Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Ministry of Justice - MOJ** **2 HM Inspectorate of Prisons** **3 Chief Coroners Office for PFD's**
1	**CORONER** I am Simon BURGE, Assistant Coroner for the coroner area of Nottingham City and Nottinghamshire
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 18 November 2021 I commenced an investigation into the death of Paul Martin GOBELL aged 59. The investigation concluded at the end of the inquest on 18 November 2024. The conclusion of the inquest was that: See attached
4	**CIRCUMSTANCES OF THE DEATH** See attached
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) 1. Paul Gobell was serving a life sentence for rape. He had served fifteen years in a closed prison, most recently at HM Prison, Whatton. In August 2021, he was deemed by the Parole Board to be suitable for a move to open conditions and was therefore transferred to HM Prison Hollesley Bay on 20/10/21. He was there for just two and a half weeks. Within a few hours of his return to HM Prison, Whatton on 04/11/21 he was subject to a Control & Restraint incident. His behaviour at this time was reported to be refractory and aggressive. During the incident he received a soft tissue injury which necessitated a trip to the A&E department at the local hospital. As a result, the usual First Night Interview did not take place that evening, nor on the following day. As a result there was no welfare check and no ACCT was opened. There is no national or local policy in place stating what arrangements should be made to carry out a welfare check when, for operational reasons, the First Night Interview cannot take place. 2. Paul Gobell was assessed as being suitable to share a cell in June 2021, having previously been considered high risk. He was not informed off this change until immediately prior to the C&R incident on 04/11/21 and had never had to share a cell before. The Cell

	Sharing Risk Assessment carried out by Healthcare and Reception staff upon his return to HM Prison, Whatton on 04/11/21 deemed him to be a standard risk. He felt that he should have been designated as high risk. He was concerned for the safety of whoever he might be required to share a cell with, due to the fact that he (Gobell) suffered from parasomnia. Despite protesting to staff, he was told that he would have to share and it was this that sparked the incident leading to the use of control and restraint techniques. Had he been pre-warned of the change to his cell sharing status this incident would not have happened. Consideration should be given to ensuring that any such change of cell sharing risk is communicated promptly to the prisoner concerned. 3. Whilst at HM Prison, Hollesley Bay, Paul Gobell rang the Probation Officer (who had dealt with his Parole Board hearing in August 2021) and told her that he felt he was a poor fit in open conditions, that the environment there was hostile and unpleasant and that he had let slip to another prisoner that he was serving a term of imprisonment for offences of a sexual nature. The Probation Officer concerned did not see fit to report these disclosures to the Offender Management Unit. An Open Conditions Suitability Assessment ('OCSA') was subsequently held at HM Prison, Hollesley Bay on 02/11/24, after Mr. Gobell spoke to an Orderly Officer and asked to be returned to HM Prison, Whatton. Despite the multi-disciplinary nature of the OCSA, no input was obtained or requested from Probation staff at HM Prison, Hollesley Bay or elsewhere. Had the relevant Probation staff been involved this would have better informed the OCSA and steps could have been taken to offer Mr. Gobell additional support, designed to encourage him to remain in the open conditions of a 'D' category prison rather than taking the regressive step of being returned to closed conditions. Consideration should be given to imposing a requirement that the input of Probation (both from the Offender Management Unit and outside) is obtained whenever a OCSA is undertaken.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 January 22, 2025. 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 **Practice Plus Group LIMITED** [redacted] I have also sent it to who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 03/12/2024**  **Simon BURGE** **Assistant Coroner for** **Nottingham City and Nottinghamshire**