HM Prison &
Probation Service

[redacted]
Director General of Operations
HM Prison and Probation Service
8th Floor Ministry of Justice
102 Petty France
London
SW1H 9AJ

[redacted]

Fiona Butler
Asst. Coroner Rutland and North Leicestershire
Coroner's Office
Town Hall
Town Hall Square
Leicester
LE1 9BG

4 March 2026

Dear Ms. Butler,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS: MR RICHARD HUNT

Thank you for your Regulation 28 Report dated 8 October 2025 concerning the tragic death of Mr Richard Hunt at HMP Stocken. I am providing the response on behalf of His Majesty's Prison and Probation Service (HMPPS).

I know that you will share a copy of this response with Mr Hunt'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. I fully acknowledge, on behalf of myself and the Governor of HMP Stocken, the very serious concerns raised in your report and we are committed to taking robust and systemic action to prevent such a tragedy occurring in the future. I apologise that this response, which describes action already taken, has taken some time to coordinate.

You raise concerns, in advance of the forthcoming inquest into Mr Hunt's death, relating to the aspirating fire system and in particular that this system is vulnerable to tampering. As your report sets out, on 19 March and 11 July 2025, Mr Hunt set fire to his cell. In the first instance (on K Wing) Mr Hunt alerted staff by sounding his cell bell, and on the second (I wing) a member of staff was alerted by the smell of smoke and raised the alarm. In neither case did the buzzer in the wing office sound to alert staff as it should have done.

Following the serious incident on 19 March, a full audit was conducted on 31 March 2025 by the Crown Premises Fire Safety Inspectorate (CPFSI) following which HMP Stocken was issued with a 28-day notice requiring the development and implementation of a strategic action plan. This action plan, which will be disclosed to you in advance of the inquest,

identified 26 actions including high level requests for changes to fire safety and detection systems as well as tasks for immediate actions such as replacing sounders on the fire alarm panels. To date, 19 of these actions have been completed with most of the remaining actions awaiting approval of spending bids.

A subsequent CPFSI inspection on 27 January 2026 returned a positive outcome, with the inspectorate judging the local fire safety arrangements to be “generally suitable and sufficient,” meaning the fire safety measures and management systems broadly meet legal requirements for identifying risks and implementing proportionate controls.

Following Mr Hunt’s death and the discovery that the fire panel located in the wing office had been tampered with, preventing the buzzer from sounding, immediate action was taken and a replacement fire panel installed. The prison’s Health and Safety team was further tasked with undertaking a review of the physical security of the fire alarm panels, which found that the panels could be accessed, posing a significant risk to operational safety. Work is ongoing to rectify this issue, with access to fire alarm panel keys to be restricted to authorised personnel only - namely ADT (the fire alarm installer and maintainer), Amey, and Health & Safety advisors, preventing further unauthorised access and ensuring compliance with safety protocols.

Notably, a review of ADT documentation indicates that the report two weeks following the death, when the panel was discovered to be blocked, was the first to reference the blockage. Earlier reports when engineers attended the site on four occasions between 11 July and 29 July) contain no mention or evidence of a blockage within the panel.

Nationally, in response to the March incident, on 3 April 2025 a Service Managers Instruction (SMI) was issued to all prison maintenance teams, reiterating their responsibility to ensure that all fire safety equipment is maintained in an efficient and fully operational condition. Data from responses to this instruction is being used to provide assurance that panels’ fault alerts are unsilenced, and that action is being taken to rectify any remaining issues.

On 3 July 2025, during routine assurance checks conducted by the prisons internal Health & Safety team, a fault was found and was reported on Planet FM system. It detailed that the fire panel in the I Wing office was not sounding. Planet FM records show that this issue was marked as resolved on 10 July 2025, one day prior to the incident involving Mr Richard Hunt who set fire to his cell.

Locally, the Governor has introduced a daily feedback system into the morning meeting he chairs whereby all fire faults are discussed and reported. There is a specific focus on any alarms which are not sounding when in fault, and alarms which are continually sounding. This is to ensure that follow-up actions are completed where appropriate by prison staff and also that the maintenance provider is made aware of faults which require attention.

In regards to your concern regarding the link between the fault panels on the wings and the main Control Room, in November 2025 Ministry of Justice Property Directorate issued a mandate for the full replacement of the fire alarm systems on I and K wings and the Care and Separation Unit, with full networking back to the Control Room master fire alarm panel to allow any alarms or faults raised by the local fire alarm control panels on those wings to be visible in the Control Room. This is currently in the design and tendering stage with the intention that it will be rolled out as soon as practicable.

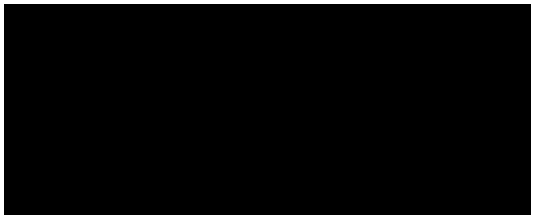
Following the concerns regarding the tampering of fire alarm control panels the Governor of HMP Stocken commissioned two fact-finding investigations to determine if staff may have been involved with the tampering of fire safety equipment, and if so whether those staff could be identified. While it has not been possible to identify any individuals, the Governor has made clear to staff the seriousness of such action, and that anyone engaging in any tampering of the fire alarm system will be subject to formal disciplinary action.

On 15 August 2025 a Governor's Order was issued mandating that tampering with fire equipment is a disciplinary offence and will be investigated. This has been reiterated at a face to face, full staff meeting on 24th September 2025, in weekly blogs and in briefings to staff issued in April, July and August 2025. These set out clearly staff's personal responsibility for fire safety, reminding staff of the need to ensure they understand the equipment in place and to report all faults and issues immediately, signposting how this is done and where support can be sought from. The Governor has also met with and written to the senior team outlining their responsibilities within their functions with regards to fire safety.

In the aftermath of these devastating incidents, HMP Stocken fully recognise the responsibility to ensure that all staff are equipped with the necessary knowledge regarding fire safety and the regulations we are obligated to follow. Fire safety training for all uniform grades currently sits at 98% and all staff covering night duty have up to date training.

I hope this response provides assurance that HMPPS is actively addressing the issues raised in your report. HMPPS will continue to offer our full assistance to the investigation into the tragic death of Mr Hunt.

Yours sincerely,



Interim Director General of Operations