

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Roger Weir, a prisoner at HMP Berwyn, on 22 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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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Roger Weir died of liver cancer on 22 October 2019, while a prisoner at HMP Berwyn. He was 52 years old. I offer my condolences to Mr Weir's family and friends.

Mr Weir had a number of pre-existing medical conditions when he arrived in prison. Healthcare staff reviewed him regularly and comprehensive care plans were devised to manage those conditions. When he became unwell in October 2019, he was promptly sent to hospital. I am satisfied that Mr Weir received a good standard of care, equivalent to that which he could have expected to receive in the community.

I am concerned, however, that the decision to use restraints on Mr Weir during his final admission to hospital on 16 October 2019, was unjustified and did not take account of his poor mobility and deteriorating health. I am also concerned that Mr Weir's next of kin was not informed of his admission to hospital until the day before he died.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman

September 2020

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Summary

Events

1. On 6 May 2012, Mr Roger Weir was charged with attempted murder and administering poison with intent. He was sentenced to eighteen years in prison and sent to HMP Winchester.
2. Mr Weir arrived into prison custody with a number of pre-existing conditions including post-traumatic stress disorder, mobility issues and a history of tachycardia (fast heart rate).
3. Throughout his time in prison, Mr Weir was reviewed regularly, and the care plans devised to manage his medical conditions were updated regularly. Appropriate referrals to hospital were made where necessary.
4. On 10 February 2018, Mr Weir was transferred to HMP Berwyn.
5. On 1 October 2019, Mr Weir was reviewed by an occupational therapist. She noticed that he was experiencing pain under his rib cage and in his forearm, which radiated up into his shoulder. He also told her that he had been experiencing some memory loss, difficulty sleeping and felt low in mood.
6. On 16 October, Mr Weir was reviewed by a prison GP. The GP suspected that Mr Weir had a gallbladder infection and was at risk of developing sepsis (a potentially life-threatening response to infection). He considered that Mr Weir needed to be reviewed at hospital. Mr Weir was sent to Wrexham Maelor Hospital by emergency ambulance the same day. He was escorted by two officers and restrained using an escort chain.
7. Following a review by hospital staff, Mr Weir was admitted to hospital as an inpatient. However, his condition deteriorated and in the early hours of 20 October, he was transferred to the intensive care unit and hospital staff told prison healthcare staff that his renal function was deteriorating, and he needed intravenous fluids and antibiotics.
8. The following day, Mr Weir's condition deteriorated further. Mr Weir was sedated and placed on a ventilator to help him to breathe. Mr Weir's restraints were removed. A prison Family Liaison Officer contacted Mr Weir's next of kin to inform him of Mr Weir's deteriorating condition.
9. Mr Weir's condition did not improve and at 2.55am, on 22 October, hospital staff withdrew all further active treatment. At 4.31am, it was confirmed that Mr Weir had died.
10. The coroner gave Mr Weir's cause of death as cancer of the liver.

Findings

11. We are satisfied that the standard of clinical care Mr Weir received at Berwyn was equivalent to that which he could have expected to receive in the community. Healthcare staff appropriately assessed his clinical needs and made timely

referrals to hospital where necessary. The clinical reviewer was satisfied that his liver cancer was not foreseeable or preventable.

12. We are concerned that Mr Weir was restrained when he was taken to hospital on 16 October and that he continued to be restrained until he was placed in a medically induced coma on 21 October. We do not consider that this was justified given Mr Weir's very poor mobility and deteriorating health.
13. We are also concerned that Mr Weir's next of kin was not told that Mr Weir had been admitted to hospital until the day before he died.

Recommendations

- The Head of Healthcare should ensure that all NEWS scores are undertaken accurately and documented in the clinical records.
- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Governor should revise the risk assessment form for hospital escorts to make it clear that:
 - healthcare staff must provide information on the prisoner's current state of health and mobility; and
 - prison managers must confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed.
- The Governor should ensure that next of kin are informed as soon as it becomes clear that a prisoner is seriously ill.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Berwyn informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
15. The investigator obtained copies of relevant extracts from Mr Weir's prison and medical records.
16. NHS England commissioned an independent clinical reviewer to review Mr Weir's clinical care at the prison.
17. We informed HM Coroner for North East Wales District of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. We wrote to Mr Weir's next of kin to ask if he had any issues he wished the investigation to consider. He did not raise any issues but asked for a copy of our report.
19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Berwyn

