

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of John Weatherill a prisoner at HMP Lindholme on 18 June 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*



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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 John Weatherill was found hanged in his cell at HMP Lindholme on 18 June 2018. He was 36 years old. I offer my condolences to his family and friends.

Mr Weatherill did not give any indication that he was at imminent risk of suicide or self-harm during his three and a half weeks at Lindholme. However, I am concerned that although Mr Weatherill had complex mental health needs and was showing signs of withdrawing from drugs or alcohol when he arrived at Lindholme, healthcare staff did not test him for substances and did not refer him urgently to the substance misuse and mental health teams for assessment and support.

I am also concerned that a roll check was not properly completed the night before Mr Weatherill was found hanged.

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

Sue McAllister CB
Prisons and Probation Ombudsman

February 2019

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Summary

Events

1. On 22 February 2018, Mr John Weatherill was remanded to HMP Hull. It was not his first time in prison. He had bipolar disorder, depression and anxiety, for which he was prescribed medication. He had a significant history of substance misuse, both alcohol and drugs.
2. On 23 May, Mr Weatherill was transferred to HMP Lindholme. At an initial health screen, a nurse recorded that Mr Weatherill had a history of substance misuse and was taking prescribed medication for anxiety and depression. The nurse did not test him for drugs or alcohol, and noted that he was agitated and distracted. The nurse referred him to the substance misuse and mental health teams, although neither had any contact with him before he died.
3. Healthcare staff failed to complete Mr Weatherill's secondary health screen.
4. A roll check (including a check on prisoners' welfare) that should have been completed on the evening of 17 June, was not done. A roll check was carried out at about 6.00am on the morning of 18 June and nothing unusual was noted.
5. At 8.07am, an officer unlocked Mr Weatherill and found him hanged from a ligature made from the tie string of a laundry bag. The officer radioed a medical emergency code and the control room called an ambulance immediately. Staff tried to resuscitate Mr Weatherill but without success. Paramedics arrived very quickly and assessed him. At 8.50am, they recorded that Mr Weatherill had died.

Findings

Assessment of risk

6. When Mr Weatherill arrived at Lindholme, staff appropriately assessed that he was not at immediate risk of suicide and self-harm.
7. Mr Weatherill was only at Lindholme for three and a half weeks before he died and, during that time, he gave prison staff no indication that he might be at risk.

Roll check

8. Staff failed to conduct the evening roll check on 17 June 2018 and check on Mr Weatherill's wellbeing.

Clinical care

9. The clinical reviewer concluded that the care that Mr Weatherill received at Lindholme was not equivalent to that which he could have expected to receive in the community.
10. During his reception screen, healthcare staff identified a number of risk factors for suicide and self-harm. Despite Mr Weatherill's complex mental health needs

and history of substance misuse, he was not assessed by the mental health or substance misuse teams before he died. This was a missed opportunity for them to have made an informed assessment of his needs.

Healthcare staff did not use recognised tools to assess Mr Weatherill when he arrived despite his symptoms of drug or alcohol withdrawal.

Recommendations

- The Governor should ensure that roll checks are properly carried out and that staff responsible for doing so satisfy themselves as to prisoners' welfare.
- The Governor should ensure that all staff understand that falsifying documents is a serious disciplinary matter.
- The Head of Healthcare should ensure that all prisoners are offered a secondary health screen in line with PSO 3050, and that staff record the outcome in the clinical records, including when a prisoner declines to attend.
- The Head of Healthcare should ensure that healthcare staff appropriately identify, treat and monitor newly arrived prisoners with possible substance misuse problems, and that prisoners are assessed and prioritised based on the urgency of their needs.
- The Head of Healthcare should ensure that healthcare staff fully assess and appropriately prioritise prisoners with a history of complex mental health problems, and record their actions and the outcome.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Lindholme informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator visited Lindholme on 21 June. He obtained copies of relevant extracts from Mr Weatherill's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Weatherill's clinical care at the prison.
14. The investigator interviewed 12 members of staff at Lindholme on 2 August and 3 August 2018, jointly with Clinical reviewer.
15. We informed HM Coroner for Yorkshire South East of the investigation. He gave us the results of the post-mortem examination and we have sent the Coroner a copy of this report.
16. The investigator contacted Mr Weatherill's father to explain the investigation and to ask whether the family had any questions or concerns. Mr Weatherill's father said that his son told him that the prison had stopped his medication which caused him to have suicidal thoughts. He wanted to know why and if his son's medication had been stopped. Mr Weatherill's father also asked why a bunk bed was being used in Mr Weatherill's cell.
17. Mr Weatherill's father received a copy of the initial report. He did not make any comments.

