Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jonathan McCarthy, a prisoner at HMP Onley, on 12 August 2018

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Jonathan McCarthy died in hospital on 12 August 2018 of bronchopneumonia and multiple organ failure while a prisoner at HMP Onley. He was 27 years old. I offer my condolences to Mr McCarthy's family and friends.

Mr McCarthy had a history of heart conditions and did not raise any issues of concern about his health before he died. The clinical reviewer was satisfied that the care he received at HMP Onley was equivalent to that which he could have expected to receive in the community.

Sue McAllister, CB
Prisons and Probation Ombudsman **July 2020**

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Summary

Events

1. In December 2011, Mr Jonathan McCarthy was sentenced to three years and six months in prison for burglary. He absconded from prison in July 2013 and was recalled to prison in June 2017. He spent time at HMP Altcourse and HMP Thameside and was transferred to HMP Onley in June 2018.

2. Mr McCarthy had a history of cardiac problems. He had had a heart attack in 2016 and was prescribed medication to prevent cardiovascular disease. On 25 June, a prison GP examined him and noted that he was not suffering from chest pain, or palpitations and his blood pressure and pulse rate were normal. The GP told him what symptoms he needed to report to healthcare staff immediately.

3. At 5.19pm on 7 August, a prisoner found Mr McCarthy unresponsive in his cell. Prison staff and healthcare staff responded and started cardiopulmonary resuscitation (CPR). An emergency ambulance arrived at 5.30pm and took Mr McCarthy to hospital where he received emergency life support.

4. Mr McCarthy did not regain consciousness. His life support was switched off and he died on 12 August.

5. The coroner gave Mr McCarthy's cause of death as bronchopneumonia and multiple organ failure as a result of heart problems.

Findings

6. The clinical reviewer considered that the healthcare Mr McCarthy received was broadly equivalent to that which he could have expected to receive in the community.

7. There were, however, areas that fell short of expectations, namely that Mr McCarthy was transferred to Onley without enough of his prescribed medication, and healthcare staff at Onley did not request his community GP records promptly. However, the clinical reviewer was satisfied that the delays were unlikely to have impacted on his clinical conditions.

Recommendation

- The Head of Healthcare at HMP Thameside should ensure that prisoners are discharged or transferred with a sufficient supply of their prescribed medications.
- The Head of Healthcare at HMP Onley should ensure that healthcare staff routinely and promptly request community medical records for newly arrived prisoners.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Onley informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

9. The investigator obtained copies of relevant extracts from Mr McCarthy's prison and medical records.

10. NHS England commissioned a review of Mr McCarthy's clinical care at the prison.

11. Our investigation was suspended while we waited for the cause of death. This has delayed the disclosure of the initial report.

12. We informed HM Coroner for Northamptonshire of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. We wrote to Mr McCarthy's next of kin, his wife, to explain the investigation and to ask if she had any matters, she wanted the investigation to consider. She did not respond to our letter.

14. Mr McCarthy's wife received a copy of the initial report. The solicitor representing her wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies in the clinical review which has been amended accordingly.

Background Information

HMP Onley

16. HMP Onley is a resettlement prison serving the Greater London area. It holds approximately 740 adult male prisoners. Northamptonshire Healthcare NHS Foundation Trust provides health services including primary care, mental health and Phoenix Futures provides substance misuses services. A GP is on duty during normal working hours. Onley falls under the jurisdiction of HM Coroner for Northampton.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Onley was in November 2018. Inspectors reported that the provision of health services was reasonably good overall but operational pressures within the prison affected access to them. A wide range of primary care services was available and waiting times were acceptable. Prisoners with long-term conditions had their needs met.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2019, the IMB reported that engagements between healthcare staff and prisoners were professional and courteous, and care was taken to reassure prisoners who had anxieties about aspects of their treatment.

Previous deaths at HMP Onley

19. Mr McCarthy was the fifth prisoner to die at Onley since January 2015, and the fourth to die from natural causes during that time. There are no similarities between our findings in the investigation of Mr McCarthy's death and the other deaths.

Key Events

20. On 1 December 2011, Mr Jonathan McCarthy was sentenced to three years and six months in prison for burglary. He had a long history of substance misuse, including cannabis, cocaine, crack cocaine, amphetamine, ecstasy, diazepam, excessive alcohol consumption. He spent time in several prisons before he absconded from HMP Hollesley Bay on 19 July 2013.

21. He was recalled to HMP Altcourse on 5 June 2017.

HMP Altcourse

22. During his reception screen at Altcourse, Mr McCarthy said he had had a heart attack in the community (in Ireland) in 2016 and was taking cardiac medications. He said his father and grandfather had had heart attacks at a young age.

23. Mr McCarthy's GP in Ireland later confirmed that Mr McCarthy had had heart attack in May 2016 and had had valve surgery and a stent inserted. He had also been diagnosed with mesenteric ischemia (reduced blood flow to the small intestine) and a blood clot due to drug use. He had not attended his GP for follow up in November 2016.

24. Mr McCarthy was referred into the prison's cardiac clinic for ongoing monitoring. He did not attend two clinic appointments. The reasons for his non-attendance were not recorded.

HMP Thameside

25. Mr McCarthy was transferred to HMP Thameside on 7 May 2018.

26. When he arrived at Thameside, his heart condition was noted and he was referred to the prison's long-term conditions clinic for review. He underwent a detox for excessive alcohol and cocaine use, which involved regular clinical observations. He was also reviewed by a psychiatrist and his medication for depression was changed and he was referred to counselling for his low mood.

