Mid Kent and Medway Coroners
Cantium House
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Maidstone
Kent
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[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

Christian Gary HINKLEY (died 29 July 2019)

	THIS REPORT IS BEING SENT TO: Victoria Atkins MP Minister of State for Prisons and Probation Ministry of Justice 102 Petty France London SW1H 9AJ
1.	**CORONER** I am Scott Matthewson, Assistant Coroner for the coroner area of Mid Kent & Medway.
2.	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3.	**INVESTIGATION and INQUEST** On 14 August 2019 the Area Coroner for Mid Kent & Medway commenced an investigation into the death of Christian Gary Hinkley who died, aged 33, on 29 July 2019 at HMP Swaleside on the Isle of Sheppey in Kent.

	The investigation concluded on 21 October 2021 at the end of an inquest conducted by me (sitting with a jury). The jury concluded that: "Christian died by smoke inhalation when he made a barricade in his cell and a fire developed but the evidence does not enable us to say how the fire started or what Christian's intentions were." The medical cause of death was: Ia. Carbon monoxide poisoning Ib. Smoke inhalation Ic. Exposure to fire II.
4.	**CIRCUMSTANCES OF THE DEATH** Christian was a serving prisoner at HMP Swaleside when a fire started in his single-occupancy cell in the late evening of 28 July 2019. The prison was in 'night state' with all prisoners locked in their cells. At some point during that day, Christian had barricaded his cell from the inside by piling cell furniture and other items against his cell door. CCTV footage of the corridor outside Christian's cell showed smoke flowing out from gaps in the door at 23:35:27 (ie, 11.35 pm and 27 seconds). The jury was unable to determine precisely when or how the fire started. There were no automatic in-cell fire detection systems installed at HMP Swaleside at the time of Christian's death (and this remains the case). The fact that a fire had started in Christian's cell was first noticed by another prisoner located in a nearby cell who operated his cell bell at 23.37:49. The officer on the wing raised the general alarm at 23:38:38. Kent Fire & Rescue Service ("KFRS") was telephoned shortly afterwards. KFRS firefighters arrived at the prison within minutes of being telephoned but could not get to Christian's wing quickly because of necessary security arrangements in place (a series of security gates which had to be unlocked and locked as the fire engine passed through the prison). The automatic smoke detection system in place at the time (located in air ducts connected to each cell and in the corridor outside the cells) detected the fire at 23:38:51. That was 3 minutes and 24 seconds after smoke was seen escaping Christian's cell on the CCTV footage. It is not known how much time had passed between the ignition of the fire and the automatic alarm sounding.

	Prison officers are trained and required to attend the scene of a fire in prison within 5 minutes of an alarm. In this case officers attended the wing very quickly (and well within 5 minutes). They attempted to deal with the fire in accordance with their training and using a system of 'inundation'. This involves officers attaching a hose to an inundation point in the cell door. This introduces a very fine mist of water into the cell at high pressure, the aim of which is to (a) extinguish the fire, (b) remove noxious gases from the atmosphere in the cell, and (c) reduce the temperature in the cell in order to increase the chances of a person in the cell surviving. Prison officers attended the scene and started inundation of Christian's cell at about 23:41:51. However, the spray of water was blocked (or partially blocked) by the barricade on the other side of the cell door. This reduced the efficacy of the inundation and the fire could not therefore be extinguished by prison staff. Several attempts were made by prison staff to enter the cell but, each time the cell door was opened, the fire was still ablaze and it was not safe to enter and so the cell door had to be closed again. Firefighters with breathing apparatus and wearing full protective equipment entered Christian's cell at 00:09:34 on 29 July 2019, extinguished the fire and pulled Christian free. This was more than half an hour after CCTV showed smoke escaping from Christian's cell. He was unconscious and not breathing. Attempts at cardio-pulmonary resuscitation were unsuccessful and Christian was pronounced dead at about 01.15h on 29 July 2021.
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: The Chief Inspector of the Crown Premises' Fire Safety Inspectorate ("CPFSI"), [redacted], conducted an investigation and provided me with a report dated 30 September 2021. In that report he explained that: • The cellular accommodation on Christian's wing was served by an automatic "in-duct" fire detection system. Domestic smoke detectors

were installed outside each cell and automatic fire detectors were located along the centre line of the ceiling in the corridor outside the cells.

- This arrangement could not reliably detect a cell fire within a known and predictable timescale from ignition or at a given point of fire development because:
    - The in-duct system is not designed to save life and is not regarded by HMPPS as a reliable fire detection system; and
    - The devices in the corridor rely on smoke exiting the cell which is variable and unpredictable because it depends on a number of factors (eg, size of gaps around the cell door, presence of service ducts in the cell, whether the window of the cell is open or not).
- The fire risk assessment for the houseblocks of this type at HMP Swaleside says that the current system "does not provide an acceptable permanent standard of fire detection."

