In 2009, Standard 60 (Suicide Prevention and Self Harm Management) and Standard 20 (Managing Deaths in Custody) were combined to form one risk based audit. Since then, 9% of the 109 audits conducted have resulted in scores of amber/red.

During the two year audit cycle, improvements have been seen in audit results. However, the three areas of weakness which are consistently reported in over half of the establishments visited are:

- Where ACCT is appropriate the required process is followed
- Regular reviews of risk plus targeted reviews if circumstances change
- Disciplines in prison share concerns which indicate risk change

The Learning Points and Prompts for Action listed below are designed to target the 3 areas of weakness and assist prisons in improving the care they give the individual and, consequently, their audit results.

**KEY LEARNING POINTS:**

- Standards Audit Unit noted that, in over half of audits conducted, management checks are often undertaken as a matter of routine by a number of different staff who failed to record deficiencies, action to be taken, actions subsequently taken and / or review dates to ensure weaknesses have been resolved.

**Example** - During a recent death in custody investigation, it was noted that a number of different managers had identified and noted discrepancies within the ACCT document however, at the time the prisoner died, these had not been addressed and the document remained incomplete.

- SAU often found that case reviews were often not managed by dedicated case managers and had not been completed on time and there was no reason noted or evidence that the prisoner has been informed or additional support put in place.
Despite requiring a multi-disciplinary approach, ACCT Case Reviews often fail to include the appropriate staff required to support the prisoner's individual needs. As a prisoner progresses through their care plan, it may be appropriate to reduce or increase the number of attendees depending on whether actions are completed or new ones added. Attendance should be tailored to only those who are providing care and support to the prisoner.

SAU found that CAREMAP actions were incomplete because they had been assigned to departments rather than named individuals. If an action is not assigned ownership, it is likely that it will not be completed.

The ACCT document is the central source of information when dealing with prisoners who are deemed to be at risk. Sharing concerns between staff is vital to providing continuity of care and effective record keeping will support defensible decision making.

Key information needs to be summarised in Observation Books and NOMIS Case Records to ensure all staff are aware of the issues affecting the prisoner.

**PROMPTS FOR ACTIONS**

- Are your ACCT management checks based on a quality assurance process that identifies and rectifies deficiencies within the document and the care given to the individual?

- Do managers carrying out assurance checks know what to look for and how to assess the quality of care being provided?

- If a Case Review has to be cancelled, note the reasons in the ACCT document and ensure that the prisoner is aware and supported until the review takes place. Under these circumstances, the case review should be reorganised as quickly as possible.

- Are a standard group of staff invited to every ACCT Case Review or is attendance based on the need of the prisoner?

- Issues and actions included in the CAREMAP must be allocated to named individuals to prevent confusion and ensure they are taken forward.

- Where information about a prisoners risk of harm is noted in other documents e.g. wing observation book, NOMIS or SIR, this should be summarised within the ACCT and vice versa.

**Example** – If, during an ACCT Case Review, the prisoner states his intentions to self harm or commit suicide, this must be noted in the wing observation book and NOMIS Case Notes.