REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Christopher Long, Senior Coroner, for the coroner area of Lancashire and Blackburn with Darwen
2.	**DATE OF REPORT** **29 June 2026**
3.	**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.	**THIS REPORT IS BEING SENT TO:** 1.His Majesty's Prison and Probation Service You are under a duty to respond to this report within 56 days of the date of this report, namely by 24 August 2026. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	**SUMMARY OF CORONER'S CONCERN** **1.** Evidence was heard that despite several staff being aware of incidents of self-harm involving a prisoner at HMP Garth an Assessment, Care in Custody Teamwork process (ACCT) was not opened. Whilst evidence was provided that staff are trained as part of their induction program and that training materials is available to staff, no assurance could be given that there was any ongoing mandatory refresher training or any system in place to monitor understanding that every member of staff is responsible for opening an ACCT where required **2.** Evidence was heard that there is a regular practice of prisoner's covering their observation panels in their cell doors at HMP Garth. Despite Governor's Orders and staff instructions being in place requiring staff to take steps to ensure any inundation is removed, this was not being adhered to. Evidence was heard that some staff were not aware of the instructions which were issued by email. As a result, the orders and notices have been updated and reissued by email clarifying expectations in relation to welfare checks and steps requires if observations panels are obscured. However, no

	assurance could be given that staff had read and understood the instructions or that there was any system outside the email system to ensure important information is cascaded and seen by affected staff. In addition, whilst the amended instructions confirm a verbal response is mandatory for welfare checks, they do not explicitly state a visual check of the prisoner is also required
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 25 April 2024, I commenced an investigation into the death of Johnpaul Digweed, aged 35 years… **The medical cause of death was** 1a Hanging **How, when and where** see Conclusion **Conclusion** Mr DIGWEED died between 17:06 on 12 April 2024 and 11:31 on 13 April 2024 at HMP Garth, Leyland. The cause of death was suicide by hanging. Mr DIGWEED was found hanging in his cell. He took deliberate steps to end his life and intended to do so. [redacted]. Numerous opportunities were missed in the months prior to Mr DIGWEED's death to assess his mental state and provide appropriate support. Routine prison procedures to monitor welfare were not carried out as per prison policy and mandatory governor's orders. The gaps in care possibly contributed to Mr DIGWEED's death. The observations on 12-13 April 2024 were also not carried out as per prison policy and mandatory governor's orders. A prisoner discovered Mr DIGWEED's body. Staff attempted resuscitation but rigor mortis had set in and attempts were futile
8.	**CIRCUMSTANCES OF DEATH** [Please explain the relevant circumstances of the individual's death, ideally this should be in no more than 500 words] See box 7
9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: [250-word statement addressing what circumstances of the death have led to the coroner's concern, and why the coroner thinks the person to whom the report is directed is responsible for taking action to prevent future deaths. This statement must not propose what action should be taken, as coroners cannot make recommendations]. **1.** Evidence was heard that despite several staff being aware of incidents of self-harm involving a prisoner at HMP Garth an Assessment, Care in Custody Teamwork process (ACCT) was not opened. Whilst evidence was provided that staff are trained as part of their induction program and that training materials is available to staff, no assurance could be given that there was any ongoing mandatory refresher training or any system in place to monitor understanding that every member of staff is responsible for opening an ACCT where required. Given your responsibility for HMP

	Garth, I consider you are responsible for taking the action that is required to prevent future deaths **2.** Evidence was heard that there is a regular practice of prisoner's covering their observation panels in their cell doors at HMP Garth. Despite Governor's Orders and staff instructions being in place requiring staff to take steps to ensure any inundation is removed, this was not being adhered to. Evidence was heard that some staff were not aware of the instructions which were issued by email. As a result, the orders and notices have been updated and reissued by email clarifying expectations in relation to welfare checks and steps requires if observations panels are obscured. However, no assurance could be given that staff had read and understood the instructions or that there was any system outside the email system to ensure important information is cascaded and seen by affected staff. In addition, whilst the amended instructions confirm a verbal response is mandatory for welfare checks, they do not explicitly state a visual check of the prisoner is also required. Given your responsibility for HMP Garth, I consider you are responsible for taking the action that is required to prevent future deaths
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1.Family of Mr Digweed 2.Healthcare provider at HMP Garth I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
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