

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Daniel Vagnoni a prisoner at HMP Bedford on 13 July 2016.

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Vagnoni was found hanging in his cell on 11 July at HMP Bedford. He died in hospital two days later. Mr Vagnoni was 35 years old. I offer my condolences to Mr Vagnoni's family and friends.

I am concerned that Mr Vagnoni's risk of suicide and self-harm was not identified and managed adequately in Bedford. In particular, the mental health team did not share key information, which meant that staff missed opportunities to manage his mental health and risk of suicide or self-harm.

Although staff suspected that Mr Vagnoni was taking a new psychoactive substance (NPS) and was in debt at Bedford, there is no evidence that these issues were adequately addressed. Bedford has no clear strategy to manage and monitor prisoners suspected of taking NPS or to reduce NPS supply and demand. In May 2016, Her Majesty's Inspectorate of Prisons criticised the prison for this and, at the time of issuing this report, there is still no such strategy in place.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

March 2017

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Summary

Events

1. On 5 February 2016, Mr Mark Vagnoni was remanded to Bedford charged with robbery. He had a history of self-harm and had been diagnosed with paranoid schizophrenia in 2007. Mr Vagnoni was taking antipsychotic medication and was under the care of the mental health team in Bedford.
2. Mr Vagnoni told the mental health team that he heard voices in the days before his fortnightly medication was due and sometimes they told him to self-harm. A psychiatrist increased his medication. No one told officers about this increased period of risk.
3. On 18 May, Mr Vagnoni told a mental health nurse that he had thoughts of hanging himself but no active plans to do so. The nurse did not think that Mr Vagnoni was at risk of suicide or self-harm because he did not have an 'active' plan to kill himself. There is no record that she spoke to officers and she did not record the conversation in Mr Vagnoni's prison records.
4. Prisoners told the investigator that Mr Vagnoni was taking new psychoactive substances (NPS) and was in debt at Bedford. Although staff suspected he was misusing substances, no one referred him for substance misuse support and these issues were not investigated. One officer submitted a security intelligence report, but no action was taken. On 7 July, Mr Vagnoni was moved to the prison's main wing.
5. On 11 July, at 6.40pm, an officer responded to Mr Vagnoni's cell bell and discovered that he had cut his wrist. He started Prison Service suicide prevention measures, known as ACCT. At about 8.00pm, the same officer found Mr Vagnoni handling a sheet, but Mr Vagnoni reassured him that he was just making a curtain. When he went back to check him again at 8.13pm, the officer found Mr Vagnoni hanging in his cell. Staff tried to resuscitate him until paramedics took over at 8.22pm. At 9.30pm, Mr Vagnoni was taken to hospital, where he remained for two days in the intensive care unit. At 3.19pm on 13 July, a doctor pronounced Mr Vagnoni dead.

Findings

6. We consider that staff at Bedford should have identified and managed Mr Vagnoni's risk of suicide and self-harm earlier, including when he told a nurse on 18 May that he was thinking about hanging himself. Officers did not remember being told about this conversation, which was not recorded in his prison records. Officers also did not know how other key risk information, such as Mr Vagnoni's use of NPS and concerns about debt, might affect his mental health. This knowledge might have had an impact on his management, in particular the decision to move him to another wing days before he was found hanging in his cell.
7. There is no strategy to tackle the demand and supply of NPS at Bedford. We are concerned that, despite staff's suspicions that Mr Vagnoni was taking NPS and was in debt, there was little security intelligence and no investigation about these

issues. Staff at Bedford did not refer Mr Vagnoni for substance misuse support or explore whether he might be at a higher risk of suicide, or self-harm, in light of his debt and drug use.

