

Learning from PPO Investigations

Self-Inflicted deaths of prisoners on ACCT

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Foreword



I am pleased to introduce this thematic report describing learning from my independent investigations into fatal incidents where the prisoner was being monitored under the Prison Service suicide and self-harm prevention procedures (ACCT¹) at the time of their apparently self-inflicted death.

Prisons have a duty of care towards prisoners, but keeping safe a burgeoning population with significant levels² of mental ill health and a host of other needs, within the limitations of the custodial environment, is hugely challenging. Staff rely on the ACCT monitoring procedures to manage the risk of suicide and self-harm. ACCT was introduced in 2005-6 and built on a previous system known as F2052SH, introduced a decade earlier. At any one time, around 2% of the prison population are 'on an ACCT' and, when implemented properly, ACCT provides a comprehensive, multi-disciplinary framework to help address the underlying cause of a prisoners' distress.

However, to be effective, ACCT requires a concerted, joined up and holistic approach. Unfortunately, as this report illustrates, my office sees too many cases where the ACCT procedure is not followed as thoroughly as it should have been or where case reviews are not carried out within specified timescales or information is not recorded. The ACCT should be a live plan which is reviewed and updated when a prisoner's circumstances or risk change, again this does not always happen.

Nearly a decade after the introduction of ACCT and a range of other safer custody measures, which saw self-inflicted deaths in custody fall, such deaths have risen sharply in recent months. It is too early to be sure why this rise is occurring, but the personal crisis and utter despair of those involved is readily apparent, as is the state's evident inability to deliver its duty of care to some of the most vulnerable in custody.

Learning the lessons from this thematic review, together with those from a related thematic study into identifying suicide risk factors, ought to help the Prison Service improve the implementation of ACCT and ensure greater safety in custody. However given the repeated weaknesses in practice we identify and the rising toll of self-inflicted deaths, I also believe it is now necessary for the Prison Service to review and refresh its safer custody strategy in general and ACCT in particular.

I would like to thank my colleague, Sarah Colover, for preparing this report which is one of a series about learning from my investigations which are intended to contribute to making custody a safer, fairer and more effective place.

My New

Nigel Newcomen CBE
Prisons and Probation Ombudsman

¹ Assessment, Care in Custody and Teamwork plan.

² Around three-quarters of all prisoners were found to suffer from one or more mental disorder in: Singleton, N. et al (1998) Psychiatric morbidity among prisoners: summary report, Office for National Statistics.

Executive Summary

- This report presents a review of 60 Prisons and Probation Ombudsman (PPO) fatal incident investigations where the prisoner was being monitored under the Prison Service suicide and self-harm prevention procedures at the time of their apparently self-inflicted death.
- The review looks at the policy background of the National Offender Management Service's current self-harm and suicide prevention procedure, known as Assessment, Care in Custody and Teamwork (ACCT) monitoring.
- Most of the healthcare received by the prisoners in the sample was assessed by our clinical reviewers as equivalent to what they might have expected to receive in the community. Where care was below standard, this was often due to the lack of mental health provision or appropriate referrals not being made.
- The ACCT process was not correctly implemented or monitored in half the cases in the PPO sample (30 prisoners).
- The characteristics and risk factors of those who died a self-inflicted death are looked at in detail in the PPO Risk Factors thematic which is published simultaneously to this report. The key areas of the ACCT process are reviewed in detail and case studies are used for illustration. They include the following areas where failings are identified and learning is highlighted for improvement:
 - Care and management plan (CAREMAP)
 - Involvement of family and friends
 - Use of triggers and warning signs
 - Ensuring a multi-disciplinary approach
 - ACCT training

1. Introduction

The safety of prisoners who are at risk of suicide or self-harm is a challenge for prisons. Staff must be alert to prisoners who display self-harming behaviour or emotional/ mental distress. In addition, they must be aware of, and record, any recent or relevant history of self-harm or mental health issues. They should also look out for distressing life events which may impact on a prisoner's well being and possibly increase their risk of suicide or self-harm. The judgement of experienced staff and the prisoner's own view are important, but when assessing a prisoner's risk, sufficient weight must be given to past behaviour and information contained in other records, for example the person escort record (PER) or medical notes, as well as input from other members of staff such as the chaplaincy, mental health practitioners or other agencies working in the prison.

This report looks at those prisoners who were being monitored under the National Offender Management Service (NOMS) suicide and self-harm prevention procedure at the time of their death. This is known as the Assessment, Care in Custody and Teamwork (ACCT) monitoring system. Ministry of Justice figures³ indicate that, at any one time, approximately 1500 prisoners are subject to individualised care planning in line with the ACCT procedures. In 2011⁴, the prison population was just over 88,000 and, at any one time, those on ACCT procedures accounted for 1.7% of the prison population.

It is a harsh reality that there are some prisoners who are so determined to take their own life that they will find a way to do so, no matter what suicide prevention process is in place. Nevertheless, given the Prison Service's duty of care to those in its custody there can be absolutely no scope for complacency. A suicide and self-harm prevention plan can put arrangements in place which allow staff time to work with the prisoner and deal with the underlying causes of their suicidal thoughts and intentions.

