



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in May 2013 at
HMP Dovegate**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man at HMP Dovegate who was found hanging in his cell in May 2013. He was 25 years old. I offer my condolences to his family and friends.

A clinical reviewer reviewed the clinical care and treatment the man received at Dovegate. The prison cooperated fully with this investigation.

On 17 April 2013, the man was sentenced to 12 weeks imprisonment for breaching a restraining order. He was also charged with an offence of burglary and was due to appear in court on 30 May. He had been in prison before and had most recently been released from prison on 14 March 2013. He had a history of self-harm and had previously attempted suicide. He was prescribed medication for depression. He was monitored under suicide and self-harm prevention procedures from 3 May to 17 May, when he said that he no longer had any thoughts of harming himself. Several days later, an officer carrying out a routine check found him hanging in his cell.

The man had a number of known risk factors for suicide and was closely monitored after he told staff he had thoughts of taking his own life. While he appears to have received good support from some prison staff, healthcare staff were not sufficiently involved in reviews of his progress and the monitoring ended without the mental health team being consulted. I am concerned that not all the issues which had been causing him anxiety had been resolved when his monitoring was ended and too much reliance appears to have been placed on what he said, rather than known risk factors. Sadly, we cannot know whether continued monitoring would have saved him.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man had been released from a previous prison sentence at HMP Dovegate on 14 March 2013. On 17 April, he was sentenced to 12 weeks in custody for breaching a restraining order and was also charged with an offence of burglary. He was sent back to Dovegate. He had a history of depression for which he was prescribed medication, and he had previously harmed himself and attempted suicide. When he first arrived he was monitored under ACCT arrangements (the Prison Service suicide and self-harm prevention procedures) but only for one day.
2. The man was assessed by a member of the prison mental health team and prison doctors, who prescribed anti-depressant medication. On 3 May, he said that he had thoughts of taking his own life. He was again monitored under the ACCT suicide prevention procedures. On 17 May, ACCT monitoring ended when he said that he no longer had any thoughts of suicide or self-harm.
3. At 6.03am a few days later, an officer found the man hanging in his cell and called for emergency medical assistance. Officers and a nurse attempted cardiopulmonary resuscitation until a paramedic arrived and assessed him. At 6.37am, the paramedic confirmed that he had died.
4. We are satisfied that the care and medical assessment the man received at Dovegate was equivalent to that which he could have expected to receive in the community. Staff took reasonable steps to protect him after he said he had thoughts of suicide but we consider that suicide and self-harm monitoring should have involved healthcare staff and should not have ended without consulting them and while there were still some indicators of risk. We cannot know whether further monitoring would have prevented his death and accept it would have been difficult to predict or prevent his actions.
5. We make five recommendations about the ACCT process, mental health reviews, record keeping and resuscitation and calling an emergency ambulance.

THE INVESTIGATION PROCESS

6. On 20 May 2013, the investigator issued notices to staff and prisoners at Dovegate, informing them of the investigation and inviting anyone with relevant information to contact him. No-one came forward.
7. The investigator visited Dovegate on 24 May and obtained copies of the man's prison and healthcare records. Telford and Wrekin NHS appointed a clinical reviewer to carry out a review of the man's clinical care. The investigator and clinical reviewer interviewed nine members of staff on 13, 14, 17 and 28 June. One doctor refused to attend an interview. Written initial feedback was given to the Director on 3 July.
8. The Coroner was informed of the investigation. A copy of the investigation report has been sent to him.
9. One of our family liaison officers contacted the man's mother to explain the purpose of the investigation and gave her the opportunity to raise any matters she wished the investigation to address. The man's mother did not identify any specific matters for the investigation to take into account. She received a copy of the draft report and did not make any comments.

HMP DOVEGATE

10. HMP Dovegate, which is near Uttoxeter, is privately run by Serco. It holds over 1,100 adult male prisoners, both on remand and sentenced. Healthcare services are provided by Serco Health.

Her Majesty's Inspectorate of Prisons

11. HM Inspectorate of Prisons (HMIP) last inspection of Dovegate was in October 2011. Inspectors noted that self-harm monitoring was of a good standard, with multi-disciplinary and meaningful reviews for those at risk of self-harm. HMIP found good relationships between the prison and the healthcare department, and that relationships between staff and prisoners had improved since their previous inspection.

