| Action Plan – Mr Leon Owens at HMP Swansea – Self Inflicted death on 19/09/2020 | | | | |
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| **No** | **Recommendation** | **Accepted/ Not Accepted** | **Response** | **Target date for completion and function responsible** |
| 1 | The Governor should initiate an investigation into SO A's actions in relation to the ACCT case review on 18 September with a view to considering whether disciplinary action is appropriate. | Accepted | A Code of Discipline Investigation was commissioned in March 2021 and is due to be completed in June 2021, following an extension having being ranted due to the availability of witnesses. | June 2021 Head of Safer Custody |
| 2 | The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national policy, in particular staff should:<br><br>• keep accurate records of case reviews and who attended or contributed;<br><br>• assess risk based on the prisoner's known risk factors, including any recent suicide attempts and incidents of self-harm, and not solely on what the prisoner tells them;<br><br>• be mindful of the protective element provided by a cellmate and ensure that when | Accepted | HMP Swansea was one of nine prisons that piloted ACCT Version 6 (V6) prior to the national implementation which began in April 2021. All staff received briefings in April 2021 which included the need to ensure that all attendees at case reviews to sign the Record of Case Review form to confirm who attended, the agreed actions, and that the notes are a true reflection of the discussions.<br><br>Suicide and Self-Harm (SASH) training is due to recommence in June 2021, following the anticipated lifting of Covid-19 restrictions. SASH training provides guidance on the effective management of the ACCT process, including the importance of reviewing all key risk factors and of taking into account any recent suicide attempts or incidents of self-harm when reviewing risk.<br><br>All staff were reminded during briefings in April 2021 of the protective element provided by a cellmate and of the need to ensure that when a prisoner who is subject to ACCT monitoring is moved into a cell on their own, this is considered and the reasons for this move are fully documented. This will also from part of the ACCT V6 case review which documents any changes that are agreed and must be signed by all attendees. | Completed Head of Operations Head of Safer Custody<br><br>June 2021 Head of Safer Custody<br><br>Completed Head of Safer Custody |

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| | a prisoner being monitored under ACCT is moved into a cell on their own, the reasons are fully documented;<br><br>• appropriate, meaningful caremap actions and mark them as complete only once they are actioned fully;<br><br>• consult previous recent ACCT documentation. | | All appropriate and meaningful actions are now recorded on the Immediate Action Plan and on the Support Actions Form in ACCT V6, and there are now additional prompts for case coordinators to ensure these are reviewed and marked as completed when appropriate.<br><br>ACCT assurance checks were implemented in April 2021 to ensure that the Support Actions Form is completed correctly and these are recorded on a database to ensure that the documentation is correct and up to date.<br><br>Staff were reminded during briefings in April 2021 to refer to previous recent ACCT documentation and all closed ACCT documents are stored in the prisoner's core record and information on any previous ACCT monitoring is available on NOMIS for the case manager to review if a new ACCT is opened. Staff were also reminded that all post closure reviews should be held within the six week post closure period in order to assess whether support should be extended, the ACCT re-opened, or full closure should take place. | Competed Head of Safer Custody |
| 3 | The Head of Healthcare should ensure a policy is in place to ensure members of the Crisis team query any ACCT reviews that they have been booked for but not subsequently asked to attend. | Accepted | A review of the draft mental health policy will take place in June 2021 to include the requirement for members of the Crisis team to query any ACCT reviews that they have been booked for but not subsequently asked to attend.<br><br>The Crisis team liaise with the Safer Custody team daily and note all ACCT reviews on the SystmOne database ledger which records attendance and the outcome of the review. The Crisis team manager now also completes weekly audit checks of the ACCT attendance to ensure compliance. | June 2021 Head of Healthcare |

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| 4 | The Governor should remind staff of the medical emergency response protocol and ensure they are clear that where codes are appropriate, they should be used immediately. | Accepted | The initial training for all operational staff includes guidance on the actions to take when there is a medical emergency to ensure that staff are aware of the medical emergency codes and the correct procedures for using them.<br><br>A notice to staff (NTS) was re-published in May 2021 to remind staff of the medical emergency protocol, including the need to ensure that all emergency codes are called immediately and this was also discussed during staff briefings. | Completed Head of Safer Custody |
| 5 | The Governor should ensure that key establishment clocks are accurate. | Accepted | All clocks were checked in May 2021 and set to the correct time, where required.<br><br>The installation of an updated CCTV system, which will provide additional cameras in previously uncovered areas and will provide further assistance in monitoring the exact timings of events, is planned to begin in June 2021. | June 2021 Head of Safer Custody |
| 6 | The Governor should ensure that during a restricted regime, key work is delivered in line with the Exceptional Delivery Model. | Accepted | A process was introduced in October 2020 to ensure that if a key worker is not available when key work sessions are required, other staff are identified through the daily rota system to undertake the sessions.<br><br>The process also ensures that all prisoners that are subject to ACCT monitoring, including any within the post closure period, have one case note recorded per day which is assurance checked, as part of the current Exceptional Delivery Model for key work. | Completed Head of Operations |
| 7 | The Governor should remind managers of the importance of offering support to all staff | Accepted | A review of the process of supporting staff following a death in custody was initiated in June 2021. This will assess whether further measures are required for informing staff of a death in custody, particularly if they were not present at | August 2021 Head of Safer Custody |

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| | involved following a death in custody. | | the time of the incident or at the de-brief. It will also assess how staff are informed of, and access, the support that is available to them.<br><br>Prison managers were reminded in May 2021 to ensure that the de-brief following a death in custody should provide staff with structured information around the support services that are available. A notice to staff (NTS) was also re -published in June 2021 informing all staff of the support available. | Completed<br>Head of Safer Custody |