Recommendations

- The Governor and Head of Healthcare should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that staff:
 - consider all the known risk factors of a prisoner and share information, in particular between healthcare and prison staff about a prisoner's mental health to provide collaborative care and treatment;
 - investigate and deal with any indication that a prisoner is in debt, and is taking new psychoactive substances in order reduce the risk of suicide and self-harm posed by debt and NPS.
- The Governor and Head of Healthcare should ensure that there is an effective strategy to reduce the supply of and demand for new psychoactive substances, and that staff are vigilant for signs of their use and are briefed how to respond when prisoners appear to be under the influence of such substances.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Bedford informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
9. The investigator visited HMP Bedford on 14 July 2016. He obtained copies of relevant extracts from Mr Vagnoni's prison and medical records.
10. The investigator interviewed 12 members of staff and a prisoner at Bedford between August and November 2016.
11. NHS England commissioned a clinical reviewer to review Mr Vagnoni's clinical care at the prison. She interviewed five members of staff with the investigator.
12. We informed HM Coroner for Bedfordshire District of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers, contacted Mr Vagnoni's mother, and subsequently received a letter from her legal representatives, who wanted the investigator to consider the following issues, which have been addressed in the report:
 - Mr Vagnoni's suicide and self-harm monitoring;
 - the emergency response;
 - the medication that Mr Vagnoni received at the prison.
14. Mr Vagnoni's mother received a copy of the initial report. The solicitor representing her wrote to us raising a number of comments and questions. We have provided clarification by way of separate correspondence to the solicitor. The solicitor also pointed out two factual inaccuracies in this report and we have amended accordingly at paragraphs 16, 26 and 62.
15. The service also received a copy of the draft report.

Background Information

HMP Bedford

16. HMP Bedford is a local prison holding about 500 men. Northamptonshire Healthcare NHS Foundation Trust (NHFT) and the Westminster Drugs Project (WDP) are the healthcare providers. There is an inpatient unit with nine cells and a four-bed dormitory. There is also a gated cell (for prisoners under constant supervision) and two safer cells (with minimal ligature points to prevent prisoners hanging themselves).

HM Inspectorate of Prisons

17. The most recent inspection of Bedford was in May 2016. Inspectors found self-harm levels had risen significantly since their last inspection in 2014. They found that staff did not manage ACCT procedures well, with poor assessments, insufficient and incomplete care plans, inconsistent case management at reviews, poor attendance by appropriate specialists at reviews and observational contact rather than interaction between staff and prisoners. Inspectors found that the integrated mental health team provided a reasonably good level of secondary mental health care, although the range of treatment for primary mental health was limited and needed further development.
18. Inspectors found that ready availability of drugs, particularly new psychoactive substances (NPS), was having a serious impact on the safety of the prison. Despite this, there was no effective drug supply reduction strategy in place. More than half of prisoners said that it was easy or very easy to get drugs in the prison.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to November 2016, the IMB reported that the number of incidents involving self-harm have increased. There has been an upsurge in bullying, related to an increase of demand of new psychoactive substances.

Previous deaths at HMP Bedford

20. Mr Vagnoni was the fifth prisoner to take his life at Bedford since 2013. In two of our investigations (in June 2013 and September 2014), we found staff operated suicide and self-harm prevention procedures ineffectively. Since Mr Vagnoni's death, two more prisoners have killed themselves at the prison.

Assessment, Care in Custody and Teamwork

21. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner.

Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

New Psychoactive Substances (NPS)

22. New psychoactive substances, now covered by the Psychoactive Substances Act 2016, are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
23. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
24. NOMS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and NOMS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

25. On 5 February 2016, Mr Mark Vagnoni was remanded to HMP Bedford charged with robbery. This was not his first time in prison. He had a history of self-harm and threatening to kill himself in and out of prison.
26. At an initial health assessment, Mr Vagnoni told a nurse that he had burned his arm with a cigarette in 2007. The medical records show that Mr Vagnoni was diagnosed with schizophrenia in 2007. Mr Vagnoni said his mental health was being managed in the community through the Care Programme Approach (CPA – mental health services are assessed, planned, co-ordinated and delivered to mental health patients).
27. Mr Vagnoni was taking flupentixol, an antipsychotic medication, administered every two weeks by depot injection (a slow release and slow acting injection). Mr Vagnoni told her that he did not have any current thoughts of self-harm or suicide. She referred him for a mental health assessment and considered him to be fit for standard location, work and any cell occupancy. Mr Vagnoni was then located in a shared cell in the first night centre (C Wing).

