

	REPORT TO PREVENT FUTURE DEATHS REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013
1	CORONER I am Michael James PEMBERTON, Area Coroner, for the coroner area of Manchester West.
2	DATE OF REPORT 18 May 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.
4	THIS REPORT IS BEING SENT TO 1. Ministry of Justice 2. Greater Manchester Mental Health Trust 3. Sodexo 4. Health & Safety Executive 5. NHS England You are under a duty to respond to this report within 56 days of the date of this report, namely by 13 July 2026. I, the coroner, may extend the period if an appropriate application is made.
5	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.
6	SUMMARY OF CORONER'S CONCERN 1. No ongoing training has been provided to prison officers since initial training on basic life support or first aid. 2. The Prison Service Order relating to clinical holds and consistency of healthcare for prisoners was noted to be 20 years old and made no

	reference to mental health conditions or neurodiversity issues, leading to a danger of bias of consideration of only physical health issues. 3. Training of mental health nurses from primary mental health care charged with completing a segregation algorithm.
7	ACTION SHOULD BE TAKEN In my opinion, unless action is taken to address the above concerns, there is a significant risk of future deaths and I believe each of you have the power to take such action.
8	INVESTIGATION AND INQUEST On 13 November 2024 I commenced an investigation into the death of Jake Anthony O'BRIEN aged 22. The investigation concluded at the end of the inquest before a jury between 20 April 2026 and 06 May 2026. The medical cause of death was recorded as: I(a) Hypoxic Ischaemic Brain Damage with Pneumonia I(b) Hanging The conclusion of the jury at the inquest was: Jake Anthony O'Brien died as a consequence of an act of self-ligature [REDACTED] however, it is unclear whether this was done with an intention to end his life or during a period of mental health crisis when he was unable to comprehend the consequences of his actions
9	IRCUMSTANCES OF DEATH The findings of the jury were recorded as follows: Jake Anthony O'Brien died on 12 November 2024 at Salford Royal Hospital. On 9 November, Jake was found suspended by a ligature [REDACTED] in a cell at HMP Forest Bank. He died of irreversible hypoxic ischaemic brain injury and pneumonia. During the previous weeks to months, Jake had acute psychotic episodes as well as self-neglect and other behaviour that was out of character. It is also evident that Jake had not been taking his medication for a few weeks as well as having a pending referral to an MSU (Edenfield). Due to the above factors, there were concerns about his capacity, meaning that on the balance of probabilities it cannot be determined whether he could form a specific intent to end his life. During our deliberations, we identified a few factors which, on the balance of probabilities, may have contributed to Jake's death. Jake should have been placed on medical hold due to the ongoing Section 48 assessment. The lack of continuity of care may have contributed to a decline in Jake's mental health and subsequent death. The lack of ownership/oversight of Jake's mental health through a named nurse/clinician was a serious concern. This resulted in poor communication

	between members of the wider MDT as well as communication between medical and custodial staff. This also likely contributed to nobody carrying out a formal capacity assessment. However, we appreciate the difficulties caused by trying to maintain confidentiality between medical and custodial staff. This was compounded by multiple digital systems and differing access between different individuals and organisations involved in Jake's care. We identified that there was a delay in CPR commencing. This appeared to be due to inadequate refresher training resulting in a lack of confidence, which was of significant concern. There was also concern about the provision of training relating to completing the segregation algorithm. We identified that there was a lack of appreciation of Jake's ongoing accumulation of risk factors and incidents in relation to self-harm and behaviour deterioration. There was a lack of systematic risk assessment and thorough action planning. We concluded that the frequency of observations should have been increased. The complex crossover of differing roles and responsibilities and lack of professional curiosity from medical, nursing and custodial staff are likely to have contributed to confusion and solo working. This led to a serious failing in Jake's care.
10	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: 1. No ongoing training had been provided to prison officers since initial training on basic life support or first aid, meaning that officers confronted with discovery of a ligature situation were unable to provide immediate and basic life support due to a lack of confidence and unfamiliarity of what to do in a situation when every second can count in promoting the chances of an optimal recovery. Training is now to be provided by Sodexo to staff, but it is unclear what the position is within public sector prisons or nationally. 2. Further evidence was provided that a national standard of one trained first aider to 50 prisoners was set by the Health and Safety Executive on a workplace basis. Clarification may be helpful to determine whether this includes life-preserving response in what is an extraordinary type of working environment within a prison. 3. The relevant Prison Service Order (3050) relating to clinical holds and consistency of healthcare for prisoners was noted to be 20 years old. It makes no reference to mental health conditions or neurodiversity issues and how they may affect the appropriateness or consideration of a prison transfer weighed against clinical judgment to place a clinical hold on transfer. It was apparent that not all witnesses considered these issues,

	with some displaying a bias to consider only physical health issues as reflected by the wording of the PSO. 4. Evidence was heard that no mental health nurses from primary mental health care charged with completing a segregation algorithm form for segregated prisoners to determine medical suitability had received training on how this should be done, definitions to be applied, or necessary escalation to healthcare for a Multi-Disciplinary Team meeting to occur. On the evidence, a question of whether a prisoner had self-harmed during this period of custody was viewed as meaning since arrival at the establishment, meaning that any acts of self-harm at a former establishment were not included in the risk assessment matrix. Alongside the confusion of when to refer to healthcare for advice (given a view that healthcare were attending to do this assessment), there was an apparent missed opportunity to escalate to secondary mental health care, ongoing bizarre behaviour being witnessed on Jake's part.
11	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. HM Inspectorate of Prisons 2. Prison and Probation Ombudsman 3. Inquest Charity 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 the 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.
12	SIGNATURE Michael James PEMBERTON Area Coroner for Manchester West