Worcestershire Health and Care NHS
NHS Trust

Ministry of JUSTICE
National Offender Management Service

**National Offender Management Service**
Equality, Rights & Decency Group,
4th Floor (post point 4.12),
Clive House
70 Petty France
London SW1H 9HD

Mr Geraint Williams
Senior Coroner for Worcestershire

13 November 2015

Dear Mr Williams,

Thank you for your Regulation 28 report dated 21 September, addressed to both the Governor of HMP Hewell and Worcestershire Health and Care NHS Trust, concerning the recent inquest into the death of Liam Smith who died on 17 August 2014. Your report has been passed to the Equality, Rights and Decency Group (ERDG) in the National Offender Management Service (NOMS), as we have responsibility for the policy on suicide prevention and self-harm management and for sharing learning from deaths in custody. This response is provided on behalf of NOMS, the Governor of Hewell and the Worcestershire Health and Care NHS Trust.

I have addressed the points you have made in the order that they were raised.

1. Evidence suggested that Mr Smith was at risk of inadvertent self harm and that therefore in accordance with PSI 64/2011 ACCT procedures should have been opened in respect of him. Witnesses confirmed their understanding of that mandatory requirement but indicated that they would use their clinical judgement in deciding whether or not to open an ACCT. It is of concern that staff may therefore not be following mandatory PSI instructions and that prisoners are not receiving appropriate protection by way of the ACCT process.

As you are aware, chapter 5 of Prison Service Instruction (PSI) 64/2011 sets out the policy on the Assessment, Care in Custody and Teamwork (ACCT) process. ACCT is a prisoner-centred, flexible care planning approach which is used in all prisons to manage a prisoner's risk or self-harm or suicide.

Managing suicide and self-harm risk within the prison estate is a difficult and complex issue. It is recognised that many prisoners present with a number of static and dynamic risk factors that may lead to them being more susceptible to risk of self-harm, such as substance misuse, childhood adversity or mental health issues. Any prisoner, who is identified as being at risk, must be managed and supported using the ACCT procedures.

Staff are often required to take difficult decisions and make judgements about a prisoner's risk of harm based on a number of factors. It is important that a full assessment of a prisoner's risk is undertaken including input from clinicians in order to make a fully informed decision about a prisoner's risk to themselves which will inform the decision as to whether an ACCT document should be opened.

Additionally, the policy states that if a member of staff receives information which may indicate a risk they must open an ACCT. It is not the intention of the policy to require staff to open an ACCT automatically in every circumstance where a risk "may" be indicated but it is expected that they *communicate their concerns immediately to the Residential, Daily or Night Operational Manager, and/or consider opening an ACCT Plan and make a record of their decision in an appropriate source e.g. observation book, NOMIS.*

A review of the ACCT process is currently ongoing, which will inform changes to the current policy in PSI 64/2011.

2. Evidence was given that certain medical information which arrived at the prison with Mr Smith was not disseminated to those in reception or those who later had dealings with him which meant that they were unaware of the potential risk of suicide or self harm. It was suggested by some witnesses that documentation "goes astray" is only found much later.

It is accepted that the reception processes in relation to communicating with escort staff were not as robust as ideally they should have been. Both the prison and healthcare provider have reviewed their procedures in reception to ensure that systems are in place that communication between reception staff and the escort provider is recorded appropriately. In Mr Smith's case it appears that the Person Escort Record (PER) was not used appropriately, in that the medical in confidence information provided by health care professionals in the court was not attached to the PER.

3. Healthcare Staff indicated that they do not always read relevant sections of the Systm 1 notes and that the "summary page" of Systm 1 does not always "pull through" relevant information with a result that staff may be unaware of that information.

The concerns you have raised regarding healthcare staff not reading relevant sections of the records have been taken very seriously. All registered clinical staff have a professional obligation to review relevant parts of the notes; this message has been reiterated and addressed with all clinical staff. The second part of the concern relates to information being 'pulled through' onto the summary page. This matter is being taken to the West Midlands Regional SystmOne User Group so that the learning generated through Mr Smith's death can be shared much wider than one prison. In the meantime, this issue has been raised with clinical staff in a staff meeting at HMP Hewell and the learning is being disseminated across the three prisons in which the Trust provides healthcare.

4. Evidence suggested only limited interaction between members of Healthcare Staff and prisoners who were deemed as "high risk drug users" with a concern that warning signs are missed.

The Trust has confirmed that they have now changed their practices relating to high risk drug users. The initial contact for those undergoing any type of detoxification is from the caseworker who has contact the day after the person is received into the prison. Additionally, a follow up ledger to SystmOne has been introduced within three working days of the detoxification programme ending. An audit will be undertaken within the first quarter of 2016 to check that the processes are working effectively.

We hope you the contents of this letter have been helpful in providing some national context and additional assurance that the concerns that you have raised have been, or are being, addressed locally at HMP Hewell.

We note that you have provided a copy of your letter to [redacted] and [redacted] and we shall be obliged if you could kindly forward to them a copy of our response. We do consider

it may be useful to share our response with the Chief Coroner in light of the national implications of the revision of the relevant PSI.

Yours sincerely

J. Towley

Jacqueline Towley