

**Prisons &
Probation**

Ombudsman
Independent Investigations

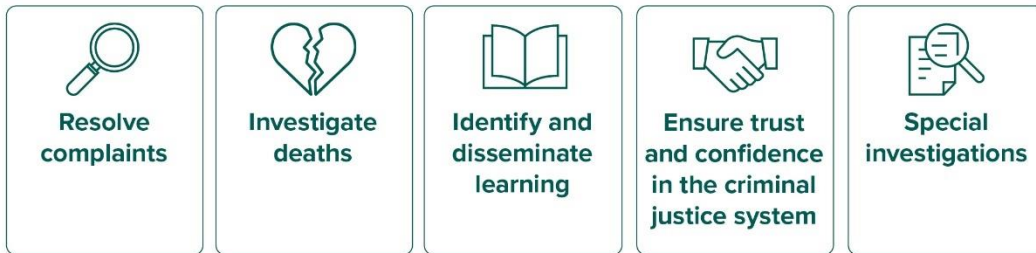
Independent investigation into the death of Mr Peter Weyman, a prisoner at HMP The Verne, on 19 March 2023

A report by the Prisons and Probation Ombudsman

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



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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. 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.
3. Mr Peter Weyman died in hospital of lung cancer on 16 March 2023, while a prisoner at HMP The Verne. He was 72 years old. We offer our condolences to Mr Weyman's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Weyman received at The Verne was not equivalent to that which he could have expected to receive in the community. The clinical reviewer found that there was inconsistent use of the NEWS2 tool (used to assess clinical deterioration), and staff did not escalate Mr Weyman's care as they should have done. This is an issue we have raised repeatedly with The Verne. The healthcare provider has told us that they have introduced refresher training and a NEWS2 audit. The clinical reviewer made several other recommendations which the Head of Healthcare will want to address.
5. We found that there was a delay in progressing an application for Mr Weyman's early release on compassionate grounds, partly because no one discussed Mr Weyman's wishes with him until a late stage. We bring this issue to the attention of the Governor and Head of Healthcare.

The Investigation Process

6. HMPPS notified us of Mr Weyman's death on 19 March 2023.
7. NHS England commissioned an independent clinical reviewer to review Mr Weyman's clinical care at The Verne.
8. The PPO investigator investigated the non-clinical issues relating to Mr Weyman's care.
9. The PPO family liaison officer wrote to Mr Weyman's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP The Verne

11. Mr Weyman was the seventeenth prisoner to die at The Verne since March 2020. Of the previous deaths, 15 were from natural causes and one was self-inflicted. We have previously made recommendations about the use of the NEWS2 tool to assess clinical deterioration. The healthcare provider told us in September 2023 that they had introduced refresher training and a NEWS2 audit.

Key Events

12. On 21 February 2018, Mr Peter Weyman was sentenced to 13 years imprisonment for sexual offences. On 7 March 2019, he was moved to HMP The Verne.
13. On 18 March 2022, a nurse at The Verne saw Mr Weyman after he said he was having breathing difficulties. The nurse took his observations which were within the normal range. As Mr Weyman had chronic obstructive pulmonary disease (COPD, a group of lung conditions that cause breathing difficulties), a plan was made for him to be reviewed at the long-term condition clinic.
14. On 23 March, a nurse went to see Mr Weyman for the long-term condition review, but he was not in his cell. The appointment was not rearranged.
15. On 20 June, a nurse saw Mr Weyman at the long-term condition clinic after he reported that he was short of breath when walking.
16. Over the next few months, Mr Weyman's respiratory conditions were assessed by the healthcare team at The Verne. His inhalers were reviewed, and a nurse said that his inhaler technique was good. In September, a nurse created detailed asthma and COPD care plans to ensure these conditions were managed appropriately.
17. On 24 December, a nurse saw Mr Weyman after he had told prison officers that he was struggling to breathe. He was taken to hospital for an assessment. At hospital, a doctor diagnosed Mr Weyman with exacerbation of his COPD and a chest infection. The doctor prescribed him antibiotics and steroids, and he was discharged back to The Verne.
18. Over the next few weeks, Mr Weyman continued to have breathing difficulties but was regularly monitored by the healthcare staff at The Verne. They continued to take his observations which were recorded as being within the normal ranges.
19. On 12 January 2023, a nurse saw Mr Weyman after prison officers reported that his blood oxygen level had been low overnight when he was walking. The nurse told Mr Weyman that his blood oxygen level would naturally be lower when he was moving. The nurse did not arrange any further clinical assessments for his low blood oxygen level.
20. On 31 January, a paramedic at The Verne saw Mr Weyman, after he reported that he was having breathing difficulties. The paramedic took observations, which were within the normal ranges. The paramedic advised Mr Weyman to rest and arranged for him to be seen by a GP.
21. The next day, the paramedic at The Verne again saw Mr Weyman after he continued to have difficulty breathing. The paramedic took his observations, which were within the normal ranges. As a precaution, the paramedic arranged for Mr Weyman to have further tests.
22. On 2 February, a GP at The Verne saw Mr Weyman to discuss his ongoing breathing difficulties. The GP arranged for Mr Weyman to have an urgent X-ray and blood tests.

