

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Weatherley, a prisoner at HMP Thameside, on 24 February 2018

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

OGL

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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 Stephen Weatherley died on 24 February 2018 at HMP Thameside from the combined toxic effects of cocaine and methadone, after swallowing a package containing drugs the previous day. He was 41 years old. I offer my condolences to Mr Weatherley's family and friends.

The day before he died, Mr Weatherley's girlfriend and sister visited him at Thameside and staff suspected that his girlfriend passed Mr Weatherley a drugs package during the visit. Staff intervened immediately and searched Mr Weatherley, but found nothing. They also watched CCTV of the visit. Later that day, during a telephone call to his girlfriend, Mr Weatherley told her that he had swallowed the package. The prison was not aware of this conversation until after his death.

I am satisfied that staff had no reason to believe that Mr Weatherley had swallowed drugs, and that there was, therefore, no reason for them to consider that he was at risk or to arrange for him to be monitored.

I do, however, have some concerns.

Mr Weatherley's cell bell was not answered for around 25 minutes on the morning of his death and his cell mate had to ring the bell again to obtain staff assistance when Mr Weatherley became unwell. The clinical reviewer has concluded that the outcome is likely to have been the same for Mr Weatherley even if staff had responded immediately to his cell bell. Nevertheless, the delay was unacceptable and could be critical in future cases.

I am also concerned that there was an unacceptably long delay of 16 minutes in getting the paramedics from the prison gate to Mr Weatherley's cell, and that Mr Weatherley's family was not told of his death until over 36 hours after he had died.

I also need to record that the PPO investigator encountered unacceptable delays in obtaining documentation from Thameside and in arranging interviews with relevant staff. We have had similar problems in other investigations at Thameside and the prison needs to improve its PPO liaison arrangements.

Despite being given extra time to respond to the findings of our investigation, Thameside failed to provide a response during the agreed extension period, which we consider unacceptable. However, we have since been provided with an action plan on how they intend to address our recommendations.

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

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Summary

Events

1. On 24 June 2017, Mr Stephen Weatherley was remanded in prison custody charged with murder. He was moved to HMP Thameside on 27 September.
2. On 23 February 2018, Mr Weatherley's girlfriend and sister visited him. During the visit, staff suspected that his girlfriend passed him a package containing drugs. Staff intervened and searched Mr Weatherley, but found nothing.
3. At around 7.00am on 24 February, Mr Weatherley's cellmate rang their cell bell and spoke to a member of staff on the in-cell telephone. The staff member told the investigator he could not hear clearly what Mr Weatherley's cellmate was saying, but he asked an officer to attend the cell. CCTV footage shows no one attended.
4. At around 7.25am, Mr Weatherley's cellmate rang the cell bell again and told the officer who answered that Mr Weatherley was fitting on the floor. Staff attended and called an ambulance. While ambulance paramedics were attending to Mr Weatherley, he had a cardiac arrest and, at 8.46am, a prison doctor pronounced he had died.
5. After Mr Weatherley's death, the investigator listened to the phone calls he made following the visit. He told his girlfriend that he had swallowed the package she had passed him. The post-mortem examination showed that Mr Weatherley died from the combined toxic effects of cocaine and methadone.

Findings

6. Mr Weatherley died because he swallowed a package of drugs that had been passed to him by his girlfriend during the visit on 23 February.
7. We are satisfied that, after searching Mr Weatherley and watching the CCTV of the visit, it was not unreasonable for staff to believe that they had prevented the passing of drugs during the visit on 23 February. Mr Weatherley did not disclose that he had swallowed drugs. In these circumstances, we are satisfied that there was no reason for them to arrange for Mr Weatherley to be observed for any ill effects.
8. We do, however, have some concerns.
9. Staff told the investigator that Mr Weatherley had been placed on closed visits previously, after his sister attempted to pass drugs to him during a visit on 7 October 2017. No documentary evidence relating to this decision was provided to the investigator, so it is unclear when the decision to impose closed visits was made, when it was reviewed and lifted, and the reasons for those decisions.
10. We are concerned that when staff did not find drugs on Mr Weatherley after the visit on 23 January, they did not search Mr Weatherley's visitors and the rooms they were held in, and did not call the police.
11. It appears to be standard practice at Thameside for healthcare staff to 'examine' a prisoner after a use of force from outside the cell door, rather than in person. We do

not consider that this meets the requirements of Prison Service Order 1600. If Mr Weatherley had been able to speak to the nurse directly, it is possible that he might have disclosed that he had swallowed drugs.

12. The long delay in responding to Mr Weatherley's cell bell on 24 February was unacceptable, as was the delay of 16 minutes in getting the ambulance paramedics from the prison gate to Mr Weatherley's cell. We note, however, that the clinical reviewer does not consider that the outcome for Mr Weatherley would have been different even if there had been no delays.
13. Mr Weatherley's family was not told of his death until over 36 hours after he had died, and they were not told in person by prison staff as they should have been.
14. Some staff felt they had not been supported adequately by the prison following Mr Weatherley's death.
15. The investigator encountered delays in obtaining documentation from Thameside and in arranging interviews with relevant staff. Thameside needs to improve its PPO liaison arrangements.