First night centre

28. On 8 February, Mr Vagnoni repeated to another nurse that he had schizophrenia and a history of mental health issues. She noted that Mr Vagnoni was concerned about his medication because he was having suicidal thoughts before it was due, but said he did not plan to commit suicide. She did not consider that he was at risk of suicide or self-harm and did not start Prison Service suicide or self-harm prevention measures (known as ACCT), although she noted he was due to have a mental health assessment.
29. The next day, a nurse assessed Mr Vagnoni's mental health, and recorded that he was happy and interacted well. They discussed his medication and arranged for nurses to administer 80mg every fortnight, as in the community. She also planned to keep Mr Vagnoni under the care of the mental health team and recorded that she was his key nurse. Mr Vagnoni had his medication administered the same day. Each time nurses administered his medication they reviewed Mr Vagnoni and recorded their interactions in his medical records.
30. On 13 February, Mr Vagnoni started working in the kitchen. On 23 February, Mr Vagnoni told a nurse that he was concerned because he was hearing voices just before his medication was due, but was not experiencing side effects. She referred Mr Vagnoni for a medication review with a psychiatrist, which was carried out two days later. The psychiatrist recorded that Mr Vagnoni felt paranoid and heard voices telling him to self-harm or assault others, usually two days before his medication was due. He increased Mr Vagnoni's dose of flupentixol to 100mg.
31. On 29 February, Mr Vagnoni had a CPA review with his community mental health caseworker and a nurse. The nurses noted that the psychiatrist had increased Mr Vagnoni's medication, and noted that Mr Vagnoni was working full time in the kitchen on A Wing. The nurse told the investigator that she assessed Mr Vagnoni's risk of suicide and self-harm as low, based on his presentation at the

time and did not think that he needed any particular monitoring at that point. The nurses planned a further CPA review in six months time.

32. On 17 March, Mr Vagnoni had a random drug test, and his urine tested negative for opiates, amphetamines, benzodiazepines, cannabis, cocaine and methadone. At that time, it was not possible to detect new psychoactive substances with standard tests. A prisoner, who later became his cellmate, said that Mr Vagnoni was taking 'Spice', a new psychoactive substance, daily at Bedford.

Move to E Wing

33. On 31 March, Mr Vagnoni's cellmate accused Mr Vagnoni of stealing tobacco from him. An officer located Mr Vagnoni in a temporary cell in C Wing and separated them, but he did not submit an intelligence report. Nobody investigated this incident. Later, officers moved Mr Vagnoni to a cell on E Wing. E Wing was Bedford's drug recovery unit at that time, but Mr Vagnoni had no known substance misuse needs. The officer said it is a small wing, so managers used it to accommodate prisoners considered more vulnerable, for example victims of bullying. No one recorded why Mr Vagnoni was taken to E Wing, or whether he was considered too vulnerable for the prison's largest wing, A Wing.
34. On 5 April, Mr Vagnoni told a nurse (who took over Mr Vagnoni's supervision) that he had no side effects from his medication.
35. On 8 April, Mr Vagnoni asked to stop working in A Wing's kitchen. On 12 April, the kitchen manager told a nurse that Mr Vagnoni had left his job because he was hearing voices telling him to stab people with knives. She also told her that she understood Mr Vagnoni was in debt with other prisoners working in the kitchen. She could not remember who told her about his debt and did not report it to the security department or tell officers, and neither did the nurse. The investigator found no record of concerns about Mr Vagnoni's mental health or debt in the A or E Wings' observation books.
36. Mr Vagnoni's personal officer told the investigator that Mr Vagnoni spoke to him at least twice about his debt problems. He knew that Mr Vagnoni bought extra tobacco to pay for his debt and encouraged him to stop being in debt, but did not record the conversations. He also told the investigator that he suspected that Mr Vagnoni was under the influence of Spice at least once while on E Wing. He did not submit an intelligence report about Mr Vagnoni's debt or possible NPS use or refer him to substance misuse services.
37. On 15 April, Mr Vagnoni started working in E Wing's servery. On 3 May, Mr Vagnoni told a nurse that he was seeing black dots and felt that he needed his medication (one day before it was due). Mr Vagnoni said that he was eating well but not sleeping and told her that he was enjoying his new job.
38. On 18 May, Mr Vagnoni told a nurse at a mental health review that he was worried about the outcome of his trial because he had a judge who had recently sentenced his cellmate to a long prison sentence. He said that he had thoughts of hanging himself for two days, but no active plans to do so. Mr Vagnoni told her that he was losing motivation, was feeling down and scared. She said that she told two officers about Mr Vagnoni's suicidal thoughts, but the officers did not