Background Information

HMP Lindholme

18. HMP Lindholme is a medium security prison near Doncaster, which holds around 1,000 men. Care UK provides healthcare services and healthcare staff are on duty between 7.30am and 7.30pm every day.

HM Inspectorate of Prisons

19. HM Inspectorate of Prisons (HMIP) inspected Lindholme in October 2017. Inspectors found that levels of self-harm were higher than at similar prisons and than at the time of the previous inspection, with 207 such incidents in the previous six months. They found that prisoners did not always have timely access to all primary care and secondary health services. They noted that Lindholme's mental health provision was not meeting the high levels of need.

Independent Monitoring Board

20. 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 latest annual report for the year ending January 2018, the IMB reported that substance misuse remained an ongoing issue. They reported that prisoners were in general treated humanely. However, there were concerns about the quality of healthcare and mental healthcare in terms of waiting times and access to the relevant practitioner.

Previous deaths at HMP Lindholme

21. Mr Weatherill was the fifteenth prisoner to die at Lindholme, and the fifth to take his own life since April 2015. There are no similarities between Mr Weatherill's death and the previous deaths. There have been two deaths at Lindholme since Mr Weatherill died, one of which was self-inflicted.

Assessment, Care in Custody and Teamwork (ACCT)

22. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
23. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

24. Mr John Weatherill had a history of significant mental health issues, including depression, paranoia, bipolar disorder and anxiety disorder. He had last been monitored under suicide and self-harm prevention procedures, known as ACCT, in January 2014. He had misused alcohol and drugs from a young age and was sectioned under the Mental Health Act in June 2017 after he used 'spice', a psychoactive substance.

Events from 21 February 2018

25. On 21 February 2018, Mr Weatherill was charged with racially aggravated actual body harm, theft, criminal damage and assault by beating. On 23 February, he attended court and was remanded to HMP Hull. This was not his first time in prison, and he was last released on 30 May 2017.
26. A nurse completed Mr Weatherill's reception health screen and noted his history of substance misuse and ongoing mental health problems. Mr Weatherill arrived with medication that included amitriptyline (for insomnia and depression), quetiapine (used for the treatment of depression, anxiety disorder and bipolar disorder), mirtazapine (an antidepressant) and gabapentin (used to treat anxiety, epilepsy and nerve pain).
27. The nurse noted that Mr Weatherill showed no signs of withdrawing from alcohol despite admitting that he had drunk 210 units of alcohol per week in the community. Mr Weatherill tested positive for benzodiazepine (a sedative medication that he had not been prescribed). The nurse noted that Mr Weatherill's alcohol dependence should be monitored and referred him to the substance misuse team. Mr Weatherill said that he had no thoughts of suicide or self-harm and did not need any mental health support.
28. On 24 February, a nurse completed Mr Weatherill's secondary health screen. She noted that Mr Weatherill appeared paranoid and had alcohol withdrawal symptoms. The nurse referred him to the mental health team because of his paranoia and he started an alcohol detoxification programme. By 28 February, Mr Weatherill reported that he no longer had withdrawal symptoms.
29. On 12 March, Mr Weatherill was sentenced to three months in prison for drunkenness, assault by beating and for breaching the terms of his early release licence. This sentence was to run concurrently with his other sentences. That day, Mr Weatherill was transferred to HMP Doncaster.
30. Mr Weatherill continued to receive his prescribed medication. However, on 2 May, it was recorded in his medical record that he failed a medication check because he was caught "diverting" his gabapentin medication. (Drug diversion is a medical term for transferring a legally prescribed, controlled drug to another person for illicit use). As a result, healthcare staff started a plan to reduce Mr Weatherill's gabapentin medication.
31. On 27 April, Mr Weatherill was sentenced to one year and five months in prison for racially/religiously aggravated harassment.

