Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **before** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **The Governor HMP Stocken** **His Majesty's Prison & Probation Service** **The Crown Premises Fire & Safety Inspectorate**
1	**CORONER** I am Miss F BUTLER, His Majesty's Assistant Coroner for the coroner area of Rutland and North Leicestershire
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** On 16 July 2025 I commenced an investigation into the death of Richard Charles HUNT aged 42. The investigation has not yet concluded and the inquest has not been heard and is unlikely to be concluded until next year.
4	**CIRCUMSTANCES OF THE DEATH** Mr Hunt was a serving prisoner at HMP Stocken. On the 11th July 2025 Mr Hunt, who was housed in a single occupancy cell on I wing, [redacted] and set fire to his cell. Emergency services were called, and Mr Hunt was conveyed to hospital but died later that day. A Forensic Post Mortem provides the cause of death as :- 1a. Smoke Inhalation. This was not the first time Mr Hunt had set fire to a cell whilst a serving prisoner at HMP Stocken. He had done so 4 months earlier on 19th March 2025 in similar circumstances, when housed in a single occupancy cell on K wing.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: On both occasions prior to setting fire to his cell, [redacted] it is designed to trigger an alarm on a control panel which is housed in the Wing Office situated on each wing. The triggering of that alarm should not only display a light but also sound a buzzer to alert staff of a fault.

	On the 19th March when Mr Hunt set fire to his cell on K Wing and on 11th July when he set fire to his cell on I wing this buzzer did not sound. On 19th March 2025, Mr Hunt himself raised the alarm by sounding his cell bell and was discovered. He required CPR and was hospitalised for 3 days. The aspirating fire alarm system did not sound an alarm in the K Wing office. On 11th July the detection of Mr Hunt having set fire to his cell was fortuitous as an OSG was conducting an ACCT check on another prisoner in a nearby cell and smelt smoke. The alarm indication of a fault had been triggered 2 hours before this discovery and Mr Hunt's cell had been smouldering for around this period of time undetected. Again, no buzzer was sounded. Following the fire on the 19th March 2025, investigation revealed that the aspirating fire detection system buzzer with the Wing Office had been 'disabled' and it was believed to have been deliberately silenced for 12 months prior to the incident. Following the fire and Mr Hunt's death on the 11th July 2025, the aspirating fire detection system was inspected and reviewed across the HMP Stocken Estate by ADT alarms, who are contracted to maintain the system. That inspection revealed that the reason the alarm o I wing, which was triggered but did not sound the buzzer, was because the control panel in the Wing Office (and in which the buzzer was housed) had been deliberately tampered with, by the insertion of a rubber glove between the connectors thereby disabling the buzzer. Further inspection of the aspirating fire detection system panels across the HMP Stocken Estate found for example the control panel on L Wing had been vandalised [redacted] and that control panel units in other Wings including segregation had been deliberately forced open to gain access. I further understand that the aspirating fire detection system fault panels on the Wings do not link with the main Control Room, meaning there is no central oversight of faults (whether deliberate covering or indicating a fire) for action to be immediately taken. Whilst HMP Stocken may have a system of maintenance of the aspirating fire detection system within the prison, that maintenance system is futile if staff are going to deliberately tamper with that system to disable the buzzer which is deigned to alert them as to risk. This is not an isolated occurrence and is systemic across the HMP Stocken Estate.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 December 03, 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 Hunt's Family Practice Plus Group

	I have also sent it to : The Health & Safety Executive 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.
9	**Dated: 08/10/2025** [redacted] **Miss F BUTLER** **His Majesty's Assistant Coroner for** **Rutland and North Leicestershire**