

**Action Plan – Mr Ashley Dean Roberts at HMP Bristol – Self Inflicted on 01/05/2020**

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
1	<p><b>To HMP Exeter:</b> The Governor should ensure that ACCT documentation travels with a prisoner when they are transferred or is sent the same day if the transfer is unexpected.</p>	Accepted	<p>All ACCT documentation now travels with a prisoner at the point of any scheduled transfer. The Offender Management Unit arrange for all ACCT documents to be contained within the prisoner records and ensure that this is clearly documented on the Prison Escort Record (PER).</p> <p>Notification of transfers subject to ACCT monitoring are sent on a daily basis by the Safer Custody team to the receiving establishments. Routine checks are completed by the Safer Custody team and reception Custodial Managers (CM) to ensure the ongoing compliance against this action.</p> <p>A record of these checks is retained by Safer Custody for assurance purposes.</p>	Head of OMU and Head of Safer Custody Completed
2	<p><b>To HMP Bristol:</b> The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including in particular that:</p> <ul style="list-style-type: none"> <li>•all known risk factors are considered when determining the level of risk of suicide and self-harm;</li> <li>•ACCT observations take place in line as specified, are</li> </ul>	Accepted	<p>Case Managers are trained in ACCT processes by the national Learning and Skills team, including the need to consider and record all relevant risk information, including changes in risk, and set appropriate levels of observation.</p> <p>Notices to Staff (NTS) were issued in November 2020 reminding staff of the requirement to conduct observations as specified, at irregular intervals, and to record each observation individually. Staff were also reminded that should they receive any information relating to a potential increase in a prisoner's level of risk they must record this information in the ACCT document and inform a manger immediately. Case Managers were further reminded that if an increase in a prisoner's risk level has been identified an ACCT review must be held to consider how best to provide support and to ensure observation levels remain</p>	Head of Safer Custody Completed

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	<p>unpredictable and are recorded individually;</p> <ul style="list-style-type: none"> <li>•ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk; and</li> <li>•all relevant information about risk is documented in the ACCT document.</li> </ul>		<p>appropriate. The NTS has been added to the rolling communications strategy meaning that staff will be reminded of this action every 16 weeks.</p> <p>Daily assurance checks are now completed to ensure that observations are taking place in line with the agreed level set out in the ACCT document. Residential CMs complete weekly quality assurance checks of ACCTs on their unit including checks of identification and assessment of risk, multi-disciplinary working and information sharing.</p> <p>In order to focus on improving ACCT case management overall there is now a dedicated CM who carries out monthly quality assurance checks on 50% of all open ACCT documents.</p> <p>A Local Operating Procedure (LOP) was created in September 2020 in order to formalise how the prison can best offer support to Case Managers, improve learning, and manage ACCT documents. Learning and support is delivered locally and with the Group Safety team.</p> <p>A staff guide on how to document quality observations is available within the reception area and also electronically for staff to access as required. This was communicated to staff in September 2020 and continues to be advertised daily within the reception area.</p>	
3	Governor should share a copy of this report with CM A, the SO, Officer C and Officer D and ensure that a senior	Accepted	The report has been shared with named staff and the Head of Safer Custody has discussed the Ombudsman's findings with them.	Head of Safer Custody Completed

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	manager discusses the Ombudsman's findings with them.			
4	The Governor should ensure that decisions about a prisoner's potential transfer are carefully considered, documented and clearly communicated, ensuring their impact on a prisoner's risk to themselves is minimised.	Accepted	<p>In August 2020 the Observation, Categorisation and Assessment (OCA) team took over the management of all transfers, working in partnership with each prisoner's Prison Offender Manager (POM) and healthcare to ensure that prisoners are being sent to suitable establishments which can meet their needs.</p> <p>Prisoners can place applications regarding transfer concerns and these are answered by the OCA team and communicated back to the prisoner in writing. POMs work closely with prisoners regarding progressive moves, ensuring that decisions on transfers are communicated clearly and also documented on NOMIS. If the prisoner is being supported by the ACCT process then any relevant conversations and decisions on transfers are also documented in the ACCT record.</p> <p>Information on the transfer process is shared with prisoners during induction.</p> <p>Staff are informed via email the night before transfers by the OCA team and prisoners receive a transfer slip informing them of the transfer and location. The only exception to this is those who are being moved due to security reasons.</p>	Head of OMU Completed

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5	The Governor should ensure that unlock protocols, including the use of body worn cameras, are clearly documented, communicated and implemented effectively.	Accepted	<p>A NTS was issued in November 2020 regarding unlock protocols, including the use of body worn cameras. When a prisoner is placed on an unlock protocol, this is displayed outside of their accommodation to clearly communicate what actions are required before unlock. The prisoner is issued with a copy to ensure they understand how they will be unlocked.</p> <p>A case note is placed on NOMIS and the Duty Governor reviews all unlock protocols daily.</p>	Head of Safer Custody Completed
6	The Governor should ensure that after a prisoner is restrained, they are assessed by healthcare staff.	Accepted	<p>A NTS was issued in November 2020 regarding the need for prisoners to be seen by healthcare after any use of force incident. The dedicated use of force instructor checks all incidents daily and ensures that a F213 injury form has been completed by healthcare. Assurance that healthcare have assessed the prisoner and completed the F213 form is given at the weekly safety action meeting.</p> <p>The weekly use of force learning and development panel reviews all incidents where use of force has been used to prevent self-harm. A quality assurance check is carried out on all documentation, and body worn camera footage and CCTV is viewed. Any required actions are tasked from this meeting and evidenced.</p>	Use of Force Instructor Completed
7	The Governor should share this report with the Deputy Governor and discuss the	Accepted	The report has been shared and the Ombudsman's findings discussed in a meeting with the Governor in November 2020.	Governing Governor Completed

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	Ombudsman's findings with her.			
8	The Head of Healthcare should ensure that staff formally review a patient who repeatedly refuses to take their prescribed medication.	Accepted	<p>A copy of the Standard Operating Procedure (SOP) for the 'management of missed doses of medication or patients did not attend' was recirculated to all healthcare staff in February 2021 to remind them of the actions to take in the event that prisoners do not take their prescribed medication.</p> <p>A monthly audit of prisoners who do not attend to collect medication is completed. The audit is overseen by the medicines management lead and if any issues or trends are identified through the audit an action plan to address the issues is created.</p>	Head of Healthcare Completed