

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Patrick Weedon a prisoner at HMP Winchester on 23 October 2019

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Patrick Weedon, who was 77 years old, died in a hospice of lung cancer on 23 October 2019, while a prisoner at HMP Winchester. We offer our condolences to those who knew him.
4. The clinical reviewer concluded that the clinical care that Mr Weedon received was equivalent to that which he could have expected to receive in the community. She made two recommendations, one of which is referenced below. The other is not directly relevant to Mr Weedon's death.
5. We did not find any non-clinical issues of concern.
6. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and the clinical review has been amended accordingly. The action plan has been annexed to this report as has the amended clinical review.

Recommendations

- **The Head of Healthcare should remind all clinical staff of the importance of accurate and contemporaneous record keeping in line with NMC and GMC professional guidance.**

Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Weedon's clinical care at HMP Winchester. The clinical review is attached to this report as Annex 1.
8. The PPO investigator has investigated the non-clinical issues in Mr Weedon's care, including his location, the security arrangements for his hospital escorts and whether compassionate release was considered.

Previous deaths at Winchester

9. Mr Weedon was the eighth prisoner to die at Winchester since October 2017. Of the previous deaths, three were from natural causes and four were self-inflicted. There are no similarities between our findings in the investigation into Mr Weedon's death and the other deaths.

Key Events

10. On 1 April 2019, Mr Patrick Weedon was remanded in custody, charged with sexual offences, and sent to HMP Winchester. On 20 June, he was sentenced to five years in prison.
11. Mr Weedon had been diagnosed with lung cancer when he arrived at Winchester.
12. In June, Mr Weedon was moved to the prison's inpatient unit. He had daily welfare checks and input from the mental health team. Healthcare and custodial staff regularly discussed his care at joint meetings.
13. On 17 July, Mr Weedon complained of left sided numbness and was admitted to hospital the next day. Scans showed his cancer had spread to his brain and liver. Hospital doctors considered he was no longer suitable for treatment and on 30 July, he was discharged back to Winchester.
14. Mr Weedon's mobility and general condition gradually deteriorated further and on 1 October, he was moved to a hospice. He remained there until his death at 3.05pm on 23 October.
15. The post-mortem examination concluded that the cause of Mr Weedon's death was metastatic lung cancer (cancer that has spread within the body).

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