A well-written ACCT plan alone will not prevent a person from self-harming or even

committing suicide. The plan has to be implemented in a rigorous and timely way to have the best chance of helping the prisoner address the underlying root causes of their distress. This is best achieved by taking a holistic approach to the prisoner's care, and focusing on their individual needs and circumstances. Prisons must use all relevant information in order to assess the prisoner's current risk. Prisons should not solely rely on the prisoner's word, or how they present at a particular moment – it is a truism that a smile does not indicate that a prisoner is not at a high risk of harming themselves or taking their own life.

The continuity of support and care for prisoners at risk of self-harm and suicide is key to ensuring a successful approach to managing their immediate and future risk. At a time of significant change and austerity in the Prison Service, this may become increasingly challenging. Yet prisons are under a duty of care to ensure that they do everything they can to keep a prisoner safe, in particular complying with the ACCT procedures and providing continuity of care for those considered at risk.

1.1 History of ACCT

ACCT was not the first suicide and self-harm prevention process in the Prison Service. Before ACCT, prisons followed F2052SH procedures as set out in the original Prison Service Order 2700. F2052SH was introduced to the Prison Service between 1992 and 1994 and represented an important development in the prevention of suicide and self-harm. F2052SH was designed to tackle suicide and self-harm using a multidisciplinary, prison-wide approach. The aim was to offer each prisoner identified as being at risk of self-harm or suicide an individual support plan which was set out on the form and which followed the prisoner through the

³ https://www.gov.uk/government/news/deaths-in-prisoncustody-2011 (see Notes to Editors - point 8)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/218199/prison-population-30-12-11.xls (December 2011 figures)

prison and criminal justice system (the form would go to court with the prisoner). The form could be opened by any member of staff who was concerned about a prisoner's risk of suicide or self-harm. Prison staff saw the key strengths of the F2052SH as the care planning system and staff familiarity with the process, as well as having a support plan that enabled them to manage prisoners during crisis periods.

In 1999 Her Majesty's Inspectorate of Prisons (HMIP) published a thematic review examining the state of suicide prevention in prisons⁵. It found that there were faults with the policy and that the F2052SH procedure was very often a paper exercise which did not lead to the development of an effective care plan for prisoners at risk of suicide or selfharm. This led to a Prison Service funded evaluation of the F205SH, which was conducted by Manchester University in five prisons in 2001. The evaluation found a number of flaws with the system and made recommendations which ultimately resulted in the creation of a new suicide prevention procedure, ACCT.

The main finding from the F2052SH review was that the form and the prisoner's medical record were operated independently in a way which could hamper the sharing of pertinent information. As part of the review, staff and prisoners were asked their views. Staff generally felt they were not able to give enough time to the prisoner to properly address support plans. They felt that the format of the existing form was not fit for purpose. Prisoners reported that they found the presence of unfamiliar staff at review meetings an inhibiting factor.

The recommendations from the review were for a radical new system which would take a different approach to managing prisoners at risk of suicide or self-harm. It proposed that the new system should take a multi-disciplinary approach to the care of the prisoner and focus on effective screening and assessments. The other main recommendation was that prisoner escort and court service providers should open a warning procedure to record any current or historical concerns about self-harm or suicide

alongside the person escort record (PER). There was a further recommendation that there should be more information-sharing about healthcare interventions, both within the prison and with outside agencies, to ensure continuity of care following release into the community.

ACCT was developed in response to the recommendations made in the F2052SH evaluation. It was also intended to ensure that the changes that came into effect in 1999, when the NHS and Prison Service entered into a formal partnership to provide healthcare services in prisons, were in line with current NHS policy and national Prison Service frameworks. These included proposals for developing better ways of identifying mental health issues in prison reception, the use of the NHS Care Programme Approach⁶, and adopting a community care service model, i.e., encouraging mental health work on residential wings. ACCT was developed in partnership with the Department of Health.

Prison Service Instruction (PSI) 18/2005 introduced the new ACCT during 2005-2006. Guidance on ACCT was given in the revised version of Prison Service Order (PSO) 2700 on Suicide and Self-Harm. The revisions to the original PSO 2700 aimed to:

- Reduce the distress and improve the quality of life for all who live and work in prisons
- Reduce the number of self-inflicted deaths and incidents of self-harm
- Provide vulnerable prisoners with positive care and support
- Equip prisoners with coping mechanisms other than self-harm
- Ensure that staff are equipped to carry out this difficult work and are provided with support as required.

⁵ HMIP (1999) Suicide is everyone's concern: A thematic review by HM Chief Inspector of Prisons in England and Wales.

⁶ The Care Programme Approach is a particular way of assessing, planning and reviewing someone's mental health care needs if they have severe mental health problems, or a range of different needs.

More recently, concerns were raised by HMIP about inconsistent application of ACCT in their 2012 thematic review of the use of PERs for detainees at risk of self-harm⁷. Prisoners reported to HMIP that they had received poor support from staff and had experienced degrading treatment, exacerbating the risk that they would harm themselves.

