## Sean Robert BROCK

# **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:

Mr. Andrew Selous MP, Minister for Prisons Service.
102 Petty France
London
SW1H 9AJ

## 1 CORONER

I am Mr. Tom Osborne senior coroner, for the coroner area of Milton Keynes

## 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. <a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a>

#### 3 INVESTIGATION and INQUEST

On 14<sup>th</sup> November 2013 I commenced an investigation into the death of Sean Robert Brock aged 21 years. The investigation concluded at the end of the inquest on 6th June 2014. The conclusion of the inquest sitting with a jury was that of suicide, the medical cause of death being hanging.

The circumstances are:

- a) That this was Sean's first time at an adult high security prison
- b) That he died on his fourth day in prison.

#### 4 CIRCUMSTANCES OF THE DEATH

Sean Brock died by hanging in cell 220, house unit 1B, Woodhill Prison, Milton Keynes. He was pronounced dead at 11:11 a.m. on Sunday 10 November 2013.

## 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. -

A Governor from the prison during his evidence informed me that the number of prison officers at HMP Woodhill had been reduced by one third. The reduction in numbers will in his view compromise prisoner safety and may put prisoner lives at risk.

**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action. YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 28<sup>th</sup> October 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. COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:-Family Prison and Probation Ombudsman **Treasury Solicitor** Central and North West London NHS Foundation Trust **GEOAmey** 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 summar form. He may send a copy of this report to any person who he believes may find it or of interest. You may make representations to me, the coroner, at the time of you response, about the release or the publication of your response by the Chief Coron **ISIGNED BY CORONER**1