Mid Kent and Medway Coroners' Service
Oakwood House
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Telephone: [redacted]
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Date: 8 August 2024
Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: MINISTRY OF JUSTICE THE GOVERNOR HMP SWALESIDE

1. CORONER

I am Patricia Harding HM Senior Coroner for Mid Kent and Medway

2. CORONER'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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3. INVESTIGATION and INQUEST

On 6 March 2023 I commenced an investigation into the death of Sean Martin DAVIES. The investigation concluded at the end of the inquest . A jury found that:

Sean Davies died on 25th February 2023, between the hours of 03:00 and 07:15am, by means of suspension, [redacted], in cell FS1-02 at HMP Swaleside. He had an indeterminate sentence of imprisonment for public protection with a tariff of 5 years imposed in November 2012. This lead to the progression from his status as a B category prisoner to a C category prisoner and its revocation on the 1st October 2022, followed by an unsuccessful appeal of that decision.

with a narrative conclusion:

Suicide
Factors relevant to the death, but which cannot be concluded to have caused or contributed to the death include, a lack of communication and handovers between staff and insufficiently completed welfare checks.

1a Suspension

1b

1c

II

4. CIRCUMSTANCES OF THE DEATH

Sean Davies, aged 30 at the time of his death, was remanded into custody in November 2011 for an offence of violence. In November 2012 he was sentenced to an indeterminate sentence for public protection (IPP), the minimum term being seven years later reduced to five years on appeal. He became eligible for parole in November 2017.

In 2021 Mr. Davies transferred to HMP Swaleside in order to join the psychologically informed planned environment (PIPE) unit where he was able to fully engage with a programme which improved his chances of parole. In April 2023 he was assessed as suitable for a category C prison but this was revoked in October 2023 following an incident in August when unprescribed medication was found in his cell.

Following this Mr. Davies expressed feelings of hopelessness at clinical sessions but continued to engage and underwent a psychological assessment on 7th February 2023 which was reported to have gone well. A parole hearing had not been scheduled.

On 10th February 2023 Mr. Davies was informed of the outcome of the justice committee's review of IPP sentences in that their recommendation for a resentencing exercise had been rejected by the government

Thereafter he declined to participate in a further psychological assessment and suspended himself in the early hours of 25th February 2023. There was CCTV evidence of him [redacted]. The [redacted] was visible to anyone patrolling the landing and was seen by an operational support group officer who pointed it out to another but neither reported it.

Mr. Davies left a note stating that he had taken his own life because of the IPP sentence. He expressed frustration at the slow progress of his sentence, re-categorisation and concerns about how the parole board would view this and his past behaviour. He saw no chance of being released. He went on to say that he hoped that his death would contribute for them to change the laws of the IPP sentence.

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) There are currently 55 prisoners at HMP Swaleside subject to IPP sentences. It has been recognised by the Prison and Probation Ombudsman that an IPP sentence should be regarded as a potential risk factor for sucide and self harm (learning lessons bulletin September 2023). In the clinical review following the death of Mr. Davies a recommendation was made that the Governor and Head of Healthcare ensure that a risk formulation was completed for all prisoners subject to IPP sentences, that it was regularly reviewed and updated including where there has been an event that may increase a person's risk of suicide and self harm. Such formulation should be made readily available for all staff to refer and be stored within the prison and medical records. I understood from representations made on behalf of the Ministry of Justice that a 'national strategy' was intended for IPP prisoners. At the end of the inquest I gave the Governor and Head of Healthcare some time to notify me of the steps that had been taken in relation to the recommendation of the clinical review and any interim measures in respect of the 'national strategy'. Whilst I have been provided with the changes in practice that have been put in place by Head of Healthcare, I have been asked by the cafer custody team at HMP Swaleside to issue a Regulation 28 report so that a considered response can be provided in relation to this matter and the concerns below

(2) It was clear from CCTV evidence that prison officers and operational support group officers were not conducting roll call welfare checks and other welfare checks in line with national guidance or local policies

(3) One operational support group officer had not received training in relation to fire regulations or handovers, another did not act in accordance with the training

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you Ministry of Justice & Governor HMP Swaleside 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 4th September 2024. 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 family of mr. Davies, Oxleas NHS Foundation Trust I have also sent it to Secretary of State for Justice, Prison and Probation Ombudsman 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.

8 August 2024

Signature 

Patricia Harding Senior Coroner for Mid Kent and Medway