Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Garrick Pierson, a prisoner at HMP Bullingdon, on 23 September 2024

A report by the Prisons and Probation Ombudsman

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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

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.

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.

Mr Garrick Pierson died in hospital on 23 September 2024, after taking an overdose of verapamil (a prescription medication used to treat cluster headaches) at HMP Bullingdon. He was 34 years old. I offer my condolences to Mr Pierson's family and friends.

Mr Pierson arrived at Bullingdon on 4 June 2024 and was monitored under suicide and self-harm procedures (known as ACCT) up to 30 July, due to his mental health history and high risk of suicide. Despite this, he was allowed to keep verapamil, a highly toxic drug if taken in excess, in his possession. He stockpiled it and took a fatal dose on 23 September.

The investigation found failings with the in-possession medication risk assessment process and medication compliance checks. It also found that Mr Pierson had missed several doses of his antidepressant medication due to unclear processes around the administration of evening medication. The mental health support provided to Mr Pierson was also inadequate.

The clinical reviewer concluded that the care Mr Pierson received did not meet accepted clinical standards and was not equivalent to that which he could have expected to receive in the community.

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

Adrian Usher
Prisons and Probation Ombudsman **December 2025**

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Summary

Events

1. Mr Garrick Pierson was remanded to HMP Bullingdon on 4 June 2024, charged with sexual offences. It was his first time in prison.

2. Due to Mr Pierson's high risk of suicide, staff started suicide and self-harm monitoring (known as ACCT) as soon as he arrived. ACCT monitoring continued until 30 July (apart from three days in June when it was stopped and restarted).

3. On 20 August, a mental health nurse tried to see Mr Pierson for a mental health assessment but he was at work. The nurse noted that she would rebook to see him the following week but this did not happen. No one from the mental health team saw Mr Pierson after his last ACCT review on 30 July.

4. On 17 September, Mr Pierson asked a GP to increase his antidepressant medication (mirtazapine) due to constant low mood. The GP increased the dose from 15mg to 30mg and changed the administration time from 4.00pm to 8.00pm. Mr Pierson did not receive any mirtazapine on 20, 21 or 22 September and there was no reason documented for the missed doses.

5. On 19 September, an officer recorded that he had called E Wing to let them know that Mr Pierson was coming back from a legal visit and that he was tearful. An officer on the wing spoke to Mr Pierson on his return but he did not document the conversation.

6. Shortly after 1.00am on 23 September, Mr Pierson's cellmate pressed the cell bell to tell staff that Mr Pierson had taken 123 verapamil tablets. (Mr Pierson was prescribed verapamil for cluster headaches and was allowed to keep the medication in his possession.) According to his cellmate, Mr Pierson said he had done something silly and that, "Now they will sort my meds out".

7. Staff responded swiftly and healthcare staff contacted Toxbase for advice. They were told it was a fatal dose and that Mr Pierson should immediately go to hospital. Staff called for an ambulance at 1.23am and escorted Mr Pierson to reception to wait for the ambulance. Mr Pierson was conscious and engaging with staff at that time but he began to deteriorate in reception while waiting for the ambulance. The ambulance arrived at 2.44am and took Mr Pierson to hospital. Mr Pierson died in hospital at around 4.40am.

8. Staff later found some notes in Mr Pierson's cell in which he indicated he would be better off dead and apologised to the victims of his offence. The notes were not dated.

Findings

9. We found that healthcare staff did not appropriately assess the risk associated with Mr Pierson having verapamil, a highly toxic medication, in his possession. Furthermore, the process for checking if prisoners were correctly taking their in-

possession medication was inadequate. Mr Pierson must have been stockpiling his verapamil medication since 12 August.

10. There was confusion about the process of administering medication in the evening, during the prison's night state, meaning that Mr Pierson did not receive his antidepressant medication on three evenings. There was no record of why these doses were missed and healthcare staff appeared to be unaware.

11. The mental health support provided to Mr Pierson was inadequate. Although he was on the mental health team's caseload, he was only seen by the mental health nurse during ACCT reviews and there was no structured care plan in place. Once Mr Pierson was no longer being monitored under ACCT procedures, he did not receive any formal support from the mental health team and staff failed to follow up a missed mental health assessment on 20 August.

12. Although the officer on E Wing did not document his conversation with Mr Pierson on 19 September after his legal visit, we are satisfied that he considered whether ACCT monitoring was required and concluded it was not.

