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** 21 September 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 16 November 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** Evidence was heard that national guidance did not require an ACCT to be reviewed where a key support measure was removed in the post-closure period. The "Post-closure" section of the Prison Safety Policy Framework was considered at the inquest. It was noted that it does not contain any guidance about steps that should be taken if risks change after the ACCT is closed but prior to the post closure review. In particular, it did not contain any guidance about bringing the post-closure review forward in these circumstances or re-opening the ACCT pending the post-closure review taking place.
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 31 October 2024, I commenced an investigation into the death of Clive Andrew Cocking aged 63 years… **The medical cause of death was** 1a Hanging **How, when and where** See conclusion **Conclusion** Mr. Clive Andrew COCKING died on the Twenty Second of October 2024 at HMP Wymott, 1 Wymott Drive, Ulnes Walton Lane, Leyland. Mr COCKING died as a result of suicide by means of hanging despite adequate measures being followed to prevent self-harm and suicide. Mr. COCKING was discovered in his cell by a prison officer. Help was summoned, life saving treatment was administered but health care professionals and paramedics were unable to resuscitate Mr. COCKING. Mr. COCKING was pronounced dead at the scene**.**
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: Evidence was heard that national guidance did not require an ACCT to be reviewed where a key support measure was removed in the post-closure period. The "Post-closure" section of the Prison Safety Policy Framework was considered at the inquest. It was noted that it does not contain any guidance about steps that should be taken if risks change after the ACCT is closed but prior to the post closure review. In particular, It did not contain any guidance about bringing the post-closure review forward in these circumstances or re-opening the ACCT pending the post-closure review taking place.
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: *[please do not use individual's names, but instead roles/titles]* 1.Family 2.PPG Healthcare 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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