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HM Prison & Probation Service

Mr Nigel Meadows
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6 March 2020

Dear Mr Meadows

Thank you for your Regulation 28 Report of 20 December 2019 following the inquest into the death of Tomasz Nowosad at HMP Manchester on 2 February 2017, and for allowing a small extension to the statutory deadline for my reply.

I am grateful to you for bringing to my attention a number of matters of concern, many of which are relevant across the prison estate. I have consulted with the Governor of HMP Manchester and, where relevant, will mention action that has been taken locally at the prison as well as work that is taking place at national level. I understand that the healthcare provider is responding separately to your concerns about clinical issues.

I know that you will share a copy of this response with Mr Nowosad's family, and I would first like 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.

Before turning to your concerns, I would like to clarify the position with regard to the number of self-inflicted deaths at HMP Manchester in recent years. At 5.1 you correctly point out that there were two such deaths in 2019, and four in 2018. However, it is not the case that there have been 29 such deaths since 2016. The correct figure for the period 2016-2019 is 11 self-inflicted deaths.

A number of your concerns relate to the Assessment, Care in Custody and Teamwork (ACCT) case management process for those identified as being at risk of self-harm or suicide. We have been working hard to improve the way that this system operates. Following a comprehensive review, we have devised a new version of the form and associated guidance, and I am pleased to note that much of what you have suggested has been adopted as part of that. We believe the new version will make the system easier to operate and thereby improve the quality of care offered to prisoners. It was piloted in ten establishments in 2019 and the feedback has been positive. We are currently making some further changes before rolling it out across the prison estate later in 2020. I am confident that this will address the concerns that you have raised and bring further improvements to the work that staff do to keep prisoners safe.

I would like to comment more specifically on four issues that are at the heart of the concerns that you have raised.

First, risk assessment (5.1-5.3). You have described an over-reliance on a prisoner's presentation and what they say, rather than a consideration of all risk factors, and drawn attention to the fact that this has also been identified by the Prisons and Probation Ombudsman in relation to other self-inflicted deaths at the prison. You have explained the need for a holistic approach to risk assessment, and for decisions to be made in a defensible way, and recorded appropriately. These are issues that have been at the centre of our thinking as we have redesigned the ACCT guidance, which will be much clearer about the risks, triggers and protective factors that staff should be seeking to identify, and the ACCT form itself, which will provide prompts to look for other factors that may be relevant as well as space for staff to record the reasons for decision. The associated training packages are currently being redeveloped and will be delivered to all new staff through POELT training and made available as refresher training for existing staff. A specific session on the risks and triggers for self-harm and suicide will form a major part of this training.

Second, interpretation services (5.4). You express concern about inconsistent use of such services by staff. A national contract with The Big Word ensures the availability of interpretation services across the prison estate. The new ACCT guidance will emphasise the importance of their use throughout the process, and the new ACCT form will include prompts to consider the use of the service at every significant point, including assessments and case reviews. In advance of the roll out of the new version of ACCT, the Governor of HMP Manchester has taken action to improve the use of the service at the prison, for example by making conference style telephones available for use at case reviews.

Third, the movement of a prisoner subject to ACCT to a new location, particularly where this involves discharge from a specialist location such as inpatient healthcare (5.7-5.11). Your concern here is that information should be passed between locations, and particularly that staff at the receiving location - and the prisoner themselves - should be clear about the reasons for the move. Again, the new ACCT form will assist with this, providing a specific template for use at case reviews that occur in specialist locations, including healthcare centres and segregation units. Where a decision to discharge is the result, it provides a prompt to share relevant information with the receiving location (from which a member of staff must attend the review). The new ACCT guidance is much clearer about the need to involve the prisoner in all decisions that are taken, including those concerning location. In advance of implementing the new system, it is now the practice at HMP Manchester for a case review to be held prior to any location move, including moves from healthcare to residential wings. These reviews are attended by a representative from the new location, providing an opportunity to discuss any concerns and issues relating to risk, including how a change to location and regime might affect risk. Notes of the review and any decisions made are recorded in both the ACCT document and in the NOMIS case notes. Where an enhanced assessment has been completed by the psychology department, this is also forwarded to the new location.

Fourth, safer cells (5.13-5.14). You are concerned that more such cells should be available, and that the movement of prisoners who are subject to ACCT from a safer cell to another location should be carefully managed. I understand the importance of reducing access to the means of suicide wherever possible. Physical safety, including increasing the provision of accommodation free of ligature points, is one of the work streams in our national prison safety programme. You will appreciate that large amounts of capital investment are necessary to improve the environment in this way, and we are not able to move as swiftly as we would want to. However, wherever possible we are increasing the numbers of safer

cells available to governors. At HMP Manchester there are currently fourteen safer cells. Ten are in the healthcare unit, five of which are equipped with CCTV. Four non-CCTV cells around the prison have electro-chromatic doors. Whilst there are currently no plans to increase the number of safer cells, we will keep this under review.

Whilst safer cells are an important part of our strategy for managing acute risk of suicide, they are not a long-term solution in terms of care for individuals. The multi-disciplinary engagement and support that is provided through ACCT is designed to manage and mitigate risk by identifying and meeting individual needs. In most cases this can be done without the removal of ligature points or observation through CCTV. As explained above, the new ACCT form and guidance are clear that all changes of location, including moves out of safer cells, require careful management.

Thank you again for bringing these matters of concern to my attention. I hope that this response has provided reassurance that those that are for HMPPS are being addressed, at national level through the roll out of improvements to ACCT and, wherever possible, locally at HMP Manchester in advance of this.

Yours sincerely

PHIL COPPLE

Director General for Prisons