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Dear Mr Pears

Inquest into the death of Mark Daniel Vagnoni

Thank you for your Regulation 28 Report of 11 October 2017 following the conclusion of the inquest into the death of Mark Vagnoni. I am responding to the matters of concern that you have raised for Her Majesty's Prison and Probation Service (HMPPS).

I know that you will be sharing a copy of this response with Mark's mother, and I would like first to express my sincere condolences for her loss. Every death in custody is a tragedy and the safety of those in our care is my absolute priority.

I am grateful to you for bringing these matters of concern to my attention. I will address the issues that you have raised in the order that they appear in your report.

ACCT observations during the night state

Your first concern is about the potential for prisoners to be particularly vulnerable during night state, and the need for greater observations or other strategies to be undertaken, when staff resources are limited, and until the first ACCT case review can take place and mental health input is available.

Prison Service Instruction 64/2011 Safer Custody states that the level of ACCT observations needs to be set on the basis of a consideration of the level of risk, and with particular regard to any factors which may increase risk, and this would include an inability to undertake a full ACCT case review with mental health input during the night state. National policy also states that observation levels must be clearly documented on the front cover of the ACCT document, with observations made at unpredictable times.

In July 2017 HMPPS issued a learning bulletin entitled 'ACCT - Conversations and Observations' to all prisons, reminding staff of the importance of setting appropriate observation levels for prisoners supported by the ACCT process. HMP Bedford additionally issued a staff notice in October 2017 to remind all ACCT case managers about assessing risk and setting appropriate observation levels, and the importance of undertaking a full ACCT case review within 24 hours of an ACCT being opened. It also reminded staff that if a prisoner's level of risk changes, especially during the night state, they must immediately inform the night orderly officer who will ensure the ACCT is reviewed and observation levels increased if necessary. Additional support, including consideration of use of Samaritans phones or access to Listeners, may also be given depending on the needs of the prisoner.

All relevant staff at HMP Bedford have received training in setting the appropriate level of ACCT observations for a prisoner at risk. An improved assurance check on completed ACCT documentation was introduced at the establishment in October 2017. Senior managers now complete weekly checks on documentation, as well as providing feedback and guidance to ACCT case managers and staff.

You may find it helpful to know that the ACCT is currently being redesigned and there are plans to roll out a revised version of the document. As part of this redesign, a summary sheet of ACCT observations and conversations will be included to improve information sharing.

NOMIS layout and ACCT Alerts

You express concern that the layout of NOMIS, the prisoner electronic record system, is not helpful to staff as they need to drill down beyond the initial screen to be alerted to past ACCTs.

The current layout of NOMIS contains alerts on the home screen which allow staff to see important, current information on a prisoner, including whether they are on an open ACCT. Past information is easily accessible through the prisoner's history section, and all prison staff who need to access NOMIS are trained in its use before being given access to the system. The course is designed to make staff aware of where and how the information about a prisoner is recorded.

The investigations into the death of Mr Vagnoni brought to the attention of the Governor the fact that some staff at Bedford were not fully familiar with the use of NOMIS. In light of this, a Notice to Staff was published in October 2017 reminding them of the importance of refreshing their knowledge by completing the e-learning course. Any staff identified as needing additional support in the use of NOMIS will have this included in their staff learning and performance review. The Notice to Staff set out where important information regarding a prisoner's ACCT history is located, and the importance of clearly recording information on NOMIS. HMP Bedford is currently developing a standardised induction programme for all new staff who will be using NOMIS to ensure that they have the knowledge required to use the system effectively. The new induction programme will come into effect by December 2017.

Wing transfer documentation

Your final concern is that there was no wing transfer documentation which included information about past ACCTs and risk factors about Mr Vagnoni,

As you may be aware, PS1 75/2011 Residential Services requires that any information regarding the needs, risks or behaviours of prisoners who are showing signs of distress or self-harm must be properly recorded in the wing occurrence book or equivalent, and shared appropriately with other teams.

In October 2017 all staff at HMP Bedford were reminded through a Notice to Staff of the importance of ensuring that all available information, including any identified risk factors, must be considered prior to changing a prisoner's location, and shared with staff responsible for their care at the receiving location. Information must be shared both verbally and on NOMIS, with entries also made in the wing observation book. Residential managers are required to undertake monthly checks on wing observation books and NOMIS to ensure that information is being recorded accurately and comprehensively.

Thank you again for bringing these matters of concern to my attention. Please be assured that learning from the circumstances of Mr Vagnoni's tragic death is shared widely across the prison estate.

Yours sincerely

Michael Spur

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