REGULATION 28 REPORT ON ACTION TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

- A. NHS England, PO Box 16738, Redditch, B97 9PT
- B. Chief Executive Officer Practice Plus Group (PPG) Hawker House 5-6
 Napier Road Reading Berkshire RG1 8BW
- C. Lord Chancellor and Secretary of State for the Ministry of Justice, 102 Petty France, London SW1H 9AJ,
- D. Serco Group plc, Serco House, 16 Bartley Wood Business Park, Bartley Way, Hook, Hampshire, RG27 9UY (responsible for HMP Thameside)

1 CORONER

I am Mr Hassan Shah, Assistant Coroner for the coroner area of Northampton.

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 08/11/2018 I commenced an investigation into the death of Mr Jonathan Michael McCarthy ("Mr McCarthy"). The investigation concluded at the end of an inquest on 12/10/2023. I recorded the conclusion as natural causes.

The medical cause of death was:-

- 1a Bronchopneumonia and multi organ failure
- 1b Acute cardiac arrhythmia (with initial resuscitation)
- 1c Myocardial fibrosis (related to drug and alcohol abuse)

4 CIRCUMSTANCES OF THE DEATH

Mr McCarthy died on 12th August 2018 at University Hospital Coventry and Warwickshire as a result of a cardiac arrhythmia whilst at HMP Onley. The arrhythmia occurred as result of scarring of the heart.

5 CORONER'S CONCERNS

Upon Mr McCarthy's arrival at HMP Altcourse on 5 June 2017, it is recorded that he had an outstanding hospital appointment. There was no evidence that HMP Altcourse took any steps to verify this appointment.

Mr McCarthy was transferred to HMP Thameside on 7 May 2018. It is recorded that he had an appointment to see the cardiologist at Whittington Hospital on 13 June 2018. There was no evidence that HMP Thameside took any steps to verify this appointment. He was transferred from the prison on the next day, 14th June 2018.

It was suggested in evidence that HMP Thameside automatically re-arrange all community medical appointments for security reasons. It was clarified that the prison would only try to get a new appointment if there was a specific security concern.

There was also no evidence that Mr McCarthy had a fitness to transfer assessment at either HMP Altcourse or HMP Thameside.

In light of these matters, I consider that a Regulation 28 report is required in relation to the policies and procedures for: -

- 1. verifying a prisoner's pre-existing community hospital appointments.
- 2. determining the clinical importance/urgency of pre-existing community hospital appointments and the impact of security issues upon this assessment.
- 3. assessing fitness to transfer and determining medical hold.

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 **Thursday 7**th **December 2023**. 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:-.

- a) (Spouse of Mr McCarthy).
- b) HM Prisons and Probation Service (HMPPS)
- c) Northamptonshire Healthcare NHS Foundation Trust
- d) Prisons and Probate Ombudsman

Similarly, you are 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.

9 H Shah - Mr H Shah - Assistant Coroner