19. HMP Berwyn is a newly built prison that opened in 2017 in Wrexham, North Wales, and holds around 2,100 men. Healthcare services are provided by Betsi Cadwaladr University Health Board.
20. GP services are provided by Gables Medical Health Offender Limited who provide 19 sessions a week. They also provide an out of hours service.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Berwyn was in March 2019. Inspectors noted that overall the quality and governance of the integrated health provision was very good.
22. Clinical environments were considered to be clean and equipped well enough to meet the needs of the population. A wide range of primary care services were available and waiting times were considered to be acceptable.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to 28 February 2019, the IMB recognised the initial difficulties experienced when implementing the medication policy, particularly in a new establishment. However, they considered that those initial difficulties had been successfully overcome.
24. The IMB also noted the introduction of health and wellbeing peer mentors. The scheme was introduced to give prisoners an opportunity to discuss the choices they make in relation to their healthcare. Healthcare staff were expanding the scheme to assist with the issue of those prisoners who did not attend healthcare appointments.

Previous deaths at HMP Berwyn

25. Mr Weir was the fourth prisoner to die at HMP Berwyn since 2017. Of the previous deaths, two were from natural causes and one was a drug-related death. There have been two further deaths from natural causes since Mr Weir's death. There are no similarities between Mr Weir's death and the other deaths.

Key Events

26. On 6 May 2012, Mr Roger Weir was charged with attempted murder and administering poison with intent. He was sentenced to eighteen years in prison and sent to HMP Winchester. In 2013, he was transferred to HMP Swaleside.
27. In February 2017, Mr Weir complained of acid in his stomach and extended periods of diarrhoea. He was reviewed by a prison GP and was diagnosed with irritable bowel syndrome and having possibly developed fatty deposits around his liver due to his central obesity. He was referred to hospital for an ultrasound scan and underwent blood and liver function tests.
28. Mr Weir was referred to a prison GP for further review. The GP noted that Mr Weir's blood tests had not shown anything of concern and that the ultrasound scan test had only identified fatty deposits around his liver. Mr Weir was advised to inform healthcare staff if he had any further concerns.
29. On 10 February 2018, Mr Weir was transferred to HMP Berwyn.
30. A prison nurse carried out an initial health screen. She noted Mr Weir's prescribed medications and pre-existing medical conditions, including post-traumatic stress disorder and tachycardia (fast heart rate) for which he received appropriate medication. He also had mobility issues due to a previous motorcycle accident and used crutches for short distances and a wheelchair for longer distances. He had been diagnosed with diabetes in January 2016 and had a history of low mood. The nurse referred Mr Weir to the prison's Mental Health Inreach Team (MHIRT).
31. A few days later, Mr Weir was reviewed by an occupational therapist who arranged for grab rails to be fitted in his cell to assist him with his mobility and for a more suitable chair to be made available to him.
32. In March, Mr Weir underwent comprehensive tests including diabetes, liver and kidney tests. The results found nothing of concern.
33. On 10 May, healthcare staff reviewed Mr Weir after he reported having severe chest pain, which he said was not being relieved by his medication. His observations were taken and it was noted that his blood pressure was raised and he had a slightly raised pulse. An emergency ambulance was called and Mr Weir was taken to Wrexham Maelor Hospital.
34. Mr Weir was reviewed by hospital staff but before a diagnosis could be made, he discharged himself in the early hours of the following morning. He was seen by the prison's healthcare staff on his return from hospital and the importance of following hospital advice was explained to him. His careplan was updated and he continued to be reviewed regularly by healthcare staff in the months that followed.
35. Later in May, Occupational Therapy provided Mr Weir with a self-propelled wheelchair.
36. On 1 October 2019, Mr Weir was reviewed by an occupational therapist. He told her that he had been having difficulty transferring from his bed to his wheelchair.

because his mattress was too soft. During the review, the occupational therapist noticed that Mr Weir was experiencing pain under his rib cage and in his forearm which radiated up into his shoulder. He also told her that he had been experiencing some memory loss, had difficulty sleeping and felt low in mood. The occupational therapist made a referral to MHIRT and asked healthcare staff to review him.

