HM Prison &
Probation Service

Safer Custody and Public Protection Group
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By Email

Barbara Stow

16 January 2018

Dear Ms Stow

Independent investigation into the case of WA

Thank you for your final investigation report into the circumstances surrounding WA's life-threatening attempted suicide at HMP Ranby on 18 February 2012. Please accept my apologies for the delay in responding to your recommendations.

Your investigation report has been carefully considered and I note that you have made eight recommendations covering healthcare, sentence management, residential services, first aid, incident management and internal investigation. Your recommendations have been considered by Her Majesty's Prison and Probation Service (HMPPS), HMP Ranby and HMP Lincoln. NHS England will respond separately to the recommendations directed to them.

I would like to start by drawing your attention to some important changes that have occurred since WA's life-threatening attempted suicide before responding to your recommendations.

Last year the Government's plans for prisons were set out in the Prison Safety and Reform White Paper. This includes proposals to improve the way that prisoners are managed through the custodial part of their sentence by:

- giving every prisoner a dedicated officer who can engage with them one-to-one;
- moving responsibility for planning and supporting prisoners from the community to prison governors; and
- improving case management in prisons, to co-ordinate the delivery of interventions to the prisoner to increase their effectiveness.

On 1 April 2017 Her Majesty's Prison and Probation Service (HMPPS) replaced the National Offender Management Service as the Executive Agency responsible for delivering prison and probation services across England and Wales.

I now turn to your recommendations directed to HMPPS, HMP Ranby and HMP Lincoln.

Recommendation 2

You recommended that NHS England and HMPPS:

- take note of the findings in Chapter 11, and consider jointly in the light of this investigation whether the lessons of this investigation have a wider application;
- in particular, that they consider whether they are satisfied that adequate arrangements are now in place to ensure that consistent standards of delivery are achieved by diverse healthcare providers throughout the prison estate in the following areas:

  (a) continuity of care when prisoners are transferred between establishments, including the transfer of records, guidance on 'clinical hold', and the circumstances in which summary written or oral handover is required;

(b) induction of healthcare staff, including temporary staff, so that they are familiar with the protocols and standards that govern procedures in prison that do not apply in community settings: particular areas are reception, segregation, administration of medication, and the identification of, and support for, prisoners at risk of self-harm.

NHS England will provide a substantive response to this recommendation. However, HMPPS is committed to enabling healthcare providers to deliver healthcare services to prisoners and will support and work with NHS England so that consistent standards of healthcare are delivered throughout the prison estate.

Recommendation 3

You recommended that the Governor of HMP Ranby establishes:

- that the prison's current practice complies with the requirement to check the OASys risk assessment of newly admitted prisoners and to inform their location of any identified risk of harm to self or others; and
- that residential staff at Ranby are made aware of what is expected of them when sentence management staff notify them that low, medium or high risks of self harm have been recorded in an OASys assessment.

The Head of the Offender Management Unit (OMU) at HMP Ranby has conducted a review of the practices in place for checking OASys risk assessments for new prisoners and where a new assessment has been completed. As a result of the review, which identified that information about an individual's risk of self-harm and/or suicide was not routinely shared with wing staff, the Head of OMU has instructed OMU staff to complete a case note entry on NOMIS and to notify the relevant residential unit where a risk of self-harm or suicidal ideation is identified within an OASys assessment. All residential staff have been informed, through their managers, that upon receipt of this information they must make an entry in the wing observation book, speak to the prisoner and consider whether any further action, such as opening an ACCT or signposting to additional support, is necessary.

Recommendation 4

You recommend that HMPPS look into whether the requirement for early checking of OASys assessments for new prisoners is consistently observed in other prisons and consider whether further measures are necessary to ensure that the system is used and understood.

As part of the White Paper reforms noted above, HMPPS is working on the implementation of the keyworker role, which includes assisting prisoners to settle into prisons and providing support. This will include ensuring that those prisoners who are identified as a potential risk of self-harm or suicide based on previous assessments receive the support that they require through referral into services or providing one to one support to supplement the first night and early days processes. The processes required to ensure that information flows from probation and courts, via first night and early days to the keyworkers and the OMU are being explored. PSI 64/2011 Safer Custody is being reviewed and the revised version will refer to the roles and responsibilities of the keyworker and case manager with regard to the management of risk of self-harm or suicide.