remember speaking to her about it and she did not record the conversation in Mr Vagnoni's prison records. She told the investigator that she did not consider that Mr Vagnoni was at risk of suicide or self-harm because he had no active plan to kill himself. She did not start suicide and self-harm prevention measures, but considered he would get sufficient support from his mental health care plan.

39. On 25 May, Mr Vagnoni got a second job as a cleaner on E Wing. The personal officer told the investigator that he gave Mr Vagnoni another job because he was bored and keen to work, so he thought it would help him to keep busy. On 1 June, a nurse reviewed Mr Vagnoni's mental health. She recorded that he said that he was feeling well and did not raise any concerns.
40. On 10 June, an officer submitted an intelligence report about three prisoners, including Mr Vagnoni. The officer wrote that one of the other prisoners was in debt with prisoners on E Wing and had asked to move wings. He told the investigator that he could not remember the exact circumstances, but there were a number of prisoners in debt on the wing at the time. He said that he heard that Mr Vagnoni was in debt, but had not asked to be moved from E Wing. He also told the investigator he saw Mr Vagnoni under the influence of Spice. He did not refer Mr Vagnoni for substance misuse support.
41. Nurses administered Mr Vagnoni's medication on 15 June and 29 June. He did not report any issues or side effects on either occasion. (Mr Vagnoni's next dose was due on 13 July, but he died before it was administered.)

Move to A Wing

42. On 4 July, the personal officer dismissed Mr Vagnoni from his job serving food because he stole some meals. He told the investigator that he spoke to Mr Vagnoni and told him that he was going to allow him to keep his job as a cleaner so that he could remain on the wing. However, records show that Mr Vagnoni stopped working as a cleaner on 3 July.
43. On Thursday 7 July, an officer told the investigator that he spoke to the personal officer, who agreed that Mr Vagnoni could not stay on E Wing because he was no longer working on the wing. The personal officer did not remember the conversation. A prisoner described Mr Vagnoni as 'begging' officers not to move him to A Wing, because he had debt problems with some prisoners there. An officer moved him to a single cell on A Wing that day.

Monday 11 July

44. On Monday 11 July, at around 6.00pm, Mr Vagnoni pressed his cell bell. When Officer A got to Mr Vagnoni's cell, he asked for tobacco. He told Mr Vagnoni that he was dealing with another incident, so he could not provide him with tobacco at that time. He said that Mr Vagnoni kept ringing his cell bell and asking for tobacco. When he responded to Mr Vagnoni's cell bell at 6.40pm, he saw that Mr Vagnoni had cut his left wrist. He began ACCT monitoring for Mr Vagnoni and a Supervising Officer (SO) completed an Immediate Action Plan. The SO decided that staff should check Mr Vagnoni twice an hour until he was properly assessed.

