REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • HM Prison and Probation Service Copied for interest to: • Chief Coroner • Foster Parents of the Deceased • HMP Manchester • Ministry of Justice • Greater Manchester Mental Health NHS Foundation Trust • Delphi Medical
1	**CORONER** I am Mr Zak Golombeck, Area Coroner for Manchester (City) Area
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	**INQUEST** A jury concluded the inquest into the death of Liam Turner on 31st January 2024 and recorded that he died from: 1a Toxicity of ADB-BUTINACA ("[redacted]" / novel psychoactive substance) in combination with[redacted] The jury returned a conclusion of Drug related death.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased died at HMP Manchester on 6th December 2021. His death was caused by a mixed toxicity of a psychoactive substance and prescription medication. There were admitted failings made by the Ministry of Justice (on behalf of HMP Manchester) relating to the fact that a prison officer should have raised concerns that the Deceased was under the influence of an illicit substance with healthcare earlier than he did; however, these failings did not contribute to the Deceased's death. When three officers found the Deceased unresponsive in his cell, they moved him from his bed to the floor in preparation to commence cardiopulmonary resuscitation

	(CPR); however, CPR was not commenced until the healthcare nurses (and subsequently paramedic) arrived. I sought evidence about training for CPR, and I was informed by one witness that he received training in 2006 as part of his Emergency First Aid at Work (EFAW) training; however, he had never had any refresher training. The training certification expires after 3 years, and it is not mandatory for prison officers to receive refresher or additional training.
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 **MATTER OF CONCERN** is as follows: It is not mandatory for prison officers to have basic first aid training (which includes the provision of CPR) which is in-date. Once a prison officer's three-year period has expired, whilst they may be reminded by the prison establishment that their certification is no longer live, it is not mandatory for them to renew this. For example, at HMP Manchester, at present 52% of prison staff received Emergency First Aid at Work (EFAW) training within the past three years as part of their initial officer training. Therefore, 48% of prison staff will have training certification (which includes CPR) which has expired. The evidence admitted was that the main reason for this is due to it not being mandatory for prison staff to have up-to-date training.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 **Monday 1st April 2024**. 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 Interested Persons. I have also sent it to organisations who may find it useful or of interest. 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:** **NAME OF CORONER:** **05/02/2024** **Mr Zak Golombeck** HM Area Coroner for Manchester City Area **Signed:**