32. On 4 May, Mr Weatherill was transferred to HMP Moorland. During his reception health screen, the nurse noted that he should continue his drug treatment and reduce his dose of gabapentin (as he had been caught diverting his medication). Mr Weatherill admitted using subutex (a heroin substitute) on 3 May and was assessed on 9 May by a substance misuse worker. He told the nurse that he was withdrawing from subutex and subsequently tested positive for the drug. It was noted that Mr Weatherill was already on the substance misuse programme and was required to attend one-to-one sessions and complete in-cell work on relapse prevention. He subsequently completed the detoxification programme at Moorland.

HMP Lindholme

33. On 23 May, Mr Weatherill was transferred to HMP Lindholme for security reasons. Officer A interviewed Mr Weatherill and assessed his immediate risks and needs. He noted that Mr Weatherill had mental health problems and should be located in a single cell. Mr Weatherill said that he had no thoughts of suicide or self-harm.
34. Nurse B completed Mr Weatherill's reception screening. She noted that he appeared "on edge", agitated, distracted and was unable to sit still. He discussed his family's mental health history and his own drug use. He admitted to using subutex in Moorland. Nurse B told the investigator that she did not test Mr Weatherill for drugs or check his clinical opiate withdrawal score (a tool which quantifies the severity of opiate withdrawal) because the reception area was not an appropriate environment in which to collect and analyse prisoners' urine specimens. She told us that that SystmOne (the electronic database of medical records) was not working when she did the healthscreen and she transcribed the information electronically later that day.
35. Nurse B recorded that Mr Weatherill had a history of substance misuse, anxiety and depression. She referred him to the substance misuse team, the mental health team and the Pharmacy Department. She assessed his risk of sharing a cell, and noted that Mr Weatherill had said that he had a complex mental health history which increased the risk he posed to others. Mr Weatherill said that he had no thoughts of suicide or self-harm. His current prescribed medication was gabapentin and quetiapine, amitriptyline and mirtazapine. His medication was checked and authorised for prescription to be administered by healthcare staff.
36. Nurse B said that she should have arranged a secondary health screen for Mr Weatherill in line with medical guidelines, but failed to do so.
37. Later that evening, Mr Weatherill was allocated a double cell on L Wing, which he did not have to share with anyone.
38. Medical records show that while at Lindholme, Mr Weatherill attended the medication hatch twice a day to have his medication administered. (This continued until the day before his death.)
39. On 2 June, Mr Weatherill telephoned his father. They talked about his transfer to Lindholme. Mr Weatherill told his father that he would be released from prison on 27 December 2018.

40. On 4 June, Dr C, a prison GP, reviewed Mr Weatherill's medications. She recorded no issues.
41. On 8 June, Mr Weatherill did not attend his mental health review with Nurse D. She telephoned the wing and an officer told her that Mr Weatherill was aware of his appointment and had been "let off" to attend. She noted that a further appointment to see Mr Weatherill would be made. There is no evidence that this took place.
42. Medical records show that that a secondary health screen had been scheduled for Mr Weatherill on 11 June but he did not attend. There is no evidence that a subsequent appointment was made or that he attended a secondary health screen.