37. A healthcare support worker, reviewed Mr Weir the following day. She took his observations and a urine sample, which found nothing of note.
38. On 3 October, an occupational therapist carried out a mental health review. He noted that despite Mr Weir feeling low in mood, Mr Weir said that he had no thoughts of self-harm. The occupational therapist noted that his mood was to be expected given his concerns about his upcoming release from prison in May 2021.
39. On 8 October, a healthcare support worker, reviewed Mr Weir after he reported feeling generally unwell and had vomited after eating his lunch. He also told her that he had hot sweats during the night, making it difficult to sleep. He was concerned that despite increasing his fluid intake in the previous few days, he had not experienced any increase in his urine output. The healthcare support worker spoke with a prison GP who advised her to take Mr Weir's observations and carry out a urine dip test. The tests found nothing of concern.
40. On 14 October, a healthcare nurse reviewed Mr Weir after prison officers raised concern for his well-being. She noted he was extremely pale and had noticeably lost weight since she last saw him. He told her that he had felt unwell for the previous week, had no appetite and had pain in his back. He also told her his eyesight had deteriorated recently and that he was finding it increasingly difficult to focus due to blurred vision. He did not report any issues with his bowels or passing urine. The nurse referred Mr Weir to a GP for review and asked another healthcare nurse to review him.
41. Also on 14 October, a prison officer recorded that Mr Weir had told him that healthcare staff said he needed to see a GP but that he feared for his safety if he left the houseblock because of the nature of his offence. Prison staff had told him he would be escorted to see the GP and a prison officer recorded that Mr Weir said he was "going to give it some thought and then let staff know but he is aware that his condition may not get better until he sees the doctor".
42. A nurse reviewed Mr Weir on 15 October. When she arrived at his cell, she noted that although he was lethargic and appeared unwell, he could support his own weight when assisted. He told her he had abdominal pain and that he had regularly vomited after eating. She took his observations and noted his blood pressure was slightly raised. She used the National Early Warning Score (NEWS) system (a tool to assess the severity of a patient's condition, with 0 being no symptoms, and 5 needing urgent clinical assessment) to measure the severity of his symptoms, and incorrectly gave him a score of 2. She diagnosed him with a possible viral infection and referred him to a prison GP for review.
43. On 16 October, Mr Weir was reviewed by a prison GP. He suspected that Mr Weir had a gallbladder infection and was at risk of developing sepsis (a

potentially life-threatening condition which occurs in response to infection). He considered that Mr Weir needed to be reviewed at hospital. At 2.45pm, Mr Weir was taken to Wrexham Maelor Hospital by emergency ambulance. He was accompanied by two officers and was restrained using an escort chain.

44. Following a review by hospital staff, Mr Weir was admitted to hospital as an inpatient. On 18 October, hospital staff informed him that he could eat and drink as normal but would need to stay in hospital for observation. Hospital staff updated prison healthcare staff regularly about Mr Weir's condition.
45. His condition deteriorated and just after midnight on 20 October, he was moved to the intensive care unit. Hospital staff told prison healthcare staff that Mr Weir's renal function was deteriorating, and he needed intravenous fluids and antibiotics.
46. On 21 October, his condition deteriorated further and at 12.15pm he was placed in an induced coma. A Custodial Manager (CM) visited Mr Weir in hospital. Hospital staff told him that Mr Weir's condition was extremely serious and that he was under constant observation. They also told him that they needed to speak with his next of kin to discuss his medical history. The CM contacted Mr Weir's next of kin to notify him of Mr Weir's deteriorating condition. At 2.00pm a prison manager authorised the officers accompanying Mr Weir to remove his restraints.
47. Mr Weir's condition did not improve and at 2.55am on 22 October, hospital staff withdrew all active treatment. A hospital doctor confirmed Mr Weir's death at 4.31am.

Post-mortem report

48. The post-mortem report gave Mr Weir's cause of death as hepatocellular carcinoma of the liver (cancer of the liver).

Contact with Mr Weir's Family

49. At 9.00am on 21 October, a CM and the Deputy Head of House, were appointed by the prison to act as the family liaison officers.
50. When hospital staff told the CM that they needed to speak with Mr Weir's next of kin, he contacted his next of kin to inform him of his admission to hospital and the seriousness of his condition. His next of kin agreed to speak with hospital staff. Due to his own health issues, he asked to be kept updated on Mr Weir's condition by telephone.
51. At 4.35am on 22 October, one of the family liaison officers telephoned Mr Weir's next of kin to inform him of Mr Weir's death.
52. A family liaison officer contacted Mr Weir's next of kin later the same day. He thanked the family liaison officer for her earlier telephone call but said that he was surprised at Mr Weir's death as he was only informed of his admission to hospital the previous day. The family liaison officer said that it was only when the severity of Mr Weir's condition became apparent, that they contacted him. The family liaison officers continued to offer Mr Weir's next of kin support.

53. Mr Weir's funeral was held on 14 November. Representatives from the prison attended and a prison chaplain, a member of the prison's chaplaincy team conducted the service.
54. In line with national guidance, the prison offered a financial contribution to Mr Weir's funeral.

