

Thomas Ralph Osborne Senior Coroner for Milton Keynes

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
1	CORONER
	I am Thomas Ralph Osborne, Senior Coroner for 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 16/02/2015 I commenced an investigation into the death of Lee Anthony Boden. The investigation concluded at the end of the inquest on 18 September 2015. The conclusion of the inquest sitting with a jury was that the deceased had died as a result of Misadventure and the lack of forward planning for his release from prison increased the risk of him using heroin.
4	CIRCUMSTANCES OF THE DEATH
	Lee Boden had been released from HMP Lindholm on 13/02/15 and ordered to reside at an approved premises in Great Holm, Milton Keynes He arrived at the Hostel at 2.20pm on 13/02/15. He was seen to leave the Hostel twice during the afternoon and returned at 7pm. At 7.15pm he entered the downstairs bathroom. At 11.10pm Hostel staff have attempted to enter the bathroom but Mr Boden was slumped against the door. The Police were called and gained entry. CPR was administered and an ambulance called. CPR was continued but without success and Mr Boden was confirmed dead at 12.10am on 14/02/2015. Drugs and drug paraphernalia were found in the bathroom with Mr Boden and needle marks were noted to his groin. He had expressed that he did not wish to be in Milton Keynes as he wished to return home to care for his mother.
	After post-mortem examination, his cause of death was given as 1a) Central Respiratory Depression 1b) Illicit Heroin Use
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
	 (1) That the deceased was not informed of his intended placement in Milton Keynes until the day before his release. (2) The sudden arrival at the hostel would have increased his risk of using heroin. (3) That he had been in the bathroom for almost four hours before he was discovered. (4) Having just been released from prison and being unable to return to his home, he should have been recognised as a vulnerable resident. (5) There appears to be no protocol in place for continuing monitoring of new arrivals who remain vulnerable.

6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you, The National Probation Service, 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 24 th November 2015. 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 Mr Boden The Prison and Probation Ombudsman
	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 29 th September 2015
	Signature Tom Osborne Senior Coroner for Milton Keynes