HM Prison & Probation Service

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Mr G R Williams
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Dear Mr Williams,

Inquest into the death of Kelvin Speakman

Thank you for your Regulation 28 Report of 27 February issued to HMP Hewell and Her Majesty's Prison and Probation Service (HMPPS) following the inquest into the death of Kelvin Speakman. I am responding as Director General of Prisons.

I know that you will share a copy of this response with Kelvin's family and I would first like to express my sincere condolences for their loss. Every death in custody is a tragedy and the safety of those in our care is my absolute priority.

I am grateful to you for bringing to my attention your concerns about the management of the ACCT process at HMP Hewell. You have specifically highlighted a lack of compliance with national and local policy, inadequate documentation, and poor information sharing and communication. You have also identified that although the prison has accepted repeated recommendations made by the Prisons and Probation Ombudsman about the same failings, they continue to occur. As such you consider that the operation of the ACCT process at the prison is in need of an urgent and radical overhaul.

In order to improve adherence to ACCT policy, from April 2019, the Group Safety Lead at the West Midlands Regional Office will deliver coaching sessions to ACCT case managers at the prison. These sessions will emphasise the importance of sharing information and of accurate and comprehensive recording, so that staff have everything they need to make appropriate decisions and prisoners subject to ACCT procedures are properly managed. She will also work with senior managers at the prison and will carry out bi-monthly assurance checks of all ACCT documentation. Any learnings from the coaching sessions and bi-monthly checks will be discussed with the Governor and at the monthly Safer Custody and Safety Intervention meetings at the prison.

Since January 2019, HMP Hewell has been operating a new quality assurance process. A member of the senior leadership team now carries out a daily review of all ACCT documents, making sure that they have been completed in accordance with instructions. They also check that healthcare staff attended first case reviews and that all necessary actions have been taken.

In terms of healthcare attendance at all first case reviews, in March 2019 all members of healthcare staff at the prison were reminded by way of a written staff briefing that they must attend all first ACCT case reviews, as well as any subsequent reviews when necessary, and must record their attendance clearly in the ACCT document and on their IT system. They must also record any information relevant to risk. In the event that healthcare staff are exceptionally unable to attend the first review, an ad hoc review will be held as soon as possible after the initial review in order that healthcare views can inform the management of the case. Staff have also been reminded about the HMPPS Learning Bulletin (ACCT - Case Reviews, CAREMAPs and Levels of Conversations and Observations), which was issued to all prisons in July 2018. This highlights the importance of healthcare attendance at case reviews.

On a national level, following a review of ACCT, HMPPS is in the process of piloting an updated ACCT case management system, which will be evaluated in the summer of 2019. The evaluation will inform the final revised version that will be rolled out nationally in early 2020. As part of this exercise we have developed clearer guidance to all prisons about the ACCT process, including advice about recording how decisions were arrived at. The guidance also reiterates the importance of health care attendance at case reviews. The new guidance will be made available on our intranet, so it can be accessed by all staff. We have also produced a new case review document, requiring the names of everyone who contributes to a case review to be recorded, along with details of key conversations and events such as appointments. This will make information more readily available to all staff. A new quality assurance tool is also being rolled out alongside the updated ACCT document, which assesses whether the process is being followed correctly.

Thank you again for bringing these matters of concern to my attention. Please be assured that learning from the circumstances of Kelvin's tragic death will be shared more widely with colleagues across the prison estate.

Yours Sincerely,

PHIL COPPLE

Director General - Prisons