Recommendations

- The Director should ensure that staff:
 - record clearly the reasons for the decision to impose closed visits; and
 - review the decision regularly and record the outcome of the reviews, including the reasons for no longer imposing closed visits.
- The Director should ensure that visitors are searched after a visit if staff suspect that they made an unsuccessful attempt to pass drugs or other contraband, and that the police are called.
- The Director should ensure that healthcare staff are able to examine a prisoner in person after a use of force, subject to a risk assessment, in line with PSO 1600.
- The Director should:
 - by 31 March 2019, provide the Ombudsman with confirmation that he is satisfied that the cell call system is fit for purpose; and
 - review the current protocol for recording and answering emergency cell bells to ensure that:
 - staff respond to all cell bells promptly;
 - staff update the cell bell log accurately with specific information, including the time it was activated and the name of the staff member asked to respond;
 - all staff are told immediately about any malfunction in the cell bell system and what to do in such circumstances; and
 - staff report problems with cell bells immediately and they are fixed promptly.
- The Director should ensure that staff facilitate the access of ambulances and paramedics through the prison gate and ensure there are no unnecessary delays.

- The Director should ensure that the prison complies with Prison Service requirements for contacting the families of deceased or seriously ill prisoners and that they have adequately trained family liaison officers.
- The Director should ensure all staff, irrespective of status, position or experience, are provided with formal support from the prison, immediately following a death in custody.
- The Director and Head of Healthcare should both, by 31 March 2019, confirm to the Ombudsman that, following a death in custody, a single point of contact appointed by the Director will coordinate the response to all the Ombudsman's requests for information and for arranging interviews with prison and healthcare staff, in line with the requirements of PSI 58/2010.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Thameside informing them of the investigation and asking anyone with relevant information to contact her. No-one responded.
17. The investigator visited Thameside on 13 March. She obtained copies of relevant extracts from Mr Weatherley's prison and medical records. She visited the wing where Mr Weatherley lived and spoke to prisoners and staff who had had contact with him. The investigator interviewed Mr Weatherley's cellmate and the family liaison officer.
18. NHS England commissioned a clinical reviewer to review Mr Weatherley's clinical care at the prison.
19. The investigator interviewed nine members of staff at Thameside on 24 August, accompanied by the clinical reviewer. In addition, the investigator interviewed six members of staff by telephone during August and September.
20. We informed HM Coroner for Inner South London of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
21. One of the Ombudsman's family liaison officers wrote to Mr Weatherley's next of kin's legal representative to explain the investigation and to ask if Mr Weatherley's family had any matters they wanted the investigation to consider. They wanted to know what happened on the morning Mr Weatherley died, what medication he had been prescribed and if he was being regularly monitored. Mr Weatherley's family also wanted to know why they were not informed of his death until 9.45pm on Sunday 25 February.
22. We provided a copy of our draft report to the legal representatives for Mr Weatherley's family. They did not identify any factual inaccuracies.
23. We shared our initial report with Her Majesty's Prison and Probation Service (HMPPS) so they could check the factual accuracy of our report and provide us with an action plan to address our recommendations. HMPPS failed to provide a response to us within the agreed timescale of four weeks, although we gave them two extensions to the deadline, amounting to eight weeks in total. We do not consider that this is acceptable. However, they have since provided a response and an action plan.
24. Thameside identified four factual inaccuracies, three of which we have not accepted. We have accepted one factual inaccuracy and amended target dates in the recommendations accordingly.

Background Information

HMP Thameside

25. HMP Thameside is a local prison in south-east London that holds up to 1,232 men. It is run by Serco. Oxleas NHS Foundation Trust has provided healthcare services since April 2015. There is 24-hour nursing provision and an 18-bed inpatient unit. Clinical drug services are delivered by Addaction and psychosocial services by Turning Point.

HM Inspectorate of Prisons

26. The most recent inspection of Thameside was in May 2017. Prisoners told inspectors it was easy to get illicit drugs. Inspectors found that, while Thameside had a focused drugs supply reduction strategy, too many drugs were available. Outcomes for prisoners with drug and alcohol problems were found to be good, but substance misuse treatment services were not sufficiently integrated and were hampered by Turning Point's lack of access to medical records. There was an identified problem with the provision of healthcare services and a mismatch between supply and demand for the number of prisoners held at Thameside.
27. Inspectors found that cell bells were not answered as promptly as they should have been, which, in their view, indicated a lack of management oversight which needed to be addressed.

Independent Monitoring Board

28. 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 annual report, for the year to June 2018, the Board found that Turning Point provided a good service to men with substance misuse issues.

Previous deaths at HMP Thameside

29. Mr Weatherley was the eighth prisoner to die at Thameside since February 2015. Of the previous deaths, one was self-inflicted, one was drugs-related and five were from natural causes. There have been two deaths from natural causes since. We have previously made recommendations about ensuring cell bells are working properly, avoiding delays in the emergency response and the need to inform the next of kin promptly and in person after a death in custody.

Incentives and Earned Privileges Scheme (IEP)

30. Each prison has an incentives and earned privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and wear their own clothes. There are four levels: entry, basic, standard and enhanced.

