National Offender Management Service

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Equality Rights and Decency Group
National Offender Management Service
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Dr Andrew Harris
HM Coroner – Inner South District of Greater London

28 February 2014

Dear Dr Harris

Thank you for your Regulation 28 report addressed to the National Offender Management Service (NOMS), NHS England (NHSE), and the Governor of HMP Belmarsh. Equality, Rights and Decency Group responds to all Regulation 28 correspondence as we have the policy responsibility for suicide prevention and self-harm management, and for sharing learning from deaths in custody. Please accept this as a response from NOMS (including HMP Belmarsh) and NHSE, who has been consulted about this response.

You identified a number of issues in your letters which I have addressed below in the order which they were raised.

NOMS and NHS England consider the Coroner's expert's opinion on the risks associated with tobacco withdrawal.

Both NOMS and NHSE agree that, while comprehensive assessments are completed when a prisoner is received into prison custody in relation to their health and risk of harm to self and others, further consideration needs to be given to the extent to which screening processes should identify tobacco dependence and potential issues associated with withdrawal. Currently, prisoners undergo a number of assessments on their arrival in prison custody. Prison Service Order (PSO) 3050 "Continuity of Healthcare for Prisoners, contains a mandatory requirement that requires that "*an initial assessment of the healthcare needs of all newly received prisoners is undertaken within 24 hours of first reception by an appropriately trained member of the healthcare team to identify any existing problems and to plan any subsequent care. A health screen..takes place before the prisoner's first night to primarily detect:*

- *immediate physical health problems*
- *immediate mental health problems*
- *significant drug or alcohol abuse*
- *risk of suicide and/or self-harm*

The policy requires that if immediate health needs are detected, the prisoner is referred to the appropriate healthcare worker or specialist team. In addition, in the week following first reception, every prisoner must be offered a general health assessment. This assessment is equivalent to a primary care assessment when registering with a new practice in the community. Such assessments are not standardised, however the general health assessment should act as an opportunity for:

- gathering further medical information
- checking how the prisoner is settling in
- health education

- providing information
- health promotion

As you will recall from the evidence at the inquest, the second reception screening includes a review of the prisoner's smoking habits and how many cigarettes he/she smokes daily. The prisoner is asked whether he/she wishes to stop smoking and is offered help to do so. Smoking cessation programmes, which include the provision of nicotine replacement therapy, are available to every prisoner throughout his or her time in custody, and further evidence given explained how diazepam can be prescribed if necessary to alleviate the effects of tobacco withdrawal.

In addition, Prison Service Instruction 74/2011 'Early days in custody – reception in, first night in custody, and induction to custody', includes the requirement for an initial screening in relation to the prisoner's mood: "*The prisoner must.. be interviewed, in private if possible, to discover and record any further immediate needs and risks, and any other information about the prisoner that may be relevant, particularly during their first night in custody*". Furthermore, it requires that "*The PER and any other available documentation including Suicide & Self Harm Warning Forms, ACCT documents and CSRA assessments, must be examined, and the prisoner interviewed in Reception, to assess the risk of self-harm or harm to others by the prisoner, or harm from others*".

NOMS accepts that despite the above range of screening during the reception process, further consideration needs to be given to identifying prisoners for whom tobacco withdrawal may give rise to an increase in suicidal feelings or self-harm, and to develop the support given to prisoners who do not have access to tobacco, or to the amount they would normally rely on. NOMS is currently working with healthcare partners to develop a care pathway, that includes an appropriate level of screening, to ensure that when tobacco is not available, or it is available but in more limited supply than the level they are used to (because they have limited funds/access to prison shop), that the relevant healthcare provider ensures that appropriate support, including Nicotine Replacement Therapy is available. This is recognised as especially important in cases of poly substance users and those with mental health issues.

In addition, you will be interested to know that the Offender Health and Tobacco Cessation Teams at Public Health England (PHE), are currently working on guidance for Prisons in the management of people with nicotine addictions. As this guidance is not yet completed, PHE recommends that healthcare providers responsible for the assessment and treatment of tobacco withdrawal follow the NICE Public Health Guidance (PH45) on Tobacco Harm Reduction, which recommends that when tobacco is not available, or it is available but in more limited supply, that Nicotine Replacement Therapy is made available to supplement tobacco use. Facilitating access to extra nicotine can prevent users from experiencing nicotine withdrawal and the side effects that this may cause.

HMP Belmarsh review the areas of concern regarding the implementation of ACCT, that were raised during the inquest.