17 June 2018

43. CCTV footage shows that at 4.10pm, Mr Weatherill left his cell and talked to other prisoners before returning to his cell around two minutes later. Within minutes, prison staff began locking prisoners in their cells.
44. CCTV footage shows that at 4.22pm, prison staff unlocked prisoners on G Wing to collect their evening meal. However, Mr Weatherill did not leave his cell. At 4.42pm, staff completed a roll check by checking that all prisoners were in their cells and that the cell doors were locked. Staff raised no concerns when checking Mr Weatherill.
45. Officer E signed to say that he had completed a roll check of the wing at 7.00pm. However, CCTV footage showed that Officer E did not complete this task. At interview, Officer E admitted to the investigator that he did not complete the evening roll check.
46. Ms F, an operational support grade, started her night duty shift at 8.30pm and received a handover from Officer E. Shortly afterwards, she checked that all cell doors were locked. She was not required to check on prisoners' wellbeing unless they were being monitored under suicide and self-harm prevention procedures, known as ACCT. This was not the case for Mr Weatherill.

18 June 2018

47. At 5.57am, Ms F completed the roll check of G Wing. She told the investigator that she recalled nothing untoward when she checked Mr Weatherill's cell that morning and was adamant that she would have gained a response from him, either physically or verbally, before moving on to check prisoners in the next cell.
48. Ms F's duty ended around 7.30pm, when the day time staff started their shift. At 7.45am, the control room gave permission to staff to unlock G Wing prisoners.

Emergency response

49. At around 8.07am, Officer G unlocked and opened Mr Weatherill's cell and greeted him. Mr Weatherill was sitting on the edge of the bottom bunk bed and did not respond. Officer G looked closer and saw that Mr Weatherill had a ligature made from the tie string of a laundry bag, tied around his neck and

attached to the top bunk bed. He shouted for staff assistance and radioed a medical emergency code blue (indicating that a prisoner is unconscious or has breathing difficulties). The control room log recorded this as occurring at 8.07am. He lowered Mr Weatherill to the floor and removed the ligature.

50. Officer H arrived within 60 seconds and assessed Mr Weatherill but found no signs of life. He started cardiopulmonary resuscitation (CPR) by doing chest compressions, assisted by Supervising Officer L who conducted rescue breaths. Mr M, a custodial manager, also arrived and assisted.
51. Nurse J and Nurse K responded to the emergency code. CCTV shows the nurses arrived at 8.13am with the medical emergency bag and a defibrillator (an electronic device that monitors heart rhythm and provides an electric shock if required). Nurse K noted that Mr Weatherill was still “warm to touch”, had fixed dilated pupils and displayed no signs of rigor mortis. Prison and healthcare staff continued resuscitation efforts. The defibrillator instructed staff to continue CPR. Mr Weatherill showed no signs of life and there was a prominent red mark on his neck.
52. The paramedics arrived at 8.23am and took over advanced life support care of Mr Weatherill. At 8.50am, the paramedics pronounced him dead.

Family liaison

53. Ms N, a facilitator, was appointed as the prison’s family liaison officer. Mr Weatherill’s father was identified as his next of kin. Ms N and Mr P, a prison manager, visited Mr Weatherill’s father at 10.50am to break the news and to offer support. Lindholme contributed to the cost of Mr Weatherill’s funeral in line with national instructions.

Support for prisoners and staff

54. On the same day, Mr P debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. The prison posted notices informing other prisoners of Mr Weatherill’s death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Weatherill’s death.

Post-mortem report and toxicology results

55. The post-mortem examination established that Mr Weatherill died because of hanging. Toxicology test results found the presence of mirtazapine, amitriptyline and quetiapine, which had all been prescribed to Mr Weatherill and which were found at levels consistent with therapeutic/sub-therapeutic use. No psychoactive substances or other illicit drugs were identified in Mr Weatherill’s bloodstream.

Findings

Assessment of risk

56. Mr Weatherill had a long history of drug and alcohol misuse. Despite this, he had not been monitored under ACCT procedures since January 2014, over four years before his death. Notwithstanding some deficiencies in Mr Weatherill's initial health screen and that he did not have a secondary health screen, there was no evidence to indicate that he was at immediate risk of suicide or self-harm. During the three and a half weeks Mr Weatherill spent at Lindholme, he did not express any thoughts of suicide or self-harm, and his behaviour did not concern staff or indicate to them that he was at risk.

