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 HM Prison and Probation Service**
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 13 May 2022 I commenced an investigation into the death of Stephen COSTER aged 43. The investigation concluded at the end of the inquest on 04 December 2023. The conclusion of the inquest was that: Stephen was detained at HMP Lewes on 26.4.2022 on remand. Stephen was found in his cell on the floor naked between 5am-5.30am on the morning 3rd May 2022. Prison officers called for health care to attend Stephen's cell. Medical staff attended, very limited examination was made. At this time no treatment was given. Stephen was left in his cell in the same condition. Health care staff advised Prison staff to undertake observations. It was recorded Stephen was under the influence. At approximately 8.30am, Stephen was checked in his cell. His condition had deteriorated. Prison staff asked for healthcare to attend. Healthcare staff deemed it necessary for an ambulance to be called. Following assessment ambulance staff advised Stephen should immediately be taken to hospital. There is evidence that delays to paperwork resulted in the ambulance being unable to leave the prison grounds. The Paramedic clearly stated that Stephen should be taken to hospital immediately with life threatening conditions. Paperwork was eventually completed. The ambulance was able to leave prison at 10.29am, Stephen arrived at hospital at 10.45am. Stephen was taken to resuscitation, and received treatment at the hospital.
4	**CIRCUMSTANCES OF THE DEATH** Stephen Coster died as a result of 1a Meningo encephalitis owing to Streptococcus pneumoniae at Royal Sussex County Hospital, Brighton. The jury found that delay by the prison staff and healthcare staff in enabling the correct treatment to be given to Stephen Coster in HMP Lewes more than negligibly, minimally and trivially contributed to his death.
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) a. Evidence was heard relating to poor and inadequate record keeping by prison staff.

	b. A failure by healthcare staff to carry out adequate observations and to properly assess Stephen Coster's condition as well as a failure to escalate his case. c. Healthcare staff failed to provide the prison staff with an adequate care plan so that Stephen Coster could be monitored effectively. Evidence was heard that there was no protocol or policy in place regarding communication between Healthcare staff and Prison staff for the monitoring of sick prisoners on the wing at night. d. There was inadequate understanding amongst prison staff about when to call Code Blue. e. There was a breakdown in communication between healthcare staff and prison staff regarding transferring a sick prisoner to hospital as an emergency. Further, there was inadequate information included on the paperwork prepared by healthcare staff about Stephen Coster's condition resulting in delay in arranging for his urgent escort and transfer to hospital. f. An inadequate understanding amongst prison staff about the local policy to transfer emergency cases to hospital with a retrospective risk assessment. g. Inadequate leadership by prison staff leading to a breakdown in communication amongst junior prison staff which caused the delay in transferring Stephen from the prison to hospital. Having heard evidence from Practice Plus Group about the improvements in its service delivery which have been implemented and which are being monitored, I have decided not to send a copy of this PFD report to PPG on the understanding that action is being taken to prevent future deaths such as Stephen Coster's.
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 February 13, 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 Stephen Coster • Practice Plus Group I have also sent it to • South East Coast Ambulance Service NHS Foundation Trust • 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: 04/01/2024** Rachel Redman **Rachel REDMAN** **Assistant Coroner for** **East Sussex**