[redacted]
Contract Director
Serco UK & Europe
HMP Thameside
Griffin Manor Way
Thamesmead
London
SE28 0FJ
www.serco.com

[redacted]

8th September 2023

Official-Sensitive

FAO: HM Assistant Coroner Goldring
London Inner South Coroner's Court
1 Tennis Street
London
SE1 1YD
By Email

Dear Ms Goldring

Inquest touching upon the death of Mr Stephen Weatherley

We refer to the Regulation 28 Report dated 20 July 2023 (the "Report") which followed the Inquest, which took place from 9 May – 22 May 2023 into the unfortunate death of Mr Stephen Weatherley who died at HMP Thameside (the "Prison") on 24 February 2018. For the purpose of this response, we will refer to Mr Weatherley as ("SW").

We note that the Report has been copied to Director General Chief Executive HM Prison and Probation Service (HMPPS), Lord Chancellor and Secretary of State for Justice, Ministry of Justice, HM Chief Inspector of Prisons, HM Inspectorate of Prisons and Chair of the Independent Panel on Deaths in Custody. We provide the following response on behalf of the Prison, and we would like to take the opportunity to address you on each of your concerns in turn, for ease of reference.

The report raised two particulars concerns as follows.

<u>Concern One</u>

(1) Data recording and retention in HMP Thameside / oversight by the Ministry of Justice ("MOJ")
("Concern One")

Retention of Data

Firstly, in relation to data retention following a Death in Custody ("DIC"), Assistant Director ("AD") [redacted] provided evidence at the Inquest that he now has autonomy of this process and that there is now a system in place whereby he has set up MS Teams folders which contain all the relevant information, in accordance national PSI's. [redacted] was candid in accepting that he could not explain why documents weren't provided to the Prison and Probation Ombudsman ("PPO") back in 2018 (before he was in post) as the relevant staff members were no longer employed by Serco. However in any circumstance since, he has personally provided the PPO with the information required to further their investigations. It was offered by [redacted] during the inquest that he could show you the files in order to satisfy you that the Prison were sufficiently engaging with the process and retaining the correct information. You understandably indicated that without knowing the specific facts of the case, this might be difficult to assess.

[redacted] explained in evidence that he was aware of an IT migration which took place in 2020, requiring officers to upload any documents retained locally onto a SharePoint. As you outline, he offered this as a possible explanation as to the absence of the documents which were now lost. Whilst this migration did unfortunately mean a lot of information was lost, the positive implication is that now the IT infrastructure, as explained by [redacted], is much better. It allows much wider access to PNOMIS and means he is able to access relevant documents when requests are made.

Since then, evidence was provided in the form of a statement from me ([redacted]) on behalf of the Prison, which identified an audit from our Quality Assurance ("QA") team that [redacted] was obliged to complete. It was also submitted that one of the Contract Delivery Indicators ("CDI's") that the Prison is required to deliver under their contract with the Ministry of Justice ("MOJ") means they have to comply with relevant PSI's, which includes those specific to document retention and what should happen after a DIC.

It was indicated by me that I attend a Quarterly Contract Review Meeting with the MOJ controllers and we discuss findings from the PPO investigations. Nonetheless, an independent audit of the retention of documents on the DIC cases was instructed from the Assurance Team (part of the Serco Enterprise Risk Management team) and reporting to UK&I General Counsel of Serco. It was confirmed that this is independent to the Prison and arrangements for this are underway, with an expected completion date of September 2023. The difficulty with the case of SW was that it had been delayed for a number of years (to some extent due to the criminal liability for SW's visitors) so the management of the DIC's had long since improved and the Prison had no cause for concern in relation to the DIC information retention since my appointment three years ago.

In relation to CMS, there is some reliance on the staff to upload documents. However, again, as previously advised the QA team conduct daily audits on incidents and notify AD's of any deficiencies, which are then rectified. We are confident that the CMS system is updated and that there are plentiful safeguards in place such as the QA team and the management team to ensure documents are properly uploaded and retained.

Data Recording

Secondly, in relation to the recording of information on PNOMIS [redacted] provided evidence that in short, the PNOMIS system is now much more regularly utilized and updated. [redacted] conceded that in SW's case, the entries contained with the PNOMIS file were insufficient and he candidly accepted that it fell below his expected standards

during the Inquest and at the PFD hearing on 12 June 2023, which the Prison do not in any way dispute.

