



HM Prison & Probation Service

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Mr D M Salter, Senior Coroner
Oxfordshire Coroner's Office
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14 May 2019

Dear Mr D M Salter

Thank you for your Regulation 28 Report dated 21 March 2019, following the inquest into the death of Mr John Wright at HMP Bullingdon.

I know that you will share a copy of this response with Mr Wright's family, and I would like first 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 raised two matters of concern: information-sharing and setting the level of observation for prisoners identified as being at risk, and I will deal with each in turn.

Ensuring that all relevant information is available and used when making decisions about risk is a key priority. As you acknowledge in your report, Care UK has taken action following this case. NHS England Commissioners, Mountain Healthcare (the healthcare providers for Thames Valley Police) and the liaison and diversion service have been informed of the process for contacting the prison healthcare team with concerns about anyone coming into HMP Bullingdon. This includes details of an email address to which Care UK staff have immediate access, and telephone contact details for the reception nurse on duty at HMP Bullingdon.

Separately, the courts that serve HMP Bullingdon and the escort contractors (GEO Amey) have been reminded that safety concerns should be recorded on the Person Escort Record and shared with reception staff at HMP Bullingdon. Clinical information should be attached in a sealed envelope clearly marked "MEDICAL IN CONFIDENCE" so that it can be read by a nurse in reception. They have also been

provided with contact numbers for the safer custody team and reception, and told that urgent matters should be raised with the orderly officer.

All staff working in reception have been reminded of the importance of sharing risk information and ensuring that it is recorded on the prisoner passport. The first night custodial manager conducts regular audits of the prisoner passports to ensure that relevant information is being recorded, and that the document is being seen and used by staff working in reception.

With regard to your second concern, setting the appropriate level of observations for a prisoner who has been identified as being at risk is a difficult decision, and we have recently issued a learning bulletin to all prisons providing guidance about the issues to consider when making it. At HMP Bullingdon, the Governor has reminded the escort contractors of the importance of alerting reception staff in all cases in which constant supervision has been in place prior to a prisoner's arrival. In all such cases the process is that the duty governor is informed and all documentation is studied to establish definitively the level of observations to which the prisoner has been subject, in order to avoid confusion over different organisational terminology. In all cases in which constant supervision has been in place, an Assessment, Care in Custody and Teamwork (ACCT) is opened and any decision to reduce the level of observations will be taken at a multidisciplinary case review (including the Duty Governor, a nurse and a member of prison staff, as well as the prisoner) and recorded in the ACCT document. All duty governors have been briefed and will frequently be reminded that decisions about the use of constant supervision should be based on the level of risk and must not be affected by resource constraints.

All staff at HMP Bullingdon understand that the risk of suicide and self-harm is at its greatest during early days in custody. The prison receives around 4,500 new prisoners every year, with at least 70% of these presenting with at least some static risk factors. The Governor is committed to redoubling efforts to prevent the loss of life through a programme of learning. All reception and first night staff have received an enhanced briefing from the head of safer custody, and all senior officers and first night staff have received risks and triggers training from the safer custody lead for the South Central prison group. At national level, an early days in custody and transitions toolkit was launched in April 2019, which provided prisons with a range of resources to support work in this area.

Thank you again for bringing these matters of concern to my attention.

Yours sincerely



PHIL COPPLE
Director General - Prisons