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Equality, Rights and Decency Group
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Mr Thomas Osborne
Senior Coroner
The Coroner's Office
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22 July 2016

Dear Mr Osborne

Thank you for your Regulation 28 report dated 26 May 2016 addressed to [redacted] Governor of HMP Woodhill, and [redacted], the former Prisons Minister, concerning the recent inquest into the death of Ian Brown on 27 February 2015. Your report has been passed to the Equality, Rights and Decency (ERD) Group at NOMS headquarters, as we have responsibility for the policy on suicide prevention and self-harm management and for sharing learning from deaths in custody. I have consulted with the Governor of HMP Woodhill in formulating this response.

You have raised concern in your report that you lack confidence that HMP Woodhill will implement recommendations from Her Majesty's Inspectorate of Prisons (HMIP) and the Prisons and Probation Ombudsman (PPO), and address the matters of concern that you have raised in previous cases. Please be assured that the Governor absolutely understands your concern and is committed to making the improvements to be realised from implementation of these recommendations.

Following the recent inspection by HMIP, a monthly forum, chaired by the Deputy Governor, has been introduced to monitor progress on the actions being taken in response to all recommendations relating to the recent deaths in custody. This forum will improve assurance of compliance. A whole establishment action plan, shared by the health provider and the prison, is in place and progress on this is formally monitored monthly and reported to both the prison Senior Management Team meeting and the newly established Clinical Governance meeting.

As I explained in my letter of 6 February 2016 in response to a previous Regulation 28 report, the Deputy Director of Custody for High Security Prisons established a taskforce to conduct a review of safer custody processes at the prison, and this group now meets quarterly, chaired by the Deputy Director, to oversee the implementation of the action plan to address the recommendations of the review. Through the taskforce extra resources have been provided to the prison to assist in data analysis, focus groups and other research. At the same time the healthcare provider, Central North West London NHS Foundation Trust, completed a review of healthcare services at the prison.

An early example of the improvement that is being driven by the taskforce is in the management of the ACCT process. The establishment has now delivered Case Management

training to 90% of managers who chair ACCT case reviews. A new case review booking system is in place to improve the continuity of case manager attendance and to ensure that all members of the multi-disciplinary team are able to plan their attendance at review meetings. The prison is also implementing a system to provide each offender supported through the ACCT process with a designated case manager throughout the period for which the ACCT remains open. This approach will bring further improvement in the quality and consistency of case reviews and care plans.

The planned improvements to safety at the prison go much wider than the ACCT process, including: an 'every contact matters' approach to the way that staff engage with prisoners; a streamlined early days in custody process, from the point of reception until the end of induction, managed by the residential team; and measures to increase the involvement of prisoners in decision-making, including the introduction of 'citizenship' groups to provide support to at-risk prisoners.

I hope this provides you with assurance that the Governor of HMP Woodhill, and the Deputy Director of Custody for High Security Prisons, have put in place processes and governance that will achieve successful action in response to the recommendations from HMIP and the PPO, and the matters of concern raised in your Regulation 28 reports, and that this will bring the necessary improvements in safety at the prison.

Yours sincerely

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