REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], The Director at HMP Thameside, Griffin Manor Way, London, SW28 0FJ. [redacted], Director General Chief Executive HM Prison and Probation Service (HMPPS), 102 Petty France, London, SW1H 9AJ. Mr Alex Chalk KC MP, Lord Chancellor and Secretary of State for Justice, Ministry of Justice, 102 Petty France, London SW1H 9AJ.[1] [redacted], HM Chief Inspector of Prisons, HM Inspectorate of Prisons, 3rd Floor, 10 South Colonnade, Canary Wharf, London, E14 4PU.
1	**CORONER** I am Jenny Goldring assistant coroner, London Inner South jurisdiction.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** 1. The death of Stephen Weatherley ("SW") was reported to the coroner by HMP Thameside on 24th February 2018. 2. A forensic post-mortem was conducted on 27th February 2018 and the report was completed on 9th July 2018.The medical cause of death of SW was 1a: Combined toxic effects of cocaine and methadone. 3. On 16th March 2018, an Inquest was opened into the death of SW and an Article 2 Inquest was heard between 9th May 2023 and 22nd May 2023 with a jury. The jury concluded with a narrative conclusion and a short-form conclusion of drug-related death. 4. I have considered Prevention of Future Death ("PFD") evidence and submissions on 12th June 2023 and additional written evidence/submissions between 26th June 2023 and 5th July 2023.
4	**CIRCUMSTANCES OF THE DEATH** 1. SW died from the toxic effects of cocaine and methadone whilst detained at HMP Thameside. 2. He was a known drug dependant individual receiving methadone therapy. 3. On 7th October 2017, during a visit he was seen to attempt to plug something down his trousers. SW was searched and no item was found. He was moved to the care and separation unit ("CSU") for monitoring and his visitor was banned for 3 months from all visits. An adjudication hearing was held and there was no finding against him due to lack of evidence. 4. SW was then held on closed visits until a new decision was made on 31st January 2018 to change his status to open visits. The same visitor who attended on 7th October 2017 was allowed on open visits, contrary to local guidance. 5. On 23rd February 2018, staff monitored SW's visit and reacted to a call over the radio (by the CCTV operator), for a suspected pass, restraining SW and taking him away to a room to be searched. His visitors were taken to separate rooms to be questioned and not searched. 6. The CCTV footage was reviewed at this point and no pass was seen by staff. SW was searched and nothing was found by officers. SW was returned to his wing. The nurse was informed and given no indication that SW had received any contraband.

[1] Please direct to the relevant MOJ/HMPPS person/body with oversight of the contract under which Serco runs HMP Thameside.

	7. Various calls were made by SW that evening. At the time they were not listened to by prison officers. Later review of the calls confirmed reference to swallowing an item. SW had swallowed a package. 8. On the morning of 24th February 2018, the cellmate found SW on the floor with blood coming from his mouth and activated the cell bell at 0705. It was answered but not responded to in person. A second cell bell call was made at 0723. It was answered by staff and another member of staff was sent to the call where SW was seen lying on the floor experiencing a seizure. 9. A nurse attended the cell at 0726, and an ambulance was called. After a delay in entering the prison, the ambulance reached SW at 0741. CPR was administered and SW was confirmed dead at approximately 0847. 10. The jury found that the conveyance by SW's visitor of a list A article into the prison and passing it to SW was a material contribution to his death. 11. The decision to allow this visitor (who had been banned on 7th October 2017) an open visit on the 23rd February 2018 was a material contribution to SW's death. The decision was inappropriate due to various factors including insufficient record keeping and information sharing, inadequate scrutiny of the decision made and failure to follow policy. 12. The decision by prison staff to not to monitor SW possibly made a material contribution to his death. There was insufficient investigation after the visit and a lack of implementation of precautionary measures. The omission of searching the visitors post-visit and a defective decision-making pathway possibly made a material contribution to SW's death.
5	**CORONER'S CONCERNS** During the Inquest, the evidence revealed matters giving rise to concern. A number of these have been addressed and do not require a PFD report. For the record, I have been informed that an upgrade of the cell bell system is agreed and quotes have been requested. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – • **Data recording and retention in HMP Thameside /oversight by the Ministry of Justice ("MOJ").** • **Absence of a written policy at HMP Thameside if there is a suspected drug swallow.** **Data recording and retention in HMP Thameside/oversight by MOJ** 1. Key documents around decision making by Serco officers in respect of open/closed visits for SW were lost. 2. Record keeping of key events on 23rd and 24th February 2018 was not properly completed by Serco officers on the central system for recording, operated by the MOJ ("PNOMIS"). 3. There were only 3 entries on SW's PNOMIS record in the 5 months he was at HMP Thameside. 4. The PPO investigator encountered delays in obtaining documents, unclear and incomplete records from HMP Thameside. The decision making around closed visits/reviews was requested by the PPO in September 2018 and had not been provided at the time the PPO reported in April 2019, which pre-dated the electronic migration of data in October 2020 (see below). 5. Solicitors representing HMP Thameside informed me on 30 March 2023 that the prison was unable to adduce the 2018 versions of the local standard operating procedures in place at the time of SW's death (i.e re visits procedures) due to a large IT migration which took place around 18 months prior (October 2020), which resulted in the loss of some historical data saved on their systems. 6. I subsequently requested the underlying decision making around closed visits/review (as had the PPO before me) and was informed that these documents were no longer available, also lost in the electronic migration. 7. I was then informed (during the Inquest), that material may have been lost due to officers storing it on local desktop computers and not uploading it to the main system. 8. Having expressed concerns about record-keeping and data retention, I heard PFD evidence on 12th June 2023 about a limited internal audit of PNOMIS which revealed concerns over 15% of the records reviewed. I heard evidence that contract managers oversee the contract between the MOJ and Serco, reporting monthly on contract delivery

