



Ministry of
JUSTICE

**Government Response to the
Report into the circumstances
of the Death of Bernard (Sonny)
Lodge at Manchester Prison on
28 August 1998**

March 2010



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Presented to Parliament
by the Lord Chancellor and Secretary of State for Justice
by Command of Her Majesty

March 2010

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Contents

Mental healthcare in segregation units	3
Access to Electronic Medical Information Systems (EMIS) in segregation units	4
Disclosure of information to the police	5
Circulation of reports	6
Adjudications and use of force	7
Communications and record-keeping	8
Manchester prison	10
List of observations about inquiry procedure	11

**Government Response to the Report into the circumstances of the death of
Bernard (Sonny) Lodge at Manchester Prison on 28 August 1998**

Mental healthcare in segregation units

Recommendation 1:

I recommend that the Prison Service urges all prisons, in conjunction with their local primary care trust, to provide dedicated mental health care for segregation units.

Response:

Not Accepted.

The National Offender Management Service (NOMS) has in place a number of national policies containing both mandatory instructions and guidance which are set out in Prison Service Orders (PSO). PSO 1700 'Segregation' includes the requirement for a doctor or registered nurse to complete an Initial Segregation Health Screen within two hours of a prisoner being placed in segregation. The purpose of the screen is to determine if there are healthcare reasons against holding a prisoner in segregation. It should also provide a 'snapshot' of the prisoner's mental health well-being at the time of the screen, although any immediate physical health concerns should also be considered.

The PSO also sets standards for healthcare access during the supervision period. A doctor must visit each prisoner in segregation as often as their individual health needs dictate and at least every three days. On all other days, a registered nurse or health care officer must make the assessment of the prisoner's mental and physical health regarding appropriateness for segregation. This ensures that a member of the health care staff visits the prisoner on a daily basis to ensure that there is no reason why a prisoner should be removed from segregation on either physical or mental health grounds.

Segregation staff may contact the healthcare staff between the daily visits if they have any immediate concerns about a prisoner's mental health well-being.

Additionally a doctor or registered nurse would normally complete the Initial Segregation Health Screen prior to an adjudication for prisoners who may be given a period of cellular confinement in order to advise the adjudicator if there are health factors that would indicate that cellular confinement would be unsuitable or unsafe.

All prisons now have access to mental health in-reach services.

Access to Electronic Medical Information Systems (EMIS) in segregation units

Recommendation 2:

I recommend that Electronic Medical Information Systems (EMIS)¹ in prisons incorporate provision for clinical staff to have confidential access to medical information at a terminal in the segregation unit.

Response:

Partially accepted.

In 2009 a joint partnership between Connecting for Health (CFH), Offender Health (Department of Health) and the NOMS was set up to begin the deployment of a nationally procured clinical IT system (SystemOne). The aim of this clinical IT system is for safer and more effective care to be delivered to offenders through effective clinical case management and the exchange of clinical information between prisons. As of January 2010, SystemOne has been rolled out in 87 establishments and a further 44 roll outs are planned. Full implementation is expected by December 2010.

The requirement on providers and commissioners of health care services is that the IT system must be available in all areas where clinical care is provided.

Working with CFH, the cross-government Health and Criminal Justice Programme will ensure the optimal use of clinical IT systems to improve and assure the quality of clinical care in the criminal justice system and provide information in support of public health and commissioning.

¹ EMIS stands for Egton Medical Information System.

Disclosure of information to the police

Recommendation 3:

I recommend that the Prison Service considers issuing further guidance on disclosure in cases where the police are investigating allegations of assault involving prisoners and prison staff.

Response:

Accepted.

The NOMS recognises that this is an area on which it would be beneficial to issue further national guidance for staff. NOMS is currently in the process of revising its human resources systems and processes as part of the Human Resources Operating Model which is part of a wider benefits-led, enterprise-wide business change programme with a view to bringing about a more efficient NOMS. The NOMS will consider what additional guidance is required on disclosing information to the police and will look to incorporate this guidance as part of the ongoing changes under the new Human Resources Operating Model.

Recommendation 4:

In particular, I recommend that where the Prison Service declines to investigate possible misconduct by staff because of a related police investigation, there is a presumption that information that would have been material to a conduct investigation should be disclosed to the police.

