



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 Practice Plus Group
1	CORONER I am Rachel REDMAN, Assistant Coroner for the coroner area of East Sussex Coroners Service
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 19 December 2023 I commenced an investigation into the death of Jamie Stuart FUNNELL aged 44. The investigation concluded at the end of the inquest on 30 September 2025. The conclusion of the inquest was that: Narrative Conclusion: Jamie Stuart Funnell's death was due to the effects of drug and alcohol withdrawal that was exacerbated by a series of omissions by healthcare and prison staff.
4	CIRCUMSTANCES OF THE DEATH Jamie Stuart Funnell was detained at HMP Lewes, 1 Brighton Road, Lewes - arriving on Friday 15th December 2023 where he resided until his death at 17:16 hours on 16th December 2023. During his detention at HMP Lewes, Jamie was withdrawing from alcohol and drugs on a specialist wing, then known as K-wing. His care at HMP Lewes presented missed opportunities for detoxification identification and management, essential protocol-driven care and potentially life saving medication prescriptions and reviews. From the evidence given, the jury found multiple instances of insufficient multi-disciplinary care, inconsistent monitoring, multiple deferrals of responsibility and a definite failure in communication. HMP Lewes has displayed cases of institutional apathy that allowed a vulnerable adult to fall through its care protocols. The key points the jury saw as possibly causative in Jamie's death were as follows: - When Jamie was admitted to HMP Lewes, healthcare staff omitted to correctly identify and record vital assessments to determine the stage and nature of his withdrawal; meaning the appropriate regime was never put in place. - Conflicting accounts regarding Jamie's symptoms during his stay at HMP Lewes demonstrate a clear failure to correctly record, keep, observe and communicate when caring for a vulnerable adult. - Finally there was no instinctive initiation of CPR at the first opportunity.



	<table><tr><td data-bbox="172 315 225 356">5</td><td data-bbox="225 315 1380 1400"> 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) 1.The Standard Operating Procedure for Assessment and Management of Alcohol Dependence expired in March 2024. I heard evidence that it will be replaced by an updated Policy on 9.10.25. I asked for a copy of the draft Policy to determine whether issuing a PFD could be avoided when hearing evidence about PFD matters but was advised by the PPG's legal representative that this was not possible, without a reason why being offered. I consider that action should be taken to prevent a failure to update before their expiry all PPG's Standard Operating Procedures including this one which the Clinical Reviewer found to be potentially unclear. His findings were published on 19.4.24, a month after the Standard Operating Procedure had expired, and yet it continues to remain out of date, almost 18 months later. PPG could have reasonably expected it would be subject to scrutiny in this inquest and update it accordingly and in a timely manner. Their failure to do so indicates a cavalier attitude to reviewing and updating important Policies and action should be taken to address this. 2. I heard evidence describing the care given to Jamie Funnell after his collapse as chaotic, with faulty equipment and incorrect CPR technique. The Ambulance crews witnessed the healthcare members carrying out CPR before taking over. After Jamie's death was confirmed, a crew member raised concerns with the Duty Governor about the CPR attempts she had witnessed. I have heard evidence that although 32 eligible healthcare staff have now completed life support training, I have not heard any evidence regarding the level of this training and remain concerned, especially in light of the unsatisfactory response by PPG in its Action Plan for the PPO Report dated September 2024 that adequate training of staff and monitoring of equipment to prevent faults in its operation have been undertaken to prevent a fatality occurring in similar circumstances. </td></tr><tr><td data-bbox="172 1400 225 1440">6</td><td data-bbox="225 1400 1380 1547"> 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. </td></tr><tr><td data-bbox="172 1547 225 1753">7</td><td data-bbox="225 1547 1380 1753"> YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by December 8, 2025. 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. </td></tr><tr><td data-bbox="172 1753 225 2029">8</td><td data-bbox="225 1753 1380 2029"> COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Family of Jamie Funnell Ministry of Justice (Government Legal Department) </td></tr></table>	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) 1.The Standard Operating Procedure for Assessment and Management of Alcohol Dependence expired in March 2024. 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	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: 13/10/2025 <i>Rachel Redman</i> Rachel REDMAN Assistant Coroner for East Sussex Coroners Service