	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], His Majesty's Prison and Probation Service Executive Director Public Sector Prisons South
1	**CORONER** I am Patricia Harding, senior coroner for the coroner area of 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.
3	**INVESTIGATION and INQUEST** On 3rd July 2024 I commenced an investigation into the death of Michael Pugh, 29 years. The investigation concluded at the end of the inquest on 21st July2025. The conclusion of the inquest was suicide; Mr. Pugh having suspended himself in his cell at HMP Swaleside [redacted].
4	**CIRCUMSTANCES OF THE DEATH** Michael Pugh was found in his cell on 29th June 2024 having died. He was subject of an ACCT at the time of his death. It was determined at the last ACCT review before his death that he should be subject to hourly observations. Observations were carried out on the afternoon of 28th June 2024 but recorded incorrectly. No observations were carried out on 29th June 2024 between 07.22 and 09.57 when Mr. Pugh was discovered having died, but the ongoing record was completed retrospectively to show that they had been carried out
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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 prison officers who gave evidence in relation to observations on 28th and 29th June 2024 were relatively new recruits, one having 3 months experience following POELT training and the other 1 month experience. Both officers gave evidence that following their POELT training their understanding of the ACCT process was incomplete; one stating "observations were explained but I didn't have a fair idea what to do or how to undergo the process", another stating "I didn't understand the importance of observing a prisoner at unpredictable times. Even though I was told the observations should be hourly it was not explained to me how to stagger timing. I misunderstood what was required of me in recording the details when I recorded them as having happened at 13.00, 14.00, 15.00 and 16.00.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 19th September 2025. 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 Mr. Pugh's next of kin, Ministry of Justice, Oxleas NHS Foundation Trust. I have also sent it to Prison and Probation Ombudsman who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.

9	**DATE 25TH July 2025**	**SIGNED BY CORONER Patricia Harding**