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Director General Prisons
HM Prison and Probation Service
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HM Prison & Probation Service

Mr Nicholas Leslie Rheinberg
HM assistant Coroner area of Lancashire and Blackburn with Darwen
Coroner's Court
Faraday Court
Faraday Drive
Fulwood
Preston
PR2 9NB

28 April 2022

Dear Mr Rheinberg

Thank you for your Regulation 28 report of 22 January 2022 following the inquest into the death of Thomas Mark Anthony Moffett at HMP Preston on 6 August 2019. I am responding on behalf of HMPPS as the Director General of Prisons.

I know that you will share a copy of this response with the family of Mr Moffett, and I would like to express my condolences for their loss. Every death in custody is a tragedy and the safety of those in our care is my absolute priority.

You first raise a concern regarding evidence heard at the inquest about communication between healthcare personnel at the scene of a medical emergency and the prison and ambulance control rooms.

Following a review of this process, an additional function has been added to HMP Preston protocols to ensure healthcare staff can communicate efficiently and effectively with the prison control room and the ambulance service during medical emergencies. This function means that healthcare staff at the prison can speak directly to ambulance control via the prison control room radio, providing accurate medical information allowing North West Ambulance Service (NWAS) to allow them to allocate the call to the appropriately priority.

The control room will continue monitoring the ambulances expected time of arrival and facilitate it speedy entry into the prison. An information notice has been circulated to both prison and healthcare staff with additional training to outline the changes made and the expectations of staff to undertake them.

You further express concern regarding similar findings into the inquest into the death of Martin Brown at HMP Lancaster Farms. I wrote to you on 8 February 2022 in response to your Report to Prevent Future Deaths, outlining the improvements that had been made to information sharing between those on scene at a medical emergency and prison and ambulance control rooms.

In response to the findings of the Prison and Probation Ombudsman's (PPO) report into the death of Trevor Ferguson at HMP Garth, that establishment has undertaken activities to

improve information sharing when an ambulance is called. The PPO's final report will have been shared with you, including the prison's action in response to recommendations.

By working directly with the NWAS it is hoped the communication difficulties have now been overcome with the prisons in the Lancashire area, however we will continue to work with them to ensure our procedures are as effective as possible.

Thank you again for bringing your concerns to my attention. I trust that this response provides assurance that action is being taken to address the matters that you have raised.

Director General for Prisons