23. On 5 February, a nurse went to see Mr Weyman in his cell after he had failed to attend a healthcare appointment. Mr Weyman was wheezing and was short of breath, so the nurse took clinical observations and recorded his blood oxygen level. The nurse calculated a NEWS2 score of 6. (National Early Warning Score (NEWS2) is a clinical tool used to assess clinical deterioration in adult patients.) The score of 6 suggested clinical deterioration and should have prompted Mr Weyman to be reviewed by a doctor. However, as his oxygen level improved, his care was not escalated.
24. The next day, a nurse saw Mr Weyman and calculated a NEWS2 score of 10 (indicating a high risk of clinical deterioration which needs urgent medical attention). The nurse escalated it to a GP and Mr Weyman was taken to hospital for further tests.
25. Mr Weyman remained in hospital until 9 February, when a consultant diagnosed him with lung cancer and gave him a prognosis of approximately four weeks. The same day, a nurse at The Verne emailed the hospital's respiratory consultant and asked for a letter detailing Mr Weyman's diagnosis and prognosis so that the early release on compassionate grounds (ERCG) process could be started.
26. On 14 February, the hospital told the Head of Healthcare at The Verne that Mr Weyman would be ready to be discharged in a few days.
27. On 17 February, an occupational therapist at the hospital saw Mr Weyman to talk about his discharge from hospital. Mr Weyman said that he did not want to die at The Verne, and that he would like to be closer to his home and his sister in Yorkshire. As Mr Weyman needed 24-hour healthcare support, which the Verne could not provide, the healthcare team started looking for a hospice for him.
28. On 9 March, a prison officer from The Verne took a medical consent form to the hospital as they needed Mr Weyman's consent to progress the ERCG application. A second officer who was present at the hospital told Mr Weyman that the healthcare team was trying to arrange compassionate release for him, and that he needed to sign the form for this to progress. The officer said that he explained the form to Mr Weyman, and that Mr Weyman said that he did not want compassionate release as he would have nobody to talk to and did not want to die alone. Mr Weyman did not sign the form.
29. Over the next few days, Mr Weyman's health rapidly deteriorated and he remained on palliative care in the hospital.
30. On 16 March, at 12.30pm, Mr Weyman died.

Post-mortem report

31. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Weyman's cause of death as lower respiratory tract infection caused by lung cancer. COPD was a contributing factor.

Findings

Compassionate release

32. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release are set out in the Early Release on Compassionate Grounds Policy Framework. Among the criteria is that the risk of reoffending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of HMPPS.
33. Although a nurse started the compassionate release application promptly on 9 February, the day Mr Weyman received his terminal diagnosis, nothing further happened to it until 9 March, when healthcare staff passed a medical consent form to a bedwatch officer for Mr Weyman to sign. It is unclear who had responsibility for progressing the application and why nothing happened for four weeks. We note that Mr Weyman refused to sign the medical consent form and the application was not progressed further but there was nevertheless a delay in progressing the application initially. We make no recommendation but bring this issue to the attention of the Governor and Head of Healthcare.

Adrian Usher
Prisons and Probation Ombudsman

December 2023

Inquest

The inquest, held on 23 February 2024, concluded that Mr Weyman died from natural causes.

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