Independent Monitoring Board

12. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their most recent annual report for the year to the end of September 2012, the IMB commented that the prison continued to be safe, calm and well run. The IMB was positive about procedures to monitor those who were either a danger to themselves or others.

ACCT

13. ACCT - Assessment, Care in Custody and Teamwork - is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should not be at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

Previous deaths at HMP Dovegate

14. Since January 2013 there had been one self-inflicted death before the man's death and there was another four weeks after. All three died from hanging though each used different materials and ligature points. There were no other similarities between these three deaths.

KEY EVENTS

15. The man was born in August 1987. He had a history of depression and self-harm and had previously attempted suicide twice in 2006 by taking an overdose of medication and by jumping in front of a train. He had been in prison several times before. He had a restraining order preventing him from contacting his ex-partner and he could not contact his three children.
16. On 17 April 2013, the man was remanded into custody at HMP Dovegate for breach of the restraining order and for an additional offence of burglary. He was next due to appear at court on 30 May 2013.
17. When he arrived at Dovegate, the man's custodial documents contained a Suicide and Self Harm Warning Form which stated that he had harmed himself in police custody by headbutting the cell door and that he was very depressed. A Prison Custody Officer (PCO) immediately opened an ACCT document (the tool used to support prisoners at risk of suicide or self-harm) and a unit manager set the initial level of observation at hourly throughout the day and night until he could be assessed and reviewed the next day.
18. The man told a nurse at a reception health screen that he had been released from Dovegate on 14 March 2013. He said he suffered from depression for which he was prescribed Mirtazapine and had a history of attempted suicide and self-harm and had been a psychiatric inpatient at a hospital in 2005. He said that he drank 280 units of alcohol a week (the NHS recommended alcohol consumption for men is 21 units per week) and that he smoked.
19. The nurse recorded that the man said that he did not have any thoughts of suicide or self-harm, and that he felt he would be able to cope at Dovegate with the support of his family and friends. She referred him to be seen by the doctor.
20. The man was monitored hourly throughout the remainder of the day and throughout the night. No concerns were recorded in the ACCT document.
21. At 8.00am on 18 April, a PCO conducted the ACCT assessment interview. The man said that he was angry when in police custody which was why he had headbutted the cell door. He said that he had never harmed himself or attempted suicide in prison and the last time he self-harmed was seven years previously. He said that he had no thoughts of self-harm or suicide and asked for the ACCT to be closed.
22. Later that morning, a prison doctor saw the man and noted that he was a heavy drinker, but as he had only been out of prison for four weeks there was no need to place him on an alcohol detoxification programme. The doctor prescribed Mirtazapine 30mg and noted in the medical record that he referred him to the mental health team. There is no evidence that this referral was actioned.
23. That afternoon a unit manager and a PCO held the first ACCT case review. The man said that he had harmed himself while in police custody because he

was frustrated that he had not been allowed to smoke. He said that he had no thoughts of self-harm, was settled at Dovegate and wanted the ACCT to be closed. The manager recorded in the ACCT document that his risk of self-harm was low and he ended the ACCT monitoring. A post-closure review was set for 22 April.

24. On 22 April, the unit manager saw the man to conduct the ACCT post-closure review. He said that he had no problems, had settled in well and could cope with his present circumstances. He said he had the support of his mother and knew that he could approach prison and healthcare staff if he needed additional help. He said that he had applied to take some educational courses and had completed the gym induction.
25. On 24 April, a prison doctor reviewed the man. He told him that he was still feeling depressed and the doctor increased his prescription of Mirtazapine to 45mg. The doctor noted that he was not experiencing any symptoms of withdrawal from alcohol.
26. On 3 May, at approximately 3.00pm, a nurse saw the man as he had said he felt very low, would possibly harm himself and was thinking of ways to kill himself as he did not want to be in prison anymore. The nurse immediately opened an ACCT document. He told her he had taken two toilet disinfectant tablets the previous evening and had been sick. The nurse rang the National Poisons Information Service, which advised that there was no cause for concern as he had not displayed severe symptoms by that time. The nurse made an urgent referral to the mental health team.
27. A unit manager saw the man within an hour and set hourly observations until the first case review. The manager ensured that he was aware that he could contact the Samaritans from his a telephone in his cell. Unit staff monitored him for the rest of the afternoon and evening and it was recorded that he was watching television. By midnight he was noted to be asleep and there were no concerns raised during the night.
28. On 4 May, at 11.50am, a PCO interviewed the man for an ACCT assessment. He told the officer that his main concern was that he had been unable to contact his mother as every time he rang her mobile number it diverted to voicemail. He said he had no money as his family had not sent him any and he wanted to have a prison job as soon as possible. He said that he had no current thoughts of self-harm or suicide but was in a low mood as he had not been able to speak to his mother. The PCO arranged for him to have a supply of coffee and toiletries.
29. At 3.00pm, a unit manager and a PCO conducted the first ACCT case review. The man attended, but there was no member of the healthcare team present. He said that he felt low and that everything had got on top of him as he had no money and had been unable to contact his mother. An ACCT caremap to support him noted that he was on anti-depressant medication and had been referred to the mental health team. He had been allowed to use the unit office telephone three times during the review to try to contact his mother, but without

