

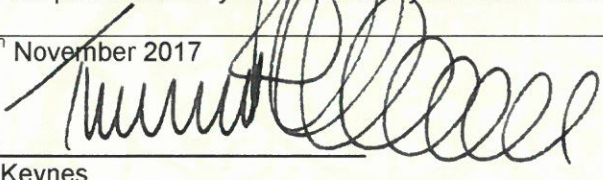


**HM Senior Coroner
for Milton Keynes**

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: The Chief Constable, Northamptonshire Police The Clerk to Northamptonshire Magistrates Courts</p>
1	<p>CORONER THOMAS R OSBORNE</p> <p>I am Thomas Ralph Osborne, HM Senior Coroner for Milton Keynes.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 12/12/2016 I commenced an investigation into the death of Mr Jason Basalat, aged 52. The investigation concluded at the end of the inquest on Friday 17th November 2017. The conclusion of the inquest was as set out in the narrative questionnaire completed by the jury, a copy of which is attached.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Mr Basalat was arrested on 09/12/16 for an assault after he had grabbed the steering wheel of a coach/bus he was a passenger on and forced it to crash into the central barriers.</p> <p>The witnesses describe his behaviour as being strange. He was charged and remanded by Northamptonshire Magistrates Court. The reason that bail was refused was for his own protection.</p> <p>He arrived at HMP WOODHILL at approximately 1430 on Saturday 10/12/16. He refused to engage with prison staff during the interview stage and notes state that there were no indications of self harm.</p> <p>At 07:15 hours 11/12/2016 he was seen in his cell by prison officers and appeared fine. At 08:05 11/12/2016 he was found hanging from a bed frame with a blanket as a noose in his cell, CPR was commenced and he was taken to Milton Keynes Hospital where his death was confirmed.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>(1) The deceased had been arrested for Dangerous Driving when, on the 9th December 2016, he tried to grab the steering wheel of bus travelling on the M1 motorway forcing it to collide with the barriers in the roadworks. Whilst in police custody the deceased was behaving in a bizarre manner and was assessed by a medical practitioner at the custody centre. When eventually transferred to Woodhill Prison after appearing on a Saturday Morning at Wellingborough Magistrates Court the warrant simply stated that the offence</p>

was "Dangerous Driving." Which did not in any way give a true picture of the offence and very little information was provided to the prison as to his behaviour or mental state. The prison informed me that it would have been helpful for them to receive a copy of the deceased's custody record that gave the full picture.

- (2) When the deceased appeared before the magistrates his solicitor was informed that it was not possible on a Saturday morning for a mental health assessment to be conducted. The court did not attempt to contact the prison to inform the prison of the problems being experienced by him due to his mental illness. Consideration should have been given as to the most appropriate place for the deceased to be held or to receive a mental health assessment.
- (3) There needs to be an urgent review by both the Northamptonshire Police and the Northamptonshire Magistrates Court as to their procedures for sharing information with the prison when it is known in advance that the prison will receive a vulnerable prisoner.

6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 22nd January 2018. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <ul style="list-style-type: none">• HMP Woodhill• Central and North West London NHS Trust• The family of the deceased <p>I have also sent it to Prison Ombudsman who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Dated 27th November 2017</p> <p></p> <p>Signature _____ for Milton Keynes</p>