Key Events

31. On 24 June 2017, Mr Stephen Weatherley was remanded in prison custody charged with murder and sent to HMP Belmarsh. He had been in prison before.
32. When Mr Weatherley arrived at Belmarsh, a nurse completed an initial health screen. The nurse noted Mr Weatherley was a regular drug user (heroin and crack cocaine) and was prescribed 30mls methadone (an opiate substitute), that he suffered from epilepsy, and that he was prescribed medication for depression.
33. Mr Weatherley was transferred to HMP High Down on 3 August. A nurse completed the initial health screen and a prison GP reviewed Mr Weatherley's medications the next day. On 5 August, Mr Weatherley told a nurse that he had had a seizure and would sue the Prison Service because his pregabalin medication had been reduced. (Pregabalin is used to treat epilepsy but can also enhance the euphoric effects of other drugs, such as opiates, and is a highly tradeable drug in prisons.) The nurse recorded there was no medical evidence of a seizure.
34. On 9 August, a nurse completed a substance misuse assessment with Mr Weatherley and gave him information about the risks of using other illicit substances while prescribed methadone. Mr Weatherley was referred to the mental health in-reach team for an assessment and review of his medication. A mental health nurse completed the assessment on 15 August. The nurse recorded his concerns that Mr Weatherley displayed drug-seeking behaviour. The nurse increased Mr Weatherley's antipsychotic medication (quetiapine) and warned him about the dangers of using illicit substances in addition to those prescribed.
35. There were two recorded incidents when Mr Weatherley was suspected to be under the influence of illicit drugs at High Down. On 22 August, a nurse recorded that he was disorientated, dazed and unable to hold himself upright, but refused to have his observations taken. He was checked a short while later by a nurse and although Mr Weatherley was still unsteady, his symptoms had improved and he was more alert. A nurse from the substance misuse team assessed Mr Weatherley on 24 August. He told her that he had accidentally smoked 'Spice', a psychoactive substance, but that because of a previous heart attack he would not knowingly have smoked the drug. The nurse recorded Mr Weatherley displayed some mild withdrawal symptoms as his methadone had been stopped for a day for safety reasons, because of his illicit drug use.
36. On 11 September, Mr Weatherley was observed to be under the influence of an illicit substance. A nurse recorded that Mr Weatherley slurred his speech and appeared pale. His methadone medication was stopped for one day, and he continued to be monitored over the next few days. A nurse gave Mr Weatherley advice on reducing his risk and information on the dangers of using psychoactive substances.
37. Mr Weatherley appeared in court on 27 September, and was taken to HMP Thameside. A nurse completed his initial healthscreen and referred him to the substance misuse team. Mr Weatherley was observed for the next five days for symptoms of drug withdrawal but none were recorded.

38. On 3 October, Mr Weatherley told a nurse that he was experiencing withdrawal symptoms, but denied he had been using illicit drugs in addition to his methadone. Mr Weatherley's methadone was increased to 35mls.
39. On 7 October, Mr Weatherley was observed during a social visit to 'plug' an item, although nothing was found when he was searched. ('Plug' is a slang term that refers to items being inserted into a person's rectum so they can be transported undetected.) Mr Weatherley was moved to the care and separation unit (CSU, often know as Segregation). The investigator was told by several prison staff that Mr Weatherley was placed on closed visits after this incident (meaning he and his visitors were not able to have physical contact during visits, thus preventing any items being passed between them). While in the CSU, Mr Weatherley was seen each day by healthcare staff and observed for any side effects, until he was returned to a standard residential wing on 11 October.
40. On 31 October, Mr Weatherley was moved to the CSU after a mobile phone charger was found connected to the back of his television. On 2 November, a nurse recorded that Mr Weatherley had become hostile when medications were dispensed and that he spat and threw a cup of water over a custodial operations manager (COM). Mr Weatherley had to be restrained and moved back into his cell, but refused to let nurses examine him. The next day a nurse referred Mr Weatherley for a mental health assessment. Mr Weatherley was seen by healthcare staff daily, until he was returned to a standard residential wing on 12 November.
41. On 1 December, a nurse completed an integrated drug treatment services (IDTS) review, which included the impact on Mr Weatherley's mental health. The nurse noted that Mr Weatherley asked for his methadone to be increased, but also appeared under the influence of an illicit substance. The nurse recorded that Mr Weatherley would remain on his current dose of methadone, that healthcare staff should assess him before administering his methadone and that the GP would review him. (Mr Weatherley failed to attend his GP appointments.)
42. Mr Weatherley's prison record has only three entries for the time he was at Thameside.
43. On 21 December at 7.32pm, an officer recorded that he had received a call from Mr Weatherley's sister. She told him that Mr Weatherley had several physical health conditions, had not received money that had been sent into him and that he was feeling suicidal. The officer recorded that he spoke to Mr Weatherley who confirmed he had a heart condition, but that he was on the correct medication and that he had a bad leg, but that healthcare was aware. Mr Weatherley told the officer that he had completed information for the payment as requested by staff, but that he had missed his canteen. Mr Weatherley told him he had no thoughts of suicide or self-harm, but said he may have shared some thoughts with his sister as he was upset, but did not mean them. The officer asked Mr Weatherley to contact his sister to reassure her.
44. On 29 December, a healthcare assistant in the substance misuse team reviewed Mr Weatherley. He noted that Mr Weatherley's mental health was stable and there were no signs of drug withdrawal.

45. On 11 January 2018, a member of the substance misuse team, recorded in Mr Weatherley's prison record that they completed a Turning Point key work session on 8 January but no specific detail was recorded.
46. On 7 February, although there is no entry on Mr Weatherley's prison record, he was found under the influence of a psychoactive substance and a COM reviewed Mr Weatherley's IEP status and downgraded him to basic.
47. On 13 February at 2.45pm, an officer entered the final entry on Mr Weatherley's prison record. He recorded, 'Good legal visit, no issues. PCO [Prison Custody Officer].' The next day, a COM reviewed Mr Weatherley's IEP status and concluded that as Mr Weatherley had made threats to staff, he would remain on basic for another 14 days. There is no entry on his prison record or documented on the IEP documentation of what or who these threats were directed at.
48. On 21 February, a prison GP was asked to review Mr Weatherley's anti-epileptic medication (levetiracetam) because he had been refusing to take it. The GP did not meet with Mr Weatherley, but reviewed his medical record and concluded that it was safe to stop the medication. The GP told the investigator that Mr Weatherley was already prescribed pregabalin, which also helped prevent seizures.

