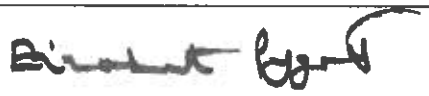
ANNEX A

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. Commissioner for Metropolitan Police** **2. Managing Director SERCO** **3. Governor of HMP Wormwood Scrubs** **4. National Offender Management Service**
1	**CORONER** I am Elizabeth Pygott assistant coroner, for the coroner area of West London.
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 22 October 2012 an inquest was opened into the death of Lee Sean MACPHERSON aged 46. The inquest concluded on 3 March 2014. The conclusion was that the medical cause of death was unascertained and the conclusion was open – the evidence did not fully or further disclose the means whereby the cause of death arose.
4	**CIRCUMSTANCES OF THE DEATH** On 17 October 2012 the deceased was found dead in his cell, a safer custody cell, on the First Night Centre at HMP Wormwood Scrubs. He had been remanded into custody the afternoon before having been arrested on 15 October, held in police custody at Heathrow Police Station overnight, conveyed by SERCO to Uxbridge Magistrates' Court and from there to prison. He had a longstanding history of paranoid schizophrenia which was partially treated by medication.
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 will 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 police risk assessment was not completed until the deceased had already been collected by SERCO and it was a police risk assessment completed in the early hours of the morning that found its way to the prison. (2) There was a lack of common understanding between SERCO staff and prison staff about what police documentation, including the police risk assessment, accompanied a person in custody, in addition to the PER. Boxes on the PER had been ticked indicating that, among other things, it was accompanied by a police risk assessment but SERCO staff said they had not seen that or the other documents.

	(3) The escort handover details on the PER were not completed by the prison staff (or SERCO staff which is a matter SERCO have already addressed). The PER and any accompanying risk assessment are of crucial importance when persons in custody are escorted from one place to another. Although these matters were not material to the outcome in this particular case it could well give rise to problems in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 5 May 2014. 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, The Independent Advisory Panel on Deaths in Custody and HM Inspectorate of Prisons. 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	 **Signed by Elizabeth Pygott Assistant Coroner, West London** **3rd March 2014**