success. The manager established that money had been sent in for him but he it had not cleared the prison's finance system and been credited to his account. The manager arranged for him to have some tobacco in the meantime.

30. The review assessed that the man risk of harming himself was low but that ACCT monitoring should continue. Staff were required to observe him eight times each day and document five conversations with him each day, until the next review on 10 May.
31. During the afternoon of 7 May, two members of the mental health team saw the man in his cell as a result of the urgent referral a nurse had made on 3 May. He told them that he had experienced thoughts of suicide since 2003 and had been prescribed Mirtazapine since 2010 but felt that the current prescription of 45mg was not helping him. He said that he continued to have thoughts of suicide but said that he did not have any plans to carry them out. He said it made him sad that he was unable to contact his children and he was worried about his forthcoming court appearance. The nurses entered this information in his medical record but not on the ACCT document.
32. A nurse recorded in the man's medical record that he was anxious and tearful throughout the consultation. The nurse also recorded that she had told two unit managers of his continuing thoughts of suicide. She discussed coping strategies with him and encouraged him to use the gym. The nurse planned to conduct a review with him a week later. His medical records show that this was the last intervention with healthcare staff before his death.
33. At 3.50pm, an ACCT review was held, attended by two unit managers, a PCO and the man. There were no healthcare staff present. He said that he was feeling stressed about his pending court appearance and was not sleeping well, but said that he had no thoughts of suicide and self-harm. A manager assessed that his risk of self-harm was raised and increased the level of observations to one every two hours. A manager reviewed the caremap but did not add any further actions.
34. On 10 May, a unit manager chaired another ACCT review which another manager, a PCO and the man attended, but again there was no healthcare staff representation. The review recorded that he said that he had no thoughts of self-harm and had received support from the staff. The ACCT caremap was reviewed and the only concern noted was that he had still been unable to speak to his mother. The review team considered that his risk was now low and decreased the number of required observations to eight a day. It was agreed that a further review would be held a week later.
35. Between 10 and 16 May, staff did not record any concerns about the man. His personal officer noted in his prison record that his mood had improved and that he felt much better.
36. Prison records show that the man had attempted to telephone his mother on 37 occasions since his arrival on 17 April up till the time of his death, but had been unable to get through. Staff had also attempted to call his mother from the wing

office several times but had also been unsuccessful. Records show that he spoke to his solicitor on 16 May. As this call was to a legal representative, it was not recorded.

