London Inner South Coroner Service
1 Tennis Street, SE1 1YD

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

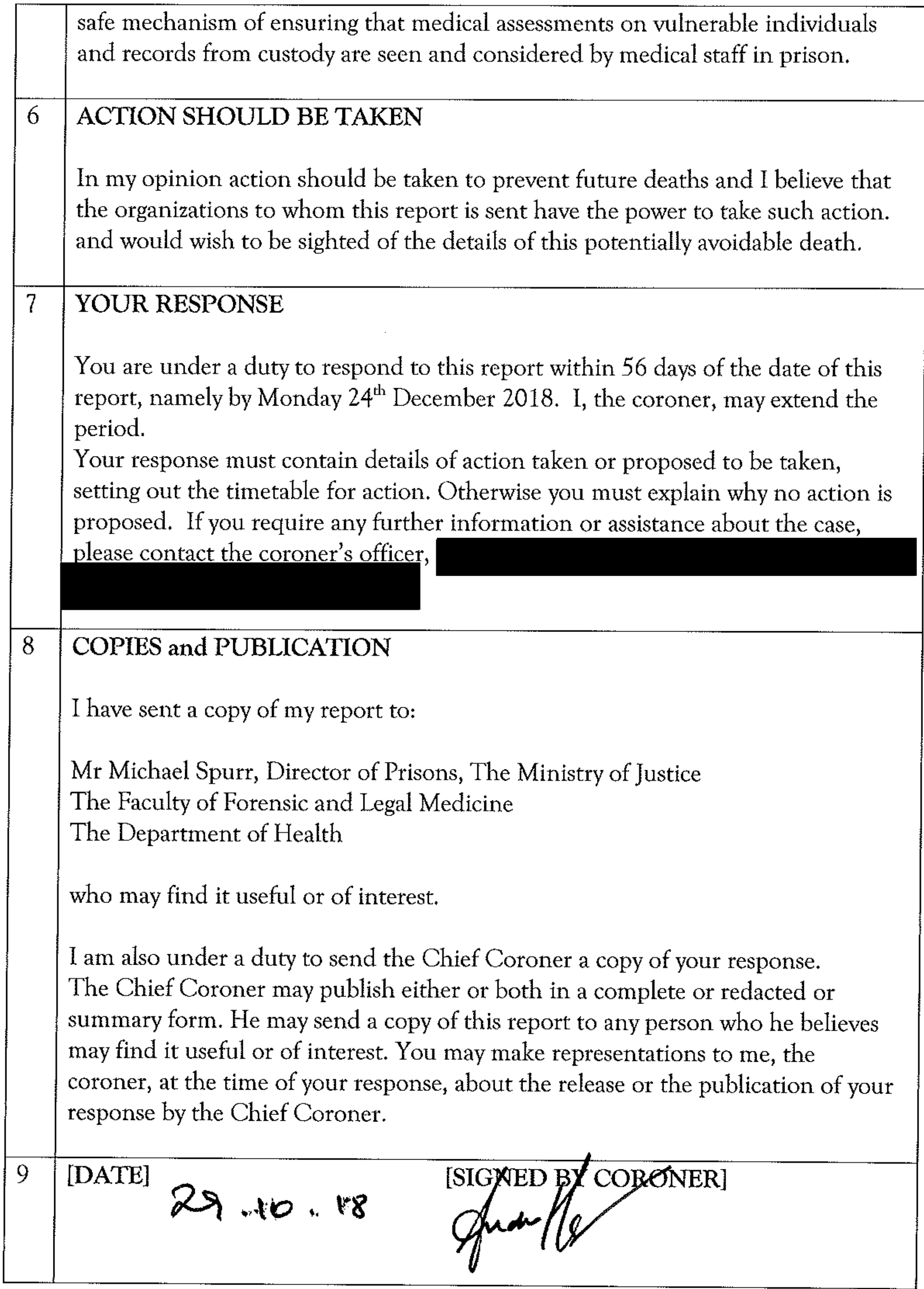
1. Commissioner Cressida Dick CBE, QPM Metropolitan Police Service, Broadway, London SW11 0BG

2. [redacted] Governor, Thameside Prison, Serco Ltd, Griffin Manor Way, London SE28 0FJ

3. Mr Ben Travis, Chief Executive, Oxleas NHS Trust, Pinewood House, Pinewood Place, Dartford, Kent DA2 7WG

1	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
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	**INQUEST** On 29th August 2017, I opened an investigation and on 8th September 2017 an inquest into the death of **Mr Thomas Patrick McAuley (02314-17 PF), who was found dead in his prison cell on 23rd August 2017** The medical cause of death given at autopsy was 1a Bronchopneumonia II Chronic Bronchitis. Alcohol and Drug Dependence The inquest concluded on 18th September 2018, before a jury, who delivered a narrative conclusion, by answering a questionnaire. The conclusion as to the death was natural causes, contributed to by two failures:

	1. There was a failure not to have ensured that the clinical information on the police custody medical form was available to all clinical staff in the prison, which probably contributed to his death. 2. There was a failure not to have conducted clinical observations in the first five days of Methadone treatment, which probably contributed to the death.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was in police custody from 5th to 7th. The narrative demonstrated that death was probably preventable ("pneumonia can generally be treated successfully") and the jury highlighted that: 1. "Dr L said that had he known about the report of current pneumonia in the police station, he would have taken a history and made more enquiries. He might examine the chest.... or repeat a chest X-Ray." (There was evidence that there was a past history of pneumonia and from police that he was seeking medication, possibly for pneumonia, but no diagnosis had been made). 2. "Nurses and doctors all agree that [the Detained Persons Medical Form DPMF] would have been useful to them. It was not available to health care staff on the wings unless its contents had been transcribed onto System One Records." 3. "This is significant because there were multiple missed opportunities for detection, monitoring and treatment"
5	**CORONER'S CONCERNS** During the course of the inquest, the evidence revealed matters giving rise to concerns that in my opinion means that there are still risks that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to a number of organizations, both locally and nationally. The **MATTERS OF CONCERN** are as follows. - 1. The reception nurse said that she would have had access to DPMFs but does not always have time to look at these. The DPMF was not available in the wings. 2. A manager of the drug addiction services in the prison said that health care staff were not always given the DPMF. 3. An Oxleas manager said that the case history notes from the prison were uploaded onto PNomis, but a prison doctor did not think he had access to this. 4. A representative of Oxleas HC reported that a new process required a nurse to tick a box when the DPMF was uploaded onto the medical records, but there was no evidence that the DPMF is universally available to health care staff. 5. There was no evidence that police doctors communicated directly with health care staff in prison, or arranged for transfer of medical information between doctors. (The police doctors were not called). 6. In conclusion, there is no assurance that doctors attending in custody, the prison service and those providing health care in prisons have established a fail-



	safe mechanism of ensuring that medical assessments on vulnerable individuals and records from custody are seen and considered by medical staff in prison.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe that the organizations to whom this report is sent have the power to take such action. and would wish to be sighted of the details of this potentially avoidable death.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday 24th December 2018. 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. If you require any further information or assistance about the case, please contact the coroner's officer,
8	COPIES and PUBLICATION I have sent a copy of my report to: Mr Michael Spurr, Director of Prisons, The Ministry of Justice The Faculty of Forensic and Legal Medicine The Department of Health 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. 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	[DATE] 29.10.18 [SIGNED BY CORONER]