HMIP found that ACCTs were very often assessed and reviewed without the benefit of any background information, unless the review was attended by healthcare staff. They also found that healthcare staff were not always involved in ACCT reviews. This was a frequent finding in inspections and HMIP has often recommended that prisons should ensure that healthcare staff attend ACCT reviews. Although prisoners themselves are an important source of information when assessing risk, the review of historic information should not be left to chance. particularly as some prisoners may try to avoid the stigma of being subject to an open ACCT.

1.2 ACCT process

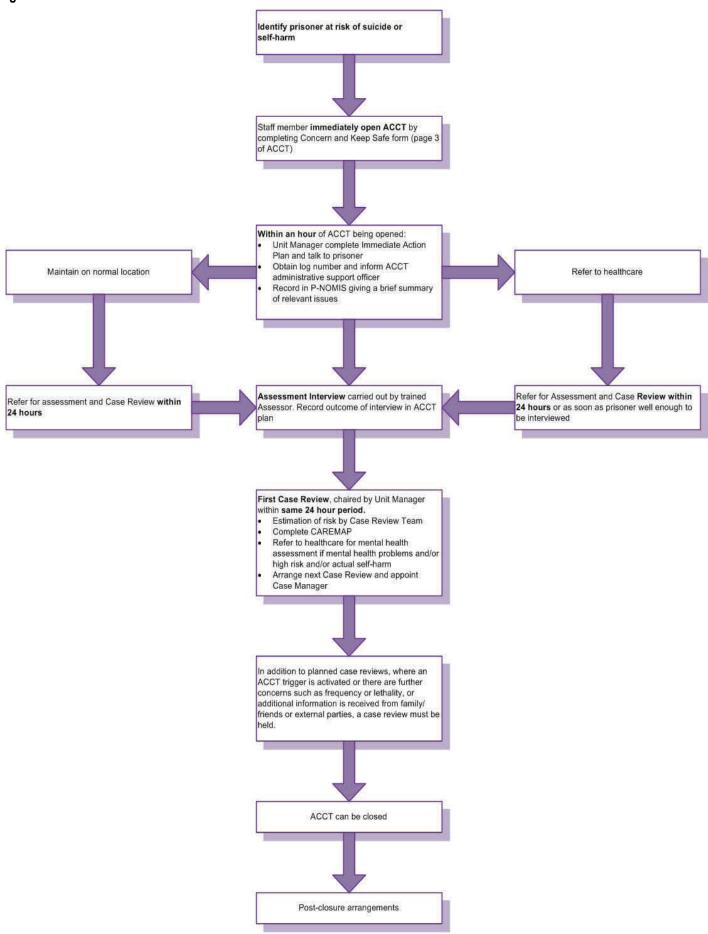
The ACCT process is necessarily prescriptive and it is expected that all stages are followed according to the timescales set out within the ACCT policy. Figure 1 shows the sequence of events that should take place once an ACCT has been opened. Actions should take place within the allocated time, except if the prisoner is moved to healthcare and is too ill to take part, then the case review should be postponed until they are well enough to do so.

An ACCT can be opened at any point when a risk is identified, by any member of staff working in the prison. A PER should accompany prisoners arriving from court. HMIP found in their recent review that there were issues around the completion of PERs. This could then have an effect on whether an ACCT would be opened at the receiving prison, if the PER did not have details of previous self-harm or suicide on it.

If it is a prisoner's first time in custody, their risk of suicide is known to be heightened. All prisoners should be assessed as part of the reception screening for risk of self-harm and/ or suicide. Reception staff should utilise all information available to them. This should include suicide/self-harm warning forms, warnings received from outside the prison – from friends/families or external agencies, or from the PER – and staff should speak to and observe newly received prisoners to look for potential risks of suicide or self-harm. The reception screening process is looked at in more detail in the Risk Factor thematic review published by the PPO.

⁷ HMIP (2012) The use of the person escort record with detainees at risk of self-harm.

Figure 1: ACCT Flowchart8



⁸ HM Prison Service (v.4) Care of at risk prisoners ACCT plan.

2. ACCT in PPO investigations

From January 2008 to August 2012 the PPO investigated 280 apparently self-inflicted deaths in prison. This is taken to mean any death of a person who has apparently taken his or her own life irrespective of intent.

The data in this report comes from data collection forms completed by PPO investigators following their investigations. The forms are split into 19 sections and cover most aspects of prison life. The investigator has access to the deceased prisoner's medical records and prison records (including security information reports), and can request any information they may need. They are also able to ask for an interview with any member of staff and serving prisoners, if they feel it will aid their investigation. The data collection forms allow some standardisation of the information collected during the investigations to enable cases to be compared, but not all information is available or recorded in all cases.

The ACCT plan is used for young offenders as well as adult prisoners. Although this report does not specifically look at the use of ACCT in self-inflicted deaths of young people, this topic was recently reviewed in a PPO bulletin on child deaths⁹. Two of the three young people who were the subject of the bulletin were on an ACCT at the time of their death. A number of failings were identified in the application of their ACCT plans. These mostly concerned a lack of child-centredness and conflicts between care or safeguarding and discipline or control mechanisms, such as adjudications and the rewards system. This prevented ACCT operating as a consistent, holistic and integrated system appropriate for children. The report recommended that ACCT processes should be more child-centred and involve senior managers, families and outside agencies as part of an effective care planning approach to managing young people at risk of self-harm and suicide. NOMS accepted these recommendations and established a working group including NHS England and the Youth Justice Board to look at the applicability of ACCT for young people (aged under 18).

