Central and North West London NHS
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5 February 2016

Mr Thomas Osborne
HM Senior Coroner for Milton Keynes
HM Coroner's Office
Civic Offices
1 Saxon Gate East
Central Milton Keynes
MK9 3EJ

Dear Mr Osborne,

Re: Regulation 28 Report – Mr Daniel Byrne

I am responding to your Regulation 28 Report which was copied to the family of Mr Daniel Byrne, the Prison and Probation Ombudsman and the Treasury Solicitors covering the recent Inquest into the death of Daniel Byrne on 27th February 2015. I am unclear whether a separate report has been addressed to the National Offender Management Service (NOMS) and should be grateful for clarification.

In the report, you ask for actions taken or proposed to be taken, to prevent future deaths following a number of self-inflicted deaths at HMP Woodhill since 2013. You concluded that there were three areas of particular concern relating to the healthcare provision for Mr Byrne at HMP Woodhill: a failure to assess adequately Mr Byrne's risk of suicide and self-harm in the health screen on reception; the lack of referral for an urgent mental health assessment and a failure to carry out the first review of Mr Byrne's ACCT.

You stated that "*there needs to be a review of the healthcare staff's role in carrying out a full and adequate risk assessment of suicide and self-harm whenever a new prisoner is seen and assessed by healthcare*". In addition, that "*consideration should be given to the introduction of a formal risk assessment tool*". We note that you raised similar concerns in Regulation 28 reports in 2014 and have considered the NOMS responses of 12 June and 31 October 2014. We note that the Equality, Rights and Decency Group of NOMS has policy responsibility for suicide prevention and self-harm management and will not repeat the description of the policy frameworks set out in the responses. We do however operate under the national frameworks set out in Prison Service Instructions (PSI) 74/2011 Early Days in

Custody and 64/2011 Safer Custody, in conjunction with prison officers, which set out the process for identification and management of prisoners at risk.

I must say at the outset of my response, that the number of self-inflicted deaths within HMP Woodhill since July 2013 is both tragic and of deep concern. We are clear that, in conjunction with NOMS, we can and must do more to ensure that no further, preventable, deaths occur. Since 2013, when CNWL started providing healthcare at HMP Woodhill, we have worked hard with NOMS to enhance the safety of the men for whom we care. In view of our own concerns about the number of deaths, we had pro-actively approached NHS England commissioners to conduct a fully independent review of healthcare provided by CNWL in the prison. We extended and formalised this request after the death of Mr Byrne in 2015. This review has now been completed and will formally report back at the end of March.

CNWL provides healthcare in a number of prisons because we have a passion for equivalence of care for those detained. Our motto is “caring not judging”. I tell you this only to stress that we are deeply committed to understanding and addressing any issues to improve safety for those in our care. We are open to, and have actively sought external support, have brought expertise in from our other prisons to HMP Woodhill, are ensuing that resource is available as required, to keep the men safe and we are working with Governor and the prison regime to drive improvements.

Since the death of Mr Byrne, CNWL has comprehensively reviewed healthcare assessment processes, including risk assessment and management, within HMP Woodhill and considered this against our best practice in other prison health care settings. This has led to a series of actions directly addressing your concerns.

While there is no nationally recognised best-practice ‘tool’ or best practice guidance, beyond the process identified in the PSIs identified above, the reception screening tool has been strengthened and more detailed questioning around mental health, risk of self-harm and suicide has been added. CNWL staff undertaking the reception screening role have been trained in its use, with all staff due to complete training by March 2016. Agency staff, where used, will also be fully trained.

From January 2016, CNWL has increased the number of experienced Mental Health trained nursing staff into the First Night Centre. The role of these staff is to support the system as a whole in assessing which of the men arriving within HMP Woodhill may pose a risk to themselves and ensuring that this risk is properly managed. NHS England has agreed additional funding for 2015-16 to increase staff capacity. In addition to the initial risk assessment on the first night, which includes a comprehensive risk assessment identifying self-harm and suicide indicators, there is now a secondary health screen carried out the next day that also screens for risks of self-harm. Further to this, a member of the Mental Health team is present at the First Night Centre (FNC) and carries out a risk assessment on all the men that arrived in the prison the day before.

