PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Mr Andre Rebello
Senior Coroner for the City of Liverpool
HM Coroner's Court
Gerard Majella Courthouse
Boundary Street
Liverpool L5 2QD

Your ref: [redacted]

30 January 2015

Dear Mr Rebello,

Re: Regulation 28 report concerning the inquest into the death of Mr Connor Smith at HMP Altcourse on 2 January 2013

Thank you for your regulation 28 report of 17 December 2014, addressed to Nigel Newcomen, the Prisons and Probation Ombudsman, about the inquest into the death of Mr Connor Smith at HMP Altcourse on 2 January 2013. I am responding, as the Deputy Ombudsman responsible for investigations into deaths in custody.

Your report identified an apparent minor factual inaccuracy in the PPO report, in that the inquest heard evidence that an officer who was listed as being present at a segregation review, and told the PPO investigator that he was present, appears not to have attended the meeting after all. During our investigation, no other attendees listed as being present at the meeting, said that the officer was not there and no one from the prison corrected this when the draft report went to them for fact check.

While obviously, we would prefer our reports to be entirely accurate, in these circumstances, this was the responsibility of the officer and the prison. There was no reason for the investigator to disbelieve the evidence at the time. I understand the officer did not give evidence at the inquest, but when interviewed, he told the investigator several times that he was at the review. We regard the apparent inaccuracy as minor, as we took no account of the officer's evidence about the review in reaching our conclusions and we consider it had no material bearing on the circumstances of Mr Smith's death.

As you know, this office is fully committed to helping avoid any future deaths in custody, but I am not clear how we can take any action in relation to the matter you identify which might help avoid any future fatality, which is the avowed purpose of regulation 28 reports. Ultimately, the services we investigate are responsible for safeguarding those in custody. We can only realistically contribute to preventing a reoccurrence of the circumstances of Mr Smith's death through the recommendations made in our investigation reports. For that reason, the memorandum of understanding between the PPO and the Coroners' Society recognises that because of our role it 'would be unusual for the conduct of the investigation by the PPO to come within [a Regulation 28] report'.

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In the sad circumstances of Mr Smith's death, the Ombudsman made four recommendations to the prison about assessment and management of depression, the operation of the Incentives and Earned Privileges scheme for people on basic, healthcare input into decisions about segregation and investigations into allegations about bullying, which we hope might help prevent future similar deaths. I do not believe there is further specific action that the PPO can take.

Yours sincerely

Deputy Prisons and Probation Ombudsman

cc: Rt Hon Chris Grayling MP - Secretary of State for Justice
His Honour Judge Peter Thornton QC, Chief Coroner
Michael Spurr – Chief Executive – NOMS
Lord Toby Harris – Chair of Independent Panel on Deaths in Custody
Family of Mr Smith
Mr Bob McColm – Director – HMP Altcourse