Friday 23 February

49. On Friday 23 February, Mr Weatherley's girlfriend and his sister visited him. The visit started around 3.30pm, and officers were using Closed Circuit Television (CCTV) to watch Mr Weatherley and his visitors; cameras were fixed on them for the duration of his visit.
50. At 4.37pm, CCTV shows Mr Weatherley's girlfriend moving her hand from her chest area to her pocket. Shortly afterwards Mr Weatherley gave her a hug and he put his hand into her pocket. Officer A was close by when he approached Mr Weatherley at 4.38pm, when Mr Weatherley took something out of his hand. CCTV footage is not clear enough to decipher what this item was but it was recorded to be possibly a lighter or some sweets. At 4.39pm, Mr Weatherley gave his girlfriend another hug and put his hand into her other pocket, he then put his hand to his mouth. Staff immediately grabbed Mr Weatherley's arms, he stumbled to his knees but quickly got to his feet and was walked away from the area, with two officers holding his arms.
51. Two officers conducted a full (strip) search of Mr Weatherley, observed by a prison manager. They asked Mr Weatherley if he had anything unauthorised, but he said he did not. Mr Weatherley was made to squat because grease stains found on his trousers near his bottom led officers to suspect that he had lubricated his rectum prior to the visit so he could 'plug' unauthorised items. Nothing was found during the search. Officers suspected that his girlfriend had placed an unauthorised item back into her bra.
52. After searching Mr Weatherley, officers completed Use of Force paperwork recording that minimal force was used during the search. Officer A recorded on the F213 report of Injury to Prisoner Form (completed whenever force is used) that the reason for the use of force was an 'attempted pass' [of contraband]. Mr Weatherley was escorted back to his cell.

53. Mr Weatherley's girlfriend and his sister were put in two separate rooms in the visits hall (Rooms 4 and 6) while Mr Weatherley was searched. They were released once the visits manager had reviewed the CCTV footage and concluded that staff had prevented a pass being made. They were not searched and the police were not called.
54. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. The investigator listened to Mr Weatherley's calls made after his visit. In total he made 12 calls to two separate numbers, a total of 32 minutes and 48 seconds. At 5.23pm, Mr Weatherley phoned his girlfriend, who was with his sister. Mr Weatherley asked if they were okay and she replied, 'I'm not alright...knew fucking fix eye was in. Radiator'. Mr Weatherley replied, 'What?' and his sister said, 'Couldn't do nothing else'.
55. A nurse was asked by Officer A to examine Mr Weatherley, as force had been used when he was apprehended in the visits hall. She spoke to Mr Weatherley through his cell door, as staff would not open it as he had recently been subject to the use of force. At 6.15pm, she recorded on the F213 form that Mr Weatherley reported no injuries and required no medical intervention.
56. At 6.26pm, Mr Weatherley spoke to his girlfriend and said, 'I had to swallow', she replied, 'Yeah, I, we guessed that' and Mr Weatherley responded by saying, 'I hope it was wrapped properly'. His sister said they would probably be on closed visits again.
57. In a call made at 7.06pm, Mr Weatherley's sister said, 'I haven't got it, it's gone. You know, door number six... if someone can go in there'. Later during the same call, Mr Weatherley's sister said, 'Down the R [radiator], that's where you need to send the cleaner'.
58. Prison staff did not listen to the telephone calls between Mr Weatherley and his visitors until after his death.

Saturday 24 February

59. An officer completed a roll check around 5.00am. He told the investigator Mr Weatherley was out of bed and appeared to be rolling a cigarette. He said he had no concerns about Mr Weatherley.
60. At 7.02am, Mr Weatherley's cellmate rang their cell bell. An Operational Support Officer (OSO) answered the call. He told the investigator he was unable to hear clearly due to noise from other staff in the area and the poor audio quality of the call. He said he shouted out to an officer, asking him to go to the cell. The officer told the investigator he had no recollection of this and was definitely not asked directly to go to the cell as, if he had been asked, he would have gone. The OSO recorded in the cell bell log 'wants someone to his door/won't say why'. CCTV shows that no officers attended the cell.
61. At around 7.25am, the cellmate rang the cell bell again and a COM answered. He told her that Mr Weatherley was lying on the floor fitting. She asked the officers present if one of them could go to the cell, and an officer responded.
62. The officer went to Mr Weatherley's cell, looked through the observation hatch and immediately radioed a 'code blue' medical emergency (used to indicate a prisoner is

unconscious or having breathing difficulties). The communications room logged the call at 7.27am and called an ambulance at 7.28am. The COM arrived at the cell and the officer then opened the door, entered and placed Mr Weatherley in the recovery position. Two nurses responded to the code blue and staff moved Mr Weatherley to the landing outside his cell where there was more space. Staff took the cellmate out of the cell, but he remained on the wing.