The newly-built Mental Health Assessment Unit is due for completion, subject to NHS England funding approval, in March 2016 (NHS England are considering the business case at present). CNWL proposed the building and staffing of this unit to NHS England health commissioners in July 2015, which would provide fourteen beds

for men experiencing mental health problems within the prison. It would provide a resource for improved care and heightened observation of those considered at most risk of self-inflicted death.

We have significantly amended the process of referral to the Mental Health team. The Mental Health team is also now substantially increased and has four Care Co-ordinators compared to one at the time of Mr Byrne's death. A template has been introduced into the electronic clinical records system alerting the Mental Health team to a new referral. All referrals are now reviewed weekly by the Consultant Forensic Psychiatrist and the multi-disciplinary team.

We have gone further and in the last year CNWL has been developing a new on-line e-learning training package, developed by our mental health staff, which will better equip staff in assessing the risk of self-harm and suicide. We have been concerned to raise the awareness of all staff but particularly those undertaking reception screening about both the risk of suicide and appropriate risk management processes. This package has been trialled across the Trust's Offender Care services and all CNWL staff in HMP Woodhill will have completed this training by the end of February 2016. Once its effectiveness has been audited, the tool will be shared with NOMS and NHS England for use in prison healthcare services outside of the Trust.

As stated earlier, following the death of Mr Byrne, CNWL recommended to NHS England that they commission an independent, expert review of all the recent deaths in custody. Due to delays in the acceptance of this recommendation and subsequent commissioning of this review it has only just ended. The formal report is not due until the end of March but the Chief Operating Officer and Clinical Director for CNWL attended a verbal feedback session on 3rd February with the Prison Governor and NHS England. The review recognised, and commended, the changes we have already outlined in this letter and highlighted that adequate resourcing of the Mental Health Team is key to having a high quality service. They also recommended benchmarking against similar prisons. NHS England has agreed to carry this out. It was also recognised that whilst those with complex Mental Health needs are 'managed well' there is very little resource available for those inmates who are primarily being supported by GPs. This will be picked up in the benchmarking exercise. There were a number of other recommendations including the need to regularly review and focus on the ACCT process recognising the importance of the prison risk assessing regularly and the quality and organisation of the process.

We continue to work closely with NOMS, and all of the changes noted above have been discussed with them. We continue to provide support for ACCT training processes and support the prison in managing the prison-led ACCT process. CNWL staff actively check each day that relevant information has been appropriately shared and that we review ACCTs at each planned review meeting. We have audited our record keeping for staff attending ACCT reviews to ensure that risk related information is both appropriately recorded and shared. This monitoring will be on-going in HMP Woodhill and in our other services. We have discussed with the Prison Governor and the NOMS the use of 'safer cells' (where all ligature points have been removed) but we understand that there are no safer cells within HMP Woodhill at this time. The use of 'constant watch' cells was also discussed and we note that this provision exists within the newly built Mental Health Assessment Unit as detailed

above. In addition, we note that the Prison has strengthened systems for ensuring that healthcare information about any new prisoner is brought into the prison and shared with healthcare at the same time that the prisoner arrives. NOMS has led a regional review mapping the prisoners' journey through custody, in order to ensure that all processes in the management of risk to self are fit for purpose, we are yet to receive the findings.

I know that you are planning to visit HMP Woodhill in March 2016. Our Clinical Director, Dr Annie Bartlett, and Divisional Director of Nursing, Helen Willetts, will be available and more than happy to answer questions about healthcare in the prison and any issue outlined in this letter.

I would also be more than willing to meet you at your offices with members of my team if that would be helpful. We are treating the HMP Woodhill situation with the highest priority and seriousness and are completely open to all feedback, discussion and external challenge. Anything in the best interest of the men we care for. Do let me know if such a meeting wold be of use.

Yours sincerely,

Claire Murdoch
Chief Executive