2.1 PPO sample

The sample used for this report comprises 60 cases where the prisoner was on an ACCT at the time of their death. This is a subsample (21%) of the 280 apparently self-inflicted deaths investigated by the PPO between January 2008 and August 2012.

The demographic make-up of the sample is very similar to all self-inflicted deaths in the same period. The majority of prisoners in the sample were male (55 in the sample and 270 in all self-inflicted deaths) and aged between 22 and 39 years (31 in the sample and 143 in all self-inflicted deaths).

The most common method of self-inflicted death in the sample was hanging and selfstrangulation (53) as highlighted by Figure 2.

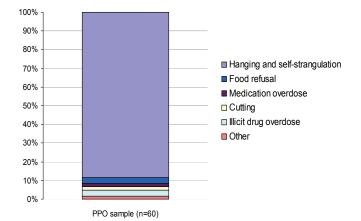


Figure 2: Method of death

2.1.1 Location of death

Over half of the prisoners in the sample died in prison (39) while over a third died in a hospital outside the prison (21). In all the cases where the prisoner died in hospital, the incident which led to their death took place in prison.

⁹ PPO (2013) Learning Lessons Bulletin: Fatal incidents investigations issue 2 Child Deaths.

Over half of prisoners were located in a normal cell at the time of their death (31). Fewer than one in five prisoners were located in the healthcare centre in the prison (11) and one in ten (6) were located on the vulnerable prisoner (VP) wing. Having VP status does not automatically mean prisoners will be placed on a separate VP unit. Prisoners who had VP status in the sample and were not on a VP unit appear to be at particular risk of suicide. In the sample, 20 prisoners had VP status but only 6 were on a VP wing at the time of their death. Giving a prisoner VP status means that they must be kept away from mainstream prisoners. This separation can be achieved on a normal wing by unlocking them when the other prisoners are off the wing and keeping them locked up when others are on association, or by placing them in a cell in a different location, such as healthcare. But the most secure and appropriate way to ensure VP prisoners do not associate with the general prison population is to keep them on a separate VP wing.

2.1.2 Equivalent healthcare provision

Two-thirds (41) of the prisoners in the sample received clinical care which our clinical reviewers deemed to be equivalent to that which they could have expected to receive in the community. Where care was not deemed to be equivalent (7), or only partly equivalent (12) to what they could have expected to receive in the community, concerns often centred on the lack of mental healthcare provision. Clinical reviewers in PPO investigations found that in some cases, the appropriate referrals were not made by prison healthcare to specialist mental health practitioners.

2.1.3 Observations and risk

In the last few days before they died, half the prisoners were deemed to be at raised or high risk of suicide (30). Over a third of prisoners (25) were thought to be at a low risk of suicide, but at risk of self-harm.

Observation arrangements will be put in place when prisoners are at risk of self-harm or suicide and prisoners will be monitored within a specified frequency to ensure they are safe and have not harmed themselves. Anyone on an

ACCT should be monitored at a level to be agreed at the immediate action plan stage and this should be recorded on the front cover of the ACCT plan. The details of the observations should be recorded in the ongoing record in section four of the plan. If the prisoner does self-harm, this should be marked in some way in the record (for example by using a highlighter pen). The level of observations should be reviewed and the guidance specifies that all entries must be meaningful and relevant to the person's mood, behaviour and situation. A time and date must be given for each entry and observations carried out in line with the specified frequency on the front cover. Observations must be carried out at irregular intervals within the specified frequency to ensure that the prisoner cannot easily predict the next check.

Those in the sample who were at raised or high risk of suicide were more likely to be on observations, and have a higher frequency of observations compared to those who were assessed as lower risk of suicide in the last few days before their death. Two-thirds of prisoners (17) who were observed every 30-60 minutes were at raised or high risk of suicide. Four prisoners who were at raised or high risk had observations less than every hour, though the majority of prisoners (13) who were observed less than every hour had been assessed as being at no risk or a low risk of suicide. Only prisoners who were at raised or high risk (5) of suicide were observed more often than every 30 minutes.

2.1.4 Mental health

The high rates of mental health problems among prisoners are well documented. Within the PPO sample of those who died on an ACCT in the past five years, over 90% of the prisoners were identified as having mental health care needs. Mental health in relation to suicide and self-harm in prison is looked at in more detail in the forthcoming PPO publication on risk factors.

3. ACCT

The policy on ACCT is found in PSI 64/2011: Management of prisoners at risk of harm to self, to others and from others (Safer Custody). This section will look at the different aspects of the ACCT process in more detail.

In the PPO sample of 60 prisoners who were on ACCT when they died, PPO investigations found that in only half the cases (30) the ACCT was correctly implemented or monitored at the time of death. There were 14 prisoners in the sample who had an ACCT which was very poorly implemented or monitored and there were 13 prisoners whose ACCT was only partially correctly implemented or monitored. The failings found in the investigations included: quality and frequency of ACCT reviews, care and management plans, observations of the prisoner, multi-disciplinary working and the timing of opening the ACCT. These are looked at in more detail below.

