National Offender Management Service

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Equality Rights and Decency Group
National Offender Management Service
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Mr Tom Osborne
HM Coroner for Milton Keynes

12 June 2014

Dear Mr Osborne

Thank you for your Regulation 28 report addressed to Michael Spurr, Chief Executive of the National Offender Management Service (NOMS), and copied to the Governor of HMP Woodhill, concerning the recent inquest into the death of Kevin Scarlett on 22 May 2013. Your letter has been passed to Equality, Rights and Decency (ERD) Group, as we have the policy responsibility for suicide prevention and self-harm management, and for sharing learning from deaths in custody. I am responding on behalf of NOMS and HMP Woodhill, and this letter has been prepared in conjunction with colleagues at HMP Woodhill, including the healthcare provider (Central and North West London NHS Foundation Trust). It has also been informed by conversations with the case holder at the Treasury Solicitor who attended the inquest.

I have noted the conclusion of the jury and your concerns that the Prison Service and healthcare did not assess the risk of Mr Scarlett taking his own life, and that you were informed that staff did not have access to a risk assessment tool or protocol for assessing such risks. As you know, the Prison and Probation Ombudsman (PPO) also found that Mr Scarlett's risk was not assessed with sufficient rigour, and that although staff had recognised that there was a risk, the full range of factors was not considered, and the approach taken to managing the risk was not holistic.

I understand that a full picture of our policy and processes for risk assessment was not provided at the inquest. I regret that this was the case, and I think it will be helpful if I set them out in detail before turning to the specific measures that have been implemented at HMP Woodhill to address these concerns.

Prison Service Instruction (PSI) 74/2011 Early Days in Custody states the mandatory requirement for all prisoners to be "assessed for potential harm to themselves, to others and from others" on reception into custody, and explains that this must be done using all available information, as well as by interviewing the prisoner (paras 2.17-2.18). Annex D gives detailed guidance on healthcare screening, suicide prevention and self harm management, and mandates a detailed medical examination that must include an assessment of safer custody concerns.

At HMP Woodhill every prisoner is assessed in reception both by trained prison staff and by a qualified nurse using the reception screening tool. A further assessment takes place during the secondary health screening within 48 hours of arrival. The results of this and all other healthcare assessments are recorded on specific risk assessment templates on SystmOne (the electronic clinical notes system). Any identified risks are communicated to the relevant prison staff, and when a prisoner is assessed as presenting a risk of suicide or self-harm, an ACCT is opened.

PSI 64/2011 Safer Custody describes the process for the identification and management of prisoners at risk, and includes a detailed section on risks and triggers (chapter 3). It mandates safer custody training for all staff who have contact with prisoners (chapter 1), and requires any member of staff who receives information or observes behaviour that indicates a risk of suicide or self-harm to open an ACCT by completing the Concern and Keep Safe form (chapter 5).

PSI 75/2011 Residential Services requires residential staff to ensure that prisoners are supported and their daily needs are met, and describes the key role that they play in spotting any signs of distress, anxiety or anger which might lead to prisoners harming themselves (para 2.3). In addition, healthcare staff consider safer custody risks during their routine interactions with prisoners, and at HMP Woodhill the mental health team is available to undertake a comprehensive mental health assessment (including a full consideration of both historic/static and current/dynamic risk factors) where this is considered necessary.

All prisoners who are identified as being at risk of self harm or suicide are subject to the ACCT process and receive a detailed assessment by a trained ACCT assessor within 24 hours. The results are recorded on the assessment template in the ACCT document, and any triggers and warning signs are identified at the first case review and noted in the relevant section. A CAREMAP is devised at the first review, and the ACCT process is then followed until the risk has been reduced.

I hope this provides assurance that there is a comprehensive and effective set of systems for identifying that a prisoner is at risk, and that where this occurs a further detailed assessment is undertaken to ensure that all relevant factors are considered and risks identified. Some specific tools, such as the reception healthcare screen, are used, but of necessity they form only a small part of this very broad set of processes.

Turning to the circumstances leading up to Mr Scarlett's death, NOMS accepts the findings of the PPO report and the inquest that, whilst there was an assessment of the risk of suicide or self-harm, this should have been conducted in a more rigorous manner. You may be aware that in response to the PPO's recommendations in this case, HMP Woodhill reviewed the local ACCT process in December 2013. The case review process was revised, and guidance on this, including the use of enhanced case reviews for prisoners with complex needs, was issued to all staff (see attached staff information notice 027/14, issued in January 2014). Notices have also been issued to remind staff of known triggers and risk factors, and more recently to highlight key learning from recent deaths in custody across the prison estate (see attached staff information notice 073/14, issued in March 2014).

Under the new arrangements consistency of decision making is achieved through the appointment of a named governor grade to manage the case of each prisoner subject to the ACCT process who is assessed as having complex needs. The case manager chairs each review and ensures that there is joined up management of the case in accordance with the risk management plan, devised in conjunction with the mental health team. Particular attention is given to ensuring that the prisoner is located appropriately (in a safer cell where necessary) and that items retained in possession are consistent with the level of assessed risk and the plan to reduce it.

I hope this provides assurance that the specific issues identified in this case, both at the inquest and by the PPO, have been addressed locally.

Yours sincerely,

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