



# Ministry of JUSTICE

National Offender  
Management Service

██████████  
Senior Caseworker: Safer Custody  
Casework  
Safer Custody and Public Protection  
Group  
National Offender Management Service  
4.15 Clive House  
70 Petty France  
London SW1H 9EX

Mr G A Short  
HM Senior Coroner for Central Hampshire

**BY EMAIL ONLY**

12 December 2016

Dear Mr Short

Thank you for your Regulation 28 Report to Prevent Future Deaths addressed to HM Prison Service, and The Samaritans, concerning the inquest into the death of Haydn Burton at HMP Winchester on 15 July 2015. Your report has been passed to the casework team in the Safer Custody and Public Protection Group (SCPPG) in the National Offender Management Service (NOMS), as we have responsibility for the policy on suicide prevention and self-harm management and for sharing learning from deaths in custody. The reply is provided after consultation with the Governor of HMP Winchester.

I note your concern that evidence at the inquest suggested that staff at Winchester are inconsistent in their implementation of the Assessment, Care in Custody and Teamwork (ACCT) process, and that the practice of undertaking ACCT observations is inadequate. I am grateful to you for raising this concern, and would like to reassure you that the Governor of Winchester, ██████████, is committed to ensuring that all operational staff are successfully trained in ACCT procedures to enable them consistently to follow national ACCT policy contained within Prison Service Instruction (PSI) 64/2011 Safer Custody. Local ACCT refresher training is due to take place on 13 and 20 December 2016 for 48 members of staff and will be delivered at least monthly thereafter. HMP Winchester is also holding a Safety Awareness Day on 21 December 2016.

This local training will cover the whole ACCT process, including how to open an ACCT, and will consider lessons learnt from previous deaths in custody, including the requirement to ensure that the ACCT assessment is completed within 24 hours, the need to make appropriate mental health referrals, and the fact that ACCT case reviews must be multidisciplinary and attended by all those involved in the provision of care for the individual concerned. A plan is being developed to deliver refresher training for ACCT case managers and assessors already in post, and to increase the number of staff trained in these roles.

In addition, more staff are being recruited, and 12 new Prison Officers are expected to complete the Prison Officer Entry Level Training (POELT) course that includes training on suicide and self-harm awareness and the ACCT process and start work at Winchester by March 2017.

The Governor has recently introduced additional management assurance checks to ensure that staff are completing ACCT documents correctly and to the required standard, and that the appropriate level of care is given any person who requires to additional support provided during the ACCT process. These assurance checks are completed by Orderly Officers, Duty Governors and the Safer Custody Team. The results are collated and will be discussed at the monthly Safer Custody meeting where trends will be identified and appropriate actions taken. In addition quality assurance checks will consider the role of ACCT Case Managers to confirm compliance, and identify any development needs. ACCT Caremap actions are checked by the Safer Custody Supervising Officer and Custodial Manager who ensure that appropriate actions have been identified and taken forward.

In addition to the multidisciplinary ACCT case reviews, Winchester now holds a weekly multi-disciplinary ACCT meeting, attended by the Head (or Deputy Head) Of Safer Prisons, the Community Mental Health Team (CMHT) and the Offender Management Unit, where every prisoner who is subject to an ACCT is discussed, to ensure that important information and concerns are communicated to all relevant departments.

In your report you also suggested that the local Prison Listener Scheme Protocol include an additional exception to the confidentiality rules to allow Listeners (prisoners who are trained by the Samaritans to offer confidential and emotional support to other prisoners), to advise staff when a prisoner confirms that they have active plans to self-harm or threatens self-harm in the future.

As the Samaritans have set out in their separate response to your report, the principle of total confidentiality is central to their work, and applies equally to the work of Listeners. This is reflected in the national partnership agreement between NOMS and the Samaritans that governs the operation of the Listener scheme, and the NOMS safer custody policy set out in PSI 64/2011. In the light of this it is not appropriate for Winchester to adopt a different policy on this point. Without the assurance of confidentiality, prisoners may not feel able to approach Listeners and talk freely in an atmosphere of total trust. Any change to this approach may lead to a reduction in the number of prisoners accepting this vital source of support and sharing their concerns. Where a Listener believes that a prisoner is seriously at risk of suicide, the Listener actively encourages the prisoner to seek further help, and if they do not wish or are unable to do so on their own, the Listener is trained to attempt to gain the prisoner's permission to alert staff to the need for help.

You also raised your concern that NOMIS, the prison case management system, is not used consistently to record details of ACCTs being opened and the reasons for doing so, and you suggested that the ACCT post closure process be reviewed.

PSI 64/2011 requires staff to ensure that "*The closure must be recorded within the case notes section of NOMIS giving a brief summary of the relevant issues*" (italics indicate a mandatory requirement). The Governor at Winchester has introduced a process whereby Wing Supervising Officers are informed each day of any ACCT post closure reviews which are due to be held, and provided with copies of the relevant ACCT plans. When the post closure interview has taken place, the ACCT is updated and returned to the Safer Prisons team to be filed within in the prisoner's core record. All Case Managers have been reminded of the importance of ensuring that the NOMIS case notes are updated following an ACCT case review, and are using the ACCT alerts on NOMIS to record the dates of an ACCT being opened and closed. The post closure process is now embedded and Winchester has seen significant improvements with regards to the completion of post closure ACCT reviews. The

management assurance checks described above include sample checks of NOMIS following ACCT case reviews, and post closures reviews, and the prison is confident that there have been improvements in this area.

I hope this letter reassures you that the Governor of Winchester is taking steps to address your first and third concerns, and that, together with the separate response from the Samaritans, it explains why we will not be taking action in response to your second concern.

Yours sincerely

