

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. [REDACTED] Medical Director, Practice Plus Group
1	CORONER I am Christopher Long senior 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 On 7 September 2023 I commenced an investigation into the death of Aaron Lee Taylor, 32 years old. The investigation concluded at the end of the inquest on 29 October 2025. The conclusion of the inquest was: With the evidence provided by the pathologist, CCTV footage from 27 August and the 28 August, combined with witness statements from the prison officer who found Mr Aaron Lee Taylor at 08:05am on the 28 August 2023, Mr Aaron Lee Taylor died between 7.30pm on the 27 August 2023 and 6am on the 28 August 2023, in a cell on the premises of HMP Garth, 1 Moss Lane, Ulnes Walton, Leyland. [REDACTED] Taking into account the three letters that Mr Taylor wrote, the preplanning and method in which Mr Taylor died, leads us to conclude Mr Taylor did take steps intending to take his own life. There were multiple failures in the measures taken to prevent self-harm and suicide. From the evidence that has been presented in court, multiple opportunities were missed by multiple professionals (nurse, GP, prison officers, mental health nurse, Prison Offender Manager, Governor, Senior prison officer) to support or offer suitable/appropriate care and resources for Mr Taylor. Inadequate preventative steps and assessments, lack of documentation, inability to adhere to policies and procedures and a 'lack of professional curiosity' as stated by an Operations Manager from GMMH who undertook an external investigation. All contributed to Mr Taylor's death. Witness testimony from a prison officer demonstrated that the relevant observations had not been carried out on the 28 August 2023. With the evidence and testimony of the pathologist, and the uncertainty surrounding time of death, we cannot say that these observations or lack of, contributed to Mr Taylor's death. As highlighted by the external investigation carried out by GMMH, there were multiple serious failures to provide minimal/adequate mental health interventions for Mr Taylor. These serious failures and inadequacies possibly contributed to Mr Taylor's death..

4	CIRCUMSTANCES OF THE DEATH Mr Taylor was discovered in his cell on 28 August 2023 by a prison officer. He was found suspended from a ligature.
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 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. – Evidence was heard that PPG Healthcare who are now responsible for healthcare at HMP Garth have not had any psychologist resource for prisoners at HMP Garth unless they have been victims of sexual assault. Even then, evidence was heard about waiting lists of many months. Evidence was also heard that a decision had not been taken to fill psychologist resource gaps by locum cover, despite those gaps having existed for 6 months
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 Friday 2 January 2026. 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: Mr Taylor's family and [REDACTED], Governor HMP Garth 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. She may send a copy of this report to any person who she 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 6 November 2025 [REDACTED] Christopher Long