National Offender
Management Service

[redacted]
Equality, Rights and Decency Group
National Offender Management Service
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Email: [redacted]

Mr Tom Osborne
Senior Coroner for Milton Keynes

31 October 2014

Dear Mr Osborne,

Thank you for your Regulation 28 Report of 29 August 2014 addressed to the Minister for Prisons, following the recent inquest into the death of Stephen Farrar at HMP Woodhill on 12 December 2013. Your letter has been passed to Equality, Rights and Decency Group in the National Offender Management Service (NOMS), as we have the policy responsibility for suicide prevention and self-harm management, and for sharing learning from deaths in custody.

You have raised concerns about the assessment of the risk of self harm or suicide during the reception process, and in particular the fact that a formal risk assessment tool is not in use either at HMP Woodhill or across the prison estate.

I note that you raised similar concerns in a Regulation 28 Report following an inquest held in February 2014 into a death at HMP Woodhill in May 2013, and that you received a detailed response to that report from my colleague [redacted] on 12 June 2014. I will not repeat the description of the policy framework given there. In summary there is a comprehensive set of systems for identifying and assessing prisoners at risk that includes some specific tools, such as a healthcare reception screening tool that has been made available to all prison establishments, but, of necessity, such tools form only a small part of the very broad set of processes involved in this complex task.

In response to your renewed expression of concern, I would like to assure you that reducing the number of self-inflicted deaths in prisons remains a priority for NOMS, and that we continue to work to improve our risk identification, assessment and management processes. In response to the recent rise in the number of deaths, additional dedicated resources are being provided for safer custody work in a number of prisons, and we have put in place additional staff at regional level to support staff in prisons and to share good practice. A learning and knowledge management team at headquarters provides further support to prisons in learning from deaths in custody and for safer custody work more generally.

Further action has also been taken locally at HMP Woodhill to address the matters about which you have expressed concern. This is described in detail in the action plan that addresses the recommendations of the Prisons and Probation Ombudsman's (PPO's) investigation into Mr Farrar's death, included in the final PPO report. In brief, the staff involved in the reception and first night processes have been reminded of the need to gather all relevant information, and of the factors that they should consider when assessing risk. The risk assessment process used by healthcare staff has also been improved and staff trained in its use.

I hope this provides assurance that the matters of concern that you have raised have been addressed and that NOMS continues to make strenuous efforts to improve its systems and processes in this important area.

Yours sincerely,

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NOMS Equality, Rights and Decency Group