3.1 Care and management plan

The care and management plan (CAREMAP) is covered in section three of the ACCT plan and sets out how the support and care to address the needs of the prisoner are to be delivered. The CAREMAP is a pivotal section of the ACCT. An effective CAREMAP engages the person at risk and identifies the most urgent and pressing issues. Issues usually refer to problems or distress the prisoner is experiencing. Resources and strategies to support the prisoner should be considered, as well as the level of risk the prisoner poses to themselves and others, which should take into account any suicidal intent or plan.

The CAREMAP should be completed at the first case review and reviewed in all future case reviews. It should set a small number of realistic and achievable goals and should clearly state who will carry out specific actions. The CAREMAP should be reviewed at case reviews and, if necessary, updated to reflect the prisoner's changing needs and risks. It is essential that the CAREMAP

remains relevant to the prisoner's current risk and reviewing the CAREMAP is a fundamental part of a casework approach which can often be missed.

In order to keep the CAREMAP up to date, staff should record information in the ACCT document giving sufficient detail about the progress and well-being of the prisoner in relation to the goals which are set out in the CAREMAP. A good CAREMAP will identify the prisoner's most urgent and pressing issues, set achievable goals to help resolve the issues and identify who is responsible for resolving each goal.

In the PPO sample, over one in four (16 out of 60) prisoners did not have an adequate CAREMAP drawn up. The inadequacies found in CAREMAPs included insufficient support being given to help prisoners achieve their specified goals. Too often it was stated on the CAREMAP that it was the prisoner's sole responsibility to reach their set goals, with no other support mentioned as part of the action. It is advisable to specify a named individual as opposed to a department because if the action is not assigned ownership, it is likely that it will not be completed. In one case, a prisoner was given the responsibility on their CAREMAP to achieve the goal of completing a transfer request to another prison. While it is important for the person on the ACCT to be given some responsibility for improving their situation, it is inappropriate to put the onus of achieving a prison transfer solely on the prisoner. In this case, the goal would have been more achievable had a member of staff also been named, as the prisoner had no power to secure a transfer.

CAREMAPS should be assessed to ensure they are still relevant to the prisoner's current needs and risks. This process should be carried out in subsequent reviews and should be the subject of rigorous management checks. This will also help to ensure the effective continuity of care which is key to the successful implementation of any ACCT document.

Case study A

Ms A was 24 at the time of her death. An ACCT was opened for Ms A after she received news that her partner had been murdered in the community. Ms A was very upset by the news and staff were concerned that she might harm herself. Ms A indicated in the ACCT assessment interview that she had experienced suicidal thoughts, but had not planned how she would kill herself. At the first case review, Ms A was still in shock, in very low mood and very tearful. Ms A was assessed as being at raised risk of harming herself. Three almost identical goals were set in the CAREMAP for her "to deal with grief".

Ms A died five days after the ACCT was opened. The investigation found that a more active approach to supporting her through her grief would have been better. The CAREMAP goals were too generic, repetitive and not specific enough to Ms A's needs. The Ombudsman recommended to the Governor that they should ensure goals set in CAREMAPs are specific, timely and relevant to each woman's needs. They should be actioned as planned, followed up at each review and subject to rigorous management checks to help ensure effective continuity of care.

Case study B

Mr B was placed on an ACCT after he barricaded his cell, displayed increasingly bizarre behaviour and told officers that he was going to cut himself if he wasn't moved. Mr B was heavily in debt with other prisoners and was given VP status and moved to the vulnerable prisoner unit. Mr B was assessed as being at low risk of further self-harm. His CAREMAP was completed with four objectives for him: i) to be in and out of his cell to use his time constructively, ii) to share a cell, iii) to be located in a safer cell and iv) to have family contact. However, it was noted in the CAREMAP that Mr B was refusing to engage in out of cell activities and that Mr B was currently a high risk for cell sharing and was refusing to share a cell. Approval for him to be located in a safer cell was noted. He was said to be in regular contact with his family, although he had previously said he had waited ten months for a visit from them. Mr B was found dead the day after the ACCT had been opened.

The investigation found that the first two objectives in the CAREMAP were not achievable because Mr B's state of mind at the time and cell sharing risk assessment would not have allowed him to share a cell. Although the third action was approved and accepted, it did not take place and it is unclear where Mr B would have been placed as there were no safer cells in the VP unit.

The Ombudsman recommended that the Governor should reinforce to staff that all ACCT documentation should be fully completed and that objectives set in the CAREMAP should be achievable and realistic.

3.2 Involvement of family and friends in the ACCT process

As recognised by the ACCT guidance, positive family and peer relationships can be fundamental to reducing a prisoner's risk of suicide or self-harm. Family contact should be considered when identifying issues in the ACCT assessment and formulating the CAREMAP. The family should be considered for involvement in the CAREMAP, if their involvement is thought to be beneficial. Other considerations should include: peer support, access to the chaplaincy, access to gym and

other regime activities, time out of cell and diversionary material (in-cell activities) among others.

