

for Bedfordshire and Luton

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO:		
MANAGORA NA CONTRACTOR A CANAGORA NA C	The Governor HM Prison 9 St Loyes Street Bedford	HM Prison & Probation Service Clive House 70 Petty France London SW1H 9EX	
1	CORONER		
	I am IAN PEARS, Acting Senior Coroner, for the Coroner Area of Bedfordshire & Luton		
2	CORONER'S LEGAL POWERS	ORONER'S LEGAL POWERS	
	I make this Report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.		
3	INVESTIGATION and INQUEST On 19 th July 2016 I commenced an Investigation into the death of Mark Daniel VAGNONI aged 35 years. The Investigation concluded at the end of the Inquest on 4 th October 2017. The conclusion of the Inquest was "Mark deliberately chose to suspend himself by a bedsheet, but the evidence does not fully explain whether or not he intended that the outcome be fatal or not". The medical cause of death was:		
	I (a) Anoxic Brain Injury (b) Asphyxiation (c) Paranoid Schizophrenia		
4	CIRCUMSTANCES OF THE DEATH		
	Mark suffered from paranoid schizophrenia and was on remand in HM Prison, Bedford, from 5 th February 2016. The jury had concerns about Mark's debt, drug taking, a Wing transfer that took place on 7 th July, information sharing, the under use of the Prison National Offender Management Information System		

(NOMIS) and the Assessment, Care in Custody & Teamwork (ACCT) opened on 11th July. On the 11th July an ACCT was opened at 18.40 hours with 30 minute observations and Mark was found hanging at 20.05 hours. He died 2 days later on 13th July 2016. 5 **CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are as follows: 1. The ACCT was opened during patrol state. The first review was planned the following morning. Apart from 30 minute observations and the information on NOMIS (which was scant) there was no ability to carry out a risk assessment with mental health input. It seems to me that prisoners are especially vulnerable during this patrol state period and greater observations and/or other strategies should be undertaken until the first review can take place. 2. The jury expressed concerns that the NOMIS layout were not helpful to staff in that the staff needed to drill down beyond the initial screen to be alerted to past ACCTs 3. The jury were also concerned that there appears to be no Wing Transfer documentation, which could have included information about past ACCTs and indeed past risk factors. **ACTION SHOULD BE TAKEN** 6 In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. 7 YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th December 2017. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed. 8 **COPIES and PUBLICATION**

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons (mother of the deceased) who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner. 9 Dated 11th October 2017 **IAN PEARS Acting Senior Coroner** for the Coroner Area of Bedfordshire & Luton