Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Governor** [redacted] **2 HM Chief Inspector of Prisons** [redacted] **3 CEO of HMPPS** [redacted]
1	**CORONER** I am Sean CUMMINGS, Assistant Coroner for the coroner area of Bedfordshire and Luton Coroner Service
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 13 April 2023 I commenced an investigation into the death of Steven HART aged 37. The investigation concluded at the end of the inquest on 09 July 2025. The jury found that: On the 30th November Mr Steven Hart was remanded to HMP Bedford. From his arrival in reception at HMP Bedford it is well evidenced that Mr Hart had an extensive history of ongoing mental health issues, including anxiety, depression, paranoia, self-harm and suicidal ideology. From the evidence provided and the witness testimony heard Mr Hart did not appear to be acutely unwell with his mental health and did not appear to meet the 'acutely' unwell criteria specified for mental health referral at that time. A GP appointment was arranged for Mr Hart to discuss medication as Mr Hart stated his mental health is better managed when taking prescribed medication. Between December 2022- February 2023 Mr Hart demonstrated varying degrees of instability with his mental health. Including two episodes of self-harm, by cutting. These episodes did appear to be resolved quickly and without escalation. On 28th February 2023, his prison general practitioner requested an urgent mental health assessment by the mental health team due to concerns surrounding Steven's mental health presentation, including hearing voices. The referral made and assessment requested was not carried out by the appropriate team and in a timely manner. This failure to complete the assessment and place Mr Hart on the mental health caseload may have contributed to Mr Hart's death. On 12th March 2023 an ACCT was opened as Steven felt unwell, had thoughts of self harming and, restlessness. Around 18th March 2023 to 20th March 2023 the prison wing Steven was staying in was put into a state of lockdown due to intelligence received that a firearm was found within the HMP Bedford. Steven did not have access to many of his normal coping mechanisms such as use of the gym, access to friends, contact with family and his medication. This caused him to experience symptoms of increased anxiety, depression and paranoia. Steven was due to have a mental health review during this time which could not take place due to the lockdown. The failure to carry out this assessment did not allow the opportunity for a full mental health assessment to be carried out and any further actions or support for Steven to be put in place. Around midnight on 19th March 2023 it is recorded that a self harm attempt was made by Steven and that he wanted to end his life. Steven made cuts to his neck and arms. As a result Steven attended hospital for further assessment and treatment. Upon returning from

	hospital Steven was admitted to the healthcare wing, an ACCT was opened, and Steven was placed on constant supervision. Steven was placed on constant supervision due to his comment 'to string up as soon as he could' and the risk he posed to himself. The officers who offered testimony in this inquest had stated that they were not aware of Steven's comment 'to string up' even though it is documented in a Nomis entry dated 20/03/23 12:37. This would indicate a general failing to distribute relevant observations and concerns regarding Steven's mental state and that staff have failed to read and review documents relevant to Steven including Nomis entries. Witnesses have stated that often they do not have time to receive handovers, read current and previous ACCT documents during their shift and again this would indicate a general failing within the prison to allow the opportunity for records to be read properly and handovers to be completed. After an ACCT review on 23'd March 2023 despite a self harm attempt [redacted] on 22'd March 2023 Steven was moved to a safer cell and placed on four irregular observations per hour with a razor ban in place. This meant Steven was placed in an alternative cell where ligature points should not be available. On 25th March 2023 Steven was under four irregular checks per hour and while the checks have been recorded in the ACCT document, CCTV demonstrates that these observations may not have been carried out appropriately and to the full standard required. At 17:02 on 25th March 2023 an officer was seen on CCTV to remove [redacted] from Steven's cell, the officer stated that he had to remove [redacted] from around Steven's neck. The officer stated that he attempted to report the incident by phone to OSCAR 1. However this was unsuccessful. The officer stated that he made no further attempts to notify OSCAR 1 either by radio, phone or the control room. Protocol states that any events such as this should be reported to OSCAR 1. By failing to follow the protocol accordingly did not allow for the opportunity for OSCAR 1 to review and assess Steven's presentation and did not allow for a multi-disciplinary team review to put further support, restrictions or observations in place for Steven. Neither officer present at the time of the incident attempted to contact OSCAR 1 whether directly responsible for Steven or not. Although this is a protocol all prison staff are aware of. Again, this is a failure on the part of all staff present at the time of the incident. From the evidence heard regarding the night shift handover on 25th March 23 it is evident that insufficient time was available for a full handover to be given and lack of vital information was provided to the receiving officer. Therefore a failure to give a full handover led to an inadequate understanding of Steven's earlier presentation and mental health state. At 21:04 the officer noticed a ligature on Steven's cell door, [redacted] The officer called for assistance and forced the cell door, where he found Steven unresponsive in his cell, an emergency medical code was radioed and a nurse started cardiopulmonary resuscitation (CPR). Paramedics arrived at 21:19 and conveyed Steven to hospital. Steven died in hospital on 29th March 2023.