In the PPO sample, the majority of families were not involved in the CAREMAP (50 out of 60). Family involvement should be judged on a case by case basis and for some prisoners at risk of suicide or self-harm, it would not be appropriate to encourage contact with their family or close friends. However, where it is thought that it would be beneficial and where family members are willing to be in involved in the prisoner's ACCT plan, it is good practice for the prison to help facilitate a visit or other forms

of communication between the prisoner and the family. This is especially important in the case of a young person and the prison should consider inviting the family to attend the next case review, as described in PSI 64/2011. Their Youth Offending Team should also be invited (where it would be beneficial).

3.3 Triggers and warning signs

An important part of the ACCT planning process is to identify events or signs which could increase the risk of the prisoner harming him or her self. Sometimes referred to as a 'risk signature' the triggers or warning signs which should alert staff and prompt further action or an immediate case review should be recorded in the inside front cover of the ACCT plan. Triggers can include events like anniversaries of the death of loved ones or upcoming court appearances, as well as more general concerns such as an upcoming visit. The warning signs should be recorded in the first case review, and as the term 'risk signature' implies, they will be different for every individual. Like the CAREMAP, triggers should be reviewed and updated at future case reviews and when an individual's circumstances change. The risk signature is not fixed, and different elements take on greater significance at different times in a prisoner's life. They should not be viewed as static, as they can often change, depending on other factors in the prisoner's life which impact on their level of risk.

The first case review should be held within 24 hours of the ACCT plan being opened, and ideally immediately after the assessment interview. The assessment interview has to be conducted by a trained ACCT assessor, but the case reviews can be carried out by a residential/case manager or equivalent grade (they do not need to be a trained ACCT assessor). The first case review should be attended by any other member of staff who has or will have contact with the prisoner at risk. Healthcare should attend the first case review; subsequent reviews should be multi-disciplinary and include staff from across the prison. The multi-disciplinary nature of the case reviews is important for many reasons, including the identification of trigger points. There may be triggers which only healthcare staff (because of

their medical expertise) may be aware of, and likewise there may be warning signs which only a specific officer – such as their personal officer or a wing officer – are aware of. If these individuals are not present at the case reviews and not recorded on the ACCT plan, then the warning signs could go unnoticed as other staff will not be alerted to look out for them.

In the PPO sample, over one in four prisoners did not have known trigger points correctly recorded on their ACCT plan. The implications of not recording trigger points in detail can result in a missed opportunity to intervene when a prisoner presents at their highest risk. While triggers can sometimes be difficult to identify, there is a better chance of uncovering them if there are staff from all areas of the prison present at the case review. Information which might not have been shared before may come to light. If there are no triggers identified, this should be recorded, instead of leaving the form blank. The form can then be updated as and when case reviews happen in order to review whether the individual's circumstances have changed.

When a prisoner displays behaviour which is part of a trigger, there should be an immediate case review (as stated in PSI 64/2011 policy on ACCT). The trigger system only works if staff act on the behaviour they have observed. Consequences of not documenting triggers can be seen in case of Mr C, where the trigger was well documented but staff failed to follow up by immediately carrying out a case review.

¹⁰ The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2011) A National Study of Self-Inflicted Deaths in Prison Custody in England and Wales from 1999 to 2007.

Case study C

Mr C had only been in prison five days before he was found dead. When Mr C was assessed by healthcare staff on reception, he became tearful and said he was hearing voices. An ACCT was opened by healthcare staff during the assessment. Mr C told healthcare that he had taken an overdose in the community three weeks earlier and had recently been bereaved. In his ACCT assessment interview, Mr C said that he was worried about his partner in the community because of their recent bereavement. He said that as long as he could hear his partner's voice by speaking to her on the telephone, he would be able to cope. Under the triggers/warning signs to prompt an immediate review, the prison officer wrote 'Loss' of contact with partner/breakdown in relationship.'

The day Mr C died he had telephoned his partner a number of times. During one of the telephone conversations Mr C became upset after talking to her because she told him she wanted to end their relationship. The prison officer who noticed that he was upset following the call offered Mr C advice, calmed him down and telephoned Mr C's partner on his behalf. However, he did not ask managers to hold an ACCT review although he was aware of Mr C's ACCT and the trigger/warning signs on it. It was clear on the ACCT that a breakdown in his relationship should have prompted an immediate case review. Mr C continued to telephone his partner that day, even though he had agreed with the prison officer that he would not call her again for 24 hours so they could both calm down. Again, this could have been a trigger to call a case review, but the officer, who had planned to talk to him about it the next day. had gone off shift. Mr C was found dead that evening.

Although there was no clear evidence available to staff that Mr C was having suicidal thoughts, an ACCT review should have been held the day that he died following the telephone conversations. The Ombudsman recommended that all prison staff use the triggers recorded in a prisoner's ACCT document to prompt an ACCT case review where increased risk is identified.

