

**Action Plan – Mr Adam Quelch at HMP Bure – Self-Inflicted Death on 25/08/2020**

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
1	<p>The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:</p> <ul style="list-style-type: none"> <li>• case reviews consider all relevant information that affects risk, and staff only reduce the frequency of observations when there is evidence that the risk has reduced; and</li> <li>• conversations are carried out as directed and documented in the ongoing record.</li> </ul>	Accepted	<p>Suicide and Self-Harm (SASH) training is delivered to all staff and provides guidance on the ACCT process, including the importance of considering all relevant risk information when making the decision of whether to reduce observations and only doing so when staff are fully satisfied that the risk has sufficiently reduced.</p> <p>The implementation of ACCT Version 6 (V6) is currently underway and the updated SASH training will be delivered to all staff from July 2021. The ACCT V6 documentation now requires all case review attendees to sign the Record of Case Review form to confirm that support actions are agreed and that the conversation is fully documented and is a true reflection of the discussion.</p> <p>ACCT quality assurance (QA) checks are completed to ensure that all conversations are documented appropriately and any discrepancies are challenged immediately. The ACCTs are routinely discussed at the QA briefings, the weekly Safety Intervention Meeting (SIM) and management meetings. Case managers are also reminded during briefings of the need to record the reasons for any decisions within the ACCT documentation and that these decisions should be defensible and evidence based.</p>	<p>December 2021 Head of Safety and Head of Business Assurance</p>
2	<p>The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff:</p> <ul style="list-style-type: none"> <li>• enter cells as quickly as</li> </ul>	Accepted	<p>The initial training for all operational staff includes guidance on the actions to take when there is a medical emergency to ensure that, subject to a dynamic risk assessment, cells are entered as quickly as possible. An information for colleagues (IFC) notice will be published in June 2021 to remind all staff of the process when there is a medical emergency during a patrol or night state.</p> <p>A further IFC notice will also be published in June 2021 to remind staff of the</p>	<p>June 2021 Head of Safer Prisons  June 2021</p>

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	<p>possible in life-threatening situations;</p> <ul style="list-style-type: none"> <li>• undertake resuscitation on a firm surface, where this is achievable without delaying the start of CPR.</li> <li>• take a defibrillator to all medical emergencies.</li> </ul>		<p>importance of commencing CPR at the earliest opportunity, taking into consideration the surface on which the patient is located.</p> <p>The process for staff bringing a defibrillator to all medical emergencies was reviewed in May 2021 and this will be updated by June 2021. The updated process will ensure that the patrol or night state staff are aware that they are responsible for bringing a defibrillator to all medical emergencies.</p>	Head of Safer Prisons
3	<p>The Head of Healthcare should ensure that healthcare staff:</p> <ul style="list-style-type: none"> <li>• review a prisoner’s existing medical record as part of the initial screening process; and</li> <li>• conduct mental health assessments separately from the ACCT process.</li> </ul>	Accepted	<p>All healthcare staff were reminded in March 2021, during the local quality assurance meeting, that patients may omit information from the reception screen and therefore it is vital to screen the patient record to identify any risks.</p> <p>All records are reviewed on the SystemOne database and the Digital Prisoner Escort Records (DPERs). Pre-transfer questionnaires are also sent to the transferring prisons prior to transfers taking place to identify any physical and/or mental health needs including history of self-harm and attempted suicides to aid with the continuation of care of patients.</p> <p>The Head of Healthcare has a Local Operating Procedure (LOP) for healthcare involvement in the ACCT process and, in accordance with PSI 64/2011, it details the responsibilities of the healthcare involvement in the ACCT process. All ACCTs now are conducted separately from one to one mental health assessments to ensure the patient has every opportunity to be supported in the ACCT process.</p> <p>Two SASH training sessions were held in April 2021 for healthcare staff which</p>	Completed Head of Healthcare

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			<p>included guidance on the ACCT procedures and healthcare staff will receive further training on the implementation of the updated ACCT V6 from July 2021.</p> <p>Managing healthcare involvement within the ACCT process is monitored and audited through the Practice Plus Group model of 'PROTECT'. This audit tool captures the key themes of lessons learnt through deaths in custody and is undertaken throughout the year on an annual audit schedule. Results of these audits are reviewed and discussed through Local Quality Assurance meetings within HMP Bure. Where themes are identified and in need of further exploring these are escalated through to the Regional Quality Assurance Meetings which are held bi-monthly for further discussion.</p>	
4	<p>The Head of Healthcare should ensure that healthcare staff:</p> <ul style="list-style-type: none"> <li>• regularly review prisoners' prescribed antidepressant medication, in line with NICE guidelines;</li> <li>• record the reasons for prescribing any medication for an illness that has not been formally diagnosed.</li> <li>• supervise the dispensing of medication closely when a prisoner is being managed under ACCT procedures.</li> </ul>	Accepted	<p>The current practice is to review all available records at the point of referral by the mental health practitioner. Staff will be reminded of this process in June 2021 during the Mental Health Clinical Team meeting. A healthcare questionnaire is sent to all sending establishments prior to transfer to identify any healthcare concerns or risks.</p> <p>Yearly antipsychotic monitoring takes place for all patients that are prescribed antidepressants and includes ECG and blood tests which is in line with the current guidance and all reviews are up to date.</p> <p>Staff are aware that a diagnosis of ADHD should be conducted by a specialist in this area. This will be discussed further at the Mental Health Clinical Team meeting in June 2021, where the importance of recording reasons for prescribing medication will be highlighted. All ADHD prescriptions remain under a Consultant Psychiatrist and this will be raised and discussed with the</p>	June 2021 Head of Healthcare

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			<p>National Consultant Psychiatrist to review process for prescribing during 2021.</p> <p>Those on an ACCT must be observed taking their medication by a member of healthcare, following which, the patient's in possession status is then reviewed by healthcare during the next Multi-Professional Complex Case Clinics (MPCCC) meeting. This is attended by different members of healthcare including the GP, Psychiatrist and Nurses.</p>	
5	The Governor should ensure that a copy of this report is shared with the prison manager, CM A, CM B, OSG A, the consultant psychiatrist and the mental health nurse, and that a senior manager discusses the Ombudsman's findings with them.	Accepted	All staff named had the report shared with them in April 2021 and the findings were discussed with a manager.	Completed Head of Safer Prisons Head of Healthcare