A small audit was completed by [redacted] in short order to assist you with your concerns before 12 June 2023. However, as provided in my statement dated 26 June 2023, the Prison have instructed the same Serco independent audit team to conduct an independent review of a wider selection of PNOMIS files. Again, arrangement are in place to have this completed by September 2023 and we understand that our legal team, DWF LLP, offered to share the results of the same with you on our behalf. It is understood that this offer was made in email correspondence on 05 July 2023.

We understand that the MOJ may wish to address you in relation to the latter half of your *Concern One*. However, for the sake of completeness, a copy this letter and my earlier statement has been provided to them.

Concern Two

(2) Absence of a written policy at HMP Thameside if there is a suspected drug swallow ("Concern Two")

In terms of *Concern Two*, there is a written Serco Custodial Security Strategy ("SCSS") dated July 2021 which outlines when a prisoner can be put through the bodyscanner and it incorporates the national policy 'Use of X-ray Body Scanners (Adult Male Prisons)' dated 18 May 2022 and reissued 3 October 2022[1] which states:

> **Any prisoner can be body scanned upon receipt of intelligence into the prison. This may be prior to a prisoner's arrival at the prison or at any time whilst they are present within the prison. No prisoner can be forcibly scanned.**

This is clear written guidance that any prisoner at any time whilst they are in the prison can be taken to the bodyscanner on grounds of intelligence. It does however state that they cannot be forcibly scanned. No prisoner in any establishment can be legally forced to be scanned using the bodyscanner. This reflects the evidence of [redacted].
One of the grounds upon which a prisoner can be searched through the bodyscanner is below:
Reasonable suspicion during or following a visit that the individual is likely to be internally concealing contraband.
In the instance where a scan is conducted, the same SCSS sets out that:

> **Ensure that the body scan is recorded on NOMIS. The date, dosage and justification (either intelligence or reasonable suspicion) of each scan must be recorded on NOMIS. This must be recorded as soon as practical after the scan is conducted. The NOMIS record must also record whether or not any suspected contraband was detected by the scan.**

This written policy contains clear guidance, which addresses some of your concern in relation to *Concern One*.

Finally, you heard evidence from [redacted] during the PFD hearing on 12 June 2023 that if a prisoner refuses to be scanned, they will be sanctioned and sent to the CSU under prison discipline rules and that as part of this process, their risk to self should be considered. There

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1115596/x-ray-body-scanners-use-pf.pdf

is a dual function to this, in that it protects the prisoner themselves but also reduces channels for prisoners to distribute any items into the main prison population.

This is further supported by the SCSS, which outlines:

> **If a prisoner refuses to be scanned, or intentionally moves to distort the image, it may be appropriate to charge the prisoner with an offence against prison discipline under Rule 51(22) Prison Rules 1999/Rule 55(25) Young Offender Institution Rules 2000 (see PSI 05/2018 Prisoner Discipline Procedures (Adjudications) for further detail), or have their incentive level downgraded and in accordance with the Prison's Incentive Scheme. If staff believe that this is the case, they should consider whether it is necessary to manage the prisoner, in terms of risk to self, as if they do have an internally concealed item (as below).**

The management of Security at any prison is, as you can imagine, a lengthy framework. The SCSS itself consists of 494 pages and underwrites the functions of all staff obligations. In relation to the bodyscanner and searching, all of the above falls under 'Function 3' of the SCSS. You will recall from [redacted] witness statement dated 8th June 2023 that notices were sent to staff outlining their obligations to make themselves familiar with the various functions, which included function 3. Staff are also trained in using the bodyscanner before using it (as is stipulated in the national framework) and therefore the information within this function is known to them.

The National Policy further underpins that:

5.101 If the prisoner refuses or is unable to safely remove or pass a suspected item the prison must consider the risks presented by that prisoner to themselves and/or others. In all cases the prison must consider the location and observation requirements of the prisoner. This could include use of segregation and/or ACCT, if applicable, locating the prisoner in healthcare, or sending the prisoner for outside medical intervention. This decision should be made in conjunction with the advice from healthcare.