4	**CIRCUMSTANCES OF THE DEATH** Steven Hart was remanded to HMP Bedford on 30 November 2022. He had a documented history of mental health issues, including anxiety, depression, paranoia, self-harm, and suicidal ideation. During his time in custody, he experienced several episodes of self-harm and was intermittently supported through the ACCT (Assessment, Care in Custody and Teamwork) process. In March 2023, following a prison lockdown and a period without access to his usual coping mechanisms and medication, Mr Hart's mental health deteriorated further. On 25 March 2023, after an earlier incident where he was found with a [redacted] around his neck, he was not referred for further risk assessment as required by protocol. Later that evening, he was found unresponsive in his cell, having used a ligature attached to a faulty observation panel. He was taken to hospital but died on 29 March 2023 from asphyxiation due to hanging.
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: (brief summary of matters of concern) 1. Failure to Adequately Monitor and Audit Cells for Ligature Points Mr Hart was placed in a "safer cell" designed to have no ligature points. However, the observation panel [redacted] was broken, [redacted] which he was able to thread a ligature and hang himself. Staff and witnesses confirmed that the damage to the cell door was known, and that maintenance was generally responsive, but the cell was not taken out of use despite the increased risk. The prison's own post-inquest review acknowledged that the design of the observation panels allowed prisoners to open them from inside, creating an opportunity for self-harm. Interim and permanent solutions were only implemented after the Inquest had commenced nearly two and a half years after Steven's death indicating a likely failure to tackle safety concerns promptly or appropriately. 2. Failure to Effectively Communicate Risk and Incidents There was a general failure to distribute and communicate relevant observations and concerns regarding Mr Hart's mental state. Staff often did not have time to receive handovers or read current and previous ACCT (Assessment, Care in Custody and Teamwork) documents during their shift. After a serious self-harm incident with Steven involving [redacted] the officer involved failed to report the incident to OSCAR 1 (the officer in charge), as required by protocol. He simply removed the [redacted] and did not conduct any further assessment or review of Steven. This failure prevented a multi-disciplinary review and possible escalation of risk management. The night shift handover on 25 March 2023 was insufficient, with lack of vital information provided to the receiving officer, leading to inadequate understanding of Mr Hart's risk. 3. Failure to Carry Out Appropriate Observations Observations of Mr Hart were reduced from constant supervision to four irregular checks per hour, despite ongoing risk factors and recent self-harm attempts. CCTV evidence suggested that required observations were not always carried out to the proper standard, and some checks may not have been performed at all. The officer insisted they were although CCTV evidence strongly suggested that was improbable. The jury found that the failure to call OSCAR 1 after the telephone cord incident directly impacted Mr Hart, as it possibly prevented a further ACCT review and escalation of observations or removal of ligature materials. The death of Steven Hart was contributed to by systemic failings in cell safety, communication, and observation practices. There were, paradoxically, along-aside poor practice and care, examples of exceptionally good practice by a group of officers of which several have left the prison service. There was generally a failure to implement robust systems for cell safety audits, enforce effective communication and handover protocols, and ensure strict compliance with observation requirements for vulnerable prisoners.
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 November 19, 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 [redacted] **HMP Bedford** **Prisons and Probation Ombudsman (PPO)** **Northamptonshire Healthcare NHS Foundation Trust (NHFT)** **Prison Officer** [redacted] I have also sent it to **inquest.org.uk** 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 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 by the Chief Coroner.
9	**Dated: 24/09/2025** [redacted] **Sean CUMMINGS** **Assistant Coroner for** **Bedfordshire and Luton Coroner Service**