ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Minister for Justice** **2. The Secretary of State for Health** **3. NHS England**
1	**CORONER** I am Alan Romilly Craze, senior 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 22nd June 2016 I commenced an investigation into the death of Justin Peter Gallagher. The investigation concluded at the end of the inquest on 21st November 2018. The conclusion of the inquest was NATURAL CAUSES.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was received at HMP Prison Lewes on 20th March 2016 after being sentenced for a number of offences. During his time at Lewes he was admitted to the in-patient unit for about three weeks and spent the same amount of time in the segregation block. On 24th May 2016 he was found collapsed in his cell on the segregation block. He was taken to Haywards Heath Hospital where he died on 17th June 2016. The post-mortem gave his cause of death as 1a. Hypoxic brain injury; 1b. Cardiac arrest; 1c Laryngeal carcinoma with upper airway obstruction; 2. Bronchopneumonia, chronic obstructive pulmonary disease, previous cigarette smoking and excess alcohol.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence 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. – (1) The prison never obtained his previous medical history. No proper care plan was drafted for him and there was no single clinician responsible for his care. (2) A number of external hospital appointments were cancelled at short notice because of lack of resources (no available escorts etc.) and there was no system available for arranging such visits.

	(3) The deceased died of cancer but this had never been diagnosed and opportunities to have discovered his condition were missed. (4) There was no involvement of the family and so a source of important information was missed. (5) The underlying problem was that healthcare in the prison was the responsibility of three different organisations, namely the prison service, the local mental health NHS Trust (who were given the responsibility of dealing with all physical health matters and running the healthcare centre), and a separate organisation who supplied GPs. These three organisations had entirely separate database systems.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 11th October 2019. 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: 1. The deceased's father 2. Sussex Partnership NHS Foundation Trust (the healthcare provider) I am also under a duty to send the Chief Coroner a copy of your response. 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	**16th August 2019** **Senior Coroner for East Sussex**