for Bedfordshire & Luton

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: [redacted] HM Inspectorate of Probation 1st Floor Manchester Civil Justice Centre 1 Bridge Street West Manchester M3 3FX
1	**CORONER** I am 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.
3	**INVESTIGATION and INQUEST** On 6th October 2015 I commenced an Investigation into the death of Antony Richard **COUGHTREY** aged 42 years. The Investigation concluded at the end of the Inquest on the 23rd of October 2017. The conclusion of the Inquest was that Antony Richard **COUGHTREY** died as a result of suicide but the Jury went on to find that there was a failure to manage his Licence adequately and this had caused or contributed to his death. The medical cause of death was: I (a) Hanging I (b) I (c) II Chronic Pancreatitis
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death where that Antony **COUGHTREY** had been returned to prison for Breach of his Licence, having been released after serving 23 years of a life

	sentence when he had been charged with an assault upon his brother. Once back in prison he hanged himself.
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 following a death of a prisoner who had been released on licence following a life sentence, there was no internal investigation by the Probation Service or any inquiry resembling a Serious Incident Review. They seem to have led to an air of complacency as to the Probation Service's role in managing Mr Coughtrey 2. I also felt there was a failure in the procedure for referring a prisoner back to the Parole Board when there had been a clear breach of the Conditions of Licence set out by the Parole Board.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **15th March 2018**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 (as per the attached list). 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

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	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 15th January 2018.** ..... **Tom OSBORNE** **Senior Coroner** **Milton Keynes**