63. A nurse recorded that Mr Weatherley appeared to be having a seizure which lasted a couple of minutes, and she administered rectal diazepam. She said that the diazepam appeared to work as Mr Weatherley stopped fitting. His eyes were open and he was breathing, but he was not responsive. They continued to monitor Mr Weatherley and he was given oxygen.
64. Paramedics arrived at Mr Weatherley's cell at 7.46am. While they assessed Mr Weatherley, he went into cardiac arrest. Paramedics started cardiopulmonary resuscitation (CPR).
65. The lead paramedic asked the cellmate if Mr Weatherley had swallowed anything. Initially the cellmate did not give any information, but a nurse spoke to him and he told her that Mr Weatherley had swallowed 3.5 grams of cocaine just before they were locked into their cells the previous day. The cellmate told the investigator that Mr Weatherley had also drunk illicit alcohol (known as hooch) to try to bring up the drugs.
66. Paramedics continued CPR although Mr Weatherley showed no signs of life. A prison GP arrived at 8.40am and, at 8.46am, he pronounced Mr Weatherley had died.
67. The holding rooms that Mr Weatherley's visitors were put in the day before were searched around 9.30am by an officer. In Room 6 a small package was discovered behind the radiator. Tests showed it contained cannabis.

Contact with Mr Weatherley's family

68. The duty Director asked a COM to act as the prison's family liaison officer (FLO). The COM was the only qualified FLO on duty, but had already said some months before that she did not want to undertake FLO duties. The duty Director attempted to contact another FLO at home, but he did not respond.
69. The duty Director contacted a prison chaplain, who agreed to act as FLO, and they left the prison at 3.45pm to visit the family to break the news of Mr Weatherley's death. However, although the correct address was recorded on Mr Weatherley's prison record, the information either provided to or recorded by the duty Director was incorrect, which meant that he and the chaplain went to the wrong address. They returned to the prison and he contacted the police several times to ask them to notify Mr Weatherley's next of kin of his death.
70. The police informed the prison around 10.00pm on Sunday 25 February that they had informed Mr Weatherley's family. Another officer took over the FLO role on Monday 26 February, and offered ongoing support to Mr Weatherley's family. The prison contributed towards the cost of the funeral in line with national instructions.

Support for prisoners and staff

71. The duty Director debriefed most of the prison and healthcare staff involved in the emergency response and offered their support and that of the staff care team. However, this was not done until the next day and several members of staff were not present.
72. The prison posted notices informing prisoners of Mr Weatherley's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Weatherley's death.

Post-mortem report

73. A pathologist concluded that Mr Weatherley died from the combined toxic effects of cocaine and methadone. Cocaine and benzoylecgonine (formed in the liver when cocaine is metabolised) were detected at very high concentrations that are within the range where deaths have been attributed to cocaine overdose. The concentration of methadone detected was also high and above the range of methadone maintenance therapy and within the wide range where deaths have been associated. Results also identified previous use of a synthetic cannabinoid, but the pathologist was not able to indicate how long before his death Mr Weatherley had taken the drug or if he would have been under the influence at the time of his death.

Findings

Visit on 23 February

74. Prison Service Instruction (PSI) 15/2011 *Management of Security at Visits*, states:
- “Closed visits and visitor bans both engage ECHR Article 8 (Right to private and family life) and as such (a) cases must be considered on an individual basis; (b) any decision to impose closed visits or bans must be proportionate to the risk they are meant to be reducing and (c) any measures imposed must be reviewed on a regular basis. Closed visits and visitor bans may, in the first instance, be imposed for up to three months duration. Closed visits are an administrative measure, not a punishment. As such, they can be applied regardless of whether or not a prisoner has been charged at adjudication with smuggling prohibited items through a visit and the decision should be reviewed every month.”* [Italics indicate mandatory instructions.]
75. Staff told the investigator that Mr Weatherley had been placed on closed visits after his sister attempted to pass drugs to him during a visit on 7 October 2017. The investigator was not provided with any documentary evidence of this decision, or of any subsequent reviews, so it is unclear when the closed visits were lifted and the reasons for that decision.
76. There were only three entries made on Mr Weatherley’s prison record for the entire time (five months) he was at Thameside. The investigator was initially provided with an incomplete security file, but when the full copy was provided, information about Mr Weatherley being subject to closed visits was missing. We found separate systems - the Serco case management system and NOMIS the electronic prison record - were being used to record information, and information that should have been easily available (including information about closed visits, IEP decisions and Mr Weatherley’s general behaviour) was either not recorded or held on individuals’ email accounts, rather than on the shared system accessible to all.
77. According to the information provided by Thameside, there was no prior security intelligence about drugs being passed to Mr Weatherley and the decision to monitor his visit closely on 23 February was made spontaneously when visits staff realised it was his sister. However, when trying to establish the circumstances of the previous imposition of closed visits and how this informed decisions on 23 February, we found that prison records were unclear. We make the following recommendation:

The Director should ensure that staff:

- **record clearly the reasons for the decision to impose closed visits; and**
- **review the decision regularly and record the outcome of the reviews, including the reasons for no longer imposing closed visits.**

Post visit management

78. Staff monitored Mr Weatherley and his visitors for the duration of their visit on 23 February. The visits manager said they had no intelligence that drugs were going to be passed but staff were always suspicious of Mr Weatherley and his visitors

because of his involvement with drugs and that, when they realised it was Mr Weatherley's sister visiting, he directed them to keep a close watch.