Roll checks

57. Completing roll checks ensure the security and integrity of the prison and also ensures that staff check on prisoners' welfare. Officer E signed a formal document to confirm that he had completed the roll check on the evening of 17 June. However, CCTV footage showed that he had not done so.
58. Officer E admitted during interview that he had not completed the check. He said that this was his first night shift on a big wing since starting work at Lindholme and other staff had told him that, if there had been no prisoner movement after the cell doors were locked and checked at 5.30pm, he could just sign without actually completing a roll check. He therefore missed an opportunity to check on the welfare of Mr Weatherill and other prisoners. The prison is conducting a disciplinary investigation into Officer E's actions.
59. While we cannot know whether or not the outcome for Mr Weatherill would have been different if Officer E had conducted the roll check, in other circumstances, it might make a difference. We make the following recommendations:

The Governor should ensure that roll checks are properly carried out and that staff responsible for doing so satisfy themselves as to prisoners' welfare.

The Governor should ensure that all staff understand that falsifying documents is a serious disciplinary matter.

Clinical care

60. The clinical reviewer noted that overall, the mental health and substance misuse care that Mr Weatherill received was not equivalent to that which he could have expected to receive in the community.

Reception and secondary health screen

61. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners requires prisons to assess the healthcare needs of all newly arrived prisoners to identify any existing health conditions and plan the relevant care.
62. There is no evidence in Mr Weatherill's medical records that he had a secondary health screen, as he should have done. The reception nurse told us that she did

not book an appointment for him and although one appears subsequently to have been scheduled for 11 June, Mr Weatherill did not attend.

63. We share the clinical reviewer's view that continuity of medical care is key to gather medical information about a prisoner, check how he is settling in and to educate him about health issues relevant to him.
64. We are particularly concerned that healthcare staff failed to address Mr Weatherill's history of mental health and substance misuse issues promptly. While we cannot know whether or not staff would have identified that these issues increased his risk, it was a missed opportunity for them to have found out more about his needs and medical history to make an informed assessment. We make the following recommendation:

The Head of Healthcare should ensure that all prisoners are offered secondary health screening in line with PSO 3050, and that staff record the outcome in the clinical records, including when a prisoner declines to attend.

Substance misuse support

65. During his reception screening, Mr Weatherill was described as agitated, distracted and unable to sit still. Nurse B did not properly consider whether his presentation might be linked to his recent misuse of alcohol or drugs. She did not test Mr Weatherill for drugs or assess whether he had symptoms of opiate withdrawal or the severity of any such symptoms. She told the investigator that this was because the reception screening area was not suitable for undertaking such tests.
66. While Nurse B referred Mr Weatherill to the substance misuse team, his appointment was arranged for 18 June, 26 days after his arrival at Lindholme. Mr Weatherill had a significant history of drug and alcohol misuse and he presented as agitated during his reception screening. Nurse B should therefore have referred for Mr Weatherill for a drug test and substance misuse support urgently. This did not happen. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff appropriately identify, treat and monitor newly arrived prisoners with possible substance misuse problems, and that prisoners are assessed and prioritised based on the urgency of their needs.

Assessment of mental health

67. The initial health screen in reception is the first opportunity for staff to assess prisoners' mental health and risk of self-harm. While Nurse B correctly referred Mr Weatherill to the prison's mental health team, this was arranged for 8 June, 16 days after his arrival at Lindholme. Mr Weatherill did not attend this appointment. Staff identified that Mr Weatherill had complex mental health and substance misuse issues and was taking antidepressants. These needs should have been prioritised and assessed properly and urgently so that he could access mental health services more quickly. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff fully assess and appropriately prioritise prisoners with a history of complex mental health problems, and record their actions and the outcome.

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