



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

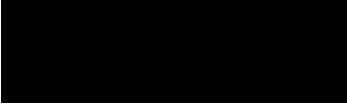
NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS THIS REPORT IS BEING SENT TO: 1 The Chief Constable, Northamptonshire Police
1	CORONER I am Sophie LOMAS, Assistant Coroner for the coroner area of Northamptonshire
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 06 March 2023 I commenced an investigation into the death of Alexander Philip MCCORMACK aged 34. The investigation concluded at the end of the inquest on 24 September 2025. The conclusion of the inquest was Suicide.
4	CIRCUMSTANCES OF THE DEATH Alexander (Alex) McCormack was found deceased on 27th February 2023 inside a tent within Fermyn Woods Country Park, Brigstock. [REDACTED] [REDACTED] A post-mortem examination found that he had died due to [REDACTED] Toxicity. In the months leading up to his death Alex had encountered a stressful situation in his personal life which had led to mental health concerns and suicidal ideation. He had expressed his suicidal thoughts and plans on many occasions and had received support from [REDACTED] mental [REDACTED] health [REDACTED] services. Alex lived in Derbyshire. On 26th February 2023 Alex contacted local mental health services expressing an intent to end his life on that day. He explained the method he would use but would not disclose his location. Derbyshire police were contacted and began a high risk missing persons enquiry. As part of that enquiry cell site data was obtained which indicated that Alex's location could be within the Northamptonshire area. Northamptonshire police were asked to carry out checks on addresses linked to Alex within that area. At 1.19am on 27th February 2023 Derbyshire police formally requested that the missing persons enquiry be transferred to Northamptonshire police and that they accept primacy for the investigation. This was accepted via email with a signed form sent. Derbyshire police emailed the transfer document so that it could be uploaded onto the Northamptonshire COMPACT system. The transfer document contains all enquiries undertaken by the transferring force, including risk assessments, known contacts / addresses and cell site data. The officer responsible for importing the transfer information was unfamiliar with the process. Another officer of the same rank was also unfamiliar with the process, whilst a third officer was able to provide some practical advice and an aide memoir but did not complete the process. Due to the difficulties in transferring the information, there was no COMPACT record on the Northamptonshire system up to the point where Alex was found deceased. Although the transfer of information did not take place, Northamptonshire police



	did continue to undertake searches for Alex overnight but due to the vast geographical nature identified by the cell site data he could not be located. Alex was found by members of the public walking their dogs on the morning of 27th February 2023.
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) The court heard evidence that when transferring missing persons cases between forces, the transfer is accepted by completion of a signed transfer document. Assuming primacy of an investigation does not depend on the importing of a COMPACT file. However, the court also heard that until a transfer of information is complete, the receiving force may not be able to accurately assess the risk and fully take ownership of the investigation. This gives rise to a concern that this could lead to delay in formulating lines of inquiry. The court heard evidence that whilst new recruits to the force, and those promoted internally, are trained on COMPACT and importing cases, this is not covered on the induction training for transferees from other forces at a particular rank. Guidance on how to transfer / import cases is available on the force intranet but this would need to be accessed and followed by the relevant officer at the time of importing the information; essentially leaning through experience. This gives rise to a concern as it could be during a busy night shift where a Reactive Inspector has competing high risk priorities.
6	ACTION SHOULD BE TAKEN 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.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by December 13, 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 Chief Coroner and to the following Interested Persons The family of Alexander MCCORMACK Derbyshire Police 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 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. 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	Dated: 19/10/2025  Sophie LOMAS Assistant Coroner for Northamptonshire