Case study D

Mr D was remanded in prison having been charged with a serious offence. He had not been in prison before. Mr D was put on an ACCT on three separate occasions but each time said that he would not kill himself because of his family and because it was against his religion. During a meeting with a member of healthcare, Mr D showed him a ligature he had made some time earlier, healthcare opened what was to be Mr D's final ACCT. There was no evidence that Mr D had made ligatures before and showed them to staff. The triggers section of the ACCT plan was not completed on the day the ACCT was opened and at no point were any triggers listed in the ACCT document before Mr D's death. This was despite the fact that Mr D was desperately trying to get a deportation order approved so he could be closer to his mother who was ill. He also had concerns about his wife and children in the event that he was deported and he was stressed and anxious about his current situation.

On the morning that he died, Mr D tried telephoning his wife 77 times. When he got through to her, he told her that he wanted a divorce and that the relationship was finished. None of the staff were aware of this telephone conversation although they did know that he was worried that his wife was planning to leave him. Mr D was found dead that afternoon. It is clear that Mr D had a number of significant triggers that could have been listed, including his mother's health, his concerns about his wife and his parole application.

During the course of the investigation, the PPO investigator reviewed ten ACCT plans which had recently been closed by staff across the prison. The investigator found that in five cases, no triggers had been listed. This highlighted that the findings in the case of Mr D were not an isolated incident.

The Ombudsman recommended that the prison should have a full audit of ACCT processes, particularly checking that the trigger sections of the ACCT document are completed, or that it is noted that there are no known triggers where this may be the case.

3.4 Multi-disciplinary approach

A multi-disciplinary approach is encouraged throughout the ACCT plan. Opening an ACCT is not restricted to a certain member or level of staff. Any member of staff who receives information – from any source including a family member or an external agency – or observes behaviour which may indicate a risk of suicide or self-harm, must open an ACCT. The opening of an ACCT must be recorded on the Prisoner **National Offender Management Information** System (P-NOMIS) with a brief summary of the relevant issues so that all members of prison staff can see that an ACCT has been opened for that prisoner. If wing observation books are retained, it should be recorded that an ACCT has been opened. Healthcare should be informed, including the mental health in-reach team where appropriate, so that the opening of the ACCT plan can be noted in the clinical record. If the prisoner has any interaction with healthcare, then relevant information should be requested which can contribute to the assessment and subsequent risk management of the prisoner.

Prisoners who do not speak English must be given access to an interpretation service so they can fully participate in the ACCT process. This is particularly important to enable the required multi-disciplinary approach to be followed and allow the prisoner to understand the various staff from different backgrounds involved in their care. This applies to case reviews as well as on going care. This is not always the case and PPO investigations have found that telephone interpretation services are not always used by staff, even though they are available in all prisons.

As well as carrying out the actions mentioned above, everyone who contributes to the support and care of the prisoner should be invited to the first and subsequent case reviews. Those invited to attend could include the wing officer, the person who first raised the initial concern, healthcare, staff from probation, education, drug and alcohol counselling service (CARATS), psychology, and the Independent Monitoring Board (IMB) representative as well as other agencies operating in the prison or in contact

with the prisoner. Although PSI 64/2011 states that the case review should be timely and not unduly delayed to ensure full attendance, attendance should be prioritised by those invited. In some investigations, key members of staff who have been involved in the prisoner's care or treatment have not attended the case reviews and key information has been missed. Multi-disciplinary reviews ensure that relevant staff and specialists are able to offer support or insight into an individual's behaviour.

The multi-disciplinary approach also applies to keeping the ACCT document itself up to date: any member of staff – operational, medical, from the chaplaincy or another department or agency should update the document if they find out new information which could alter the risk of the prisoner. Any new information should be recorded in the ongoing record section of the ACCT document, found in section four. Information recorded in the ongoing record can allow others involved with the prisoner to better understand the prisoner's current situation and how they can care for them.

In one case the PPO investigated, the prisoner was on an open ACCT and telephoned his sister. During the conversation, his sister became very concerned that he might selfharm. The sister was so alarmed that she telephoned the prison and spoke to one of the chaplains. She told the chaplain that her brother had told her to look after their mother and the previous time he said that to her, he had gone on to self-harm. The chaplain did not go to healthcare to see the prisoner or put the information in the ACCT ongoing record section. The chaplain telephoned the nurse in the healthcare unit where the prisoner was currently located and passed on the information. Instead of the nurse increasing the care and support for the prisoner, she did nothing. She did not record the information in the ACCT and she did not update his medical record. During the night, the prisoner hanged himself. The warning from the prisoner's sister should have led to additional support for, and closer supervision of, her brother. Given that the information indicated that the prisoner's risk of self-harm was raised, the nurse should have acted to increase the support for the prisoner,

but there is no evidence she did anything. This was a serious failing in a situation where it was clear that intervention was necessary, potentially to save a life.

In another case, the prisoner's behaviour was observed by staff as becoming increasingly bizarre the day before he died. He had barricaded himself into his cell and was acting in a very paranoid manner. He was also screaming and shouting allegations against staff. Although a number of staff said

that the prisoner was acting in a clearly distressed way, no mental health assistance was requested and there was no mental health input into the ACCT. This was despite the prisoner having a history of mental health issues and having previously self-harmed in the establishment. Given this information and the staff's concern, a multi-disciplinary review should have been conducted as this would have facilitated the expertise of specialist staff such as the healthcare team, chaplaincy and others.

