Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** HM Prison and Probation Service Practice Plus Group
1	**CORONER** I am Rachel REDMAN, Assistant Coroner for the coroner area of East Sussex
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 22 April 2021 I commenced an investigation into the death of Trevor Alan MONERVILLE aged 33. The investigation concluded at the end of the inquest on 25 September 2023. The conclusion of the inquest was a narrative verdict finding that Trevor Alan Monerville died as a result of natural causes, namely SUDEP having suffered from epilepsy and non epileptic attack disorder. He was detained at HMP Lewes initially on the healthcare wing, and then on M wing in a single cell. Monitoring ceased once the ACCT was closed on 10.03.21. On 18.04.21 in the morning Trevor was found unresponsive in his cell and death was confirmed soon after. The communications between all organisations within the prison and between the prison and outside agencies, the monitoring systems, the sharing of medical information and engagement with Trevor's family were found to be inadequate and there was insufficient and inadequate management of Trevor's care.
4	**CIRCUMSTANCES OF THE DEATH** Trevor Monerville had been detained at HMP Lewes since 30.11.20. He was moved to M wing on 16.01.21.He was placed in a single cell and appeared settled and was part of the daily cleaning crew. He was last seen by the night staff at around 0500hrs on 18.04.21 during routine checks. At 0950hrs he was found unresponsive face down in his cell floor. Prison staff rolled him onto his back and saw blood around his nose. CPR was started and am ambulance called. The ambulance crew continued CPR in spite of obvious signs of rigor mortis in his lower limbs for approximately 1 hour. ROLE was confirmed at 1059hrs. A brief search of the cell revealed a significant quantity of medication in tablet form some of which was no longer coated and stuck together indicating it had been removed from the mouth. The cause of death found at post mortem examination was 1a Sudden Unexpected Death in Epilepsy.

5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: a. Consideration should be given to the review of the treatment, monitoring and management of patients with a history of epilepsy or seizures by both the prison staff and healthcare staff. In particular, there was no seizure care plan, no seizure diary and once the ACCT had closed on 10th March 2021, there was no formal mechanism of monitoring Trevor's condition. Further, the ACCT is not a suitable mechanism for such monitoring. The CSRA policy is designed to protect other prisoners, but not those who suffer from medical conditions as Trevor suffered. PPG in their evidence to be considered relating to PFD matters state that a care plan dashboard is now in place at HMP Lewes but this does not appear to be individualized or tailored to the prisoner's clinical requirements. b. Communication between healthcare and prison staff especially when Trevor was returned to the wing, between the prison staff and family, briefing by prison managers to officers on the wing about Trevor's condition were all inadequate. Evidence was heard about the lack of integration of various IT systems which contributed to poor communication. In spite of the evidence from PPG regarding the sensitivity of medical records which should not be disclosed to the prison staff, I remain concerned that there was no effective monitoring and management of Trevor on the wing once the ACCT was closed. There was no mechanism in place for prison and healthcare staff to report their concerns about Trevor's non compliance with taking his medication to Security, thus preventing the cell from being searched for retained medication. c. There was a lack of training of prison staff in dealing with long term health conditions such as epilepsy on the wings. I understand there is a deficit in national policy within the prison service to manage and support prisoners with epilepsy and seizures.
6	**ACTION SHOULD BE TAKEN** 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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by March 07, 2024. 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 ▪ Family of Trevor Monerville I have also sent it to: ▪ Prisons and Probation Ombudsman

	▪ Independent Advisory Panel on Deaths in Custody ▪ HM Inspectorate of Prisons who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 16/01/2024** Rachel Redman **Rachel REDMAN** **Assistant Coroner for** **East Sussex**