Ministry of JUSTICE
National Offender Management Service

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Mr Andre Rebello
Senior Coroner

15 July 2016

Dear Mr Rebello

Thank you for your Regulation 28 report addressed to the Secretary of State for Justice, concerning the recent inquest into the death of Lee Rushton on 28 January 2015 at HMP Liverpool. Your report has been passed to the Equality, Rights and Decency (ERD) Group at NOMS headquarters, as we have responsibility for the policy on suicide prevention and self-harm management and for sharing learning from deaths in custody.

As you will be aware, we work hard to learn lessons from each death in custody, and in particular look to recommendations from recent investigations by the Prisons and Probation Ombudsman and Coroner's Inquests to help us identify areas for improvement. I would like to thank you for drawing our attention to the issues you raise in your report, and hope the response below addresses these to your satisfaction.

You have raised concern with regards to:
"When a prisoner is on an ACCT (Assessment, Care in Custody and Teamwork) and a CSRA (Cell Sharing Risk Assessment) indicates an inmate should be in a cell alone for the protection of others. What consideration should be given to the ACCT Care plan with regard to a mandatory ACCT review? Should this already be covered in policy or guidance consideration should be given to reminders being issued and or if necessary mandatory training across the prison estate in the light of the jury's findings"

The Safer Custody policy, Prison Service Instruction (PSI) 64/2011, sets out the need to share reliable, accurate and timely information relating to risk of any individual in prison care. It also sets out the many factors, both static and dynamic, relating to risk and triggers and how they can affect an individual at risk of suicide or self-harm. Where an ACCT plan is opened, policy requires that the first case review should identify the prisoner's most pressing needs, resulting in the suicidal ideation or self-harming behaviour, and identify appropriate actions to address these needs. These actions will be reflected in the Caremap.

A Caremap may include that the individual should be placed in a cell with a cell-mate for peer support. Where a prisoner on an ACCT is assessed as high-risk by the cell-sharing risk assessment, and in balancing the safety of both prisoners, the ACCT case review team consider them to be unsuitable to share a cell, the review team must consider and include in the Caremap what alternative support will be put in place, and review this decision at further case reviews.

If heightened or exceptional risk has been identified, cases should be dealt with through an Enhanced Case Review. This is aimed at those prisoners whose behaviour is so challenging and disruptive that they need additional case management in order that their heightened or

exceptional risk of harm to self, others and/or from others is managed within the normal custodial regime. This action will be reviewed at further case reviews.

A review of compliance and delivery of the ACCT process has been completed by NOMS and will be published shortly. Action required to implement the findings of the review includes providing clear information for staff and prisoners about the ACCT process and their role in it, updating PSI 64/2011, improving the Safer Custody training packages and introducing more innovative ways to deliver this learning. Since December, we have issued a number of communications to staff, including 'Thematic Review on Safer Custody Audit', 'Suicide Prevention - myth busting', 'Suicide prevention - providing support' and 'Suicide prevention - high risk situations'. Further communications will be issued once the ACCT review has been published.

I hope this provides you with assurance that the matters of concern that you have identified are being fully addressed.

Yours sincerely

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