HM Prison & Probation Service

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David Donald William Reid
Senior Coroner for Worcestershire
Worcestershire Coroner Service
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20 September 2021

Dear Mr Reid,

Thank you for your Regulation 28 report of 4 June 2021 following the inquest into the death of Geoffrey Harrison Hutton at HMP Long Lartin on 8 February 2019. I am informed there was an administrative error on our part for which I apologise and as such, 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 Hutton 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.

You have identified a number of concerns relating to social care referrals and the management of Assessment Care in Custody and Teamwork (ACCT) processes at the prison. Thank you for bringing these concerns to my attention.

Following the inquest, a review of the prison's adult safeguarding policy was undertaken, and the prison is now working on a memorandum of understanding with Worcestershire County Council which will be completed by September 2021. The agreement sets out the strategic intent and joint commitment to improving the social care provision and procedures for those in custody.

The prison is also developing a directory to be used by staff in order to identify the most appropriate interventions for those in custody. This is due to be published later this month and will feature all interventions available through Worcestershire Social Care and will include information about the sensory impairment team within the local authority. A new template for referrals is more user friendly and takes less time to complete. Posters have been displayed around the prison to promote the new template and policy, and when the memorandum of understanding has been completed a notice to staff will be issued to inform all staff of the new processes.

The Safer Custody Team is responsible for managing social care referrals, and the weekly multi-disciplinary Safety Intervention Meeting (SIM) is attended by the local authority social care team, providing an opportunity to discuss any new referrals and assessments, and to

update on progress and discuss any actions to be taken. The healthcare provider, Practice Plus Group (PPG) has also signed up to the memorandum of understanding and joint working between healthcare, prison and social care teams will ensure that any outstanding referrals or actions are picked up and addressed and that sufficient time is given to discussing support options for prisoners identified as having additional needs.

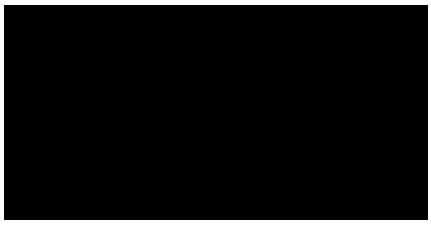
Your second concern relates to the system for allocating ACCT case managers. You may be aware that HMPPS has introduced a revised version of ACCT which went live across the prison estate in July 2021; ACCT version 6. The changes are intended to assist staff in providing high quality multi-disciplinary care and support to individuals at risk, focusing on a person-centred approach which meets the needs of each individual. The term Case Manager has been replaced with Case Coordinator to reflect the fact that everyone involved in the ACCT process is responsible for ensuring that good quality support is provided. Specific training for ACCT Case Coordinators is being provided and staff must undertake the relevant modules before taking up the role. The Case Coordinator is responsible for coordinating and documenting multi-disciplinary case reviews, ensuring that support actions (previously the 'Caremap') are progressed and completed before the ACCT is closed, and for conducting the post-closure review.

At HMP Long Lartin a new database is being implemented to support the allocation of ACCT Case Coordinators. This contains information on staff rotas, periods of leave and how many open ACCTs each Case Coordinator currently has. This will facilitate effective allocation decisions and support a renewed focus on providing consistent and proper oversight and ownership of cases. In addition, the staffing resources within the safer custody team have been reviewed and an additional manager has been introduced, providing capacity to complete more assurance work around ACCT processes.

Your final concern relates to the fact that some Operational Support Grade (OSG) staff who carry out ACCT observations at night have not received ACCT training. We are making changes to the training provided to OSG staff, making it mandatory for OSGs to complete suicide and self-harm (SASH) training, which includes material on ACCT. Initial OSG training will also be changed, so that from early 2022 all new OSGs will receive the relevant SASH training modules as routine.

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