Response:

Partially accepted.

The NOMS will issue further guidance regarding disclosing information to the police as set out in the response to recommendation 3 above.

It would be helpful to clarify the NOMS process in respect of this recommendation. The NOMS does not decline to investigate possible misconduct by staff because of a related police investigation. Once matters are referred to the police, the NOMS would put its own investigations on hold pending the outcome of police investigations.

Circulation of reports

Recommendation 5:

I recommend that the Prison Service ensures that reports into the circumstances of a death in prison are brought to the attention of all the establishments mentioned in the report's findings or conclusions so that any appropriate action can be taken and any lessons learned.

Response:

Not accepted.

In 1998 deaths in prison custody were subject to internal investigation by the Prison Service and the investigation report was not routinely circulated to all prisons mentioned in the report's findings. Since April 2004, the Prisons and Probation Ombudsman (PPO) has conducted independent investigations into all deaths in prison custody.

It is existing NOMS practice to share death in custody investigation reports with any establishment referred to in the findings or recommendations of the investigation. In addition to this, the recently established National Safer Custody Managers and Learning Team has responsibility for developing a strategy for learning from deaths and other incidents such as self harm incidents, near deaths and assaults. Any learning points that are identified, either by establishments themselves or through PPO investigations, HM Chief Inspector's inspection reports or Coroner's Rule 43 reports, will contribute to this strategy.

Quick time learning bulletins are part of the Learning Strategy and establishments are encouraged to advise Safer Custody & Offender Policy group at NOMS HQ of any learning points that arise so that these can be communicated via these bulletins. The purpose of the bulletin is to will highlight key learning points which may help establishments identify potential safer custody risks and take remedial action where it is needed.

Adjudications and use of force

Recommendation 6:

I recommend that the Prison Service advises adjudicators to consider examining use of force statements in any adjudication where force has been used following an incident of alleged assault.

Response:

Partially accepted.

The role of the adjudicator is to inquire into a report of alleged events and decide whether an offence under Prison Rule 51 or YOI Rule 55 has been established beyond reasonable doubt. As part of the adjudication, the adjudicator will hear evidence from the reporting officer and may question them, the prisoner and any other witnesses.

The evidence of the reporting officer is contained within the F1127 (notice of report) and this should include information relating to or referring to the use of force. It is for the adjudicator to decide whether additional evidence is required to investigate the charge fully; this may include considering whether evidence such as the use of force forms would provide greater clarity of the events being investigated.

The NOMS is currently undertaking an exercise to specify key aspects of the adjudication procedure which will focus on looking at how services are delivered. In parallel with this exercise, PSO 2000 'The Prison Discipline Manual' will be revised. As part of this revision, the NOMS will give consideration to the inclusion of a reference to this recommendation within the guidance/good practice section that will be issued alongside the mandatory actions.

Communications and record-keeping

Recommendation 7:

I recommend that the Prison Service considers whether specific guidance might usefully be issued on the appropriate use of prisoners' history sheets, in particular so that:

- information affecting a prisoner's custody and care is reliably recorded in his or her personal record; and
- it is referred to when prisoners change locations or other significant events occur.

Response:

Not accepted.

A new case management system, Prison-NOMIS, is currently being rolled out in public prisons and this deployment is scheduled to complete by Summer 2010. Prison-NOMIS will hold one record for each prisoner with the information being held centrally using a unique reference number. On reception, information in relation to all previous periods of custody (post 'Prison NOMIS' implementation) will be instantly available, and the prisoner's record accessible to the majority of staff via terminals sited throughout the prison.

The system has a section for case notes which will replace history sheets. These can be accessed and entered by staff remotely and it is expected to significantly improve the quality of information about a prisoner. In addition, Prison-NOMIS will indicate when there is an open Assessment, Care in Custody and Teamwork (ACCT) document on a prisoner's hot page (which is a single page that displays all key information relating to a prisoner). This will alert staff that an ACCT document is open.

The NOMS recognises that information about prisoners, including risk information, can come to establishments by direct contact from various sources, such as Probation, Offender Managers/ Supervisors, other prisons, prisoners' family, friends or solicitors, healthcare workers, or other prisoners. PSO 2700 'Suicide and Self-Harm Management' acknowledges that it is important to prisoner safety that systems are in place to allow for the speedy receipt and transfer of this information to those who can use it to keep the prisoner immediately safe and to develop the prisoners care plan.

