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HM Prison & Probation Service

Michael Wall
Assistant Coroner
Nottingham City and Nottinghamshire HM Coroner's Office
The Council House
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05 March 2025

Dear Mr Wall,

Thank you for your Regulation 28 report addressed to the Governor of HMP Ranby following the inquest into the death of Mark Beresford at HMP Ranby on 7 July 2023. I am responding as Director General of Operations for His Majesty's Prison and Probation Service. I apologise for the delay in providing this response.

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

Following evidence heard at the inquest, you have raised concerns regarding understanding of the ACCT process at HMP Ranby and Prevention of Future Deaths (PFD) evidence heard at the inquest.

Firstly, I would like to assure you that HMPPS' approach to all inquests is to fully assist the Coroner in understanding the circumstances of the death and the be absolutely transparent in recognising and learning from failings. While in some cases making formal admissions will be appropriate, staff are aware of the need to provide transparent and honest evidence which allows the jury to make their findings based on this.

I understand that during the course of the inquest into Mr Beresford's death the jury heard evidence from members of uniformed staff regarding their role in the management of the ACCT process. Embedding effective management of prisoners at risk of suicide and self-harm through the ACCT process is vital for all establishments, and HMP Ranby continues to provide regular training and guidance to staff in its operation.

You will be aware that since Mr Beresford's death guidance has been sent to staff to improve their understanding of ACCT, including the need to consider opening an ACCT and where a prisoner is already on an ACCT to hold a case review if the individual's level of risk changes. Where a case review is required, a new booking system ensures that these take

place within an appropriate timescale. A three-stage quality assurance process is also in place to identify areas where individual or wider upskilling is required.

As you will also be aware responsibility for the delivery of the management of those prisoners at risk of suicide and self-harm and the effective management of the ACCT process at HMP Ranby sits with the Head of Safety.

I am confident that all staff giving evidence at this inquest made every effort to fully assist the Coroner in the investigation of the circumstances of Mr Beresford's death. The management of prisoners at risk of suicide and self-harm necessarily requires the use of judgement, and in some cases poor decisions will be made while in others it can later become clear that other actions may have been more appropriate. It is important that staff are supported in making difficult decisions, and that where learning from mistakes in judgement are made these are dealt with productively alongside ensuring staff are made aware of the requirements and importance of their role.

I will further ensure that those senior staff attending inquests to provide the Coroner and jury with information relating to PFDs are confident in dealing with the issues raised, and receive good support from our legal representatives as to what is required when giving evidence.

Thank you again for bringing your concerns to my attention. I trust that this response provides assurance that action is being taken to address this matter.

Yours sincerely

Director General of Operations