	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **1. The Rt. Hon Robert Buckland QC MP, Lord Chancellor and Secretary of State for Justice, House of Commons, London, SW1A 0AA** **2. The Rt. Hon Matt Hancock, Secretary of State for Health and Social Care, Richmond House, 79 Whitehall, London SW1A 2NS** **3. Ms Jo Farrar, Chief Executive Officer, HM Prison & Probation Service (HMPPS), HM Prison Service, 102 Petty France, London SW1H 9EX**
1	CORONER I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2	CORONER'S LEGAL POWERS I make this report under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	INQUEST On 1st December 2016, I opened an inquest into the death of **Master Alex Malcolm aged 5 (died 22.11.16) case ref: 03101-2016 (JB)** and suspended it under Coroners & Justice Act 2009 Sch 1(2) at the request of the police. The medical cause of death was reported as 1a Head Injury. A perpetrator was found guilty of murder on 21st July 2017. On 12th July 2018 after hearing lengthy submissions and seeking his counsel's opinion, the Senior Coroner decided that there was an arguable breach of Article 2 of the European Convention on Human Rights by the National Probation Service (NPS), on the application of *Osman*, and resumed the inquest, a decision accepted by NPS at inquest. It was heard before a jury and concluded on 2nd September 2019. The jury concluded that she was unlawfully killed and delivered a narrative conclusion.
4	CIRCUMSTANCES OF THE DEATH Matters recorded by the jury as contributing to the death included: 1. The perpetrator being wrongly classified as MAPPA Category 2 Level 1 before release from prison 2. Failure to identify the perpetrator's relationship with the deceased's mother 3. Failure to share information with relevant agencies who could have notified the deceased's mother of the perpetrator's history of violent offending and put in place safeguarding measures 4. Allocation of a high risk offender to a newly qualified probation officer without

	adequate supervision 5. Failure to refer the perpetrator for a place in Approved premises 6. Failure of relevant agencies to identify, request and share relevant information 7. Failure to adequately challenge or to take action to recall the perpetrator in response to his failures to comply with licence conditions. Defects in the system were found which contributed to the death and included: 1. Changes to the NPS in 2014 leading to higher case workloads 2. NPS understaffing 3. Significant shortages of places in Approved Premises 4. Poor partnership working between prison and NPS and shortage of offender supervisors in prison Significant steps have been taken and action plans implemented to reduce the chance of future preventable deaths.
5	**CORONER'S CONCERNS** During the course of the inquest, the evidence revealed matters giving rise to concern that in my opinion means that there is still 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. A senior NPS divisional head said that providing more Approved Premises places would potentially save lives. It is understood the matter is under review but details of what steps have since been taken were not heard by the coroner. 2. The Chair of the Serious Case Review subgroup of Lambeth Safeguarding Children Board said that strengthening any arrangements around domestic violence, including putting MARACs on a statutory basis had the potential to save lives. The senior Coroner raised this issue in a Prevention of Future Deaths Report to the Secretary of State for Health earlier this year, triggered by the chair of a domestic homicide review into the death of Donna Williamson. Her evidence was clear that there were arguments for MARAC and other bodies to be put on a statutory footing and for the system to be reviewed. The response from the ministry did not specifically address the issue. 3. A senior NPS divisional head said that there were still difficulties in recruitment and retention of probation officers, one factor in which was low pay. It is understood the matter is under review but details of what steps have since been taken and their adequacy were not heard by the coroner.

6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths. I believe that the following organizations would wish to learn of the circumstances of this death and are in a position to mitigate or prevent future deaths: **The Ministry of Justice with regard to concern 1** **The Secretary of State for Health and Social Care with regard to concern 2** **The National Probation Service with regard to concern 3.** The full Record and detailed Domestic Homicide Review can be made available to Ministers if this is of assistance.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by Wednesday, 11th December 2019. 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. If you require any further information or assistance about the case, please contact the case officer, [redacted]
8	COPIES and PUBLICATION I have sent a copy of my report to the following Interested Persons: [redacted] (Mother) [redacted] (Father) [redacted] Counsel for The National Probation Service [redacted] The Probation Service Case Officer I am also sending this report to the following, who may have an interest, or as prevention may involve their organizations: the charity Safelives, the Local Government Association, Lambeth Child Safeguarding. 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	[DATE] 15-10-19 [SIGNED BY CORONER]