Recommendations

- The Head of Healthcare should review:
  - The in-possession medication risk assessment process, to include consideration of whether the medication is high-risk.
  - In-possession medication compliance checks, to include consideration of focusing checks on those at greater risk.
  - Ensure that a robust audit process is in place to check in-possession medication risk assessments are being completed correctly and that medication compliance checks are undertaken.
- The Head of Healthcare should develop an agreed local policy for medication management during night state, which should set out:
  - responsibilities for the prescriber, pharmacy, Head of Healthcare, the night healthcare team and where applicable, night prison staff;
  - how evening medications are to be accessed and administered;
  - what action to take in the event of missed medication, including incident reporting (i.e. Datix) and advising the prescribing clinician or team; and
  - the audit process to ensure compliance.
- The Head of Healthcare should review the mental health process to ensure that prisoners are not lost to follow-up and that upcoming important dates are highlighted and appropriately escalated.

The Investigation Process

13. HMPPS notified us of Mr Pierson's death on 23 September 2024.

14. The investigator issued notices to staff and prisoners at HMP Bullingdon informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

15. The investigator obtained copies of relevant extracts from Mr Pierson's prison and medical records.

16. NHS England commissioned two independent clinical reviewers to review Mr Pierson's clinical care at the prison.

17. The investigator and the clinical reviewers interviewed eight members of staff and one prisoner between October and December 2024.

18. We informed HM Coroner for Oxfordshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. The Ombudsman's office contacted Mr Pierson's father to explain the investigation and to ask if the family had any matters they wanted us to consider. Mr Pierson's father wanted to know how his son had managed to store so much medication and why it had taken the ambulance so long to arrive. We have addressed these issues in this report and the clinical review.

20. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies. Following representations from Practice Plus Group, we removed the fourth recommendation. Practice Plus Group provided an action plan which is annexed to this report.

21. We sent a copy of our initial report to Mr Pierson's father. He did not notify us of any factual inaccuracies.

Background Information

HMP Bullingdon

22. HMP Bullingdon is a local and resettlement prison, serving the courts of Oxfordshire, Berkshire, Buckinghamshire and Wiltshire. Practice Plus Group provides healthcare services. (Cotswold Medicare Ltd provided GP services up to June 2025.)

HM Inspectorate of Prisons

23. The most recent inspection of HMP Bullingdon was in November 2022. Inspectors reported that, while prisoners subject to ACCT said they felt well-supported, the quality of the ACCT documents was inconsistent. They noted that a new quality assurance process had started to improve the quality of ACCT documents but was not yet embedded.

24. Provision of mental health support was prompt and reasonable, although inspectors noted there was scope to improve the range of psychological interventions on offer. Prisoners were effectively screened at reception and referred to mental health services promptly. A duty staff member was available to respond to urgent matters and attend initial ACCT reviews.

25. Inspectors noted that the in-house pharmacy was well managed with in-possession risk assessments completed on arrival. However, they noted that these assessments were not always reviewed at appropriate levels and reasons for any changes was not always recorded. There were limited provisions for midday or night-time administrations, and some medicines were not prescribed in accordance with therapeutic efficacy.

Independent Monitoring Board

26. 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 to 30 June 2024, the IMB reported that healthcare provision was generally good. However, they noted that services had been placed under strain due to shortages of both healthcare and operational staff. In a survey conducted in May 2024, 68% of prisoners who responded said that it was very difficult or quite difficult to speak to someone in healthcare, and 59% said that it was very difficult or quite difficult to get support for mental health and wellbeing. The results showed some improvement from the previous survey in September 2023 when figures were 75% and 77% respectively.

Previous deaths at HMP Bullingdon

27. Mr Pierson was the eleventh prisoner to die at Bullingdon since September 2021. Of the previous deaths, one was self-inflicted, eight were from natural causes, and in one the cause was unascertained. Up to the end of September 2025, there have been two further deaths, one self-inflicted and one from natural causes. There are

no similarities between the findings from our investigation into Mr Pierson's death and the findings from our investigations into the previous deaths.

Key Events

28. On 16 May 2024, Mr Garrick Pierson was arrested for sexual offences. He was due to be bailed the next day but was transferred to a psychiatric hospital after he reported suicidal thoughts. He was discharged back into police custody on 3 June.

