M. E. Voisin
His Majesty's Senior Coroner
Area of Avon

18th March 2026 REF: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Ministry of Justice, [redacted] Director General Operations.**
1	**CORONER** I am M. E. Voisin HM Senior Coroner for Avon
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 17th January 2023 I commenced an investigation into the death of Clare Louise Dupree. The investigation concluded at the end of the inquest 17th March 2026. The conclusion of the inquest, held before a jury, was a narrative. ***Box 3 on the jury Record of Inquest stated***… "On the 26th December 2022 Clare Louise Dupree suffered sustained inhalation of smoke in Cell 59, Residential Unit 6, at HMP Eastwood Park. The lack of Automatic in-cell Fire Detection (AFD) caused a delay in detecting the fire, which resulted in her death on 28th December 2022." ***Of relevance to this report Box 4 on the jury Record of inquest stated …*** "...The use of DSDs (domestic smoke detectors) instead of AFDs (automatic fire detection) possibly contributed to Clare's death. The lack of AFD's caused a delay in alerting staff to the fire in Clare's cell …Clare died from sustained inhalation of smoke due to a delay in detection of fire as a result of arson."
4	**CIRCUMSTANCES OF THE DEATH** Clare was a 48 yrs old female and was taken into custody at Eastwood Park Prison on 19th November 2022, she had a history of poor mental health.

	On 26th November 2022 there was a fire in her cell, caused by a vape, staff were alerted by the DSD outside of her cell. She was removed from the cell after the fire service arrived, was taken to Southmead Hospital where she died from: 1a) Hypoxic-ischaemic brain injury, lower respiratory tract infection and multi-organ failure 1b) Inhalation of products of combustion
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 **MATTERS OF CONCERN** are as follows. – At the start of the inquest the MOJ made an admission it said … 1. "The Ministry of Justice has determined that in-cell automatic fire detection (AFD) is necessary to minimise the risk of harm from fires. 2. As at 26th December 2022, cell 59 on Residential 6 was not and is not currently equipped with in-cell AFD 3. For those cells which do not have in -cell AFD, battery powered standalone domestic smoke detectors (DSD's) are in place outside cell doors, including cell 59 on Residential 6. This was the position as at 26th December 2022. The use of DSD's as a mitigatory measure was agreed in 2015, in consultation with the Crown Premises Fire Safety Inspectorate. The Ministry of Justice acknowledges that the use of DSD's in this way is a less effective way of minimising fire risks than in-cell AFD but has adopted them after thorough consideration as being the most effective available means of reducing risk as far as practicable until the installation of in-cell AFD can be completed " During the inquest evidence was heard from [redacted] from HMPPPS - that in cell AFD's are now planned for Eastwood Park with a start date of June 2026. I also heard about the position in relation to the prioritisation list for others in the prison estate. That said I also heard the frustration of [redacted] from the CPFSI about the time this is taking to implement. The matter of concern is therefore … that in cell AFD is still to be implemented/completed at EWP prison and in addition a number of prisons across the prison estate. That the current use of DSD's only seek to mitigate the risks from an in-cell fire.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Ministry of Justice 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 19th 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: • Clare's family • Ministry of Justice • Healthcare – Practice Plus Group • Mental healthcare – Avon & Wiltshire Mental Health Partnership Trust • Crown Premises Fire Safety Inspectorate • Cardiff & Vale Health Board and to the following who may find it useful or of interest: • HM Inspectorate of Prisons, • HM Prison and Probation Service and to • the Independent Advisory Panel on Deaths in Custody; 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.
9	Signature M. E. Voisin HM Senior Coroner for Avon

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