




Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS THIS REPORT IS BEING SENT TO: Minister of State for Prisons, Parole and Probation
1	CORONER I am 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.
3	INVESTIGATION and INQUEST On the 1 st of November 2022 I commenced an investigation into the death of Leah Shannon Croucher aged 19. The investigation concluded at the end of the inquest on the 19 th of June 2024. The conclusion of the inquest was: Unlawful killing
4	CIRCUMSTANCES OF THE DEATH On the morning of the 15 th of February 2019 Leah left her home address to walk to work, however she never arrived. Later on the same day her family reported Leah as missing to the police. A police investigation followed but they were unable to locate or establish what had happened to Leah. On Monday the 10 th of October 2022 Police were alerted to the presence of a body located in the loft of a Milton Keynes house. The house was located on the route Leah would take to work. The body was subsequently identified as being Leah Croucher. A police investigation followed. The police confirmed that the circumstances and evidence supported that Leah Croucher had been abducted and murdered either on the day or shortly after she had gone missing. Strong evidence was obtained identifying an individual as the perpetrator. This person had died from suicide on the 20 th of April 2019. He was a known repeat sex offender subject to supervision by the probation service and the police before, and at the time of the murder.
5	CORONER'S CONCERNS During the course of the investigation my inquiries revealed matters 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: (brief summary of matters of concern) Leah Croucher was unlawfully killed by a man who was subject to supervision by the probation service and the police. Despite that supervision he was in breach of the terms of



	<p>his probation and was able to kill Leah when it was known that he was a predator and danger to females. There should be a fundamental review of the process for monitoring sex offenders in the community and the sharing of information between all agencies particularly the police and probation service to ensure that a similar death can be prevented.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by September 25th, 2024. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <p>Chief Probation Officer England and Wales.</p> <p>Chief Constable Thames Valley Police.</p> <p>Croucher family.</p> <p>I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.</p> <p>I may also send a copy of your response to any person who I believe may find it useful or of interest.</p> <p>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.</p> <p>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.</p>
9	<p>Dated: 01/08/2024</p> <p></p> <p>Tom OSBORNE Senior Coroner for Milton Keynes</p>