79. The visits manager said he and his colleagues reviewed the CCTV immediately after the visit, but saw nothing of concern. He said he was certain at the time that staff had stopped whatever was planned between Mr Weatherley and his visitors and so had no concerns about his health. He said he had stopped hundreds of passes while working in visits, and would always put a prisoner in the segregation unit or healthcare for observation if he had concerns.
80. The visits manager said when the Serco investigator visited Thameside after Mr Weatherley's death, they viewed the CCTV footage in extreme slow motion and that the pass happened so quickly they were only able to spot it after viewing the footage several times. The investigator viewed the CCTV footage and found that the pass and swallow were very difficult to see, but Mr Weatherley briefly put his hand to his mouth just before he was restrained.
81. Mr Weatherley made several telephone calls after he returned from his visit where he can clearly be heard to ask if 'it' [the package] was well wrapped as he had had to swallow it. The visits manager said he was made aware of these calls only after the Serco investigation. He said it was possible to listen to calls immediately, but that in this instance he did not consider doing so, as he believed that any planned pass had been intercepted.
82. The Royal College of Emergency Medicine Best Practice Guidelines (2014), *Caring for Adult Patients Suspected of Having Concealed Illicit Drugs*, say that people suspected of swallowing a drugs package in an unplanned attempt to avoid detection by the authorities should be taken to hospital and observed for a minimum of six to eight hours. It states that the person may take several hours to develop symptoms and it is very variable depending on the type of wrapping of the package. It notes that deaths have occurred after this timescale, but that has been due to no clinical observations having been taken, which might have identified signs of toxicity earlier. The guidelines state that if suspicions are high, the person should be kept under observation longer (usually 12 to 24 hours).
83. We consider that, after searching Mr Weatherley and watching the CCTV, it was reasonable for prison staff to believe they had stopped a planned drugs pass. Mr Weatherley did not disclose that he had swallowed a package of drugs. As a result, we are satisfied that there was no reason for staff to consider that Mr Weatherley was at risk or to put any monitoring arrangements in place after the visit.
84. We do, however, have some concerns about what happened after the visit.

Treatment of Mr Weatherley's visitors

85. PSI 15/2011, *Management of security at visits*, states Local Security Strategies (LSS) must ensure systems are in place to prevent passing of unauthorised articles during visits and that if visitors are found to have conveyed any banned item, the police should be notified and the visitors prosecuted. Mr Weatherley's visitors were not searched again after they had been put into separate holding rooms, and the holding rooms were not searched after they had left. The visits manager said the police would typically be called if a visitor had been found with any contraband or a pass had been observed. He said that the prison would not normally search

someone again after they had entered the prison and that he only became aware drugs had been found in one of the rooms the following morning.

86. The duty Director on the day Mr Weatherley died, said that he would have expected Mr Weatherley's visitors to be searched again after the visit, as well as the rooms they were held in, and that there was no reason why Mr Weatherley's telephone calls could not have been listened to that evening. He said the situation should have been managed better.
87. We are concerned that Mr Weatherley's visitors and the rooms they were held in were not searched after the visit. If staff believed that they had prevented a pass of drugs, it follows that the visitors would have still had the drugs in their possession and we are surprised that no further action was taken and the police were not called. If prisons are to combat the serious problem of drugs, they need to take every opportunity to prevent drugs entering the establishment and to work with the police to do so. We make the following recommendation:

The Director should ensure that visitors are searched after a visit if staff suspect that they made an unsuccessful attempt to pass drugs or other contraband, and that the police are called.

Healthcare examination

88. The emergency response nurse said she was never informed there was a possibility that Mr Weatherley may have swallowed a package. She said she was walking towards Houseblock One at around 6.10pm, when Officer A stopped her and asked her to complete the F213 form. She said Officer A explained that Mr Weatherley had been stopped in visits and restrained as a parcel had been passed across the table. She said she knew a nurse should be called immediately someone is restrained and the F213 completed as soon as possible, not several hours after an incident, but that in her experience that never happened. She said communication between prison and healthcare staff was very difficult from both sides, and while efforts had been made to improve, it continued to be problematic.
89. The COM said it was impractical to complete the use of force documents in the visits hall and that it was normal practice at Thameside for the paperwork to be completed after a search and that healthcare would be called over to the wing to examine a prisoner.
90. Prison Service Order (PSO) 1600, *Use of Force*, says that healthcare practitioner (a doctor or nurse) must be informed whenever force has been used to restrain a prisoner. He or she must examine the prisoner as soon as possible and must complete a F213 in all cases even if the prisoner appears not to have sustained any injuries.
91. The nurse told the investigator that Officer A would not unlock the cell door and would only allow her to speak to Mr Weatherley through the hatch because he had been restrained earlier in the day. She said this was the standard practice.
92. In our Learning Lessons Bulletin, *Use of Force – further lessons*, published in 2016, we said that we do not consider that a look through a cell hatch meets the requirement in PSO 1600 for a prisoner to be 'examined' by a healthcare practitioner. We consider that where it is not possible to conduct a proper examination immediately after an incident, the prisoner should be seen again by

healthcare a few hours later. This gives time for the prisoner to calm down and also for any physiological effects, such as bruising or pain, to develop. We also said that, wherever possible, we consider the prisoner should be able to speak to healthcare staff out of the hearing of officers.

93. We are concerned that it appears to be standard practice at Thameside for post use of force 'examinations' to be conducted from outside the cell door instead of in person. This is unsafe practice and does not comply with the instructions set out in PSO 1600. We recognise that there may be circumstances where a prisoner poses too great a risk for a nurse to enter the cell, but we consider that this should be the exception rather than the rule and only after a risk assessment has been conducted.
94. The nurse was not called to examine Mr Weatherley until he was placed in his cell on the houseblock more than one and a half hours after the restraint in the visits hall, and she was not able to speak to Mr Weatherley face to face. If she had been, this may have given him an opportunity to tell her that he had swallowed a package and to ask for advice
95. We make the following recommendation:

The Director should ensure that Healthcare staff are able to examine a prisoner in person after a use of force, subject to a risk assessment, in line with PSO 1600.

