Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Ministry of Justice** **2 The Governor of HMP Nottingham** **3 Nottinghamshire Healthcare NHS Foundation Trust** **4 Northampton Healthcare NHS Foundation Trust**
1	**CORONER** I am Ms Alexandra Pountney, Assistant Coroner for the coroner's area of Nottingham and Nottinghamshire.
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** An investigation into the death of Jonathan Mark Thornton was opened on 30 March 2025, and the final inquest was heard by me, concluding on 17 February 2026.
4	**CIRCUMSTANCES OF THE DEATH** Jonathan Mark Thornton died at the Queens Medical Centre in Nottingham on 12th July 2024 following an attack by a fellow inmate on 28th June 2024 in the shower block on B-Wing landing 1 at HMP Nottingham, from which he sustained a severe head injury. The inmate who attacked Jonathan had a complex psychological history and was arrested for attempted murder in the community. As a result of that arrest, he was remanded to HMP Nottingham. At the time of his arrest, the inmate was under the care of the Community Forensic Team, having been released 6 months previously into the community from a low-secure forensic unit on a s.37/41. The background to his s.37/41 was that the inmate had been charged with GBH arising out of an assault on a fellow inmate whilst serving a custodial sentence at HMP Birmingham in June 2011. He was subsequently sentenced to a Hospital Order and detained at Rampton Hospital, which is a high-secure forensic hospital. The Court imposed a Restriction

	Order without limit of time *i.e.* an indefinite restriction order. He was placed at a 24-hour staffed support living scheme in Nottingham City Centre on 17 November 2023 an was arrested for attempted murder on 29 May 2024. This complex psychological history was either not known, or not understood, by the operational prison staff and many of the healthcare staff at the prison.
5	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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. Information sharing between the CFT and Prison Healthcare. During the course of the inquest, I heard that there had been various barriers to information sharing between the community forensic team and prison healthcare. There was no formal system in place for the handover of information between these teams at the time of Jonathan's death or at the conclusion of the inquest. Prison Healthcare staff were often unavailable or uncontactable for handover meetings. The handover of information between CFT and Prison Healthcare is vital for the risk assessment and management of prisoners who are known to the CFT (often some of the most complex and high-risk prisoners). I am concerned that the lack of formal information sharing between the two departments gives rise to a risk of future death. 2. Information sharing between Prison Healthcare and Operational Prison Staff. This case illustrated a lack of communication and information sharing between Prison Healthcare and the Operational Prison Staff which was concerning to me. I heard evidence that Prison Healthcare had in place a quasi 'watch and wait' plan for monitoring a potentially high-risk inmate. Not only was this plan not communicated to all of the healthcare team, but it

relied upon reporting of deterioration in behaviours from operational prison staff who were completely unaware that (i) they were being tasked with this role; and (ii) what to look for. Furthermore, the operational prison staff told me that having a broad understanding (within the confines of confidentiality) of a prisoner's mental health risks and triggers would improve the safety and security of the prison for the officers and prisoners. It would enable them to properly assess and manage risk, but that there was no effective mechanism in place by which to achieve this. I am concerned that the lack of formal information sharing between the two departments gives rise to a risk of future death.

3. Categorisation and visibility of alerts on NOMIS/DPS

I heard that NOMIS/DPS has preset categorisation of alerts. The categories are limited and broad. This means that 'violent' prisoners – regardless of the particulars of that violence – will all be categorised together. This case illustrated quite clearly that there are certain categories of offender who require better particularisation of their risk. In this case, that was those prisoners with a history of assaulting fellow inmates. I was told that unless a prisoner has assaulted a cellmate, which would be subject to its own assessment, the operational prison staff would not necessarily know whether their violent behaviour was aimed at prison officers, other prisoners or simply a genera violent behaviour linked to their offending. Clearly, each of these categories gives rise to a particular risk within a prison setting. I am concerned that if more detailed categorisation and/or information is not provided to the operational prison staff within NOMIS/DPS alerts, with clear visibility, this gives rise to a risk of future death. I understand that this is controlled nationally.

Moreover, I understand that the Healthcare Staff are unable to view NOMIS/DPS alerts. This gives rise to the same risk.

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 3 June 2026. 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: **All IPs** who may find it useful or of interest. 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. She may send a copy of this report to any person who she 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: 8 April 2026** **Ms Alexandra Pountney** **Assistant Coroner**