45. At around 7.00pm, Officer A checked Mr Vagnoni and did not note anything concerning. Ten minutes later, he recorded that Mr Vagnoni was watching television. At 8.01pm, CCTV (closed circuit television) shows he went back to Mr Vagnoni's cell. He told the investigator that he saw Mr Vagnoni holding a bed sheet, folding it and running it through his fingers. He asked Mr Vagnoni if he was making a ligature, but he said that he was making a curtain to cover his window. (Officers told us that many prisoners do this to stop the daylight disturbing them, because the cells have no curtains.) He left the cell and told the investigator that he was worried, but Mr Vagnoni had reassured him.
46. At 8.13pm, Officer A checked Mr Vagnoni again and saw him hanging from the bars of the window in his cell with a sheet around his neck. He radioed for help, but he did not call a code blue (indicating that a prisoner is unconscious, not breathing or is having breathing difficulties). The communications room officer radioed a code blue and called an ambulance immediately. He went into the cell and a minute later, another officer arrived and cut the ligature. They then tried to resuscitate him.
47. At 8.16 pm, a nurse arrived with a prison GP and attached a defibrillator to Mr Vagnoni's body. The defibrillator advised to continue resuscitation, which they did until 8.22pm, when the paramedics arrived and took over. Eventually, paramedics found Mr Vagnoni's pulse. At 8.58pm, officers took Mr Vagnoni out of his cell in a stretcher and, at 9.30pm, Mr Vagnoni was transported to hospital without restraints, where he remained in the intensive care unit for two days.
48. On 13 July, a doctor pronounced Mr Vagnoni dead at 3.19pm.

Contact with Mr Vagnoni's family

49. On 11 July at 9.50pm, an officer, phoned Mr Vagnoni's mother, who he had named as his next of kin, and told her that Mr Vagnoni was in hospital. Mr Vagnoni's mother arrived at the hospital at 11.45pm, where she met the officer.
50. On 12 July, the officer met Mr Vagnoni's mother at the prison again. Mr Vagnoni's mother and family were present at hospital when Mr Vagnoni died the next day.
51. Mr Vagnoni's funeral was held on 10 August 2016. The prison contributed to the funeral costs, in line with national instructions.

Support for prisoners and staff

52. After Mr Vagnoni's death, a governor debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
53. The prison posted notices informing other prisoners of Mr Vagnoni's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Vagnoni's death.

Post-mortem report

54. A post-mortem examination was not carried out, but the coroner recorded that the cause of Mr Vagnoni's death was brain injury due to lack of oxygen, asphyxiation and paranoid schizophrenia. The toxicology examination did not find any NPS or other drugs in Mr Vagnoni's blood when he died.

Findings

Assessment and management of risk

55. Prison Service Instruction (PSI) 64/2011 about safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action. The risk factors were also listed in our thematic report published in 2014. Those that applied to Mr Vagnoni while he was in Bedford, included a diagnosed mental illness, recent contact with psychiatric services and mental health in-reach teams, history of self-harm and threats to kill himself. Mr Vagnoni had also a history of substance misuse, was suspected of taking NPS and being in debt with other prisoners. All staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and act appropriately to address any concerns, including beginning suicide and self-harm prevention procedures, if necessary.
56. Just after he arrived at Bedford, Mr Vagnoni told a nurse that he had thoughts of suicide just before his medication was due. She noted that he was due to have a mental health assessment, but did not record the conversation in Mr Vagnoni's prison records and there is no evidence that she spoke to officers about it. Despite his risk factors and his suicidal thoughts, she did not consider that he was at risk of suicide or self-harm.
57. On 18 May 2016, Mr Vagnoni told a nurse that he was worried about the possible outcome of his trial, was anxious and low in mood, and said that he was having thoughts of hanging himself. Although she recognised that these were significant risk factors for suicide and self-harm, she did not begin ACCT monitoring because Mr Vagnoni said that he did not have any 'active' intention or plan to commit suicide. She told the investigator that she thought the mental health team were already supporting him, and he did not need any further support.
58. We would have expected the nurse to have identified that Mr Vagnoni was at risk of suicide or self-harm. ACCT suicide and self-harm risk guidance suggests that a prisoner's risk is 'raised' when he has suicidal ideas and a plan to kill himself. She also said that she told two officers that Mr Vagnoni had suicidal thoughts, however the officers did not remember that conversation and she did not record it in his prison records.
59. Officers were also not aware that Mr Vagnoni reported he felt more vulnerable before his medication was due. Just four days before he was found hanging, officers moved Mr Vagnoni to A Wing, which he was apparently anxious about. The move coincided with the few days before his medication was due, a period of increased risk. The failures in communication between the mental health team and officers highlights missed opportunities to identify and manage Mr Vagnoni's risk of suicide or self-harm as a multidisciplinary team.
60. In our learning from PPO investigations on mental health, published in January 2016, we said that it is vital that relevant information is communicated to prison staff when mental health problems are identified by healthcare staff, so that they are as informed as they can about a prisoner's need and can play a part in providing support. When prison staff are well informed about a prisoner's mental