The Team Leader of the CPFSI investigation, [redacted], attended the inquest and gave live evidence. He told the me that:

- The Ministry of Justice ("MOJ") conducted a test on the survivability of cell fires (in 2007) and concluded that:
    - Personal injury to a person in the cell would be expected within 6 minutes of ignition of the fire
    - Unconsciousness would be expected within 7 minutes of ignition
    - Death would be expected within 8 minutes of ignition
- In 2015 the CPFSI carried out an inspection at HMP Swaleside and concluded that the system in place there was not capable of detecting fires sufficiently early. A Notice was issued advising the prison to take action to address this problem.
- Four years later, in April 2019, the CPFSI carried out a further inspection at HMP Swaleside and concluded that the system in place at HMP Swaleside was *still* not capable of detecting fires sufficiently early. Yet again, a Notice was issued advising the prison to take action to address this problem.

- The only effective way to address this problem is to install in-cell automatic fire detectors.

- To date in-cell automatic fire detectors have not been installed at HMP Swaleside (or in most other prisons).

[redacted], the National Fire Lead at HM Prison and Probation Service ("HMPPS") gave live evidence. He told the me that there is a plan to install in-cell automatic fire detection systems in all prisons in England and Wales. This programme is currently in the development stage. Given the enormity of the undertaking and the logistical challenges this will take some years to complete.

In answer to a number of written questions by me on this topic the MOJ told me that:

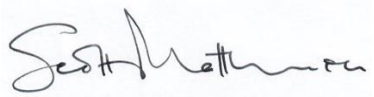
- "Fire safety systems are complex in nature and can take between two and three years to deliver at a single establishment. We currently are developing projects at 35 sites across the estate which we expect – with sustained funding – can be delivered within the next five to seven years. Accommodation which requires fire remedial work beyond this period will rely on availability of funding through the Spending Review process. The start date for construction works at HMP Swaleside is scheduled for December 2022."

The Chief Inspector of the CPFSI has also advised me in writing on 4 November 2021 that:

- "Fire deaths in prison over the last decade have almost exclusively involved prisoners who are on or have recently been on an Assessment, Care in Custody Teamwork Programme or who have a history of barricading and fire-setting in prison or a conviction for arson, or all of these. This information is collected in prisons and is recognised as fire risk information by prison staff but they often cannot act on it to address the risk because there are no fire-safer cells (i.e. fitted with suitable in-cell automatic fire detection) in the wing (or in another wing at the prison) to which the prisoner can be moved."

- ***"Every prison wing is already fitted with an automatic fire detection system for spaces other than for cells. Whilst it may not be technically possible to add fire detectors to every cell from the existing system, it may well be possible for in-cell fire detectors to be added to a small number of cells in each wing, and for prisoners on ACCT or with a history of barricading prison fire-setting and***

	arson to be placed in those fire-safer cells. This should be considered by HMPPS and MoJ." I am concerned that: (a) The system of fire detection in HM Prisons is currently inadequate and unsafe. This evidence came from MOJ and CPFSI witnesses and was undisputed. (b) Whilst there is a plan to install in-cell automatic fire detectors in all prison cells the MOJ estimates that this may take up to 7 years to complete in 35 prisons across England and Wales (and perhaps longer for others). (c) From the MOJ's own study in 2007 it is expected that a prisoner in a cell will die within 8 minutes of ignition of an in-cell fire. (d) There is no reasonable prospect of local Fire & Rescue Service firefighters attending the cell with breathing apparatus and firefighting equipment within that timescale. (e) As it stands, and until in-cell fire detectors are installed to prisons, there is a significant risk of death from in-cell fires because the current fire detection systems cannot reliably detect a fire within a timescale that will enable life-saving steps to be taken in time. (f) That risk is further increased for prisoners with a history of suicide/self-harm, barricading and/or arson. (g) The Chief Inspector of the CPFSI tells us that simple measures could be taken to reduce the risk of death by fire in prison, namely adding in-cell fire detectors to a small number of cells in each wing for prisoners (a) on an ACCT, (b) with a history of barricading (c) with a history of prison fire-setting or (d) with a history of arson, and placing such prisoners in those fire-safer cells. Accordingly, this situation should be reviewed and consideration given as to whether any steps should be taken to reduce the risk of death by cell fires in prisons (as an interim measure before in-cell detection systems are installed across the prison estate). In particular, the suggestion of the Chief Inspector of the CPFSI – highlighted in bold above – should be considered carefully.
6.	**ACTION SHOULD BE TAKEN**

	In my opinion, action should be taken to prevent future deaths and I believe that you and/or your organisation 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 30 December 2021. 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 following: • HHJ Thomas Teague QC, the Chief Coroner of England & Wales • Mr Hinkley's parents • HMP Swaleside • Oxleas NHS Foundation Trust • Integrated Care 24 • Kent Fire & Rescue Service I am 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.	Signature:  Scott Matthewson, Assistant Coroner, Mid Kent & Medway 4 November 2021