20 August 2026

Mr Edward Steele, Assistant Coroner
East Riding of Yorkshire and Kingston-upon-Hull
The Coroners Courts & Office
The Guildhall
Alfred Gelder Street
Kingston upon Hull
HU1 2AA

[redacted]

Dear Mr Steele

Mr David Clairmonte - Response to Regulation 28 report

I write to you in response to the Regulation 28 report dated 26 June 2026 which was addressed to Priory Hospital Stockton Hall (**PHSH**). The report was issued following the Inquest touching the death of Mr David Clairmonte, who died on 4 October 2024 following his discharge from PHSH on 9 October 2023. The inquest concluded on 19 June 2026 and resulted in a narrative conclusion.

In the Regulation 28 report you raised two areas of concern for Priory to consider:

1. *Evidence was heard in relation to Mr Clairmonte undertaking acts of self-harm whilst under constant supervision in the psychiatric hospital, Stockton Hall. The purpose of the supervision was to prevent Mr Clairmonte from self-harming. To the extent that various incidents occurred, it is a concern that this was able to happen whilst being on constant observations.*

2. *Evidence was also heard that, contrary to NICE guidelines, the opportunity for HMP Full Sutton prison staff to visit Mr Clairmonte at Stockton Hall Psychiatric Hospital, prior to the transfer, was denied. HMP Full Sutton Custodial Managers attempted to visit Mr Clairmonte in order to allow him the opportunity to express any concerns about the transfer and for them to answer any questions. This was so in the context of Mr Clairmonte having been in the psychiatric hospital for six years. Mr Clairmonte was only given, by Stockton Hall, a notice period of three days of the fact of the transfer to a custodial environment.*

Priory response to matter of concern 1

As a preliminary point, please note that mental health provider observation and engagement policies and practices seek to minimise the risk of self-harm but in practice they are unable to prevent it entirely. This is particularly the case when a patient is focussed on causing harm to an existing wound to their body: to eliminate the risk completely, the arms and hands of the patient would require constant restraint. As such, policies and practices need to strike a balance between keeping the patient safe whilst avoiding disproportionate restrictions and having due regard to privacy and dignity without which any recovery will be impeded.

In Mr Clairmonte's case, there was adherence to the relevant Priory policy with escalation to enhanced observations when this was needed. Mr Clairmonte also had restricted access to specific items from time to time. There were ongoing risk assessments to manage Mr Clairmonte's self-harm risk but in reality staff found it challenging to prevent his inflicting wounds on his stoma as this would be obscured

by a blanket (or similar) which he was entitled to use to satisfy his personal needs for warmth, comfort or privacy. For clarity, staff would intervene immediately upon discovering that Mr Clairmonte had self-harmed to minimise any injury sustained to his stoma.

Whilst the staff at PHSH have significant experience acquired over many years of dealing with very complex self-harm behaviours, as a learning organisation PHSH has nonetheless reflected on whether Mr Clairmonte's level of engagement with staff and apparent maintenance of his normal routines may have created the impression that he was not self-harming and whether more could have been done to assess this risk. Priory's Self-Harm Professional Nurse Specialist has been partnering with the PHSH team to review the incidents of Mr Clairmonte's self-harm whilst on 1:1, 2:1 and arm's length observations. Any learning from this will be rolled out to inform practice in relation to current patients engaging in self-harming behaviours. Our nursing colleague has also offered to deliver a self-harm clinical skills training package to the teams within PHSH, thereby supporting our ongoing management and interventions for patients who self-harm.

Priory response to matter of concern 2

For clarity, we believe relevant references should be made to NHSE Guidance rather than NICE Guidelines in relation to the concern raised.

In line with the NHSE document '*Transfer and remission of adult prisoners under the MHA: Good practice - Guidance 2021*', once Mr Clairmonte's remittal to prison was confirmed by the MDT at PHSH, a Section 117 meeting was arranged. Though it is part of this good practice guidance for patients and their family and/or carers to be invited to this meeting, it was not considered clinically appropriate in this case.

As was explained at the Inquest (and as set out in the letter dated 15 June 2026 submitted to the Inquest by [redacted] the Medical Director at PHSH, a copy of which is attached) the clinical decision to inform Mr Clairmonte three days prior to his return to prison was made to ensure his safety. The MDT considered that if informed of his remittal earlier, there was an increased risk of significant self-harm by Mr Clairmonte over a longer period. [redacted] clearly gave evidence that it was not his intention for the teams at HMP Full Sutton that they should not or could not attend PHSH. They could attend PHSH but only after Mr Clairmonte was informed of the intended remittal.

This approach was an exception to the hospital's usual practice and was decided upon by the MDT after considering Mr Clairmonte's overall risk history and current presentation, which is part of a person centred approach. This was therefore atypical but was a decision made in good faith and was necessary to protect Mr Clairmonte from further self-harm.

Mr Clairmonte's family was informed of this decision and was supported to visit Mr Clairmonte during the weekend prior to his transfer back to prison. HMP Full Sutton staff attended on the day of transfer but no healthcare or clinical support was provided by prison staff at that time.

We would like to assure you that we always work collaboratively and transparently with external parties when making arrangements for transfers or remittals to or from prison but we must ensure that we always place the best interests of the patient firmly at the centre of our decision-making.

I trust that the actions outlined above will provide the assurances you seek in respect of this matter.

Yours sincerely,

[redacted]

Chief Executive Officer
Priory