37. On 17 May, a unit manager chaired an ACCT review accompanied by another manager, a PCO and the man. Again there was no member of healthcare staff or staff of any other discipline present. At the review, he said that he felt much better, had no thoughts of suicide or self-harm and that he continued to receive good support from staff. The review agreed that that the ACCT should be closed. A post closure review was set for 24 May.
38. That evening, the man telephoned a friend three times. He said that he wanted to speak to his mother and he was frustrated at not being able to get through to her. He was also concerned about his children and wanted pictures of them. His friend told him that his ex-partner had moved to Nottingham with a new boyfriend. He was angry about this and wanted to know who the boyfriend was. He said that he would fight for the children when he was released.
39. The man socialised with other prisoners during the association period and, in the evening, played pool with two PCOs. At approximately 9.00 pm, a Security Officer (SO) conducted an evening roll check to ensure that all prisoners were present and accounted for. The SO did not speak to him during the check and he did not use his cell bell at any time that night to call staff.
40. In the morning the SO was conducting the early morning roll count (another security check) when he arrived at the man's cell. He looked through the observation panel and saw him suspended from the light fitting with knotted bedding around his neck. The SO radioed an emergency code blue (to indicate a prisoner had been found not breathing or with breathing difficulties and that an emergency ambulance is required) and went straight into the cell.
41. The SO supported the man's body, cut the knotted bed sheet using his anti-ligature tool (a specially designed knife carried by all officers) and carefully lowered him to the floor. He told the investigator that he had been a police officer for 30 years and had had extensive first aid training. He said that rigor mortis was clearly present and that the body was very rigid. He checked for a pulse but could not find any signs of life so started cardiopulmonary resuscitation (CPR).
42. The SO was quickly joined by medical staff and a PCO. They continued CPR, with the assistance of another SO who had also arrived at the scene. They attached an automated external defibrillator (AED - which monitors the heart rhythm and administers electrical shocks to the heart to restore the normal rhythm when necessary). The AED advised that there was no shockable rhythm.
43. The control room called an ambulance at 6.11am. A paramedic arrived at 6.26am, assessed the man and pronounced that he had died.

44. As with all deaths in prisons, the police undertake an initial investigation to check whether a criminal investigation is necessary. The police found a letter in the man's cell, written to his mother and ex-partner in which he said he found it difficult not being able to see his children and that "... it is time for me to go all I do is mess things up, you will all be better off without me". He ended his letter by asking his mother to play a particular song at his funeral.

Contact with the man's family

45. Two prison family liaison officers were appointed. They visited the man's mother at 8.30am to break the news and explain the circumstances of his death and offer support. They kept in contact with the family to provide ongoing support and offered financial assistance towards the funeral expenses.

Support for staff and prisoners

46. The duty director held a hot debrief at 8.30am for the staff involved in the emergency to discuss what had happened and to offer support. The services of the prison's care team were made available.
47. Officers and members of the chaplaincy supported prisoners affected by the incident. Prisoners subject to suicide and self-harm monitoring were reviewed in case they had been adversely affected by the man's death.

ISSUES

Assessment of risk

48. The man suffered from depression for which he was prescribed medication and had previously attempted suicide in the community in 2006. When he first arrived at Dovegate, he said he had no thoughts of suicide or self-harm and the first night assessment on 17 April did not identify any concerns. However, as he had been observed headbutting a wall in police custody, the staff opened an ACCT. We consider that this was appropriate. As well as the suicide and self-harm warning from the police, he had a number of other risk factors, although it is not clear that they were considered. He was not allowed to have contact with his children, had a restraining order preventing him from contacting his ex-partner, had mental health issues, alcohol problems and had made two previous suicide attempts.
49. This ACCT was closed the next day, after the man explained his actions at the police station. Earlier, a doctor had referred him to the mental health team and noted that he drank heavily. He did not prescribe a detoxification programme as he considered that he had not been out of prison long enough to have acquired a dependency which would lead to severe withdrawal symptoms. He said that he wanted the ACCT to be closed. We consider that too much emphasis was placed on his presentation when making this decision, rather than balancing this against his other risk factors and the ACCT was closed prematurely.
50. On 3 May, the man said that he was thinking of ways to kill himself and staff immediately responded appropriately by opening an ACCT again.
51. At subsequent ACCT reviews, the man consistently said he did not have any thoughts of self-harm or suicide. However, there was no mental health input into the ACCT reviews which were missed opportunities for a holistic assessment. PSI 64/2011 states that ACCT reviews should be multidisciplinary. In this case a member of the mental health team should have attended the reviews. On 7 May, he saw two nurses from the mental health team and told them that he continued to have thoughts of suicide, was sad he was unable to contact his children and was anxious about his forthcoming court case. The nurses did not make an entry in his ACCT document to record this. He was reported to be anxious and tearful throughout the consultation yet a very short time later on the same day, the ACCT review recorded that he had no thoughts of suicide or self-harm.
52. The ACCT was closed ten days later on 17 May, when the ACCT review noted an improvement in the man's mood. The one caremap action for him to contact his mother had not been achieved. While we are satisfied that staff made extensive and commendable efforts to achieve this goal it is a mandatory requirement of PSI 64/2011 which gives guidance to prison staff about ACCT procedures that ACCTs should not be closed until all the caremap actions have been completed. We learnt subsequently that his mother had barred all calls from the prison. It is unfortunate that the prison did not attempt to contact his

mother by other means when it became apparent that telephone calls were not getting through. Perhaps of greater concern is that the absence of input from healthcare staff meant that important information from a different perspective was not considered at all throughout the two weeks that he was subject to ACCT monitoring and the ACCT was closed without consulting them. He had also indicated that he was anxious about his forthcoming court case yet the ACCT was closed less than two weeks before, without any evidence that this was taken into account.

