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Ministry of JUSTICE
National Offender Management Service

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Equality, Rights and Decency Group
National Offender Management Service
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Mr Andrew Tweddle
HM Coroner for Durham and Darlington
HM Coroner's Office
PO BOX 282
Bishop Auckland
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Dear Mr Tweddle

Thank you for your Regulation 28 report dated 10 December 2014, concerning the recent inquest into the death of Geraldine Liege Kilborn on 2 December 2013 at HMP&YOI Low Newton. This response has been formulated in consultation with the Governor of HMP&YOI Low Newton. I am aware that your report was also sent to Tees, Esk, Wear Valley NHS Foundation Trust and Care UK who will be replying separately.

Your letter raises two concerns, and I will address these in turn.

The breakdown of information sharing between mental health staff and the other staff involved in ACCT reviews

Prison Service Instruction (PSI) 64/2011 Safer Custody describes the importance of information sharing and is very clear that healthcare staff have a duty to pass on information that involves issues of patient safety, vulnerability or immediate risk to self or others to relevant staff. This duty applies in any situation in which the prisoner's safety is compromised, even if they are unable or unwilling to give consent.

This is primarily a matter for the healthcare provider, but I can inform you that an amended arrangement has been put in place to facilitate the presence of a member of the mental health team at ACCT reviews that take place at the weekend. Effective mental health input is now ensured in all cases in which a prisoner has mental health issues: for prisoners who are located in the healthcare centre, a band 5 nurse is allocated as case manager; and for prisoners located elsewhere a member of the mental health team attends all case reviews. Briefing sessions have been introduced to facilitate the sharing of information between prison staff and the mental health team, ensuring that all staff are able to make a meaningful contribution to the decision about the level of risk.

Case reviews

PSI 64/2011 recognises that the ACCT process will operate more effectively if there is continuity in the attendance of staff from relevant departments/services at case reviews. Whilst not stated explicitly in the policy, it is clear from the list of mandatory actions for the

review team that those present must make themselves familiar with the information contained in the ACCT document.

At HMP&YOI Low Newton the same staff attend ACCT reviews wherever possible. All relevant information, including developments since the last review, is discussed at the case review. This includes any information from the SystmOne record that it is appropriate for healthcare staff to share. In complex cases the enhanced case review team involves all relevant disciplines and is chaired by a higher level operational manager than a typical ACCT case review, usually the head of safer custody. In response to your report, all case managers and case review chairs have been reminded of the need to familiarise themselves with all relevant information, including the records of previous reviews and recent entries in the ACCT document, before conducting a case review.

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

Yours sincerely

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