29. On 4 June, Mr Pierson was remanded to HMP Bullingdon. It was his first time in prison. Staff immediately started suicide and self-harm prevention procedures (known as ACCT). Mr Pierson said he had anxiety, depression, and cluster headaches, but he had no medication with him. Staff moved him to the healthcare unit and checked on him hourly throughout the night. Mr Pierson was subsequently prescribed antidepressants and verapamil for his cluster headaches, along with other pain relief and medication to treat high cholesterol and stomach acid.

30. On 5 June, staff held Mr Pierson's first ACCT review. Nurse A, a mental health nurse, attended. Mr Pierson told staff that he had been charged with multiple rapes and expected to receive between five and ten years in prison. He said he had planned to kill himself before he was arrested and was struggling with being in prison. He said that his relationships with family and friends had broken down and that previous coping mechanisms were no longer working for him. Nurse A noted that Mr Pierson said he had constant thoughts of self-harm and while he had no active thoughts of taking his life, he said he would do so if given the opportunity. Staff considered he was at high risk of suicide and self-harm. Staff moved Mr Pierson to the induction wing and placed him under constant supervision.

31. On 6 June, Mr Pierson was accepted onto the mental health team's caseload and allocated to Nurse A.

32. By the time of his ACCT review on 8 June, Mr Pierson reported feeling better in himself and said that he was adjusting to the prison regime. He said he felt supported by staff on the induction wing and had also spoken to his father. Staff reduced checks to three an hour.

33. On 11 June, staff moved Mr Pierson to the vulnerable prisoners unit (E Wing). At his ACCT review, Mr Pierson said he was happy with the regime but continued to have anxiety and insomnia. He told staff that he previously used cannabis in the community to help him sleep. Staff referred him for support from the substance misuse team.

34. Due to Mr Pierson's risk of self-harm, staff decided that he could only have some of his medication in his possession. This included verapamil. He collected three verapamil tablets from the pharmacy each day.

35. On 24 June, staff agreed to stop ACCT monitoring. They referred Mr Pierson to a Managing Emotions group and agreed that Nurse A would check in with him after his court appearance on 2 July.

36. On 27 June, Mr Pierson had a meeting with his legal team who told him he could be facing 15 to 20 years in prison. Mr Pierson reported feeling overwhelmed and he self-harmed by scratching his arms. Staff restarted ACCT monitoring and set checks at one an hour.

37. On 2 July, Mr Pierson attended court by video link and pleaded guilty to the offences. Video link staff noted that he was tearful and said he expected to get a sentence of 12 to 15 years. He said he had a supportive cellmate and was currently supported by the ACCT process. He said he had no current thoughts of suicide or self-harm.

38. On 4 July, Mr Pierson attended an assessment with a member of the substance misuse service. He said he had been a regular user of cannabis from the age of ten. He said he would like to complete in-cell workbooks around cannabis and emotions, as well as attending specific workshops including enhancing self-esteem, managing emotions, relapse prevention, and mindfulness.

39. Staff continued to monitor Mr Pierson under ACCT procedures. At his ACCT review on 30 July, staff noted that he had made good progress and had obtained a job as an industrial cleaner. Mr Pierson was happy about this and said he was looking forward to having something to do. Staff agreed to stop ACCT monitoring and set a post-closure review date of 6 August. However, this review did not take place.

40. On 5 August, Mr Pierson had his first key worker session with Officer A. Officer A noted that Mr Pierson was keen to have contact with his son and to get enhanced prisoner status. Mr Pierson complained that he was not getting enough positive behaviour points to progress to enhanced status. He also told Officer A that he needed a change to his antidepressant medication.

41. On 20 August, Nurse A tried to see Mr Pierson to carry out a mental health assessment but he was at work. At interview, Nurse A confirmed that she had not seen Mr Pierson as his care coordinator, other than during ACCT reviews. She therefore had not seen him since his last ACCT review on 30 July, but she said she was not concerned about him as she knew he had a job and officers on the wing had not reported any issues. Nurse A said that care coordinators were not expected to see people on their caseload with specific regularity, stating that it varied according to individual need. When she did not see Mr Pierson on 20 August, she noted that she would re-book the mental health assessment for the following week but this did not happen. She said that she had a period of annual leave around that time and was unable to comment on why Mr Pierson's appointment was not followed up in her absence, other than to say that she was not concerned about him.