Answering Mr Weatherley's cell bell

96. The cellmate pressed the emergency cell bell at around 7.00am. The OSO told the investigator that he could not hear clearly but Mr Wilson sounded 'peed off' rather than distressed. The OSO said prisoners often used their emergency cell bells to request other things and were often demanding. He said the in-cell phone system was very poor, as you could not hear properly, and they routinely did not work.
97. The OSO recorded in the cell bell log book that a request had been made to go to cell C1-07 (Mr Weatherley's cell), but no time was recorded. He said that the cell bell logs were introduced some years ago, as staff often used to just make notes on scraps of paper. He said it was not an oversight that the time was not recorded, but that times were never routinely recorded, although he believed this may have changed since Mr Weatherley's death.
98. The OSO said an officer, not an operational support grade, would normally be responsible for responding to an emergency cell bell. He recalled the office was very busy as the night shift was handing over to the day shift. He told the investigator he shouted loudly and asked an officer to go to cell C1-07. The officer said he had no recollection of anyone shouting or asking for someone to go to Mr Weatherley's cell, but was certain he had not been asked directly as, if he had been asked, he would have gone.
99. PSI 75/2011, *Residential Services*, says that prisoners should be able to summon assistance from within their cell and that staff must respond 'promptly' and must acknowledge all requests for assistance by personal contact with the prisoner. It also says that staff are responsible for reporting any faults with the system.

100. HMIP has an expectation that cell bells should be answered within five minutes. During their most recent inspection of Thameside in May 2017, inspectors noted cell bells were not answered promptly, which they concluded indicated poor management oversight.
101. It is unclear exactly what happened after the OSO answered the cell bell at around 7.00am, but we do know nobody went to Mr Weatherley's cell until after the cellmate had rung it again around 25 minutes later. We note that the night shift was handing over to the day shift at the time and there were therefore plenty of staff available to answer the bell. The duty Director on the day Mr Weatherley died, recorded in the hot debrief minutes that a full investigation would take place. Although Serco completed a factual report of events after Mr Weatherley's death and identified that the initial cell bell had not been answered, no evidence has been provided to show that Thameside investigated the matter further.
102. The clinical reviewer has concluded that the outcome is likely to have been the same for Mr Weatherley, even if staff had responded immediately to his cell bell. Nevertheless, the delay was unacceptable and could be critical in future cases. We have previously identified problems with cell bells not working properly at Thameside and we are very concerned to be told that there is a difficulty in hearing what prisoners are saying and that they often do not work. We make the following recommendation:

The Director should:

- **by 31 March 2019, provide the Ombudsman with confirmation that he is satisfied that the cell call system is fit for purpose,**
- **and review the current protocol for recording and answering emergency cell bells to ensure that:**
 - **staff respond to all cell bells promptly;**
 - **staff update the cell bell log accurately with specific information, including the time it was activated and the name of the staff member asked to respond;**
 - **all staff are told immediately about any malfunction in the cell bell system and what to do in such circumstances; and**
 - **staff report problems with cell bells immediately and they are fixed promptly.**

Management of Mr Weatherley's substance misuse

103. Mr Weatherley had a history of taking illicit drugs while at Thameside and during previous periods in prison custody. Healthcare staff at High Down and Thameside noted that Mr Weatherley often exhibited drug-seeking behaviour in prison and that he was observed to be under the influence of illicit drugs on several occasions. Although Mr Weatherley said his methadone dose was not holding his withdrawal symptoms, when reviewed by the IDTS team at Thameside, his mental health was assessed as stable and there were no signs of opiate withdrawal symptoms. A prison GP told us that methadone doses in prison are significantly less than those used in the community.

104. The clinical reviewer found that the management of Mr Weatherley's substance misuse was satisfactory.

Management of Mr Weatherley's physical health

105. Mr Weatherley had epilepsy due to his substance misuse and had previously been prescribed clonazepam, a potent benzodiazepine (highly sought after and tradeable drugs in prison). However, in 2015 a neurologist said this was an inappropriate treatment for his epilepsy and Mr Weatherley was prescribed an alternative (levetiracetam). Mr Weatherley often refused to take this medication while at Thameside, and the prison GP said Mr Weatherley's preference for clonazepam may have been motivated by his benzodiazepine dependence.
106. The prison GP was asked by healthcare staff to review Mr Weatherley's anti-epileptic medication because he had been refusing to take it. Although he did not meet with Mr Weatherley, having reviewed his medical records, he stopped the prescription of levetiracetam on 21 February. He concluded that taking the anti-epileptic medication erratically, increased the risk of seizures. He said pregabalin, another drug prescribed to Mr Weatherley, also helped prevent seizures so there was no significant risk of stopping levetiracetam.
107. The clinical reviewer concluded that, overall, the care provided to Mr Weatherley during his time at Thameside was equivalent to the care he could have expected to receive in the community.

Emergency response

108. PSI 03/2013, *Medical Emergency Response Codes*, contains mandatory instructions that prison staff should prevent unnecessary delays in escorting ambulances and paramedics to the patient. Ambulance paramedics recorded that they arrived at the prison gate at 7.30am but did not arrive at Mr Weatherley's cell until 7.46am, 16 minutes later. Thameside did not provide any explanation for why it had taken so long to get the paramedics through the gate. We make the following recommendation:

The Director should ensure that staff facilitate the access of ambulances and paramedics through the prison gate and ensure there are no unnecessary delays.

