National Offender Management Service

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Equality, Rights and Decency Group
National Offender Management Service
4th Floor, Clive House,
70 Petty France,
London, SW1H 9HD

[redacted]

Lydia Brown
Assistant Coroner for Leicester City and Leicestershire South

23 August 2016

Dear Ms Brown,

Inquest into the death of Mr Michael Williams on 15 September 2015 at HMP Leicester

Thank you for your Regulation 28 Report of 11 July 2016 addressed to the Governor of HMP Leicester, concerning the recent inquest into the death of Mr Williams. Your report has been passed to Equality, Rights and Decency (ERD) Group in NOMS, as we are responsible for policy on suicide prevention and for sharing learning from deaths in custody. This response has been prepared in consultation with the Governor of HMP Leicester.

You have raised three concerns, and I will address each in turn.

Mr Williams should have been observed 4x every hour during the evening of 15th September 2015. Several of these checks were missed, and after he blocked the observation panel, he could only be heard, not seen.

(1) Observations (where they were carried out) were documented at precise 15 minute intervals, commencing on the hour and therefore predictable. This is not best practice and should be discouraged.
Prison Service Instruction 64/2011 Safer Custody sets out very clearly the requirement for observations to be conducted at unpredictable times, for example four times an hour, as opposed to every 15 minutes. All relevant staff at HMP Leicester have been reminded of this, and management checks are now in place to ensure that staff are correctly undertaking observations. All ACCT documents are quality assured and monitored by the Head of Safer Custody.

(2) There was no explanation for the missed observations.
In a notice to staff dated 24 March 2016, all staff were reminded of the importance of ACCT observations The new Safer Custody toolkit that will be introduced in August 2016 provides clear instructions to staff regarding ACCT procedures and the importance of conducting ACCT observations.

(3) Mr Williams was unobserved for approximately 1 hour before the cell door was opened and he was found deceased. The jury found this was an inappropriate delay and I agree with them. Clear guidance and training should be provided and regularly repeated to assist the prison Officers in managing such situation in a timely way.
The contingency plan at HMP Leicester was revised in April 2016, and the amended plan has been brought to the attention of staff through training and briefings. Staff have been made aware that they must intervene quickly if the observation panel has been blocked and a prisoner is refusing to engage. In particular, where there appears to be an immediate danger to life, cells can be opened by an individual member of staff. In such circumstances, the staff member must make every effort to obtain a response from the prisoner and then make a dynamic risk assessment of the situation based on what they can and cannot see through the observation panel and on what they know of the prisoner. The toolkit mentioned

above will include guidance on how to respond in an emergency and how to communicate with hard to engage prisoners.

Thank you for bringing these matters of concern to our attention. We hope that the contents of this letter have been helpful in providing some national context, as well as assurance that they have been, or are being, addressed locally at HMP Leicester.

Yours sincerely

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NOMS Equality, Rights and Decency Group