

**Action Plan – Mr Thomas Walker at HMP Pentonville – Self Inflicted on 09/07/2020**

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
1	<p>The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular staff should:</p> <ul style="list-style-type: none"> <li>•ensure there is a consistent case manager;</li> <li>•consider all relevant information when assessing risk and set the frequency of observations based on the level of risk;</li> <li>•set caremap actions that are specific, meaningful and tailored to the individual to reduce their risk;</li> <li>•hold a post-closure review within seven days of closure; and</li> <li>•ensure all actions and information are properly recorded on the ACCT document.</li> </ul>	Accepted	<p>Following Mr Walker’s death Safer Custody now track all new ACCTs and discuss the case reviews scheduled to take place each day at the morning briefing to ensure that the assessment, first case review, scheduled reviews and post closure reviews are carried out within the required timeframes. This process was reviewed in July 2021 to ensure that it is line with the new ACCT v6 quality assurance processes.</p> <p>The tracking of ACCT reviews has also improved the consistency of case management with scheduled reviews being handled by the same case manager in the majority of cases. Allocated case managers work with healthcare colleagues, in primary care and mental health, to support a multidisciplinary and consistent person centred approach, with actions specific to individual risk and support.</p> <p>The Safer Custody Custodial Manager (CM) is responsible for overseeing all ACCT documents and a quality assurance process has been embedded since December 2020 – this quality assurance model mirrors the revised national ACCT v6 model.</p> <p>All ACCT documents, including those in post-closure, are quality checked by managers on a weekly basis to ensure that levels of risk and observation have been appropriately assessed, information recorded correctly, and all caremap actions completed. Any poor practice or training need identified is actioned following this review.</p> <p>National ACCT case manager training has been impacted by the Covid-19 pandemic, however, business cases are ongoing to fast track access to this</p>	Head of Safety December 2021

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			training.	
2	The Prison Group Director for London should write to the Ombudsman by 30 June 2021, setting out what he is doing to satisfy himself that effective action is being taken to improve the quality of ACCT assessments and reviews at Pentonville.	Accepted	The Prison Group Director for London will respond to the Ombudsman in writing.	Prison Group Director Completed
3	The Governor should ensure that staff: <ul style="list-style-type: none"> <li>•develop a process for identifying unusual canteen spending that may indicate bullying;</li> <li>•investigate suspected or alleged bullying in line with the prison's violence reduction policy;</li> <li>•support victims of bullying by making CSIP referrals; and</li> <li>•refer cases to the Safety Intervention Meeting where</li> </ul>	Accepted	<p>There has been a national change in the way that prisoner accounts are overseen and there are now limits on account balances. Guidance will be issued to all parties involved in the prisoner accounts and finance team to ensure that staff are aware of how to highlight concerns about unusual spending, which includes reporting this to the senior management team and submitting a mercury intelligence report (MIR) to the security department.</p> <p>When a MIR is submitted in relation to canteen spending, Safer Custody are notified and the prisoner's accounts are placed on hold until the finance team receive clarification on the legitimacy of the spending pattern. If there are concerns about bullying a Challenge, Support and Intervention Plan (CSIP) referral will be considered.</p> <p>All incidents of suspected or alleged bullying identified through intelligence,</p>	Head of Safety and Business Assurance Completed

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	appropriate.		<p>emails and staff reports are sent to Safer Custody and now result in an automatic CSIP referral. An investigation into the allegations is documented to determine whether additional support or intervention is required.</p> <p>The safety intervention meeting (SIM) referral process was reviewed in May 2021 and a more effective process is now in place. The improved process allows for all staff to submit a referral for the SIM meeting using an electronic form that highlights the specific reasons for the submission, including bullying, court appearances, violence, family issues etc. This will support and reinforce the violence reduction policy in regards to allegations of bullying and allow a multi-disciplinary approach to supporting individuals and the wider prison. All prisoners subject to CSIP are discussed at the SIM.</p>	
4	The Governor should ensure that staff activate their BWVCs at the earliest opportunity during any reportable incident.		<p>All staff are now reminded over the radio net to activate their body worn video cameras (BWVCs) when attending a reportable incident. Orderly Officers also remind staff of this requirement each day when overseeing the issuing of BWVCs.</p> <p>The use of BWVCs is monitored at the monthly safety meeting to identify activation levels. Where it is identified that BWVCs have not been activated when they could or should have been informal advice and guidance is issued to the staff involved.</p>	Head of Security Completed
5	The Governor should ensure that there is a local emergency response protocol, agreed	Accepted	A meeting took place in November 2020 with the London Ambulance Service and the process for ambulance attendance was reviewed. A protocol was agreed which now allows the LAS to enter the establishment with work mobile	Head of Safety and Security

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	with the local ambulance service, so that both prison and ambulance personnel know what the logistical and operational arrangements are when an ambulance is required.		<p>phones and this has been communicated to both the LAS and staff working in the gate areas of the prison.</p> <p>In addition, there was a review of the timings and access process for LAS vehicles to access the prison and all areas and this will form part an assurance process for monthly monitoring by the Head of Security.</p> <p>Ambulance requests and response times are monitored and discussed monthly at the safety meeting.</p>	Completed
6	The Governor should share this report with SO A and SO B and arrange for a senior manager to discuss the Ombudsman's findings with them.	Accepted	The report has been shared and the findings discussed with all named parties.	Head of Safety Completed