27. Mr McCarthy reported no physical health problems throughout his time at Thameside. On 11 June, a series of appointments were booked for him following a routine nurse review: a heart trace, blood tests (including cholesterol) and a follow up depression review.

28. Before these appointments took place, Mr McCarthy was transferred to HMP Onley on 14 June.

HMP Onley

29. A nurse completed Mr McCarthy's reception health screen when he arrived at Onley and noted that he had a heart attack in 2016 and had a stent inserted. The nurse noted that Mr McCarthy was prescribed medication for the prevention of cardiovascular disease and to control his blood pressure. Mr McCarthy was a

heavy smoker and declined help to stop. The nurse noted that Mr McCarthy had arrived with only one day's supply of his prescribed medication.

30. On 25 June, a prison GP, examined Mr McCarthy and noted that his blood pressure and pulse rate were within an acceptable range. Mr McCarthy said he did not have chest pain or palpitations and the GP told him to contact healthcare staff urgently if this changed.

31. The GP noted that Mr McCarthy had not initially received his prescribed medication when he arrived at Onley but that this had been quickly put right. The GP asked a healthcare administrator to request Mr McCarthy's community medical records. Mr McCarthy signed the consent form for this on 20 July.

32. The request was sent to Mr McCarthy's community GP in Ireland on 25 July. The GP responded on 2 August and told the prison GP to contact them. Mr McCarthy died before the prison received his community records.

33. Mr McCarthy did not report any concerning symptoms after seeing the prison GP.

Events of 7 August 2018

34. At approximately 5.19pm, a prisoner found Mr McCarthy unresponsive in his cell. An officer went to the cell and called an emergency code blue (to indicate a prisoner has stopped breathing or is unconscious). The control room called an ambulance immediately.

35. At approximately 5.23pm, a healthcare paramedic, arrived at the cell and started cardiopulmonary resuscitation (CPR). Healthcare managers also arrived and assisted with CPR. A defibrillator detected a shockable rhythm, but Mr McCarthy went into cardiac arrest.

36. At 5.30pm, an emergency ambulance arrived and took Mr McCarthy to Leicester Royal Infirmary. Mr McCarthy was escorted by two officers. He was not restrained.

37. In hospital, Mr McCarthy received emergency life support. He did not regain consciousness and on 12 August, it was confirmed that Mr McCarthy had died.

Contact with Mr McCarthy's family.

38. On 7 August, the prison appointed a Senior Officer (SO) as Mr McCarthy's family liaison officer. At 5.45pm, they informed Mr McCarthy's next of kin, his wife, of her husband's condition. The SO arranged for Mr McCarthy's wife to visit Mr McCarthy in hospital.

39. The SO continued to liaise with Mr McCarthy's family and to update them with any changes. Mr McCarthy's family were with him when he died.

40. On 10 September, Mr McCarthy's body was repatriated to Ireland. The prison contributed to the cost of the funeral in line with national policy.

Support for prisoners and staff.

41. After Mr McCarthy's death, there was no formal debrief for the staff involved in the emergency response because he had been at hospital for some time. The escort staff at the hospital were offered support and given the opportunity to discuss any issues arising.

42. The prison posted notices informing other prisoners of Mr McCarthy's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr McCarthy's death.

Post-mortem report

43. The post-mortem gave Mr McCarthy's cause of death as bronchopneumonia and multi-organ failure, caused by acute cardiac arrhythmia (an abnormal heart rhythm) with initial resuscitation, and idiopathic myocardial fibrosis (scaring of the heart with an unknown cause).

44. The clinical reviewer said that bronchopneumonia and multi-organ failure are both common in a critically ill patient receiving life support, and that idiopathic myocardial fibrosis is a condition associated with abnormal heart rhythm and sudden cardiac death.

45. Blood samples taken when Mr McCarthy was admitted to hospital on 7 August were negative for illicit substances (although the testing did not include testing for synthetic cannabinoids, also known as 'Spice').

Inquest

46. An inquest held on 12 October 2023 concluded that Mr McCarthy died from natural causes.

Findings

Clinical care

47. The clinical reviewer concluded that Mr McCarthy's clinical care was equivalent to that which he could have expected to receive in the community. Mr McCarthy had a history of heart problems and did not report any concerning symptoms before his death.

48. The clinical reviewer did, however, identify some concerns, although these she was satisfied these did not contribute to Mr McCarthy's death.

Medication

49. The clinical reviewer found that Mr McCarthy arrived at Onley with only one day's supply of his prescribed medication, and he did not receive his medication for four days. The expected practice is to transfer a prisoner with seven days' supply. The clinical reviewer noted that Mr McCarthy received his prescribed medication in the seven weeks before his death and that the four-day delay was unlikely to have impacted on his clinical conditions.

50. However, we recommend:

- **The Head of Healthcare at HMP Thameside should ensure that prisoners are discharged or transferred with a sufficient supply of their prescribed medications.**

Community GP records

51. Prison Service Order (PSO) 3050, Continuity of Healthcare for Prisoners, requires that, when a new prisoner arrives in reception, prison staff try to obtain relevant information from the prisoner's GP or other relevant health services the prisoner has recently been in contact with.

52. Although the prison GP asked healthcare staff at Onley to request Mr McCarthy's community records on 25 June, Mr McCarthy did not sign the consent form for this until 20 July. The reason for this delay was not recorded.

53. Although the community records should have requested earlier, the clinical reviewer noted that Mr McCarthy did not report any concerning symptoms prior to his death, and that he had been made aware of sign and symptoms he needed to report immediately.

54. We make the following recommendation:

- **The Head of Healthcare at HMP Onley should ensure that healthcare staff routinely and promptly request community medical records for newly arrived prisoners.**

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