ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Ministry of Justice.**
1	**CORONER** I am Mr Edward Steele, assistant coroner, for the coroner area of East Riding of Yorkshire and City of Kingston Upon Hull.
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 25 October 2024, I commenced an investigation into the death of David Charles Spencer Clairmonte ("Mr Clairmonte"), aged 39 years. The investigation concluded at the end of the inquest on 18 June 2026. The conclusion of the inquest was a Narrative. The Narrative conclusion read: Mr Clairmonte was treated for a natural disease, but resentful of the disfigurement and limitations on his life that the stoma presented. It was recognised that Mr Clairmonte had a complex personality disorder, resulting in increased impulsivity which may have exacerbated the frequence of self-harm related to the stoma upon which he had become fixated. Over time, these repeated serious episodes of self-harm caused irreversible and irreparable damage. This led to a serious degeneration in his health and a depletion of his physiological reserves, due to the complexities of his nutritional status and damage to his bowel from self-harm incidents, leading to his death. Box 3 of the Record of Inquest read: David Charles Spencer Clairmonte died on 4 October 2024 at 13:38 at York District Hospital following admission for repeated episodes of self-harm. The prognosis was poor due to internal damage caused by self-harm. Mr Clairmonte was deemed to have capacity throughout the admission and, despite the best efforts of treating physicians, he refused treatment, continued to deteriorate and ultimately died. There was no third-party involvement in his death. Whilst the supervision of Mr Clairmonte at Stockton Hall could have been considered adequate in the short-term, it did not meet Mr Clairmonte's long-term complex needs. There were missed opportunities in not using NICE guidelines within the transition process from Stockton Hall to HMP Full Sutton. This may have resulted in a less than satisfactory transfer for Mr Clairmonte. The contradictory evidence given regarding efforts to find suitable placements for Mr Clairmonte on leaving Stockton Hall raises questions as to the efficacy for a search for a suitable placement for Mr Clairmonte. These failings did not probably contribute to the death, but they may have done so.

	His medical cause of death was recorded as: **1a** Intra-abdominal sepsis, acute haemorrhagic pancreatitis and hypokalemia. **1b** Chronic enterocutaneous fistula, intra-abdominal scarring and chronic dehiscence of a laparotomy scar. **1c** Repeated episodes of intra-abdominal self-harm following surgery for Chron's Disease.
4	**CIRCUMSTANCES OF THE DEATH** Mr Clairmonte was transferred from Stockton Hall Psychiatric Hospital, after having been there for nearly six years, to HMP Full Sutton on 9 October 2023. He had been treated for various self-harm incidents involving his stoma. In his final year, Mr Clairmonte was a patient at hospitals in relation to his physical health issues, including a period of months at St James's Hospital, Leeds from 1 April 2024. Mr Clairmonte's final attendance at hospital was from 27 September 2024 until his date of death, 4 October 2024, at York District Hospital. Mr Clairmonte was admitted due to being very unwell and at the point of a cardiac arrest, due to the losses from his bowel that put heart under compromise. Mr Clairmonte died in hospital.
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. – (1) Prison officer escorts from HMP Full Sutton to accompany Mr Clairmonte to hospital were not identified quickly enough to facilitate an expeditious transfer, during a medical emergency. Evidence was heard that on 13 September 2024 Yorkshire Ambulance Service attended at HMP Full Sutton and, despite a concerning NEWS score indicating several ref flag sepsis markers, Mr Clairmonte was delayed in leaving for nearly an hour due to prison officer escort staff not having been identified. During that period, the oxygen cylinder brought in by the paramedics had run out.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 21 August 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: the family of Mr Clairmonte, Ministry of Justice, The Priory Group, York & Scarborough Teaching Hospitals NHS Trust, Spectrum, Tees, Esk & Wear Valley NHS Trust, Practice Plus Group and Leeds Teaching Hospitals. 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. 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	**[DATE]** **26 June 2026**	**[SIGNED BY CORONER]** **HM Assistant Coroner Edward Steele**