HM Prison & Probation Service

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Ms Henrietta Hill QC
HM Assistant Coroner for Inner South London
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6 May 2021

Dear Ms Hill

Thank you for your Regulation 28 report of 10 February 2021 following the inquest into the death of Jason O'Rourke at HMP Belmarsh on 2 April 2019. I am grateful to you for granting an extension to the statutory deadline for my response.

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

Following evidence heard at the inquest you have raised concerns in relation to the 'immediate needs' form completed for prisoners on arrival at HMP Belmarsh. This is a locally produced document created in line with the Prison Service Instruction (PSI) 07/2015 *Early days in Custody.* You will be aware that the early days in custody is a period in which risk of self-harm or suicide is heightened and the wellbeing of prisoners in our care is the primary concern of staff throughout the reception and first night process. Following the inquest a review of the form has taken place, and a new version is now in use. This provides clearer guidance to staff on the actions to take should any concerns about a prisoner's risk of suicide or self-harm be identified, including communicating concerns or previous ACCT history to healthcare colleagues, and documenting decision making so that information is available to wing staff once the prisoner moves onto the wings after their induction period. I attach a copy of the updated immediate needs form for your information.

As well as using the immediate needs form to capture information shared by prisoners on how they are feeling, staff working in the reception and first night areas receive specific training in how to recognise risks and triggers for self-harm and suicide and how to support prisoners through the first few days in prison. Beyond the reception and first night process, all staff are trained in how to open an ACCT should they identify evidence of increased risk of self-harm or suicide.

You also raised a concern in relation to the nightly roll checks carried out by Operational Support Grade (OSG) staff and the lack of a robust system to ensure that these checks have been completed. The purpose of roll checks is to ensure that prisoners are accounted for, located where they should be, and alive and well. It is mandated that four roll checks are carried out over each 24 hour period and the times of the checks are locally agreed and

set out in each prison's Local Security Strategy (LSS). The duties and expectations of night staff are clearly communicated and staff receive training and shadowing before working alone on the wings overnight. For OSGs these duties include carrying out a roll check at the beginning and end of each shift which must be reported to the control room and signed for.

Spot checks by the Night Orderly Officer (NOO) and night visits by an operational manager are in place in establishments, including Belmarsh, to ensure that staff are carrying out their required duties and these provide an opportunity for OSGs to raise any issues or concerns with workload or any unexpected incidents that have occurred during their shift which may prevent them from being able to carry out the roll check or report the roll at the required time. The NOO can be called upon for assistance by OSGs at any time during the night shift.

In the light of the concerns that you have expressed, the Governor of HMP Belmarsh is working with the Long Term and High Security Estate (LTHSE) safety team to review the quality assurance processes in place for roll checks. As a first step, a system has been implemented whereby when a night OSG arrives a discipline officer remains on the wing until a full roll check has been completed, recorded and signed for on the wing and reported to the Orderly Officer. Spot checks are in place to ensure that the process is being followed. The LTHSE safety team will be visiting Belmarsh to identify further opportunities for improvement and to test compliance with this new process, and the LSS more generally.

I understand that the question of using CCTV for assurance was explored at the inquest. CCTV is deployed in prisons for reasons of safety and security and not for general surveillance or monitoring staff performance. Playback of CCTV coverage is only authorised in certain circumstances, such as where there is reason to believe that safety or security has been compromised, or to assist with a formal investigation. Where there is suspicion that roll checks are not being carried out, CCTV could be used as part of an investigation into those suspicions, but it cannot routinely be monitored as part of the assurance process. Staff are aware that CCTV is in use around the establishment and that their actions may be scrutinised following an incident such as a death in custody.

If staff are found to have failed to carry out the required tasks or when there is a question over their performance and ability to manage the wing overnight there will be a thorough investigation to determine what has happened and to ensure that staff who fail to uphold the values of HMPPS by putting prisoner's safety at risk are held to account through disciplinary procedures. Staff are aware that failure to carry out the duties entrusted to them will result in disciplinary action, and that, depending on the circumstances, the outcome may range from advice and guidance in order to support them to perform better, to dismissal from the service.

Thank you again for bringing your concerns to my attention. I trust that this response provides assurance that action is being taken to address the matters that you have raised.

Yours sincerely

Director General for Prisons