Regulation 28: Prevention of Future Deaths report

Peter Keith JONES (died 05.11.22)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Metropolitan Police Service (MPS)** **6th Floor, New Scotland Yard** **Victoria Embankment** **London SW1A 2JL**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 11 November 2022 I commenced an investigation into the death of Peter Jones aged 68 years. The investigation concluded at the end of the inquest yesterday. The jury made a narrative determination, which I attach.
4	**CIRCUMSTANCES OF THE DEATH** On 5 November 2022, Mr Jones spent some 18 hours in the public waiting area of Stoke Newington Police Station, before climbing onto the flat hood of one of the phone booths, and jumping off onto the concrete floor. He suffered devastating injuries from which he died shortly thereafter.

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. The jury noted that without the presence of a flat topped telephone hood, there would have been no means for Mr Jones to take his life in this manner. However, I heard at inquest that the telephone hoods in Stoke Newington Police Station have been replaced since Mr Jones's death, and the flat kind are nowhere else in the MPS estate. The jury also found that there was an MPS failure to have sufficient oversight of the public reception area from "the box", the area that faces out to the public reception area. I heard that every police station has a different geographical layout, and that some of these are old buildings. However, a senior police officer giving evidence did accept that station officers could be positioned in the box facing out towards the public area, rather than further into the office facing each other.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 7 April 2025. 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 following. • Mr Jones's two sisters • HHJ Alexia Durran, the Chief Coroner of England & Wales

	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. I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 04.02.25 *ME Hassell*