health issues, this can help them to relate to that prisoner's behaviour, to recognise distress and to respond in the most appropriate manner to support that prisoner.

61. A prisoner told the investigator that Mr Vagnoni was taking Spice every day, stole tobacco from other prisoners and sold items, such as clothes or toiletries, in order to pay his debts and finance his addiction to Spice. Two officers said that they had both noticed that Mr Vagnoni was under the influence of Spice while on E Wing. They did not share their concerns with the mental health team. In our Learning from PPO Investigations analysis of self-inflicted deaths in 2013-14, we highlighted that debt can leave prisoners vulnerable to pressure and bullying from other prisoners.
62. We are concerned that Mr Vagnoni's risk of suicide or self-harm was not effectively identified or managed. We make the following recommendation:

The Governor and Head of Healthcare should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that staff:

- **consider all the known risk factors of a prisoner and share information, in particular between healthcare and prison staff about a prisoner's mental health to provide collaborative care and treatment;**
- **investigate and deal with any indication that a prisoner is in debt, and is taking new psychoactive substances in order to reduce the risk of suicide and self-harm posed by debt and NPS.**

Mental Health

63. Mr Vagnoni was diagnosed with paranoid schizophrenia in 2007 and was managed in the community through the Care Programme Approach (CPA). On arrival at Bedford, a nurse rightly identified Mr Vagnoni's mental health issues and appropriately referred him to the mental health team, who drew up a support plan and reviewed him frequently. The clinical reviewer concluded that Mr Vagnoni's mental health care and medication were appropriately managed.

NPS

64. We are concerned about the prevalence of NPS in prisons and its effect on the behaviours and health of those taking it, including an association with suicide and self-harm. A prisoner told us that Mr Vagnoni was taking Spice every day in Bedford and Spice was widely available in the prison. An officer said that he suspected Mr Vagnoni was taking Spice and told him not to, but he did not record his concerns, submit an intelligence report or refer Mr Vagnoni to substance misuse services. He also told the investigator that Mr Vagnoni spoke to him about debts at least twice while he was on E Wing, but he did not record or investigate the possible debts. Another officer suspected Mr Vagnoni was using Spice and in debt. He submitted an intelligence report, but did not speak to Mr Vagnoni about his suspicions or refer him to substance misuse services for support. The kitchen manager also heard that Mr Vagnoni left the job in April

because he was in debt to other workers, but she did not tell the security department.

65. The Head of Security told the investigator that the prison had raised staff awareness about the dangers associated with prisoner's use of NPS, and modified their disciplinary measures to tackle its supply and demand. However, we found no evidence of a robust plan to tackle NPS, and are very concerned that Bedford does not have a policy about NPS management at the time of issuing this initial report (January 2017). HM Inspectorate of Prisons reported in May 2016 that NPS was readily available at Bedford, which was having a huge impact on the safety of the prison and that there was no effective drug supply reduction strategy.
66. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff of the dangers of NPS; the need for more effective drug supply reduction strategies; and better monitoring by drug treatment services. It is important that prisons do all they can to eradicate the use of new psychoactive substances and other illegal drugs. We make the following recommendation:

The Governor and Head of Healthcare should ensure that there is an effective strategy to reduce the supply of and demand for new psychoactive substances, and that staff are vigilant for signs of its use and are briefed how to respond when prisoners appear to be under the influence of such substances.

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