## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>The Rt Hon Elizabeth Truss MP,<br>Secretary of State for Justice,<br>The Minister of Justice,<br>70, Petty France,<br>London.<br>SW1H 9HD.<br><br>Mr Rupert Soames,<br>Chief Executive of SERCO,<br>[redacted]<br>DWF LLP,<br>1, Scott Place,<br>2, Hardman Street,<br>Manchester.<br>M3 3AA.<br><br>Sir Bernard Hogan-Howe,<br>Commissioner of the Metropolitan Police<br>Empress State Building<br>Lillie Road<br>London.<br>SW6 1TR |
| 1 | **CORONER**<br><br>I am Dr Fiona Wilcox, Senior Coroner, for the coroner area of Inner West London |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 3th May 2015 in inquest was opened touching the death of Ms Michelle Ann Lawrence who died on the 2nd May 205 at Flat 11 Windsor Court, 12, Dunsford Road, Wimbledon, London.<br><br>The inquest was concluded on the 8th September 2016 at Westminster Coroner's Court, sitting at the Royal Courts of Justice with a jury.<br><br>The following findings and determinations were made by the jury:<br><br>The **medical cause of death** was recorded as:<br><br>1(a) *Respiratory Failure.*<br>*(b)Multiple Sedative Drug Overdose*<br><br>*2 Hepatitis C* |

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| | **How, when and where and in what circumstances** the deceased came by her death:<br><br>*Ms Michelle Ann Lawrence died as a result of respiratory failure. She was pronounced dead at 09:25 at home on 02/05/2015 at home. She died as a result of taking a cocktail of prescription and illegal drugs which caused respiratory failure.*<br><br>**Conclusion** of the Jury as to the death:<br><br>***Ms Michelle Ann Lawrence died as the result of a drug related misadventure.*** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Evidence taken at the inquest was that Ms Lawrence had been admitted to the custody of the police on 30/4/2016 at approximately 1pm following arrest. It was noted on booking in that there were risk markers on the PNC for conceals and drugs and that she had in February 2015 hidden drugs in her knickers and vagina, which had later been removed in hospital. The booking- in Sergeant noted this and referred her for strip searching. This was carried out and nothing found. Following her death, the CCTV was analysed showing her removing a plastic container probably from her vagina and taking pills from it on 4 separate occasions whilst in police custody. None of this was noted by custody staff at the time. She was released to the custody of SERCO and thence to the custody suite at Wimbledon Magistrates' Court at 7:10 am on 1st May 2015 and released from their custody at approximately 16:00. Again nothing adverse was noted whilst she was in the custody of SERCO. She was collected by her partner and taken home where is likely to have taken heroin.<br><br>She was found deceased by her partner at her home address at approximately 9:00am 2nd May 2015.<br><br>Pathological and toxicological evidence in the case was consistent with her having died from the effects of taking multiple sedative drugs, prescribed and illegal. This may have included tablets taken whilst in custody.<br><br>The evidence was also that there was no independent investigation of the time spent in the custody of SERCO such that any CCTV from there was lost and statements were taken internally by the company with no statement of truth, sometime after the death.<br><br>At no point either by the police, the nurse practitioner who saw her in police custody, or whilst in the custody of SERCO was she asked whether she had concealed anything. This was despite the warnings on her PNC, the fact she was strip searched by a police officer who had interviewed her in relation to possession of drugs concealed whilst in custody in February, and evidence that conceals are common and increase risk to detainees and others.<br><br>There was also evidence that whilst in Wimbledon she shared a toilet and on that day another detainee may have secreted drugs and attempted to distribute them by leaving them in the toilet. It is apparently not routine for staff to check the toilet for such matters after detainees have used it.<br><br>The evidence was also that there is apparently very little provision for strip searching by SERCO, both in terms of environmental circumstances and the permissions required despite a not uncommon incidence of concealment.<br><br>At Wimbledon Magistrates' custody suite there is apparently only one cell with CCTV coverage and that is in the male detainees' section.<br><br>On the PNC section where risks are highlighted and detailed there are only 60 characters available to describe the background to the risk. In order to find more detail the custody staff have to access other electronic documents which can be difficult in a busy unit. This meant for Michelle that the booking in Sergeant was not aware of details |

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| | that were later provided to him that he says would have caused him to upgrade her risk and possibly consider asking for an intimate search or constant supervision. This may have avoided the death. |
| 5 | **CORONER'S CONCERNS**<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) That there is no independent investigation into the deaths of persons following release from private providers of custody analogous to the IPCC such that important evidence is lost that upon analysis may be used to learn lessons and thus prevent future deaths.<br><br>(2) That detainees are currently not asked about concealment. Such questions at booking in by police and on transfer between custody providers and when in consultation with health care professionals would provide an opportunity for some individuals who conceal to be identified either by positive responses to such questions or by allowing staff to assess their credibility. Ms Lawrence had admitted to taking drugs whilst in custody in February 2015.<br><br>(3) That facilities for strip searching appear to be virtually non-existent for those in the custody of SERCO.<br><br>(4) That SERCO staff do not appear to routinely check toilets for concealed items after they have been used by detainees.<br><br>(5) That all custody suites have sufficient facilities for CCTV monitoring of detainees at risk in custody whether held by the State or private custody providers.<br><br>(6) That the number of characters on the PNC where risks are described and highlighted need to be increased to allow sufficient meaningful detail to be recorded to allow accurate risk assessment by staff without having to trawl through multiple electronic documents. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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. It is for each addressee to identify the concerns relevant to their own areas of responsibility. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 3rd January 2017. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons : |

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| | [redacted]<br>(via email)<br><br>[redacted]<br>(via MPS Legal Services email)<br>IPCC<br>90 High Holborn<br>London.<br>WC1V 6BH<br><br>Director Wimbledon Custody Suite<br>(via MPS Legal Services email)<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **1st November 2016.**<br><br>**Dr Fiona Wilcox,**<br>**HM Senior Coroner,**<br>**Inner West London,**<br>**Westminster Coroner's Court,**<br>**65, Horseferry Road,**<br>**London.**<br>**SW1P 2ED.** |