REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Director General of the Prison Service, 102 Petty France London SW1H 9AJ and I am sending a copy of the report to the Governor HMP Preston for information purposes
1	**CORONER** I am Nicholas Leslie Rheinberg, assistant coroner for the coroner area of Lancashire and Blackburn with Darwen
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** An investigation into the death of Anthony George Smith aged 34 was commenced on 16th May 2022. The investigation concluded at the end of the inquest on 7th June 2023. The conclusion of the inquest was that Mr Smith died as a result of self-suspension but his intention in doing so could not be determined
4	**CIRCUMSTANCES OF THE DEATH** Mr Smith at the time of his death at HMP Preston was suffering an acute relapse in respect of his schizophrenia. He was delusional, hallucinating and hearing voices. On 4th May 2022 he was found hanging in his cell. He was cut down and officers commenced cardio-pulmonary resuscitation
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) An officer attempting resuscitation carried out mouth to mouth resuscitation without the safeguard of mouth protection which was not available in the prison at the time. Mr Smith was a regular drug user who on occasions injected drugs. Performing mouth to mouth resuscitation carried with it the risk of transmission of blood born viruses with possible fatal consequences. (2) The lack of available protection not only carried with it a risk to those who performed resuscitation but potentially also to the person suffering a cardiac arrest in that without protection the would-be resuscitator might decline to provide rescue breaths (3) Consideration should be given to informing prison governors of the need to secure a readily accessible supply of protection masks. PSI 29 of 2015 on the subject of First Aid is currently under review and might be a vehicle for providing appropriate direction.

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 3rd August 2023. 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 family of the deceased and the healthcare providers for HMP Preston. 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 this 7th June 2023**  ***Nicholas Rheinberg***