53. The Director of Dovegate told the investigator that, as a direct result of the initial internal review held after the man's death, he had given a directive that all ACCT reviews will be multidisciplinary and that no ACCT document will be closed without input from healthcare staff. We welcome the fact that some action has been taken quickly.
54. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. However, we are concerned that staff relied so heavily on the man's presentation rather than his known risk factors. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged. We make the following recommendation:

The Director should ensure that:

- **ACCT assessments identify the prisoner's needs, level of risk and triggers of distress with clear time-bounded actions to reduce risks;**
- **Multi-disciplinary ACCT reviews consider all the known risk factors when determining the risk of suicide and self-harm and whether risk has reduced;**
- **That healthcare staff record all important information about risk factors in the ACCT ongoing record; and that**
- **ACCTs are not closed until all caremap actions have been completed.**

Clinical Care

55. The clinical reviewer has considered the man's standard of health care at Dovegate. He noted that at the initial reception health assessment the doctor recorded that a blood test, substance misuse referral and mental health referral should occur. There is no indication in the medical record that these requests were actioned as a result of that entry, although there is a record that he did not attend a blood test appointment on 14 May, when prisoners were not able to move around the prison. That appointment was rescheduled.

56. The clinical reviewer surmised that the referrals did not take place as expected because the doctor did not flag them up on SystmOne (the electronic medical record) correctly. He discussed this issue with the Head of Healthcare, who said that all locum doctors are now given formal induction and are allocated to work specific treatment sessions well in advance which should reduce the chance of this happening again.
57. The correct use of the computerised medical record system in prison by all healthcare staff, including visiting doctors is critical to ensure that prisoners receive continuity of care. During his time at Dovegate, the man saw two doctors, neither of whom were permanently employed at the prison. We agree with the clinical reviewer that it is essential that visiting doctors follow local protocols and procedures and we make the following recommendation

The Head of Healthcare should ensure that locum doctors are fully trained in the use of SystmOne and can arrange follow up appointments appropriately.

Mental Health

58. The clinical reviewer assessed the man's mental health care and considered that the mental health team's response to him was appropriate and that the referral procedure mirrored that used in the community.
59. The clinical reviewer noted that although the prison doctor increased the dose of Mirtazapine, he did not chase up the referrals to the mental health or substance misuse teams. The doctor did not indicate that he had used a recognised test to assess his state of mental health. The clinical reviewer considered that it would have been good practice to have arranged a follow up after increasing the dose of Mirtazapine to see if there were any side effects.
60. After the man's prescription of Mirtazapine was increased to the maximum recommended dose of 45mg, no review was arranged. The National Institute for Health and Clinical Excellence (NICE) issued updated guidance on the treatment and management of depression in adults in October 2009. This states that patients who have been started on antidepressants should be seen after two weeks, then at intervals of two to four weeks for the next three months. The next section states that a person under 30 who is started on antidepressants should be reviewed after one week and frequently thereafter.
61. The clinical reviewer believes that it would have been good practice for the man to have been reviewed by doctors seven days after the increase in his medication for his treatment needs to be fully considered. We make the following recommendation:

The Head of Healthcare should ensure that prisoners being treated for depression have regular reviews that consider all treatment options.