Recommendation 5

You recommended that the Governor of HMP Ranby is asked:

- to note the absence of case notes or other evidence of constructive engagement with WA;
- to consider what practical arrangements are now in place at Ranby to cultivate positive interaction between staff and prisoners and whether more can be done; and
- to report to HMPPS accordingly.

The Governor of HMP Ranby has noted your finding in relation to the absence of case notes or other evidence of constructive engagement with WA and he recognises the importance of positive engagement with prisoners, as well as the recording of such conversations in case notes so that information can be shared with other staff. All staff working on residential units have a responsibility to ensure that relevant case notes, particularly those detailing any significant events or concerns regarding a prisoner, are entered on NOMIS. Residential managers at HMP Ranby undertake a monthly review to ensure that regular case notes are being made for all prisoners. Staff have been reminded in a staff notice and the monthly safer prisons newsletter that every contact matters.

HMPPS recognises that effective staff-prisoner relationships are crucial in ensuring prisons are safe, decent and secure environments which support rehabilitation. We have introduced the Five Minute Intervention (FMI), which provides officers with two days of training that equips staff to turn everyday conversations into rehabilitative interventions by helping them:

- identify and respond to criminal thinking styles and criminal attitudes;
- enhance prisoners' decision-making, planning and perspective-taking; and
- use these skills to make every opportunity to talk with prisoners count

A number of officers and most of the senior management team at HMP Ranby have attended the FMI training workshop, which reinforces the importance of recording all contact with a prisoner.

In order to cultivate positive interaction between staff and prisoners, HMP Ranby encourages prisoners and staff to communicate together in a professional manner. Staff also work with prisoners through engagement and consultation groups such as the older prisoner forum and the prisoners' council meeting.

The White Paper proposal to provide every prisoner with a dedicated officer who can engage with them one-to-one whilst in custody will have a significant impact on interaction between prisoners and staff.

Recommendation 6
You recommended that HMPPS checks whether provision and deployment of first aid staff and equipment at Ranby are now at an acceptable level.

The Health and Safety Manager at HMP Ranby has reviewed the provision and deployment of first aid staff and equipment and has concluded that the prison has an appropriate number of staff trained in first aid. Nevertheless, the Governor has decided that first aid training will be provided to additional staff whenever this is operationally possible.

All areas of the prison contain an emergency first aid kit. Staff review the content of these kits on a weekly basis and request replacement items from the prison healthcare as necessary.

Recommendation 7
You recommended that HMPPS reviews the guidance to establishments about action following life-threatening incidents of self-harm to ensure that it makes clear that evidence must be preserved.

Since the incident involving WA, HMPPS has issued PSI 9/2014 Incident Management, which provides guidance on resolving serious incidents with the minimum risk of harm to staff, prisoners, visitors and the public. National Operations Unit provides contingency plan templates to establishments to use as a guide for formulating local contingency plans. These templates cover scene and evidence preservation. Both the PSI and the contingency plan templates are subject to continuous review, and prisons are required to review their local contingency plans as part of the debrief process following any serious incident.

Additionally, HMPPS has issued PSI 15/2014 Investigations and Learning Following Incidents of Serious Self-harm or Serious Assaults which came into effect on 14 April 2014. The PSI reminds prisons to retain all documentation relating to the prisoner(s) involved in the incident (for example the core record, medical record, and ACCT and CSRA forms) when they are advised that an independent investigation may be required.

Recommendation 8
You have recommended to HMPPS that:

- An inquiry into an incident of life-threatening self-harm should always include an examination of healthcare as well as the actions of the discipline staff.
- Findings and conclusions should take account of both aspects considered jointly.

Having considered your recommendation, HMPPS has reviewed the annexes to PSI 15/2014 'Investigations and learning following incidents of serious self-harm or serious assaults.' Prisons are now asked to consult with their healthcare departments when conducting a fact-finding review of the incident so that relevant information can be shared and considered as part of the prison's fact-finding review. Additionally, and in the longer-term, HMPPS will consider this recommendation when revising PSI 15/2014 so that the benefits of sharing relevant information between the prison and healthcare provider during the local investigation process are explained.

I would like to thank you for bringing your concerns to our attention, and trust that you find the response helpful and reassuring.

Yours sincerely

Chris Barnett-Page