Additionally since Mr Lodge's death the Prison and Probation Services developed the Offender Assessment System (OASys) jointly as a structured system designed to help practitioners assess the likelihood of reconviction and

the likely seriousness of the type of offence he or she is likely to commit. It also measures how an offender changes during the period of supervision/sentence. The system includes a Risk of Serious Harm (RoH) assessment that covers risk of harm to self as well as risk of harm to others. Whilst it does not replace existing suicide and self-harm assessments, it is a source of valuable information about risk.

Recommendation 8:

I recommend that the Prison Service considers issuing specific guidance about recording information received from family, friends or outside agencies that a prisoner may be at risk of suicide or self-harm.

Response:

Not accepted.

Since Mr Lodge's death in 1998, the NOMS has undertaken a widespread review of Safer Custody policies resulting in major changes to the management of at risk prisoners. In 2007 the NOMS published a revised Prison Service Order (PSO) 2700 'Suicide and self-harm management' which addresses the issues raised by this recommendation.

PSO 2700 recognises that families, friends and outside agencies can be a valuable source of information in the management of at risk prisoners. Annex 8G states "where information reflecting a concern for a prisoner, who may be at risk of self harm or suicide is received from outside the establishment, the concerns must be recorded, eg in the observation book and in the F2052A, (history sheet), along with the action taken".

In addition the revised audit and compliance tool issued during 2009 seeks to measure performance specifically in this area by requiring that "there should be procedures for people who are not staff – family, lawyers, etc. – to report concerns about prisoners to relevant prison staff". This means that establishments must demonstrate effective systems for receiving, recording and actioning information received from external sources reporting concerns about prisoners. Such systems must be well publicised to external parties.

Manchester prison

Recommendation 9:

I recommend that the Governor of Manchester and his colleagues:

- examine each stage of the process of vetting Samaritan volunteers and selecting Listeners to identify and eliminate any avoidable delays;
- ensure that Listeners can be made available in all locations at any time of day or night; and
- make provision for prisoners to use the Samaritans telephone in private.

Response:

Accepted.

The Governor of HMP Manchester will arrange for all stages of the vetting procedure for both Listeners and Samaritans to be examined, with a view to streamlining the process whilst meeting the necessary requirements for vetting Listeners and Samaritans.

Listener care suites are currently available in three locations within HMP Manchester providing access to a Listener at any time day or night. In addition, Listeners are in place throughout locations in the prison offering additional support. Continued joint working with the Samaritans will allow for sustained numbers of prisoners appropriately trained to deliver this service in all locations within the prison. Operational Instructions to all duty managers with regard to accessing Listeners at any time day or night for prisoners who are experiencing distress will be circulated.

The Governor of HMP Manchester will identify appropriate locations within the prison so that prisoners may use the Samaritans telephone in private. This work will be carried out in conjunction with appropriate risk assessments in order to develop a protocol for use at any time day and night.

List of observations about inquiry procedure

Procedure observation 1 – Status of the investigation:

The need to compel a key witness to give evidence caused additional delay and expense. Those who conduct similar inquiries in future may wish to seek conversion to a statutory inquiry at an early stage if there are indications of a lack of cooperation from witnesses such that compulsive powers may be required.

Procedure observation 2 – Inquiry procedures:

The Inquiries Act 2005 and the inquiry Rules 2006 provide a helpful guide to procedures that are fair to all parties. Those who conduct similar investigations in future may find it helpful to refer to them in devising procedures. Where there is a possibility that an investigation may be converted to a statutory inquiry, it may be particularly helpful to have regard to the Act and the Rules in order to avoid any conflict between the procedures applying to the non-statutory stage and those that apply in the event of conversion.

Procedure observation 3 – The bereaved family:

In inquiries of this kind it may be appropriate for the bereaved family to be offered an opportunity to speak briefly in person as part of the closing procedures immediately before the final legal submissions, provided that it is understood that new allegations and evidence cannot be introduced at that stage.

Response:

The NOMS welcomes the observations of the Chair about the inquiry procedure. We will carefully consider these observations as part of the learning process for Article 2 investigations.



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