REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Governing Governor H.M.P.Preston** **2. Secretary of State for Justice** **3. Parliamentary Under Secretary of State for Prisons and Probation**
1	**CORONER** I am Nicholas Leslie Rheinberg, assistant coroner for the coroner area of Preston and West Lancashire
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 4th December 2014 an investigation into the death of Christopher Shaun Talbot aged 65 was commenced. The investigation concluded at the end of the inquest on 28th November 2017. The conclusion of the inquest was that Christopher Talbot had died as a result of self-inflicted asphyxiation by means of a plastic bag placed over his head whilst in his cell at Preston Prison.
4	**CIRCUMSTANCES OF THE DEATH** Christopher Talbot had been recalled to prison on revocation of his licence. He arrived on 26th November 2014. Reception staff failed to record details of a warning that he was at high risk of suicide. An Officer concerned about Mr Talbot's manner on 27th November 2014 opened an ACCT. At 9.30 pm on 28th November 2014, Mr Talbot was observed by the night patrol officer on C Wing, lying on his back in his cell with his right hand either holding or resting on a plastic bag. Recognising Mr Talbot as a vulnerable prisoner, the Officer sought help but failed to ask for immediate assistance, failed to clearly state the nature of the risk and did not keep the prisoner under constant observation. In the event Mr Talbot put the plastic bag over his head before officers arrived in his cell at which point he was not breathing and there was no cardiac output. Although both were restored Mr Talbot died later in Preston Hospital.
5	**<u>CORONER'S CONCERNS</u>** 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. – <u>For the attention of the Governor</u> (1) The Supervising Officer on duty at Reception when Mr Talbot arrived had never received training in her duties but merely gained experience by shadowing another officer. It did not appear that any written material was provided so as to inform her of her duties, including the PSI "Early Days In Custody, Reception In, First Night In Custody And Induction To Custody" or a guidance document summarising the main provisions of the PSI. Lack of such written material and reliance solely on shadowing as a means of

	training might bring about a position where bad habits are proliferated or important considerations missed. (2) A Senior Officer gave mouth to mouth resuscitation to Mr Talbot without the use of a guard. It is understood that although mandatory for more junior officers at HMP Preston, carrying a breathing guard at all times is discretionary for certain senior grades. Lack of such a guard might put an officer in personal danger when attempting to revive a prisoner or dissuade that officer from intervening, with potential adverse consequences for the prisoner. (3) It is understood that following the death of a prisoner a notice to this effect is issued to the prisoners and staff but that staff are not informed of the manner of an unnatural death. Thus, it appeared that staff attending to give evidence at the inquest were unaware of another recent previous death involving a plastic bag, knowledge of which might have led to extra vigilance in the case of Mr Talbot, when as a vulnerable prisoner, he was observed holding a plastic bag. <u>For the attention of the Secretary of State for Justice / Prisons Minister</u> Following the investigation into the death of Mr Talbot by the Prisons and Probation Service Ombudsman a recommendation was made to the Governor at HMP Preston, which was accepted This was to the effect that night staff who have concerns about the behaviour of a prisoner identified as at risk of suicide or self-harm, should request immediate assistance, clearly stating the nature of the risk and keeping the prisoner under observation until help arrives. The Governor implemented the recommendation by issuing a written local instruction. You are asked to consider whether such an instruction might be issued nationally.
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 25th January 2018. 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 namely the legal representatives of the family of the deceased, the prison health provider, HMP Forest Bank and Greater Manchester Police and the Government Legal Department 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	**Dated 29th November 2017 SIGNED** **Nicholas Rheinberg Assistant Coroner**