Inspire
Better
Health

Prevention of Future Deaths

Following the above inquest, the Coroner has expressed concerns about the way Bristol Community Health manage risk of self harm and suicide and has made recommendations in regard to the prevention of future deaths.

These concerns have highlighted learning for Bristol Community Health and the action plan has been completed to address this learning.

1. The inquest demonstrated that healthcare understanding of the Prison Service Instruction (PSI) 64/2011 did not fully meet the requirements of this policy. In particular this related to the low threshold in place for opening an ACCT document.

Healthcare were considered to be possibly applying clinical judgement in response to a prisoners declaration of self harm/suicide and this does not reconcile with the required actions within the PSI.

All healthcare staff will therefore revisit the PSI through Suicide and Self Harm (SASH) training and local training/meetings.

This training will ensure that staff are fully aware of their obligations when adhering to PSI 64/2011.

2. Staff who gave witness statements within the inquest did not appear to recall their ACCT training or provide assurance they had completed this.

A number of activities will be completed to reinforce the meaning and purpose of the PSI to support this recollection.

This will also include the process of how and when to open an ACCT and healthcare responsibilities in regard to attending First Case Reviews.

Evidence of training and local learning will made available for review to the Coroner.

Head of Prison Health Services

13/07/2017

Inspire Better Health

Callum Smith – Prevention of Future Deaths Action Plan

Coroner recommendation s	Action	Completion Date	Action Owner
At the conclusion of the inquest I expressed my concern in relation to assessing risk of suicide and self harm and how from the evidence heard it appeared that there was a potential conflict between how healthcare/ mental healthcare staff assess the risk in this area and the requirements of the ACCT policy for all staff working with prisoners to follow the requirements of PSI 64/2011	The Prison have implemented rolling programme of comprehensive ACCT training - labelled Suicide and Self Harm Training (SASH), including the emphasis on the lower threshold for opening an ACCT . All existing healthcare/mental healthcare staff have been mandated to attend this training within the next 6 months. All new starters will be required to attend the training within 3 months of commencing employment.	30/9/17	Head of Healthcare
There was evidence that healthcare/ mental healthcare staff needed to be reminded of the lower threshold for opening an ACCT and that this is fundamentally different to the way that they carry out an assessment and/or risk assessment of a patients risk of suicide or self harm for medical/mental health care and treatments as per PSI 64/2011	ACCT process flowcharts to be placed in all healthcare delivery rooms to serve as a reminder and ACCT 'orange' documents to be available in healthcare areas.	31/7/17	Head of Healthcare
	ACCT overview to be incorporated into new staff induction process. Staff mentors completing induction process with new member of staff will ensure reading and understanding. New staff members will sign acceptance.	31/8/17	Head of Healthcare
I was concerned that staff who apparently had been trained did not appear to consider that they had when giving evidence and therefore would ask that this is reviewed to ensure that healthcare/ mental healthcare staff receive detailed training on the ACCT process as it clearly is an important and recognised policy in preventing a risk of self harm or suicide	SASH training requirements to be at reinforced monthly team meetings. 'Bite sized' scenarios will be presented at team meetings with team discussion on appropriateness of opening an ACCT. Evidence of these scenarios will be made available on request.	Monthly	Team managers across the whole of healthcare
	InspireBetterHealth staff training and development matrix to be developed which will enable an accurate record of training received to be collated and maintained.	31/8/17	Head of Healthcare

I indicated that I would ensure that this report was copied to the prison as they would need to be aware of this, as it is often they who provide the ACCT training for healthcare/ mental healthcare staff	Training matrix will be available at any time to Head of Prison Health Services to provide wider assurance of implementation.		
	"Five minute interventions" training course delivered by the prison to be assessed for suitability for healthcare staff and if appropriate, all staff to receive the training	Assessment completed by 31/8/17	[redacted] Head of Healthcare
	Staff will complete clinical incident form if any resistance shown by prison staff when attempting to open an ACCT document. All such incident forms will be shared with Head of Safer Prisons governor and discussed at the Local Quality & Delivery Board.	Shared at monthly meeting in July 17. Ongoing thereafter.	[redacted] Head of Healthcare