RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS
REGULATION 29 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

THIS RESPONSE IS BEING SENT TO:

The Assistant Coroner, Jenny Goldring for the Coroner Area INNER SOUTH LONDON in response to a '**REPORT TO PREVENT FUTURE DEATH REGULATION 28'** following an inquest into the death of **Mark Smith** that concluded on **24 March 2026**.

1.	**RESPONDENT** In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, **Practice Plus Group (PPG)** provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths.
2.	**DATE OF RESPONSE** 2 JUNE 2026
3.	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The **MATTERS OF CONCERN** were identified in the report are as follows: **(1)** The wrong dose of medication could be prescribed and/or administered with life threatening consequences. Albeit I have seen evidence of significant improvements in the healthcare provision at HMP Thameside since 2019 (e.g HMIP report February 2026); as recently as 2024 to 2025 HMIP and IMB reports noted "significant risks with management of medicines" and "prescribing errors." Whilst recent internal audits in 2025 show significant improvements, medication incidents (datix) are recorded in late 2025 and the principal pharmacist notes a very busy site with multiple prescriptions screened daily. Further, during the inquest it proved difficult to establish how Systm 1 (the medical note system) operated and whether there were risks inherent in the system itself. For example, it was suggested the system would convert mg into ml or pre-populate entries such as 100ml, in contradiction to the subsequent PFD evidence provided. **(Practice Plus Group)** (2) I remain concerned a similar situation could arise as did in Mark's case regarding a discharge back to prison from QEH without an MDT meeting despite repeated requests

	from prison healthcare and there could be a risk to life. I note PFD evidence provided regarding improved liaison between QEH and the prison GP but note no reference to liaison between QEH and the head of the healthcare in prison, who visited QEH twice in Mark's case. Further, as recently as 2025 an incident occurred when there was a lack of understanding at QEH around the limited provision in healthcare in prison. I am concerned as to how awareness of the limits of prison healthcare will be disseminated on a continuing basis to new and locum staff at QEH. **(QEH and Practice Plus Group)** (3) Healthcare staff may be unable to enter a prisoner's cell at night and monitor them in a situation which may not constitute a "medical emergency" but in which a patient nevertheless requires attention; a patient could decline and the situation become life threatening. I have received detail from Serco of "an escalation process" if Oscar 1 and Hotel 1 cannot agree about entry to a cell and I have been told this has been "recommunicated" to all staff. However, this is not recorded in a policy. I am concerned about awareness of the process for all prison and healthcare staff including on an ongoing basis. **(Serco and Practice Plus Group).** **(4)** There are no larger disabled cells (which can accommodate hospital beds and wheelchairs) adapted to also facilitate a constant watch. Serco say no need is identified, but as recently as March 2026, a request was made (and permitted) for a door to be left open (for access) in a disabled cell. If there were security concerns, then this might not be possible, and a similar situation might occur to that in Mark's case. **(HMPPS)** **(5)** I am concerned there were numerous missed and falsified observation entries in Mark's case and how similar incidents can be prevented given the reliance on handwritten sheets being scanned onto the system at a later stage. I appreciate the efforts made with training and audits. **(Practice Plus Group)**
3.	**DETAILS OF ACTION TAKEN,** how has the concern been addressed. [If no action is proposed please explain why here]. *Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.* We do not propose to respond to the points raised above in respect of HMPPS and other organisations where they do not touch upon PPG. We will seek to address each point as listed above. (1) In respect of medication management, we are glad to hear that the improvements to the service have been noted. This was addressed extensively in the witness statement of the Head of Healthcare dated 30 March. As noted, the prescribing audit in February 2026 scored 94.12%, and the medication administration audit in August 2025 scored 91.6% (the latter being carried out yearly). HMP Thameside is a busy remand prison with up to 1200 prisoners at any one time. This is not something within PPG control or that will be subject to change. All new admissions to the prison go through an initial reception screening with healthcare, this is then followed up with a second screening within 7 days and a medicine reconciliation to ensure correct prescribing and continuity of care. PPG also introduced the Early Days in Custody ("EDIC") pathway which

