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. Secretary of State for Health** **2. NHS England** **3. Secretary of State responsible for prison management**
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 21st March 2018 I commenced an investigation into the death of Martin Leslie Haines, aged 60, who died at Lewes Prison on 18th March 2018. The investigation concluded at the end of the inquest on 6th April 2019. The conclusion of the inquest found by the jury was a narrative conclusion: Cardiac arrest in the presence of Venlafaxine, Amitriptyline and alcohol.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was detained in Lewes Prison and was seen on numerous occasions by primary healthcare staff for, amongst other conditions, a wound on his toe which caused a lot of pain and discomfort. He was diagnosed with Type II Diabetes but there were warning signs which could have led to a diagnosis of cerebrovascular disease and the appropriate diagnostic tests were not carried out. On 18th March 2018 he was found dead in his cell. There was confusion and delay in responding to the discovery of his body, but in fact rigor mortis had set in so this did not contribute to the causation of his death. The subsequent post-mortem examination led to the discovery of alcohol, Venlafaxine and Amitriptyline in his system and the pathologist considered these had contributed to his death.
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 fact that the deceased was able to brew or distil his own alcohol. (2) The failure to carry out diagnostic testing and monitoring for his diabetes and to

	confirm his considerable cardiovascular disease. (3) The standard of care appears to have fallen well below that which he could have received in the community. (4) There were no protocols or agreements between healthcare staff and the prison service as to how best to respond to an unresponsive body. (5) In my opinion, the underlying problems were due to the fact that responsibility for healthcare in the prison was split between the prison service, Sussex Partnership Foundation Trust (which is a mental health provider but was also contracted to run all healthcare, both physical and mental within the prison), Medco Ltd who provided the GPs and Forward Trust who were contracted to treat alcohol and substance misuse in the prison. There was insufficient communication between these bodies and they had separate IT databases.
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 Sussex Partnership NHS Foundation Trust who appeared as an Interested Person. 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**