Case study E

This was Mr E's first time in prison. He arrived at prison with a Person Escort Record (PER) and a suicide/self-harm warning form. Mr E had a history of depression and had taken an overdose in the community following the breakdown of a relationship. The nurse who saw Mr E at reception was aware of his history of self-harm and depression, but she made no note on his prison file of either. Instead she based her assessment on how he presented himself and that he said he felt fine.

Over a month later, an officer opened an ACCT for Mr E after he had a telephone call with his partner. During the telephone call, his partner stated that she was ending their relationship. Mr E was very distressed after this call and the prison officer thought Mr E needed more support, so opened an ACCT. Two ACCT case reviews were held but healthcare were not represented at either review and there was a different discipline officer and a different case manager at each.

Although Mr E's self-harm was thought to be caused by emotional problems rather than symptoms from a mental health diagnosis, the prison's local protocol said that prisoners who had exhibited previous self-harming behaviour should be referred to the mental health team for assessment. This did not happen when Mr E arrived at the prison.

It is good practice for there to be a consistent case manager in ACCT reviews, and reviews should be scheduled to facilitate this as far as is possible. However as staff work shifts, ACCT reviews should not be delayed merely to allow the same case manager to attend. Given that Mr E had a history of harming himself, his personal relationship was breaking down and he was on an ACCT for that reason, he should at least have been brought to healthcare's attention.

The Ombudsman recommended that all appropriate staff are present at ACCT reviews. A recommendation was made to healthcare to ensure that healthcare staff working in reception are aware of the importance of recording all information which arrives with prisoners. It was also recommended that healthcare staff should ensure that they refer prisoners with a recent or relevant history of self-harm to the mental health team for assessment.

3.5 ACCT Training

In order for all sections of the ACCT process to be conducted and managed in the most effective way, it is imperative that staff receive relevant training on ACCT procedures. Training should be kept up to date and refresher courses should be provided for staff. ACCT training should not be limited to discipline staff but should include any staff who may need it, such as: healthcare, chaplaincy and other agencies working in the prison and coming into contact with prisoners. The PPO thematic review of recommendations¹¹ highlighted the numerous recommendations made to prisons to keep their ACCT training up to date and to ensure that all relevant staff members have it. It is the prison's responsibility as a whole to look after those prisoners who are at risk of suicide or self-harm, but a prisoner's ACCT plan is only as good as those individuals responsible for its implementation. This is reflected in the fact that an ACCT can be opened by any member of staff, so it is essential that all members of staff are fully equipped with the skills they need in order to recognise at risk behaviour and feel confident opening an ACCT.

3.6 Enhanced case reviews

Under Prison Service procedures, prisons have the discretion to manage the most severely disruptive, volatile and difficult to manage prisoners using an enhanced case review process. Enhanced case reviews are designed to allow staff to respond more effectively to the prisoner's individual needs to provide a flexible but consistent approach to changing the prisoner's behaviour and managing their risk. When prisoners are placed in anti-ligature clothing (known as 'alternative clothing' in the policy) it is a Prison Service requirement that this triggers an enhanced case review. Case reviews must be chaired by a Custodial Manager of a minimum grade and the panel should include a member of the mental health team, the residential manager of the unit the prisoner is located, an appropriate psychologist and other specialists who work with the prisoner

such as the offender manager, drug worker or teacher and a member of the chaplaincy and Independent Monitoring Board.

Although the cases are not included in the ACCT sample reviewed in this report, the PPO has investigated a number of self-inflicted deaths recently where the prisoner displayed behaviour which we considered should have at least led to some consideration of whether an enhanced case review process was needed. In some cases, we found that the failure to do so was to the detriment of the prisoner's safety. Too often, anti-social behaviour and other complex behaviours are not identified as signs of increased vulnerability which need to be explored with the prisoner. Families should also be involved were possible and appropriate. Enhanced case reviews prompt the involvement of more senior prison managers, something that is not usual during standard ACCT procedures and helps to develop a more holistic assessment of risk. The process should ensure that all the relevant people who need to be consulted about a prisoner's management are at every case review, and information is shared more effectively through a coordinated approach to managing the individual's risk.

¹¹ PPO (2013) Learning from PPO investigations: Making recommendations.

4. Lessons to be learned

- The goals set on CAREMAPs should be realistic, achievable and relevant.
- A named member of staff should be specified next to each CAREMAP goal and a target date set for completing the goal.
- The trigger section must be completed on all ACCT plans, even if it is to say that there are no known trigger points.
- Triggers should be reviewed and updated as and when is necessary for the individual.
- Staff must conduct an immediate case review if a trigger behaviour is observed, as set out in PSI 64/2011.
- ACCT reviews must be timely and multi-disciplinary, with consistent staff attendance, if possible.
- Staff from across the prison and agencies working within it should be invited and encouraged to attend ACCT reviews and offer input into the individual's care.
- ACCT plans should be treated as a holistic approach to managing an individual's care and support.
- All staff who come into contact with the individual should be responsible for updating the ACCT plan if they feel that their risk of self-harm or suicide is heightened.
- All staff should be up to date on their ACCT training and those that are not should be provided refresher training at the earliest opportunity.

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