Kent and Medway Coroners' Service
Oakwood House
Oakwood Park
Maidstone
Kent
ME16 8AE
[redacted]

Date: 24 March 2026
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

[redacted], **Minister of State for Prisons, Probation, and Reducing Reoffending**

1. CORONER

I am Mr. Ian Potter, area coroner for 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 18 November 2024 an investigation into the death of Thomas Daniel RUGGIERO was commenced. The investigation concluded at the end of the inquest heard by me before a jury between 9 - 20 March 2026. The conclusion of the inquest was:

Mr Ruggiero died by ligaturing himself in circumstances where his intention could not be ascertained.

1a Hanging

1b

1c

1d

II

4. CIRCUMSTANCES OF THE DEATH

Thomas Daniel Ruggiero was 39 years of age at the time of his death. He was serving an eight year prison sentence. At the time of his death Mr Ruggiero was being held at HMP Swaleside.

Mr Ruggiero had complex mental health needs and his diagnoses included severe Emotionally Unstable Personality Disorder (EUPD), Antisocial Personality Disorder (ASPD), and Polysubstance misuse. As a result of these diagnoses, Mr Ruggiero was well known to self-harm and was heightened risk. He had been subject the ACCT provisions on numerous occasions and had had multiple stays in the in-patient unit or IPD at HMP Swaleside.

While still subject to an ACCT and requiring hourly observations, Mr Ruggiero was found unresponsive in his cell at HMP Swaleside on the morning of 16 November 2024, having ligatured. Following attempts at treatment and resuscitation, Mr Ruggiero died at the prison later that day.

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 **MATTER OF CONCERN** is as follows:

While the evidence called at the inquest predominantly related specifically to matters at HMP Swaleside, I did hear some evidence that relates more widely to the prison estate. Matters of a more localised nature have been addressed, under cover of a separate report, to the Governor of HMP Swaleside. This report relates only to matters relating to the wider prison estate.

(1) The evidence was that in November 2024, up to (and possibly more than) 90% of prison officers at HMP Swaleside were new in post and still in their probationary period. I was told in evidence by a Supervising Officer (SO) that on 16 November 2024, he 'possibly did not have the right mix of staff in terms of skills and experience to keep the wing safe'.

In this inquest, the jury found that, "the communication between prison staff was insufficient and lacked clarity".

I was told that the level of officers still in their probationary period has now reduced. I was also made aware of the 'Urgent Notification' (UN) from HM Chief Inspector of Prisons in relation to HMP Swaleside (December 2025), which included in the rationale, "Staff, many of whom lacked experience, were not confident in challenging poor behaviour and there was a lack of order and control." This suggests to me that the issue is ongoing.

When exploring the evidence further, I was told that issues relating to the recruitment and retention of prison officers were significant and that this is not something that it is confined only to HMP Swaleside. There was evidence that this is a much wider issue.

Without sufficient numbers of experienced prison officers across the prison estate, the staffing issues seen in this particular inquest are likely not isolated. I highlight to you my concern that high levels of inexperienced staff will undoubtedly contribute to future deaths of those in custody.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you 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 19 May 2026. 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 Ruggiero's family
- Ministry of Justice
- Oxleas NHS Foundation Trust

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. She may send a copy of this report to any person who she 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.

24 March 2026

Ian Potter, Area Coroner for Kent and Medway