42. On the same day, Mr Pierson had a review with the substance misuse team. He told the substance misuse worker that he was doing well and was waiting for his sentencing at court on 27 September. He said he was struggling with the in-cell workbooks because of his dyslexia. The substance misuse worker offered to arrange for a peer supporter to help him. Mr Pierson also said that he was struggling with cravings and was getting angry at times. The substance misuse worker encouraged him to use distraction packs and agreed to send him some.

43. On 21 August, Mr Pierson had a key worker session with Officer A. He reported that he had received a positive behaviour point and was awaiting a medication review. Officer A told him that he could not help him to have contact with his son as he was not allowed to have contact with children or vulnerable adults. Mr Pierson did not have any further key worker sessions.

44. On 17 September, a GP saw Mr Pierson. Mr Pierson asked the GP to increase his mirtazapine (an antidepressant) as he was experiencing constant low mood. The GP increased the mirtazapine from 15mg to 30mg and changed the administration time from 4.00pm to 8.00pm. Although he did not note the reasons for the change of time in Mr Pierson's medical record, the GP said at interview that this was to help improve Mr Pierson's sleep and to make him less drowsy during the day. He said at interview that he did not know how the 8.00pm medication would be administered and he believed this would be the responsibility of the pharmacist to ensure the change took place as prescribed.

45. Records show that Mr Pierson did not receive any mirtazapine on 20, 21, or 22 September. We found no documented reason why this medication was not administered and we found no evidence of any follow-up. Mr Pierson's cellmate told the investigator that Mr Pierson was frustrated that he had to constantly request his medication before anyone gave it to him. He had even set an alarm for 8.00pm so that he could press the cell bell to alert staff that he needed his medication. Mr Pierson's cellmate said that when staff attended they said they would chase it with healthcare but it did not arrive. He alleged that staff told Mr Pierson that the night nurse in charge said it was not their job to dispense his medication.

46. During interviews, there was ambiguity about how medication should be administered out of hours and what should happen if medication was missed. The Head of Healthcare said that any night-time medication should be added to the ledger of the night nurse in charge. The GP said at interview that he thought it was the role of pharmacy staff to ensure night-time medication was administered. The pharmacy technician said he was not aware of any specific process for 8.00pm medication. He said he did not consider it was his role to add night-time medication to the night nurse in charge's ledger, although he would add missed medication (for example for prisoners who were due to collect theirs at 4.00pm and were delayed in doing so) to the ledger. During the investigation, we found no evidence that Mr Pierson's mirtazapine was on the ledger. Nurse B, the nurse who was in charge on the night of 22 September, said that Mr Pierson's medication was not on his ledger that night.

Events of 23 September

47. Mr Pierson's cellmate said he heard Mr Pierson being sick at around 1.00am and when he asked what was wrong, Mr Pierson said "I've done something silly". He said he had taken 123 verapamil tablets and that he hoped staff would now sort out his medication. His cellmate pressed the cell bell to alert staff and staff attended immediately.

48. Nurse B did not assess Mr Pierson at that stage. He told the investigator he did not want to waste time. He said that he immediately called Toxbase (poisons advice centre) and when he told them that Mr Pierson had taken 123 verapamil tablets, they said it was a fatal dose and he needed to go to hospital immediately. Nurse B contacted the prison's night orderly officer to request an ambulance for Mr Pierson. He said he then went to complete the necessary paperwork for his escort to hospital. Records show that the ambulance was requested at 1.23am.

49. Nurse B said he considered whether he should administer activated charcoal to Mr Pierson (which can reduce the effects of overdose if taken within an hour) but it was not immediately available to him. He said it would have taken around eight minutes for him to collect it from the out of hours storeroom on F Wing and he would have needed a member of prison staff to escort him. Nurse B said, given what Toxbase had told him about the serious nature of the overdose, he prioritised getting Mr Pierson to hospital and preparing the necessary escort paperwork.

50. A senior healthcare assistant (HCA) escorted Mr Pierson from his cell to reception to wait for the ambulance. She said that, while waiting for the ambulance, Mr Pierson deteriorated. He was being sick and feeling dizzy. She took some physical observations, tried to make him comfortable, and kept him talking. Despite having been logged as a priority 1 emergency (meaning requiring an urgent response) by the 999 operator and prison staff making further calls to find out why the ambulance had not yet arrived, paramedics finally reached Bullingdon at 2.44am and took Mr Pierson to hospital, where he died at around 4.00am.