It has been recommended to the Serco board that wording to this effect and including additional wording (underlined) where they simply refuse to go through the scanner and not just refuse to remove an item, is now incorporated within the SCSS and re-shared with staff. Please see recommended wording below:

5.101 If the prisoner refuses or is unable to safely remove or pass a suspected item <u>(or simply refuses to be scanned at all)</u> the prison must consider the risks presented by that prisoner to themselves and/or others. In all cases the prison must consider the location and observation requirements of the prisoner. This could include use of segregation and/or ACCT, if applicable, locating the prisoner in healthcare, or sending the prisoner for outside medical intervention. This decision should be made in conjunction with the advice from healthcare.

Whilst this was not previously written in the SCSS (but was in national policy), you will recall the oral evidence of [redacted] that when a prisoner goes through body scanner, if they fail it then they go to CFU or healthcare. '***If plugged or secreted they go to CFU and if swallowed then they go to healthcare.'*** He also gave evidence that the Prison now have a '***good relationship with healthcare'*** and seek their advice in such circumstances. Even in the case where prisoners are taken to CSU, it is still healthcare who conduct the initial health assessment and complete the algorithm, which dictates how often a prisoner should be monitored. You will recall from his evidence that the use of the bodyscanner generally has revolutionised the way in which prisons are able to detect items as you can either prove or

disprove the existence of a secreted item very easily. Although [redacted] was unable to point to 'where it was written down' in the hearing, he did indicate the same premise for decision making that is highlighted above from the national policy. We are confident that trained staff at the Prison, in conjunction with healthcare, would ensure any prisoner at risk of having secreted an item is properly managed.

In real circumstances as at today's date, any suspicion which leads to a request for a prisoner to go through a bodyscanner which is then subsequently met with a refusal to partake in the scan would only raise staff suspicions further. A manager would check the CCTV and they would consult healthcare with the relevant facts/suspicions (as was submitted in evidence during the Inquest and at the PFD hearing on 12 June 2023). More specifically, if a member of healthcare is told by Prison staff that they have either seen a prisoner put their hand to their mouth or it has been seen on CCTV (or in any other very limited circumstance) they could properly suspect a 'swallow' then healthcare staff are afforded the opportunity to make a risk assessment based on their proper clinical judgement. In [redacted] evidence, he submitted that in his quite proper experience, the distinction between a suspected 'swallow' and 'plug' would mean the difference between CSU and impatient unit in practicable terms.

As you have quite rightly outlined in your Report, each case is fact specific and the above guidance reflects the same. To some extent, prison policy has to have some ambiguity to account for a variety of circumstances and is reliant on the judgement of prison staff, together with medically qualified clinicians. For the avoidance of doubt, any prisoner refusing to go through the bodyscanner (which would in all circumstances reveal a swallow) would be relocated to either CSU or healthcare, which requires the input of senior management and healthcare. A prisoner could only be moved to either location with the sign off of an AD That AD will, only with the input of professional medical opinion, make a decision on location of that prisoner. We can confirm that we will be sharing the learnings of this Inquest and indeed the contents of the Report with the senior management team within the Prison and preface with advice that where there is a suspected 'swallow' and absence of a positive bodyscanner result, they should re-locate to healthcare.

The difficulty with SW's case in 2018 was that staff restrained him, found nothing during the search and could not see a pass on CCTV (which was reviewed again by management), no 'hand to mouth' was revealed on CCTV (giving no reason to suspect a swallow) and SW and his visitors protested their innocence. In today's Prison, SW would be asked to go through the bodyscanner. If he had, the package would have been revealed and immediate steps taken to manage his safety. Alternately, he could have refused which would have raised concern (and cast doubt on his earlier protestations of innocence) and resulted in a breach of prison rules, re-allocating him to CSU for monitoring.

However, with the introduction of the bodyscanner, the development of security strategies (including more trained intelligence analysts) and the implementation of a highly skilled senior team, we are confident that the Prison is far more able than in 2018 to identify the need for earlier interventions in such tragic circumstances.

We take all Death's in Custody incredibly seriously. We reflect upon areas of concern and make every effort to prevent similar situations occurring in the establishment.

I hope this response provides you with sufficient assurance that the matters of concern that you have identified in relation to the death of Mr Weatherley are being fully addressed.

Yours Sincerely.

[redacted]

[redacted]
Director, HMP Thameside