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:** [redacted] **Minister of State for Prisons, Probation and Reducing Reoffending** **Ministry of Justice** **102 Petty France** **London** **SW1H 9AJ**
1	**CORONER** I am Joanne Kearsley, Senior Coroner for the coroner area of Greater Manchester North.
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 3rd July 2025 I commenced an investigation into the death of Mr Arron Hamer. The investigation concluded at the end of the inquest on 11th June 2026. The conclusion of the inquest was that Mr Hamer died as a result of Suicide whilst he was in custody at HMP Buckley Hall. His medical cause of death was 1a) Global Hypoxic Ischaemic Brain Injury as a result of hanging.
4	**CIRCUMSTANCES OF THE DEATH** The brief circumstances are that Mr Hamer was sentenced in 2009, at the age of 17 and received a 2 ½ year tariff on an Indeterminate Public Protection sentence. He had a background of significant childhood trauma having witnessed an attempt murder at the age of 7. His family had had to be relocated as a result. He suffered significant bullying at his new school and between the ages of 7-10 he self-harmed. He was taken into care at the age of 11 and began using drugs. His offending was linked to his drug use. Following his sentence in 2009 he remained in custody until 2022. He was then released on licence but recalled in 2023 following a positive drugs test. He had moved to HMP Buckley Hall on the 30th April 2025. He had positively engaged with a number of professionals including probation, drug and alcohol team, his keyworker and had started trauma therapy. On the 18th June 2026 he was found hanging his in cell. Upon finding Mr Hamer the Prison Officers did not cut the ligature for nearly three minutes or commence CPR. It was heard that they panicked and were visibly distressed on finding Mr Hamer. They had undertaken their basic life support training years ago on their initial prison officer 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 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. – (1) The Court heard there is no mandatory refresher training on basic life support for prison officers after they have conducted their initial prison officer training. If they do the first aid at work course this has to be refreshed every three years but only certain officers do this. For the majority they do not have refresher training.
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 10th August 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 and Mrs [redacted] (Family) and HMP Buckley Hall Prison. 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	**15th June 2026** **HM Senior Coroner Joanne Kearsley** [redacted]