	indicators. They do not conduct specific checks on PNOMIS record keeping/audits of the same. 9. I also heard evidence on 12th June 2023 that there remain two systems for record keeping, the Serco system, CMS and the national MOJ system, PNOMIS. CMS requires a layer of officer input (uploading and/or printing off) to ensure retention and distribution. A notice to staff dated 23rd June 2023 reminded them to upload material to CMS. 10. A witness statement from the director of HMP Thameside dated 26th June 2023 further explained the contractual relationship between the MOJ and Serco including the 28 contract delivery indicators. There is also a contractual requirement to ensure compliance with Prison Service Instructions (PSIs) which include PSI 04/2018 which relates to records, information management and retention policy. 11. In this witness statement, the director stated that he had instructed the Serco Assurance Team (independent of the prison team) to conduct a widespread audit of the PNOMIS and Death in Custody files, which will be completed by September 2023. Whilst I am reassured that an independent audit is being conducted, the results are not currently available. SW died in 2018 and the audit was not initiated until June 2023. **12. I accept that there have been improvements. However, given the extent and impact of the deficiencies outlined above, I remain concerned as to whether systems (for both record keeping and retention) have improved sufficiently since 2018.** **13. I am also concerned as to the level of oversight and monitoring by the MOJ (having subcontracted to Serco) of recording and retention of data, given that key data was lost, key records were not maintained and the PPO was not provided with documents requested.** **14. If key documents are not available/ incidents are not recorded contemporaneously, then the PPO and the Inquest process is frustrated. It is more difficult to identify deficiencies and prevent future deaths. Further, if communications are not recorded, there is a risk that relevant factors are not considered when officers are making potentially life-impacting decisions.** **<u>Absence of a written policy at HMP Thameside if there is a suspected drug swallow.</u>** 15. In 2018, there was no written policy as to what should occur where there may have been a drugs swallow but it had not been seen immediately by staff or on CCTV. That remains the case. 16. In SW's case, the body scanner had not been installed in 2018 and following a search of SW and review of the CCTV he was returned to the wing (and not taken CSU or healthcare). The jury found that there was insufficient investigation after the visit and a lack of implementation of precautionary measures. 17. I was informed by HMP Thameside on 12th June 2023, that in a similar situation the prisoner would now be scanned using the body scanner. If the prisoner had concealed an item in a bodily orifice he would be taken to CSU. If he had swallowed an item, he would be taken to Healthcare. I was told this is standard practice but is not written down. Further, if a prisoner refused a scan, he would be taken to CSU. The management of the prisoner in CSU would be the subject of an algorithm deployed by Healthcare, which then produced guidance as to monitoring. There would be liaison between Healthcare and CSU to ensure the prisoner was appropriately monitored. 18. At present the system relies upon good communications/decision making between healthcare and discipline staff and individual judgement. **19. I remain concerned as to the absence of written guidance for officers and the risk that if they are not aware of the above "informal" guidance, a prisoner may not be taken to the correct location (CSU or Healthcare) and/or there may not be appropriate monitoring. I appreciate that each situation is fact specific and drafting written guidance may be difficult.**
6	**ACTION SHOULD BE TAKEN** Action should be taken by HMP Thameside and the Ministry of Justice[2]: 1. Given the deficiencies in record keeping/data retention highlighted during the Inquest, consideration should be given by HMP Thameside and the Ministry of Justice (who oversee the contract) as to whether record keeping and data retention at HMP Thameside has improved sufficiently since 2018.

[2] As above, please ensure that this report is directed to the appropriate body/person within the MOJ/HMPPS.

	2. The Ministry of Justice should consider their oversight of record keeping/data retention at HMP Thameside (to ensure both compliance and ongoing improvement).They should consider how is this to be monitored and if necessary enforced. 3. Consideration by HMP Thameside as to the feasibility of a written policy to provide guidance to officers when there has been a suspected drug swallow.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2023. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to [redacted] (TV Edwards) for the family [redacted] (DWF) for Serco [redacted] (Capsticks) for Oxleas [redacted] (Womble Bond Dickinson) for We are With you. [redacted], Chair Independent Advisory Panel on Deaths in Custody, I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**25th August 2023**