Informing Mr Weatherley's next of kin

109. Prison Rule 22 states that if a prisoner dies or becomes seriously ill then the governor should 'at once' inform a prisoner's spouse or nominated next of kin. PSI 64/2011, *Safer Custody*, says that wherever possible, the family liaison officer and another member of staff should visit the next of kin or nominated person to break the news of the death.
110. The duty Director and the chaplain did not leave Thameside until 3.45pm, nearly seven hours after Mr Weatherley had died, to travel to his next of kin's address to break the news. The duty Director said they did not leave the prison earlier as he had difficulty identifying a FLO, and he did not want to break the news on his own. He believed, wrongly, that as the duty Director, he had to be the person to break the news. The officer who took over the FLO role said prison managers did not understand it did not have to be the duty Director who had to break the news. The

new FLO said he had raised concerns, including the lack of a formalised arrangement for a duty FLO, particularly over weekends, which had caused problems previously.

111. The duty Director said there was no answer at the address and that he did not consider returning to the address the next day as he had been assured the police would break the news. He became aware they had gone to the wrong address only when the police confirmed they had broken the news to Mr Weatherley's family, over 36 hours after he had died.
112. Previous investigations have identified poor standards of family liaison following deaths at Thameside. There needs to be a better understanding by senior managers of the need to ensure families are notified as soon as possible, and provided with appropriate support. We make the following recommendation:

The Director should ensure that the prison complies with Prison Service requirements for contacting the families of deceased or seriously ill prisoners and that they have adequately trained family liaison officers.

Support for staff

113. PSI 08/2010 – *Post Incident Care*, states: "The Governor [or Director] must have a local policy to identify the staff responsible for ensuring access to post incident care". While most prison staff said they had felt well supported by their colleagues in the period after Mr Weatherley's death, we have identified a number of concerns.
114. The hot debrief, chaired by the duty Director, was not held until the day after Mr Weatherley's death. He said when he returned to the prison after attempting to inform Mr Weatherley's next of kin of his death, most staff involved were no longer on duty.
115. The OSO told us that he did not feel supported. He said the morale at Thameside was so bad that 'incidents such as Mr Weatherley's death, incidents of violence, etc just seem to roll off people', and he felt upset that nobody had spoken to him after Mr Weatherley's death, or followed up why the cell bell was not answered earlier.
116. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed (or indeed good practice). It also provides those directly involved with an opportunity to process events. We therefore make the following recommendation:

The Director should ensure all staff, irrespective of status, position or experience, are provided with formal support from the prison, immediately following a death in custody.

PPO liaison arrangements

117. Following the notification of Mr Weatherley's death, Thameside appointed a PPO liaison officer. An Assistant Director took over the role of liaison officer for a short period when the PPO liaison officer was absent.
118. During her initial visit on 13 March, the investigator met with the Head of Healthcare and discussed problems the PPO had faced in previous investigations over liaison

with healthcare and obtaining information. The investigator emphasised that the appointed liaison officer should coordinate all contact.

119. The investigator visited Thameside on 19 June, and met with the Assistant Director and the newly appointed Investigations Manager, who had been assigned as the new PPO liaison officer, to discuss liaison arrangements as there had been ongoing difficulties. The investigator was assured liaison arrangements would improve. However, arranging interviews with prison and healthcare staff and obtaining information via the liaison officer continued to be problematic, and Investigations Manager did not respond to several emails and telephone calls. The investigator had to again enlist the support of the Assistant Director before liaison arrangements improved. The Assistant Director explained that emails sent to the Investigations Manager might not have been delivered due to her changing role within Serco, but no further contact was received from her.
120. The first PPO liaison officer resumed the role on 14 September, although this was not as a single point of contact, but only in relation to Serco staff.
121. While we accept the role of liaison officer can be difficult, especially when trying to coordinate with outside healthcare providers who have differing contractual arrangements to Serco staff, PSI 58/2010, *Prisons and Probation Ombudsman*, makes it clear that access to all documentation will be facilitated by the designated liaison officer. We also expect that the same liaison officer will take responsibility for arranging all interviews requested by the Ombudsman's investigator, including interviews with prison staff, healthcare staff and contractors' staff. Interviews should be arranged at times that suit the shift arrangements of different staff in consultation with their managers, but the key point is that the liaison officer should arrange all the interviews.
122. The PPO has not experienced the same liaison difficulties at other Serco-run establishments. Liaison arrangements at Thameside following other deaths in custody have consistently fallen below our expectations and raising the issues informally with individuals has not led to an improvement. We make the following recommendation:

The Director and Head of Healthcare should both, by 31 March 2019, confirm to the Ombudsman that, following a death in custody, a single point of contact appointed by the Director will coordinate the response to all the Ombudsman's requests for information and for arranging interviews with prison and healthcare staff, in line with the requirements of PSI 58/2010.

Inquest

123. The inquest into Mr Weatherley's death concluded in May 2023. The conclusion was that Mr Weatherley's death was due to the combined toxic effects of cocaine and methadone. A narrative verdict was recorded and noted that the decision to allow Mr Weatherley to have an open visit with his girlfriend, the passing of drugs by her and the decision not to monitor Mr Weatherley as a precautionary measure had a material contribution to his death.

**Prisons &
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