	supports patients during their first 14 days in custody. This was outlined in the Head of Healthcare's statement dated 17 March 2026. In addition to the usual screenings, all new arrivals are discussed at the EDIC Multi-Disciplinary Team ("MDT") referral meeting which takes place daily Monday to Friday. Every new reception patient is discussed at this meeting. This ensures that there is a safety net in place to capture all patients coming through reception and identify their needs. A plan is then put in place for them moving forward and necessary referrals made off the back of this meeting. Patients with complex and multiple needs are referred to the Multidisciplinary Professionals Complex Cases Clinic ("MPCCC") which runs every Wednesday and is chaired by the Lead GP. It is worthy of note that the EDIC meeting at HMP Thameside was listed as an example of notable positive practice under section 2.4 of the recently published independent review of progress (IRP) report by His Majesty's Inspectorate of Prisons (HMIP). These pathways and processes all feed into ensuring safe prescribing for patients and the audits are used to track progress and maintain high standards. Furthermore, there is a weekly Safer Prescribing meeting that takes place every Wednesday and is attended by senior clinicians within the service including the lead GP and pharmacist, clinical prescribers, matrons and nursing staff. This meeting focuses on those patients with complex prescribing needs and/or polypharmacy. An outcome letter is sent to patients following the meeting, notifying them of any pertinent discussion or changes to their medication regime and the rationale. SystmOne is a national records system used across all prisons in the country. It is not owned or managed by PPG and so any changes to the system are not within our control. We note that during the inquest it was difficult to establish the reasons behind mg and ml being referred to in respect of Pregabalin at different points in the records. We were not the healthcare provider at the time and so cannot comment on the reason for this. However, PPG would like to provide reassurance of the checks and balances which are in place to prevent the wrong dose of medication being prescribed and/or administered. Staff who dispense medications are trained on this and the need to remain vigilant with medication administration and medications are also subject to checks and reconciliation. (2) In terms of our relationship with QEH, this is our local hospital and therefore we naturally send out most of our emergency admissions there. Over the past year, and since the current Head of Healthcare has been in post, we have held multiple MDT meetings with QEH regarding our patients, as well as sent our Matrons (most senior clinical staff) and the Head of Healthcare to the hospital on a regular basis to meet with hospital staff and ward managers to get updates on the patients, particularly where they are out for longer periods of time. More recently we have designed an information pack on the services we provide at HMP Thameside in respect of healthcare and we ask escorting prison officers to take this out with them to hospital appointments and bed watches and handover to hospital staff. We hope that this will aid knowledge of our service and what we do and don't provide, moving forward. We also have an upcoming open day for hospital staff to be able to visit

	HMP Thameside and understand more about the healthcare service we provide. This will feature a tour of the prison, a Q&A and a presentation by senior clinicians. The event is currently being attended by 17 different members of staff from across different hospital trusts and we plan to run this event on at least a 6-month basis, moving forward. In regards to discharges from hospital, we expect the patient to return to the prison with a discharge summary. This is handed over by escorting staff in reception to either the GP or nurse (depending who is available and on duty) and will then be scanned into SystmOne for review and appropriate action. If our healthcare team were to receive what we determine to be an unsafe discharge then this is discussed with the matron, and where necessary, raised formally via an unsafe discharge form or referral. (3) Cell doors can be requested to be opened by healthcare members of staff at any point during the day and Serco prison officers are willing and obliging to help and support. However, it is worthy of note that sometimes prisoners can be on heightened unlock which means that they require a higher number of prison officers than usual to be present when their door is unlocked. The number of officers present is dependent on the perceived level of risk presented by the patient. In order for a door to be opened during night state, permission has to be granted by Victor 2 (the radio call sign for the overnight duty director). In addition, healthcare staff are able to make a special request to have a door opened either periodically or consistently for a patient for which they have specific concerns regarding. This is based on a risk assessment jointly completed between healthcare and prison staff. We have recently implemented a more formalised governance process between PPG and Serco to be able to document the above-described process and demonstrate accountability and reasoning for the decision. This process was described and outlined in the previous statement. As of February 2026, we now have a request form that is filled out by a senior clinician in healthcare initially to outline why they are requesting to have the cell door left open and for what duration of time they are requesting this (i.e., door open permanently, door open at intervals, etc). The form is then sent to the Head of Safer Custody (the Serco director responsible for this) for review and sign off. If any further information from healthcare is requested at this stage, then the director will send back. After sign off by the Head of Safer Custody, it will then be passed to the deputy director for final sign off and awareness. Training to staff on this process has been provided. We have two recent case examples of where the open-door request has been made of Serco colleagues, and granted, demonstrating an improved working relationship and better joint oversight over the issue. (4) This is a matter for HMPPS. (5) All patients residing on the inpatient unit (IPU) are checked on hourly by healthcare staff. These checks are documented and recorded on a paper log which is scanned and uploaded to a drive on our internal system where they are kept and checked on by the management covering the IPU. The inpatient unit manager carries out a monthly check to ensure that all of the forms have been uploaded and that the individual observation times are all accounted for. Healthcare staff are regularly reminded of the importance of ensuring they can account for any checks that they have signed for and this was most recently discussed and documented during the lunchtime

	handover on 10.03.2026. Record keeping / clinical documentation is dip-tested by managers as part of clinical supervision with those staff they line manage. Records are reviewed and feedback provided. The Head and Deputy Head of Healthcare also regularly review records for separate purposes and will feedback positive/ negative examples of documentation in order to assist in improving quality. Staff are fully aware of the expectations for record keeping and that any falsification of records would not be acceptable in any circumstances and would be against PPG policies and procedures, and professional code of conduct. Any such instances would be subject to disciplinary procedures. It would not be practical to have these regular observations recorded directly onto SystmOne as this would require the staff to go back to the computer station and log in for each and every check. As you can appreciate there may be several checks an hour for several different patients. We appreciate that it is not ideal to have paper-based records, and we maintain all records within SystmOne where possible to ensure continuity, good record keeping and confidentiality. It is worthy of note that a teaching session on the learnings from the death of Mr Smith (including the learning from the inquest), was delivered to staff at HMP Thameside on Friday 8th May 2026 and covered all of the points outlined in this PFD. This session was attended by 18 members of staff.
4.	**DETAILS OF FURTHER ACTION PROPOSED** *Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.*
	SIGNATURE  **Medical Director**