Emergency response

62. Staff responded swiftly when the man was found hanging. They started CPR and an automatic external defibrillator was used. As he did not have any cardiac rhythm, there were no instructions to administer a shock during CPR. Staff continued with CPR until a paramedic arrived and took over his care. After he assessed him, the paramedic confirmed that he had died.
63. However, it is clear that when the man was found rigor mortis had set in and this had been dead for some time in which case resuscitation would not have been possible. We agree with the clinical reviewer that the attempted resuscitation was unnecessary and distressing for the staff involved. We understand the commendable wish to attempt and continue resuscitation until death has been formally confirmed, but do not consider that healthcare staff should be expected to carry out CPR in these circumstances. The European Resuscitation Council Guidelines for Resuscitation 2010 state that “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile ...” We make the following recommendation:

The Director and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

64. The SO found the man at 6.03am, and used an emergency code to alert other staff to the emergency. However, an ambulance was not called until 6.11am, eight minutes later. PSI 03/2013 (Medical Emergency Response Codes), which came into effect on 28 February 2013, gives instructions to staff about communicating the nature of a medical emergency and ensuring there are no delays in calling ambulances. There is a mandatory action that:

“When the emergency is called over the radio network an ambulance must be called immediately.”

65. It is clear that the man was already dead so any delay would not have affected the outcome in his case, but in other medical emergencies even a short delay can be critical and for that reason the PSI makes it clear that an ambulance should be called immediately. While Dovegate has a protocol setting out the actions that staff must undertake in an emergency this was not followed and the control room did not call an ambulance immediately. We make the following recommendation:

The Director should ensure that an ambulance is called automatically when an emergency code is called.

RECOMMENDATIONS

1. The Director should ensure that:
 - ACCT assessments identify the prisoner's needs, level of risk and triggers of distress with clear time-bounded actions to reduce risks;
 - Multi-disciplinary ACCT reviews consider all the known risk factors when determining the risk of suicide and self-harm and whether risk has reduced;
 - That healthcare staff record all important information about risk factors in the ACCT ongoing record; and that
 - ACCTs are not closed until all caremap actions have been completed.
2. The Head of Healthcare should ensure that locum doctors are fully trained in the use of SystmOne and can arrange follow up appointments appropriately.
3. The Head of Healthcare should ensure that prisoners being treated for depression have regular reviews that consider all treatment options.
4. The Director and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate
5. The Director should ensure that an ambulance is called automatically when an emergency code is called.

ACTION PLAN: The Man – HMP Dovegate May 2013

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	<p>The Director should ensure that:</p> <p>a) ACCT assessments identify the prisoner's needs, level of risk and triggers of distress with clear time-bounded actions to reduce risks;</p> <p>b) Multi-disciplinary ACCT reviews consider all the known risk factors when determining the risk of suicide and self-harm and whether risk has reduced;</p> <p>c) That healthcare staff record all important information about risk factors in the ACCT ongoing record; and that</p> <p>d) ACCTs are not closed until all caremap actions have been completed</p>	<p>Accepted</p> <p>Accepted</p> <p>Accepted</p> <p>Accepted</p>	<p>All prisoners placed on an ACCT are assessed within 24 hours to ascertain level of risk ascertain triggers and gauge level of risk. The care plan indicates time frame for actions to be completed.</p> <p>Multi-disciplinary reviews are arranged for each occasion. Where attendance is not possible, a written report including reviews and updates are provided by each absent party that is relevant to the individual prisoner.</p> <p>All relevant risk factors highlighted by Healthcare staff during the ACCT review process are recorded in the ongoing record by the relevant case manager.</p> <p>ACCTs will not be closed until all actions detailed in the caremap have been completed. This is monitored and checked by the case manager and the Safer Custody Manager as part of a full review after the post closure interview.</p>	<p>Completed November 2013</p> <p>Completed November 2013</p> <p>November 2013</p> <p>November 2013</p>	

2	The Head of Healthcare should ensure that locum doctors are fully trained in the use of SystmOne and can arrange follow up appointments appropriately.	Accepted	All Locum GP's are given instruction on how system one operates within the prison setting.	Complete	
3	The Head of Healthcare should ensure that prisoners being treated for depression have regular reviews that consider all treatment options.	Accepted	All patients being treated for depression have regular reviews by the Primary or Secondary Mental Health Team. This is recorded in their clinical record after every review.	Complete	
4	The Director and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.	Accepted	We have a DNAR policy that all staff have read and have access to. We would ensure that all staff are made aware of any patient that had adopted a DNAR and this would be clearly marked on his medical record.	Complete	
5	The Director should ensure that an ambulance is called automatically when an emergency code is called.	Accepted	Any member of staff in attendance of an emergency situation can summons an ambulance if required. The policy relating to this instruction has now been updated	Completed	