Kent and Medway Coroners' Service
Oakwood House
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[redacted]

Date: 23 March 2026
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Governor of HMP Swaleside

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 and 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 he was 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 Poly-substance misuse. As a result of these diagnoses, Mr Ruggiero was well known to self-harm and was at heightened risk. He had been subject to 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 the 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. I must acknowledge that some of the concerns that arose during the evidence do appear to have been addressed and, as such, those concerns do not feature as part of this report.

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 **MATTERS OF CONCERN** are as follows:

(1) Emergency Cell Bell System

During the evidence there was CCTV footage of other prisoners silencing Mr Ruggiero's cell bell from outside his cell door. The jury found that this hampered the ability of prison staff to respond and react to Mr Ruggiero's needs and distress in the hour or so before his being found unresponsive in his cell.

I was told in evidence that anyone (other prisoners or staff members) can silence an emergency call bell at the push of a button outside the relevant cell door and there is no mechanism or system in place to ensure that the cell bell can only be silenced by staff. The evidence was that as and when a cell bell is silenced, staff assume that the call for assistance has been answered.

There was clear evidence that this situation has not changed in any way since November 2024. As a result the emergency cell bell system remains highly vulnerable to both misuse and abuse. In my opinion, this raises a significant risk of future deaths if action is not taken.

(2) ACCT documentation and staff approach to this

In Mr Ruggiero's case some ACCT documentation (his Care Plan) had not been completed. The jury found that this, "led to missed opportunities for all staff to understand Mr Ruggiero's triggers and other vital information in order to care for him" under the ACCT.

I heard evidence that there are now additional systems in place in terms of an 'ACCT reassurance process'. However, during the course of the inquest two supervising prison officers gave evidence to the effect that they had the opportunity to complete Mr Ruggiero's care plan, should have done so, but still did not do it. On further exploration in the evidence,

there appeared to be a view that some staff still did not see the value in the completion of such documentation.

While there have been some steps taken that are aimed at reducing the risk, I am not sufficiently reassured that sufficient action has been taken. In my opinion, the attitude of some staff towards the value of such documentation remains a real and valid concern that continues place particularly vulnerable prisoners at risk.

(3) 'Code Blue'

During the evidence in the inquest hearing there was clear confusion among prison staff regarding the calling of a 'code blue' in an emergency situation. That confusion included if / when to call a code blue and how to do so. The evidence was such that not only was there confusion at the time of events in November 2024, but that it persisted to date. I was told in evidence that the prison has issued more guidance to officers in this regard, but I was insufficiently reassured that this guidance has either had time to take effect or has taken affect at all. There is clear evidence that this presents a risk of future deaths and I am of the opinion that action needs to be taken.

(4) Staffing / Experience / Communication etc.

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. Opportunities to increase formal observations or notify health care were missed. Staff communications failed to relay the severity and complete scope of the situation."

The CCTV evidence clearly showed other prisoners regularly at Mr Ruggiero's cell door, silencing the call bell, banging and kicking at the door (including the wielding of a crutch to hit the door and observation panel), and verbally harassing Mr Ruggiero. The evidence from an SO was that he gave landing officers a clear instruction to intervene; however, it appeared that this did not happen.

I was told that the level of officers still in their probationary period has now reduced. I was also told that additional staff training is now in place to address matters such as assertiveness, and that there is also an action plan (albeit I was not shown this). 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."

While some action has been taken, I am not sufficiently reassured that this has addressed the concern and I therefore consider that the risks remain.

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 18 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 have also sent it to the Prisons and Probation Ombudsman 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. 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.

23 March 2026

Ian Potter, Area Coroner for Kent and Medway