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

Mr Samuel Jordan on 27/03/2020 at HMP Exeter

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that: • staff hold multidisciplinary ACCT reviews with the same case manager. • case managers complete care maps setting specific and meaningful care map actions. • staff set a level of conversations and observations appropriate to the prisoner's level of risk. • staff review the level of conversations and observations if the prisoner's circumstances	Accepted	Training on ACCT v6 has been provided by both local tutors and the national safety team to all staff involved in initial ACCT assessments and the local safety team conduct assurance checks on all ACCT documents, as per the ACCT v6 assurance processes. Any problems identified are escalated to the case-coordinator for action. This includes care plan actions and levels of observation appropriate to each individual's risk, including when there has been a change in circumstances. The assurance model used provides statistical data that enables the safety team to identify trends and address any shortfalls. It is not always possible to have a consistent case co-ordinator from the offset. However, every effort is made to distribute the caseload evenly between supervisors and managers following the initial ACCT case review and then ensure consistency thereafter.	Head of Safety HMPPS	January 2022

	change, for instance if they move from a shared to a single cell; and • officers conduct ACCT conversations as indicated in ACCT plans.		Following recent training in ACCT v6 module 9, provided by the national safety team, all Custodial Managers (CMs) and Supervising Officers (SOs) are now responsible for a caseload of ACCTs which is helping to improve consistency. The national safety team are booked to attend the prison in January 2022 to provide support and training for current case co-ordinators to further support the up-skilling of staff.		
2	The Governor should ensure that incidents of violence, bullying or intimidation are taken seriously, investigated, and dealt with in line with local and national policies.	Accepted	The violence reduction CM and SO will provide assurance that every act of violence has been investigated via the CSIP process within 72 hours of the reported incident. Assurance results will be implemented and reported on as part of weekly safety intervention meeting (SIM). The daily occurrence log is being amended to include a CSIP referral (considered / actioned) check box to ensure that all incidents are correctly followed up in line with policy. The CSIP process is due to be re-launched and localised training will be provided to all staff. All violent incidents are reported via the morning meeting where checks take place to ensure follow up action is being taken. An independent audit of intelligence reports (IRs) which must be submitted following a violent incident recently delivered a green rating (December 2021).	Head of Safety and Violence Reduction CM HMPPS	February 2022

3	The Governor should ensure that: • cell sharing risk assessments are reviewed when there is information that a prisoner might be at increased risk of violence towards a cellmate; and • changes that suggest increased risk of harm between cellmates are reported to a manager and recorded in NOMIS.	Accepted	A guidance document is being produced for supervisors and managers to make it clear when a cell sharing risk assessment (CSRA) should take place and the daily occurrence log has been updated to include a check box which staff will fill in once a CSRA review has taken place and a case note added to NOMIS.	Head of Safety and Violence reduction CM HMPPS	January 2022
4	The Governor should ensure that staff directly involved in a death in custody complete incident statements as soon as practicable following the death.	Accepted	The death in custody contingency plan has been reviewed and the Head of Safety is implementing an assurance process to ensure compliance with this, including that statements are completed as soon as practicable following a death in custody. This will also include ensuring that all statements have been saved electronically. .	Head of Safety HMPPS	January 2022