepted	<p>The Prison Group Director for London will respond to the Ombudsman in writing.</p>	Prison Group Director for London November 2020

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4	<p>The Governor should ensure that:</p> <ul style="list-style-type: none"> •Information about bullying and intimidation is fully and promptly investigated; •Alleged perpetrators are appropriately challenged; •Victims are effectively supported and the possible impact on their risk of suicide and self-harm properly considered and addressed; •HMPPS's Challenge Support Intervention Plan is fully implemented. 	Accepted	<p>The national case management model for violence, the Challenge Support Intervention Plan (CSIP) was fully implemented in December 2019. The safety strategy was launched in December 2019 to fully incorporate CSIP and to provide guidance to staff on supporting victims of intimidation and violence and bullying. The strategy outlines the processes for referrals to CSIP and the investigating and evidencing of outcomes for all incidents of violence and bullying.</p> <p>A Violence Reduction CM was appointed in April 2020 along with a dedicated Violence Reduction Officer within the Safer Custody function. The officer works with victims of bullying to provide support and guidance and also to assist prisoners with accessing additional support agencies for further help.</p> <p>The Violence Reduction CM oversees and provides quality assurance of CSIP case management, investigations, and actions arising from investigations. This includes making CSIP referrals for identified perpetrators of violence and bullying and also considering appropriate types of support for perpetrators and victims, whether this be managed under CSIP or via other avenues such as referral to an appropriate programme which would suit the needs of individuals.</p> <p>A CSIP assurance model is being implemented and will feed into the monthly safety meeting so that any identified issues can be discussed and resolved. This will begin in September 2020.</p>	Head of Safety September 2020

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5	The Governor should ensure that staff check that cells are fit to be occupied before placing prisoners in them.	Accepted	The Head of Residence has begun implementing a pre-occupancy decency check in all residential areas, including the first night centre. Any cells that are deemed unfit to be occupied will be not be allocated until work has been carried out to meet the decency criteria.	Deputy Governor October 2020
6	The Head of Healthcare should ensure that healthcare staff request full GP records for newly arrived prisoners.	Accepted	The Head of Healthcare along with the Clinical Lead for Primary Care Mental Health have reviewed the policy for requesting GP records. Changes within the Health and Wellbeing Operational Policy have been made to clarify that all patients who do not have a GP summary for the previous three months will have one requested from the GP surgery. This task will be split between the admin functions in Health and Wellbeing and Business Performance and is now clearly defined within the policy.	Head of Healthcare Completed
7	The Head of Healthcare should ensure that: <ul style="list-style-type: none"> •There is a clear procedure for prison staff to contact the mental health team, including a system for escalating concerns promptly when the mental health team is unavailable; and •There is a clear escalation procedure in place when a prisoner is repeatedly referred to the health and wellbeing 	Accepted	<p>The Head of Healthcare reissued guidance to all staff via a Staff Information Notice in August 2020. The guidance from health and wellbeing and in-reach services clarifies how to escalate concerns about prisoners both within the core day and out of hours.</p> <p>All healthcare staff were also reminded at handovers of the pathway for referrals to the health and wellbeing team and of the criteria for a duty review. This reminder was followed up with a global email to capture any staff who were not present at the daily handover.</p> <p>The Head of Healthcare has met with clinical leads to clarify the pathway for escalation when concerns are raised about a prisoner’s risk of suicide and this</p>	Head of Healthcare Completed

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	team and their risk of suicide has increased.		has been fed back to the relevant teams. Since February 2020 data on health and wellbeing referral sources has been collected and is submitted on a monthly basis to the quality assurance meeting. Any issues identified in the referral process are picked up and discussed with the prison healthcare Governor.	
8	The Head of Healthcare should ensure that healthcare staff review completed PHQ9 and GAD7 forms within twenty-four hours of receipt and address concerns raised promptly and appropriately.	Accepted	The Head of Healthcare and the Clinical Lead for Primary Care Mental Health initially reviewed the post system and implemented a spreadsheet tracker to log when post was received and allocated and actioned by the case worker in September 2019. A further review in January 2020 took place and it was agreed by the Lead Psychologist that the PHQ9 and GAD7 forms would be removed from in-cell work due to the complications of patients completing them inappropriately and the risk management work this was creating. The PHQ9 and GAD7 forms are now completed during a one to one assessment with a trained Mental Health Professional.	Head of Healthcare Completed
9	The Head of Healthcare should ensure that: •There is sufficient GP availability to meet the demand for urgent appointments; and •The health and wellbeing	Accepted	The Head of Healthcare and Clinical Lead for Primary Care have reviewed the average waiting time for the GP for the last 12 months and the number of sessions provided across the service. The review showed that there is sufficient GP availability to meet the demands for urgent appointments. The health and wellbeing service can also directly refer a prisoner for a GP appointment and urgent appointments can be seen on the same day.	Head of Healthcare Completed

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	team can directly and promptly refer a prisoner to a GP.		In January 2020 the pathway to refer into the GP from the health & wellbeing team was re-issued to staff via email and discussed during one to one supervision sessions with all relevant staff.	
10	The Governor should ensure that safer custody staff respond promptly to telephone calls about prisoners' wellbeing and share information with wing staff or FLOs.	Accepted	<p>The safer custody related call process was reviewed in May 2020. The new process includes a comprehensive tracker of all calls received into the safer custody hotline. Calls are tracked and actions monitored to ensure that concerns about the prisoner's wellbeing have been documented and information has been appropriately shared with relevant staff. Staff must also provide a response to the caller as soon as possible.</p> <p>A quality assurance check of this process feeds into the monthly safety meeting where any issues identified can be addressed.</p>	Head of Safer Custody Completed
11	The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior Manager discusses the Ombudsman's findings with them.	Accepted	The report has been shared with all parties, and appropriate guidance and support offered.	Head of Safer Custody and Head of Healthcare May 2020