Support for prisoners and staff

55. After Mr Weir's death, a prison manager debriefed the staff who were accompanying him at the hospital when he died, giving them the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
56. The prison posted notices informing other prisoners of Mr Weir's death. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Weir's death.

Findings

Clinical care

57. The clinical reviewer concluded that clinical care Mr Weir received at Berwyn was equivalent to that which he could have expected to receive in the community. We agree.
58. The clinical reviewer found that following his admission to Berwyn, Mr Weir underwent a thorough routine health screen which noted his past medical history and current medical state. He was also reviewed by occupational therapy, physiotherapy, speech and language therapy and mental health services. The clinical reviewer considers that Mr Weir received appropriate care for his medical conditions and that there is good evidence that comprehensive care plans were put in place to manage his care.
59. The clinical reviewer also found that between 1 October and 15 October 2019, Mr Weir was seen by a nurse or healthcare assistant on six occasions due to his vomiting, weight loss and feeling generally unwell. They took his observations regularly and carried out a urine test, but found nothing of concern.
60. The clinical reviewer was concerned however, that on 15 October, a healthcare nurse used an incorrect blood pressure reading which resulted in a NEWS score of 2 being recorded, when in fact it should have been 3. Although this had no effect on the outcome for Mr Weir, we make the following recommendation:

The Head of Healthcare should ensure that all NEWS scores are undertaken accurately and documented in the clinical records.

61. Following a review on 16 October, a prison GP suspected that Mr Weir had a possible gallbladder infection and that he might have developed sepsis. He appropriately organised Mr Weir's immediate admission to hospital.
62. The clinical reviewer has made a number of additional recommendations which we do not repeat in this report but which the Head of Healthcare will wish to address.

Restraints, security and escorts

63. When prisoners must travel outside the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this must be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account the prisoner's current health and mobility.
64. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit, including the risk to the public in the event of an escape and the prisoner's risk when he has a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change. The judgement found

that using handcuffs or other restraints on terminally ill or seriously ill prisoners was inhumane, unless justified by security considerations.

65. When Mr Weir was taken to hospital by emergency ambulance on the afternoon of 16 October, two officers accompanied him and he was restrained using an escort chain. A risk assessment was not completed until the following day. A security CM and the Head of Offender Management Services at Berwyn signed the risk assessment. The level of restraint was not changed.
66. Just after midnight on 20 October, Mr Weir was moved to the hospital's intensive care unit and on the morning of 21 October he was placed in a medically induced coma. However, the restraints were not removed until the afternoon when a CM visited Mr Weir in hospital and was told by hospital staff that his condition was extremely serious.
67. Public protection is critical, but security measures must be proportionate to a prisoner's individual circumstances. Mr Weir was a Category C prisoner. Although he was only 52 years old, he had very poor mobility and walked with crutches or sticks for short distances and used a wheelchair for longer distances even when he was well. We are concerned that despite this, it was considered necessary to restrain him. It is difficult to see how the risk assessment concluded that he had the ability to escape unaided from two escort officers. We are also concerned that the restraints remained in place after he was transferred to the hospital's intensive care unit and were not removed until after he had been placed in an induced coma on 21 October.
68. We are not satisfied that managers appropriately considered Mr Weir's physical condition at the time and how this affected his risk. We recommend:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Governor should revise the risk assessment form for hospital escorts to make it clear that:

- **healthcare staff must provide information on the prisoner's current state of health and mobility; and**
- **prison managers must confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed.**

Family Liaison

69. Prison Rule 22 says that if a prisoner becomes seriously ill, the his next of kin should be informed "at once". Prison Service Instruction (PSI) 64/2011 says that prisons must have arrangements in place for an appropriate member of staff to make contact with the next of kin of a prisoner who is either terminally or seriously ill.

70. Mr Weir's next of kin was not informed of his admission to hospital until 21 October, five days after Mr Weir was admitted to hospital and one day before he died. It was not until hospital staff said that they needed to make contact with Mr Weir's next of kin, that the prison contacted them to inform him of his condition.
71. We accept that the seriousness of Mr Weir's condition was not apparent when he was admitted to hospital on 16 October. However, we consider that the prison should have told Mr Weir's next of kin that he was seriously ill when his condition deteriorated and certainly when he was admitted to intensive care early on 20 October. We make the following recommendation:

The Governor should ensure that next of kin are informed as soon as it becomes clear that a prisoner is seriously ill.

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