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HM Prison & Probation Service

Rachel Redman
Assistant Coroner for East Sussex
Unit 56 Innovation Centre
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[redacted]

29 February 2024

Dear Ms Redman

Thank you for your Regulation 28 report of 4 January 2024 addressed to the Minister of State for Prisons, Parole and Probation following the inquest into the death of Stephen Coster at HMP Lewes on 5 May 2022. I am responding on behalf of HMPPS as Director General of Operations.

I know that you will share a copy of this response with the family of Mr Coster, and I would like to express my condolences for their loss. Every death in custody is a tragedy and the safety of those in our care is my absolute priority.

Following evidence heard at the inquest you raised concerns directed to both HMPPS and Practice Plus Group (PPG). I am responding to those relating to HMPPS.

Following the Fact-Finding report on 16 May 2022 HMP Lewes undertook a review of record-keeping practices which identified a generally very good approach by staff. Issues identified, such as the need for staff to record smaller interactions, have been addressed, with staff being reminded of the need to record all relevant information.

The prison has also conducted a further review, together with healthcare, to consider how best to manage the care and monitoring of unwell prisoners. An agreed system is now in place which clarifies that prison staff are responsible for welfare checks and medical staff are responsible for clinical observations. Healthcare staff inform prison staff of the need for checks on a particular prisoner and what level of check is required. Where healthcare feel it is clinically appropriate, a move to the inpatient unit at the prison will be facilitated so that healthcare staff are present to undertake all observations.

The prison continues to brief staff regularly regarding the appropriate use of Code Red and Code Blue, and the importance of using them to ensure the emergency services are called immediately. Shortly after Mr Costers death, a Notice to Staff was sent out to raise awareness and remind staff of their responsibilities. This was followed up by reminders in the Safety Newsletter later in the year and the Safety Nudge the following year. A number of training events have also taken place, delivered by the Safety Team, on the emergency

codes. Every person was also issued with a business card-sized pocket guide as a handy reminder, which all new staff now receive as part of their training.

Following the death of Mr Coster and the PPO's recommendations, the Deputy Governor and Head of Safety conducted a review into the circumstances of the prison escort to hospital. Their findings identified a need for improved communication with and greater clarity from healthcare staff to ensure that urgency of the matter is made clear to prison staff. This has been shared with healthcare.

Custodial Managers have the authority to dispatch an emergency escort without the relevant risk assessment where the life of a prisoner is in danger. The Local Operating Procedure for Hospital Escorts and Bedwatches refers to escorts being dispatched without the relevant risk assessment where there is an 'emergency.' The policy on emergency escorts as a whole is being actively reviewed.

Following a review into incident management the Assistant Orderly Officer now attends each Code Blue/Red to personally oversee, provide direction, and ensure standards are kept, ensuring effective leadership during the management of the incident.

Thank you again for bringing your concerns to my attention. I trust that this response provides assurance that action is being taken to address the matters that you have raised.

Yours sincerely

Director General of Operations