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Crispin Oliver Assistant Coroner for County Durham & Darlington HM Coroner's Office PO Box 282 Bishop Auckland Co Durham DL14 4FY

23 February 2023

Dear Mr Oliver

Thank you for your Regulation 28 report of 10 November 2022, following the recent inquest into the death of Michael Smith at HMP Durham on 13 July 2020.

I know that you will share a copy of this response with Mr Smith's family and I would like to first express my condolences for their loss. Each death in custody is a tragedy and the safety of those in our care is my absolute priority.

You express concern that previous actions implemented to improve the management of the Separation and Care Unit (SACU) had not had the desired effect and that staffing levels at HMP Durham needed to be increased.

I note that you have referred to a Regulation 28 response relating to an earlier death at HMP Durham. I would like to clarify that this response was sent after Mr Smith's death, which means the additional resources that were created by the Governor would not have been implemented prior to the death of Mr Smith. However, I can assure you these additional measures do remain in place at the present time which means that the staffing levels within the SACU at Durham are currently above those required by national benchmarking, the tool by which staffing levels are measured. I would also reiterate that the day-to-day running of the unit is overseen by a dedicated Custodial Manager (CM), responsible for the allocation of tasks and performance management of the officers working there. The CM reports to and is supported by the Head of Residence and Safety (a Governor grade) who forms part of the Governor's Senior Management Team. The running of the SACU is further subject to daily checks undertaken by the Orderly Officer and Duty Governor, and the Governor undertakes a weekly in-charge check. Since Mr Smith's death a new segregation weekly booklet has been introduced which amalgamates all previous segregation recording sheets together in one place. Each prisoner has their own booklet, which means an individual's records are more readily accessible to staff. The booklet also contains a section to record any comments regarding significant interactions to ensure full records are maintained.

It may also be helpful for me to explain that where prisoners are subject to a three person unlock and staff are not readily available to facilitate this, then additional staff can be drawn from across the prison to assist. I acknowledge that that this did not happen when Mr Smith required a medical assessment and accept staff did not take the necessary actions to ensure Mr Smith could be seen by a medical practitioner. However, the Governor is confident that where this situation arises in the future the resources are in place to respond effectively. A SACU pilot, which is looking at both operational processes within the SACU and the health support provided, is due to conclude in June 2023. This will assist in developing a new workforce model to support the delivery of a safe, integrated holistic approach to the care and management of those residing and working in segregation units. As result of some early evaluations, a full time nurse is now based within the SACU, which has meant there can be a more flexible approach regarding healthcare input, including the arrangements for medical assessments.

You rightly point out that during patrol/night state, when prisoners would be locked behind their door, one officer is allocated to the SACU. However where an emergency response is required staff must undertake a dynamic risk assessment before entering a cell alone. This is the position throughout the prison during this time and would be the practice whether the person is subject to a three person unlock or not, although that information is likely to form part of the risk assessment. I do note that the decision not to enter the cell alone was not criticised and the correct procedure was followed. As you will be aware there was an unusual combination of circumstances ongoing within other parts of the prison at the time which meant the arrival of assistance was slightly delayed. Unfortunately we must accept that there will be occasions where staff may have to deal with several incidents at once and that these may be taking place in other areas of the prison. We also know that at the time of Mr Smith's death, resources were being affected due to Durham being an Covid outbreak site. However, HMP Durham will review its contingency plans to incorporate the learning from this incident so that prompts are given to those responsible for managing protracted events to consider regime levels and available resources across the prison, to allow for the appropriate deployment of staff should other incidents occur at the same time.

Thank you again for bringing these matters of concern to my attention and I hope this provides you with the reassurances that you seek.

Yours Sincerely,



PHIL COPPLE

Director General of Operations