



			<p>Staff were also reminded during briefings in October 2021 that all documentation that arrives with a prisoner must be checked for any warnings or information related to risk of suicide or self-harm, and to raise any concerns with a manager if they are unsure or need further guidance. Staff were reminded to record the information considered and of the importance of recording the reasons when a decision is made not to start ACCT procedures.</p> <p>The Operations Custodial Manager (CM) will also use staff performance meetings to assess the knowledge of reception staff in relation to risk assessments, ACCT quality and information sharing, and to identify any further training needs, if necessary.</p> <p>The Head of Operations and the Safety Team created a reception training package in November 2021 which focused on safer custody and has been delivered to all reception staff, including healthcare staff. This contained guidance on risk assessing, the importance of reviewing all available documentation and of recording and sharing any risk information with all reception staff.</p>	Head of Operatons and Safety Team HMPPS	Completed
2	The Governor should ensure that a copy of this report is shared with Officer A and that a senior manager discusses the Ombudsman's findings with him.	Accepted	The Head of Safety held a meeting with the member of staff in October 2021. The report was read and the findings were discussed.	Head of Safety HMPPS	Completed
3	The Governor should ensure that staff manage prisoners at risk of suicide or self harm	Accepted	ACCT awareness sessions have been held throughout 2021 to coincide with the rollout of ACCT v6 and these will continue to be held for all operational staff. These sessions include training	Head of Safety HMPPS	Completed



	<p>in line with national guidelines, in particular that they:</p> <ul style="list-style-type: none"> <li>• consider all risk factors when assessing a prisoner's level of risk and do not just rely on what the prisoner says or how he appears;</li> <li>• ensure that the ACCT is not closed until measures have been put in place to mitigate the prisoner's risk and that risk has sufficiently reduced.</li> </ul>		<p>and guidance on recognising risk and triggers and identifying protective factors and support actions. Additionally, two training sessions were held during September 2021 and staff were reminded not to rely on the prisoner's presentation but to consider all known risk factors that are available.</p> <p>Guidance and reading materials on ACCT v6 are now located in all staff areas. This material includes an example ACCT document and a best-practice guide to assist staff. Information cards were also produced which include information on effective listening, identifying risk, sharing risk information, observations, conversations, confidentiality and all post-closure actions.</p> <p>ACCT champions were introduced in September 2021 and 19 staff have been trained to undertake this role. ACCT champions offer guidance to staff on ACCT procedures such as risk evaluation, documenting reasons for decisions and on the measures that should be considered and put into place before closing an ACCT. Additionally, two daily ACCT "floor walkers" were introduced to assist staff on a day to day basis.</p> <p>A Suicide and Self-Harm (SASH) Custodial Manager (CM) is now in post who, along with members of the Safety Team, attend weekly ACCT reviews to conduct quality assurance with the Case Co-ordinators. Any issues arising relating to the ACCT are dealt with immediately and then discussed in the safer custody monthly meeting with a multidisciplinary team.</p>	Head of Safety and Head of Operations HMPPS	Completed
4	The Governor should ensure that a copy of this report is shared with SO A and Officer B and that a senior manager discusses the Ombudsman's findings with them.	Accepted	The Senior Officer is no longer employed by HMPPS. The Head of Safety held a meeting with the Officer in October 2021 and the report was read and the findings were discussed.	Head of Safety HMPPS	Completed



5	The Head of Healthcare should ensure that prisoners referred for a standard mental health assessment are seen within 72 hours.	Accepted	<p>All prisoners who are received at Reception are subject to a thorough healthcare screen. This involves all aspects of health which includes mental health. In the event that a prisoner has a mental health issue a referral is made immediately to the mental health team by the reception nurse. It was confirmed in October 2021 that the referrals are collected the following morning and the mental health lead allocates a member of his team to see the prisoner either on that day or within 72 hours.</p> <p>In the event that a prisoner is referred to the mental health team during his sentence he will be placed on the mental health ledger and will be seen by a mental health nurse who is allocated to this task on a daily basis. The mental health team conduct weekly reviews and they have a caseload that is RAG rated to ensure priorities of consultations and interventions are met.</p>	Mental Health Lead CRG	Completed