<u>ACCT case reviews.</u>

National policy contained within PSI 64/2011 "Management of prisoners at risk of harm to self, to others and from others (Safer Custody)" reminds staff of the mandatory requirement that ACCT case reviews "*Be multi-disciplinary where possible*". Colleagues at HMP Belmarsh have confirmed that the Governor and all managers (including custodial managers and supervising officers) will attend further ACCT Case Manager refresher training, in part to underline the importance of a multidisciplinary attendance at case reviews, and the need to seek contributions from relevant departments, including healthcare staff and mental health

professionals. This refresher training will commence this month and is expected to be completed by October 2014.

In terms of attendance at ACCT case reviews, the policy recognises that "*The ACCT process will operate more effectively if there is continuity in the attendance of staff from relevant departments/services. For example, if education is seen as a relevant department to attend the review, then every effort should be made to ensure the same member of staff attends the reviews, likewise with healthcare input*". The Enhanced Case Review Team will involve all relevant disciplines and include more specialists and a higher level of operational management than a typical ACCT Case Review Team. Colleagues at Belmarsh have confirmed that the refresher training will remind all managers that ahead of any planned moves, the ACCT Case Manager will undertake a handover with the new Case Manager at the new location, and the importance of both ACCT Case Managers attending the case review prior to the relocation will be reiterated. In addition, Case Managers will also be reminded of the need to gather all relevant information and to allow those attending ACCT case reviews to review the ACCT and any risk related information they may possess (for example, on SystmOne) which the Review Team need to be aware of.

Within the ACCT process, the ACCT Assessor is expected to gather and review all available risk related information including that contained within the NOMIS notes, the F2050 (prisoner's core record), and any recent ACCTs etc, to inform the assessment. All relevant risk information should be recorded within the ACCT, and attendees at the first ACCT case review and subsequent case review meetings are expected to be familiar with the contents of the ACCT. You will be aware that the Prisons and Probation Ombudsman recommended that a local protocol was devised to ensure that information was shared between safer custody and healthcare staff, and as a result members of the mental health in-reach team now record interaction with prisoners subject to on open ACCT both on SystmOne and within the ACCT document. Case Managers have been reminded of the need to follow up any mental health referrals and are now required to follow up any referrals to ensure that it has been received and actioned – this will also be addressed in the current ACCT refresher training, in the local policy on Suicide Prevention (which is due to be re-issued on 10 March 2014) and a Notice to Staff to be issued on 3 March 2014.

National policy requires that staff ensure that a case manager or a representative from the receiving residential unit is invited to attend a case review ahead of a planned relocation within the prison, the purpose of which is to ensure that all relevant information and risk is shared and understood.

ACCT CAREMAPS

Chapter 5 of PSI 64/2011 sets out the purpose of the ACCT case review which include:

Consider and record progress against the initial CAREMAP, and the prisoner's general well-being;

Consider whether the prisoner exhibits any additional needs which may require the CAREMAP to be updated;

Discuss with the prisoner the meaning of any acts of self-harm and options for alternative coping strategies.

Colleagues at Belmarsh have confirmed that ACCT case managers will be reminded during the ongoing ACCT refresher training and in the updated local policy of the requirement to review the CAREMAPS at each case review and record the manager who is responsible for each action and who is required to feed back at the next case review.

A review of the records on SystmOne and the CAREMAP should have highlighted the fact that Mr Johnson had been referred for a mental health assessment, but this had not been completed.

Location in the segregation unit.

Policy allows prisoners subject to ACCT procedures to be located in the segregation unit in "*exceptional circumstances. The reasons must be clearly documented in the ACCT Plan and include others options that were considered but discounted*". In Mr Johnson's case, staff in the healthcare centre were concerned that Mr Johnson had become aggressive, and was threatening to damage and "kill someone" if he remained there. Staff were concerned that he therefore presented a danger to other patients, and his perceived attempt to assault the Governor led to his relocation in the segregation unit.

While it is apparent that the Governor who authorised the segregation was not aware of Mr Johnson's ACCT or the potential triggers when he was relocated from the residential unit to the segregation unit, his risk was recognised by the Nurse completing the initial segregation safety algorithm (which requires confirmation of an open ACCT, as well as signs that they are acutely unwell) and accepted by the Governor. The reasons for him being relocated to the segregation unit were documented by those attending the enhanced case review team who (as the PPO reported) thought he should remain there due to the outstanding charges (concerning the damage to his cell and his attempted assault on the Governor), and also because he was permitted to smoke there, which case review team recognised remained an extremely important concern to him.

It is acknowledged in policy and accepted by colleagues at HMP Belmarsh that prisoners who are subject to ACCT procedures should be located in segregation units only in exceptional circumstances, and that this point will be reinforced during the ongoing ACCT refresher training.

I hope you find this letter helpful.

Yours sincerely,

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