**Women’s Estate Case**

**Advice and Support Panel (WECASP)**

**Referral Form**

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| To | **Women’s Estate Case Advice and Support Panel (WECASP)** |
| Prison: |       | Date of Referral: |       |
| **Case**  |
| NOMIS |       | Full Name: |       |
| D.O.B: |       | Category: RS/PRS/IPP/YCS transition  |       | IEP level: |       |
| Index Offence: |       | Religion: |       |
| Date of Sentence/Sentence length/Remand |       | Tariff (if applicable) |       |
| PED/CRD: |       | SED: |       |
| Current location, CSU/HCC:  |       | Ethnicity: |       |
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| **Case Background** |
| **Relevant information:***(Please provide a brief summary of relevant background information on the individual, including offending history, index offence and any known information from services in regard to their time in the community.)*      |
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| **Referral Information**

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| **Reasons for the referral:***(In accordance with the Policy Framework and the referral guiding principles, please provide a summary of the reasons for your referral)* |

**Areas of consideration** |
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| Please tick (√) the areas that are also applicable for this case |
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| Continuous or a history Dirty Protest  | [ ]  |  | Post tariff Indeterminate Sentenced prisoners (ISPs)  | [ ]  |
| Held in a Care and Separation Unit or equivalent for a 42 days or more continuous period  | [ ]  |  | Difficulty engaging with staff and regime  | [ ]  |
| ‘Stuck’ and not progressing with pathway plan  | [ ]  |  | Any current or known history of self-harm and/or a suicide attempt?*If yes, please provide further details below.* | [ ]  |
| New arrival in the women’s estate with recent experience of the youth / secure estate | [ ]  |  | Known to the Enhanced Case Management Team (ECMT).  | [ ]  |
| Historic or current ACCT management and has reached ‘Enhanced Case Management’ level in accordance with [PSI 64/2011](http://home.hmps.noms.root/Intranet/ShowBinary?nodeId=/Repo/HQ/internal_communications/psi/PSI_64_2011_Safer_Custody_Final__January_2012_(2).DOC) | [ ]  |  | Located on healthcare unit as an inpatient for more than 3 months | [ ]  |

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| **ACCT and Self Harm Additional Information***Where applicable, please provide further details in relation to ACCT’s and self-harm behaviour including previous or current open ACCT’s, ACCT reviews and support plans and please specify where* ***and*** *when any self-harm / suicide attempt incidents took place – e.g. in prison/police custody or in the community).* |
| **Segregation Additional Information***Where applicable, please provide a summary of time spent in segregation and details of any segregation reviews to support the resident*.      *Please attach copy of Segregation review form if 42 days or beyond:* Yes [ ]  No [ ]  |
|      **Please provide details of care team/clinicians who have assessed the individual:**(*including name, email and role)* |
| **Summary of custodial behaviour and triggers** |
|  Please provide an outline of the behaviour that is of concern and any known triggers |
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| **Details of Actions Taken** |
| Please provide an outline of what local action has been taken so far to support the individual and staff |
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| **Has the case been discussed at a local Safety Intervention Meeting (SIM):**Yes [ ]  No [ ]  Date of last SIM meeting: (*If yes, please attach SIM minutes with the referral form)* |
| **Is this case screened into the OPD pathway**: Yes [ ]  No [ ]  *Please give details below:* *(If yes and a case formulation has been completed, please attach with the referral form)* |
| **Does this person have a disability*:*** Yes [ ]  No [ ]  *Please give details below:*        |
| **Details of adjudication history** *(please provide details of the last twelve months):* |
| **Date** | **Charge** | **Establishment** | **Outcome** | **Reason for dismissal** |
|       |       |       |       |       |
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**Establishment Referral Expectations**

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| Please provide a summary of what your expected outcomes are from the referral and outline the objectives you would like to achieve:  |
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**Establishment Governor/Director Comments:**

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| **Name:** |       | **Signature:** |       |

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| *I confirm that the WECASP Referral Form has been disclosed to the individual.* ***Only the individual’s copy must be signed.*** |
| **Name:** |       | **Signature:** |       |
| **Grade:** |       | **Date of disclosure:** |       |
| **Individuals signature confirming disclosure:** |
| Please tick here if they have refused, or are unable to sign [ ]   |
| **Offender Manager’s Details**: |
| **Full name:** *(Please include POM and COM where relevant)* |       |
| **Email(s):** |       |
| Please tick to confirm that the Offender Manager(s) is aware of and in agreement with the referral [ ]  |

* **Please check that you have attached the following**:
1. Copy of Segregation review form, 42 days or beyond
2. Last SIM minutes
3. Any additional information that would enable the Panel to make an informed decision.

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| **Please return this form to:** | **WECASP@justice.gov.uk** |