HM Prison & Probation Service

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Ms Emma Brown
Area Coroner
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By email: Coroner@Birmingham.gov.uk

20 August 2019

Dear Ms Brown

Thank you for your Regulation 28 Report of 23 June addressed to HMP Birmingham, the Ministry of Justice and G4S, which you issued following the conclusion of the inquest into the death of Marcus McGuire. As Director General for Prisons within Her Majesty's Prison and Probation Service (HMPPS), I am responding on behalf of HMP Birmingham and the Ministry of Justice.

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

I am grateful to you for bringing to my attention your concerns. You have raised concerns about the quality of the Assessment, Care in Custody and Teamwork (ACCT) processes at HMP Birmingham, and specifically the issue of the extent to which single case management is embedded at the prison, which you believe may have not have been accurately described in the evidence that you heard at the inquest.

In accordance with Prison Service Instruction (PSI) 64/2011, HMP Birmingham operates a single case manager model, and consistency of case management continues to improve. There are ongoing operational challenges in delivering this model in every case but, since the inspection to which you refer, the prison has trained additional case managers and this means that each individual has a lower caseload and is more frequently able to attend their prisoners' case reviews.

Compliance with the single case manager model is being monitored daily, and is reviewed at the monthly Safer Custody meetings. All case managers have been given additional briefing about the importance of consistent delivery of it, and the safety team for the West Midlands Prison Group is providing support and additional assurance measures to ensure that the process is embedded.

The operational reality is that there continue to be some occasions on which the case manager for an individual prisoner is not able to conduct a case review. This would include, for example, situations where an unanticipated review is required following an act of self-

harm or other notable event, and the person concerned is not on duty. When this occurs, another case manager thoroughly reviews the ACCT documentation and, wherever possible, speaks to members of staff who know the prisoner to enable them to understand the relevant risks prior to chairing the review. Similarly, if the case manager is going to be absent for an extended period then the case is transferred to a different case manager.

I am sorry to hear that you felt that the evidence that you heard did not reflect the ongoing challenges of embedding the single case manager model. Such challenges are a feature of the operational environment, but I trust that this letter will provide reassurance that consistency of case management is a priority at the prison, that wherever possible the single case manager model is being delivered, and that, where it is not, measures are in place to detect this and to mitigate the risk.

The prison has also introduced further quality assurance of every ACCT document, with checks taking place 72 hours after opening, weekly while open, and on closure. If these checks reveal evidence of a failure to comply with the national guidance contained in PSI 64/2011, the members of staff involved are provided with relevant feedback and questioned about their actions. If the non-compliance is serious and/or repeated, disciplinary action may follow.

You may also be interested to know that we are continuing to develop the ACCT process. We piloted a revised version of the form and associated guidance in nine prisons and one immigration removal centre from February to June 2019. The feedback from the sites has been positive, and a formal evaluation of the pilot is currently being undertaken. The findings will inform the development of a new version of ACCT that we intend to begin to roll out nationally in early 2020.

Thank you again for bringing these matters of concern to my attention. I would like to reassure you that the lessons learned following the circumstances of Mr McGuire's tragic death will be shared more widely with colleagues across the prison estate.

Yours sincerely,

PHIL COPPLE

Director General for Prisons