HM Prison & Probation Service

[redacted]
Safer Custody and Public Protection Group
Her Majesty's Prison and Probation Service
4th Floor, Clive House,
70 Petty France,
London, SW1H 9HD
[redacted]

C.G. Butler
HM Senior Coroner
Buckinghamshire
H.M Coroner's Office
29 Windsor End
Beaconsfield
Buckinghamshire
HP9 2JJ

2 May 2017

Dear Mr Butler

Inquest into the death of Jack Portland

Thank you for your Regulation 28 Report of 21 February 2017, addressed to the Governor of HMP Woodhill and the Chief Executive, Central and North West London NHS Foundation Trust (CNWL), following the conclusion of the inquest into the death of Jack Portland on 27 December 2015. Your report has been passed to the Safer Custody and Public Protection Group in Her Majesty's Prison and Probation Service (HMPPS – the agency that has replaced NOMS), which is responsible for sharing learning from deaths in prison custody. I reply on behalf of the Governor of HMP Woodhill.

Your report raises four main concerns covering:

1. ACCT management
2. Family involvement in the ACCT process and contact with the establishment
3. Discharge arrangements
4. Coordination of disclosure and witnesses statements.

ACCT Management

You will be aware from the evidence given at the inquest of the significant amount of activity that has taken place at HMP Woodhill to ensure that ACCT procedures are managed robustly and in line with Prison Service policy. Extensive training in suicide and self-harm prevention has been delivered to staff since Mr Portland's release from HMP Woodhill in 2015. During 2016 HMP Woodhill prioritised such training, and as a result over 93 per cent of managers at the prison have received Case Manager training, a significant improvement on previous years.

In addition to the prioritisation of training delivery, new procedures have been introduced to ensure more robust management of the process. During 2016 the Safer Prisons team introduced Case Manager Allocation and ACCT review booking systems, the aim of which is to ensure a manageable caseload for Case Managers and to ensure consistent multi-disciplinary

attendance at ACCT reviews. The team works extremely closely with the prison's healthcare providers, and CNWL were fully involved in the development of the new processes. Prison and healthcare staff work together to ensure attendance at the planned reviews.

In order to provide assurance that new procedures are fully embedded and effective, a review of the establishment's ACCT quality assurance processes took place in 2016. This led to the introduction of two new quality checks, one undertaken weekly by the wing manager and the other on a monthly basis by the Duty Governor, which assess the quality and completeness of ACCT reviews and post-closure reviews. Both checks include a section which requires managers to assess and comment specifically on the quality of caremaps, and where deficiencies are found, feedback is given to the case manager and/or wing manager who are required to take the appropriate action to rectify this.

After closure of an ACCT a post closure check will be completed by the Safer Prisons team. A quality assurance template is used to check that the post closure process has been completed within timescales, that caremap actions were considered and completed prior to closure and that the prisoner has been invited to complete the closure questionnaire. As with all quality assurance checks any feedback required will be provided to the Case Manager involved.

The Governor is confident that the increased focus on the training of staff on the requirements of the ACCT process, and the robust quality checks now in place, have led to a significant improvement in the quality, focus, and effectiveness of ACCT documents in supporting prisoners at risk of suicide and self-harm.

Family contact

The value of family involvement for prisoners, and the significant resettlement opportunities that contact with family members presents, are recognised. However, the prison can only prompt this contact (and it could only be effective) with the consent of the prisoner.

During 2016 the prison has sought to further raise awareness of the value and importance of family contact and has seen significant improvement. Family members have been invited to and attended ACCT reviews, made telephone contributions and been involved in release planning for those prisoners on open ACCTs. The Safer Prisons team is planning further work with Case Managers using some of the local examples with contributions from family members and prisoners. During the review of the local Safer Prisons Policy in May/June 2017 the 'family pathway' will be developed to ensure active involvement of families wherever possible.

Discharge

Since 1 June 2014 the provision of resettlement services for prisoners serving 12 months and under has been the responsibility of Community Rehabilitation Companies (CRCs). The prison works closely with the provider of resettlement services at HMP Woodhill, MTC Novo CRC, which is required to provide support services relating to housing and accommodation, employment training and education, finance benefit and debt.

CRC staff meet all newly arrived prisoners to assess their immediate needs and necessary interventions. They then coordinate, deliver and signpost prisoners to interventions. Each prisoner will meet CRC staff 12 weeks prior to release and a review of resettlement plans will take place, with outstanding issues dealt with in an action plan. The prison actively supports the work undertaken by the CRC within the establishment.

Since Mr Portland's release from HMP Woodhill, the prison has introduced a new database system for the management of complex cases, which allows for the live sharing of information between the establishment, the CRC, Westminster Drug Project (the providers of substance misuse support) and CNWL. The database allows a coordinated approach to resettlement planning, providing information relating to any concerns or issues and appointments upon

release, for example with GPs, drug services and housing. This ensures that no referrals are being repeated and that everyone involved in the resettlement plan is fully aware of ongoing and required actions. The use of the database will be reviewed in July 2017 to ensure that it is fit for purpose and to consider how this information sharing is used to provide multi-disciplinary support to the most vulnerable and at risk individuals approaching release.

It has also been agreed at the multi-agency meetings that any immediate concerns regarding resettlement issues in complex cases will be shared with relevant departments by an immediate phone call, and recorded on the prisoner case notes. This is to identify and address safeguarding issues, such as prisoners with accommodation issues and those suffering with mental health concerns.

From July 2017, prisoners will be able to register with a GP practice before they leave prison. The agreement includes the timely transfer of clinical information from the prison to the GP practice, with an emphasis on medication history and substance misuse management plans, to enable better care when a new patient first presents at the practice. Prisoners will be actively supported to register with a GP.

Disclosure

We regret that the provision of documents to this inquest was not achieved in the way that we would wish, and would like to apologise to you for the impact that this had on the inquest process. Much of this difficultly arose from the fact that, as Mr Portland died some months after his release from HMP Woodhill and when he was not in prison custody, the usual process by which prisons ensure that the paperwork required for disclosure to assist the Prison and Probation Ombudsman's investigation and the Coroner's Inquest is collated was not initiated. In consultation with GLD, we have agreed that in future all disclosure to the Coroner's Court will be done through GLD to avoid confusion.

The late submission of written statements was the result of our desire to fully assist the inquest process by providing them from the most relevant members of staff. Due to a miscommunication we were not immediately aware that one member of staff would not be able to address all the issues raised.

We have noted your concerns and will be addressing these in the longer term by increasing the resource in place to facilitate Coroner's inquests.

Thank you for bringing these matters to our attention. I trust that this letter has provided you with assurance that your concerns have been addressed.

Yours sincerely

[redacted]

Safer Custody and Public Protection Group