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:** **1 The Phoenix Partnership** **2 EMIS Health**
1	**CORONER** I am Laura BRADFORD, 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 04 February 2019 I commenced an investigation into the death of Finlay Stuart Ian FINLAYSON aged 54. The investigation concluded at the end of the inquest on 19 March 2024. The conclusion of the jury was that: Narrative: we the jury consider that Vinney's care was affected by the following issues, the absence of which may have delayed or changed the circumstances of his death. There was confusion and uncertainty about his medical conditions caused by information sharing and permissions issues with SystmOne, leading to an over reliance on Vinney's own statements. Some poor record keeping on SystmOne and confusion over when to reference the system. This affected both plans and reporting of interactions. Failures in communication between agencies and shifts, not helped by the numbers of different staff and agencies involved, high demand and challenging workloads and associated delays in accessing healthcare. This was particularly relevant between 21 and 24 January 19. In particular we note: a lack of quantifiable evidence, e.g. NEWS scores or notes of proportionate follow-ups and recorded observations between 21 and 24/1/19 which may have allowed any deterioration in Vinney's condition to be missed. On 25/1/19, there was a grave and unacceptable failure in communications with two or three emergency radios switched off in contravention of prison rules and protocols. This was then compounded by a delay in timely response, i.e. the proposal of a phone call rather than an in-person response, which may have been longer had it not been for decisive intervention from comms. This was followed by unacceptable indecision on calling an ambulance, in which perceptions of Vinney's mental health were a factor, and should have been automatic on account of his head injury.
4	**CIRCUMSTANCES OF THE DEATH** Vinney died of the causes in section 2 (pulmonary thromboemboli due to deep vein thrombosis with a background of metastatic carcinoma of the base of the tongue) following cardiac arrest on 25/1/2019 at HMP Lewes (Cell 216 on C-Wing), whilst on remand. He was pronounced dead at 9.16am.
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:

	(brief summary of matters of concern) During the course of the Inquest the jury heard evidence about the difficulty in information being transferred over from Mr Finlayson's GP surgery system, which uses SystmOne to the prison system (also SystmOne). The evidence was that information was not able to be freely shared between the two and it meant that there was a delay in healthcare staff in the prison accessing relevant information about Mr Finlayson's long term health issues as well as contact with his GP as recent as a week before going in to prision. Mr Finlayson sadly died in 2019 and I have heard evidence that the functioning of SystmOne has improved since his death. I was told, however, that there remains an issue with the interaction between SystmOne and other medical databases used in England and Wales. SystmOne appears to be the preferred system for many prisons and detention centres but there are still many GP surgeries that use other systems. I heard evidence that if someone goes to prison and is linked to a surgery that uses another system (like EMIS) the notes have to be printed and scanned on to SystmOne and key information has to be input onto someone's record by hand. I am concerned about the potential delay this process could cause. I am also concerned that key information could be missed by virtue of these systems not communicating with each other. I have heard evidence as to the importance of someone's medical history being available for those within the prison setting to assist with careplanning and the provision of appropriate care and in my opinion, there is a risk that future deaths could occur unless action is taken to make the transfer of this information more efficient.
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 May 17, 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 **Mr Finlayson's family** **HMP LEWES** **Sussex Partnership NHS Foundation Trust** **Med-Co Secure Healthcare Services Ltd** I have also sent it to **NHS England** **Practice Plus Group** 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: 22/03/2024**  **Laura BRADFORD** **Assistant Coroner for** **East Sussex**