The Office of Tom Osborne
Her Majesty's Coroner for Milton Keynes

1. **Mr Michael Spur,**
2. **Chief Executive of National Offender Management Service.**
   Clive House,
   70 Petty France,
   LONDON
   SW1H 9EX

Civic Offices, 1 Saxon Gate East, Milton Keynes, MK9 3EJ

Our Ref: 313/2013

Your Ref:

Reply To: Coroner

Direct Line: [redacted]

E-Mail: [redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **3. Mr Michael Spur, Chief Executive of National Offender Management Service.** **Clive House, 70 Petty France, LONDON SW1H 9EX**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 27th May 2013 I commenced an investigation into the death of Kevin Scarlett. The investigation concluded at the end of the inquest on 28th February 2014 The conclusion of the inquest sitting with a jury was a narrative conclusion that On 22nd May 2013 Kevin Scarlett was found in cell 101 at HMP Woodhill, Milton Keynes hanging from a bunk using a sheet as a ligature and died as a result of an accident. The circumstances are: as above a) That Kevin's risk of self harm or suicide was not properly assessed b) That is was appropriate for Kevin to be on a 'basic regime' c) That it was inappropriate for Kevin to be alone in a double room/cell d) That Kevin should have been allocated to a safer cell e) That Kevin should have been subject to enhanced case management

4	**CIRCUMSTANCES OF THE DEATH** As above
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. – I felt that the prison service and healthcare did not assess the risk of Mr. Scarlett taking his own life, and I was informed that the staff did not have access to a risk assessment tool or protocol for assessing such risks.
6	**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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th June 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 Family of Mr Scarlett, Treasury Solicitors and Governor HMP Woodhill 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	**Dated this day 15th April 2014** **HM Senior Coroner Milton Keynes**