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HEALTHCARE

Ms Kearsley
Area Coroner
The Coroners Court
Mount Tabor
Mottram Street
Stockport
SK1 3PA

Date 24 February 2014

Your Ref: JK/KA/01544-2012

Dear Madam

RE: Prevention of Future Death Report following the Inquest into the death of Billy Salton

I write in response to the Prevention of Future Death report dated 6 January 2014. I have considered your letter and my response will address each of the matters of concern which you raise:

1. Staff access to Medacs Policies and Procedures
2. Information from the custody staff and previous medical entries
3. Correct completion of the Medacs assessment form
4. When an individual is not assessed by a Medacs clinician

1. The access of Medacs Policies and Procedures to Medacs staff

I was also concerned to hear that [redacted] was not aware of the Medacs Epilepsy Policy. He said in evidence that he had no specific recollection of the epilepsy policy, but he was aware that the Medacs policies were available in a 'loose leaf binder in most custody suites'. As a very experienced FME [redacted] gave evidence that he had been asked to review most of the policies, but he could not specifically recall this one.

I agree that it is important that all staff know where to look to seek guidance and where the policies are to refer to. I would like to reassure you that before they start work alone, all new healthcare staff complete a 3 day shadowing period with an experienced clinician. During this 3 day period they are made aware of the content of the Medacs policies and procedures and how these can be located whilst on duty and they are now required to sign to say they have had this information. All policies and procedures are located in every custody suite in both hard copies in a file and on the desktops of the medical room computers. Every time a policy is reviewed or revised a communication is disseminated from the Head of Clinical Services via all lead clinicians by e-mail and the relevant policy is updated in the folder and the desktop. The Medacs medical room audit that is undertaken by the Lead nurses every 3 months includes a standard for ensuring the policies and procedures are in both hard and soft copies in all custody suites.

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Medacs Healthcare
Quay Plaza, Salford Quays, Salford, Greater Manchester M50 3BA
Tel: 0161 772 8485 Fax: 0161 772 8497

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Registered Office: 800 The Boulevard, Capability Green, Luton, LU1 3BA
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2. Information from the custody staff and previous medical entries

You advise that Medacs clinicians should receive as much information as possible from the custody staff about the detainee's medical condition and that even if they are there to solely administer medication, they should read any previous medical notes from the same stay in custody. I am also keen to ensure that medical staff have all the relevant information that they require in order to administer medication, and that they read other relevant information which is available. Medacs staff are required to receive a verbal handover from the custody sergeant before seeing any detainee. This has been explained more fully in policy, and is included specifically in the Medacs Foundation course.

Since this Inquest a new procedure has been ratified: 'Pre and post clinical assessment guidelines for HCPs reviewing detainees in police custody' which includes that

- *'The HCP should discuss with the custody sergeant what medical history they have gathered from the DP whilst completing their risk assessment, including any medication the DP has in their property in custody or at home and whether the DP has taken any medication prior to coming into custody...It is important that following this history gathering a decision is made to whether the DP requires this medication for the time they may be held in custody and collection of this medication is requested at this time to the custody sergeant. Record this on the medical assessment form on the care plan and on the history front sheet.'*
- *The HCP should read any previous entries on the custody medical assessment form to gather any further history that was given on previous arrests/ calls and enable them to start to build a history and management of the DP whilst in custody*
- *The HCP may also note any changes in circumstances and health of the DP and where necessary initiate referrals to the multi service providers to encourage continuity of care at the time of release*

To ensure all staff are aware of this, an email was sent to all clinicians from the Head of Clinical Services in January 2014 and reminding them of the importance of pre and post assessment actions for all detainees before and after they conduct their clinical assessment.

3. Correct completion of the Medacs assessment form

I note your advice to remind staff of the importance of recording information on the Medacs assessment form, including a care plan and any negative answers to questions asked. I agree with you that it is important for staff to record significant negatives answers, as the tendency can sometimes be to record the positive answers they receive only. Unfortunately, it is not possible for staff to make a record of every question asked, and every answer given, or refused to be given, but the significant information must be recorded.

Clinicians are trained and audited on the use of "Medacs FME" system (the electronic record system in all custody suites) and 'The use of Medacs FME Clinical Form' is covered in the foundation training and Induction Training which includes reminding staff of the importance of completing all boxes even if there is nothing to report or a negative answer received. Care plans are recorded by the clinician on the computer and printed off for the police

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In May 2013 Medacs commenced a weekly audit of the 'use of computer system' The Client Service Managers address any issues identified with the clinicians. This is a continuing task.

Lead Doctors and Lead Nurses have been tasked with completing annual audits of the quality of the medical notes of all clinicians in their teams, and have been asked to address any concerns on an individual basis with staff. A re-audit is due in June 2014.

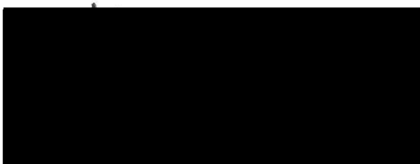
Medacs are in the process of reviewing the electronic MedacsFME system to include screening tools and dropdown boxes that will make it impossible to move onto the next section without completing the information.

4. When an assessment cannot be completed fully

I note your recommendation that if a clinician is unable to complete an assessment that this should be explained and 'any potential misleading information should not be recorded'. Given the nature of the work in police custody, our healthcare staff frequently attend to assess detainees who refuse to co-operate. In most cases it is for the detainee to decide whether they consent to an assessment, or choose to refuse, or answer questions about their health. Our Investigation report identified that in this case a nurse circled "completed" on the handwritten form re: "examination/observations completed/refused". Mr Salton had answered some questions, but refused to answer others. The handwritten forms are no longer used, and the electronic record system does not ask the staff member to select either 'complete' or 'refused'. The electronic record system means that the clinicians Care Plan is printed out and given to the custody sergeant: this reduces the risk of different information being written in the clinician's own records, to that written on the paperwork for the police.

I was of course aware of the Inquest as it proceeded, but thank you for bringing these matters to my attention.

Yours faithfully



Approved for signature by
Nigel Marsh
Chief Executive Officer

Medacs Healthcare Plc

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