51. Staff later found some notes in Mr Pierson's cell in which he said he would be better off dead and apologised to the victims of his offence. The notes were not dated.

Contact with Mr Pierson's family

52. On 23 September, at around 11.15am, the prison's appointed family liaison officers attended the home address of Mr Pierson's father to tell him that his son had died. The prison service contributed to Mr Pierson's funeral expenses in line with national guidance.

Support for prisoners and staff

53. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case by case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

54. A prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

55. The prison posted notices informing other prisoners of Mr Pierson's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Pierson's death.

Post-mortem report

56. The post-mortem report concluded that Mr Pierson had died from verapamil toxicity.

Findings

Identifying the risk of suicide and self-harm

57. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), which was the policy in place at the time of Mr Pierson's death, set out the processes (known as ACCT) that staff should follow if they identified that a prisoner was at risk of suicide or self-harm. (The PSI has been superseded by the Prison Safety Policy Framework but the ACCT process remains broadly the same.)

58. We found that staff appropriately started ACCT procedures when Mr Pierson arrived at Bullingdon. ACCT reviews were multidisciplinary and attended by a mental health nurse. Although staff briefly stopped ACCT monitoring on 24 June, they reassessed Mr Pierson's risk and restarted ACCT monitoring from 27 June to offer him additional support in the weeks surrounding his court appearance on 2 July, when he pleaded guilty to the offences. This was good practice. Staff continued ACCT monitoring until 30 July when they considered his risk had reduced sufficiently. We consider this was a reasonable decision. However, we note that no post-closure review was completed and this was not identified during quality assurance. We consider that Mr Pierson was adequately supported by ACCT and the lack of post-closure review had no impact on him. We are also aware that the safer custody team have put plans in place to improve the ACCT quality assurance process, so we make no recommendation.

59. When Mr Pierson became tearful after a legal visit on 19 September, an officer spoke to him to try to assess if he was at risk of suicide or self-harm. He alerted an officer on E Wing that Mr Pierson was returning from legal visits and had been tearful and he noted this in his prison record. The officer said he did not think Mr Pierson needed to be monitored under ACCT but he thought it would be better for an officer who knew him better to speak to him and assess his risk.

60. An E Wing officer spoke to Mr Pierson on his return to the wing but he did not write anything in his prison record to confirm what they had spoken about and whether he considered Mr Pierson could be at risk of suicide or self-harm. We are satisfied that the officer in legal visits considered starting ACCT monitoring again and concluded it was not necessary. We consider his actions in alerting the E Wing officer were appropriate in the circumstances and that it is likely that both members of staff did not think ACCT monitoring was necessary. However, it is important that staff document conversations and risk considerations. We bring this to the Governor's attention.

Clinical care

61. The clinical reviewer concluded that the healthcare Mr Pierson received at Bullingdon was not equivalent to that which he could have expected to receive in the community.

In-possession verapamil

62. The clinical reviewer considered that letting Mr Pierson retain daily in-possession of his verapamil may not have been a clinically safe decision. She noted that his medication arrangements were inconsistent. Some medicines were issued weekly, others daily, and some not at all. The system used to determine in-possession eligibility did not appear to account for the relative toxicity or lethality of each drug in overdose.

63. For example, Mr Pierson was not permitted daily in-possession of mirtazapine or atorvastatin, both of which carry low overdose risk. He was also required to collect naproxen twice daily, despite its similarly low toxicity. In contrast, verapamil, a drug known to be highly dangerous in overdose, was supplied daily in-possession (three tablets collected daily) without sufficient safeguards.

64. No checks were carried out to see if Mr Pierson was taking his medication as prescribed and we now know he was stockpiling it. The clinical reviewer estimated that to accumulate 120 tablets, he must have been stockpiling from no later than 12 August. We were told that random spot checks were carried out on ten prisoners each month. We consider this insufficient and that consideration should be given to checking on prisoners at high risk rather than selecting prisoners at random.

65. We recommend:

The Head of Healthcare should:

- **Review the in-possession medication risk assessment process, to include consideration of whether the medication is high-risk (i.e. highly toxic).**
- **Review the in-possession medication compliance checks, to include consideration of focusing checks on those at greater risk.**
- **Ensure that a robust audit process is in place to check in-possession medication risk assessments are being completed correctly and that medication compliance checks are undertaken.**

Missed doses of mirtazapine

66. Mr Pierson had requested an increase in his antidepressant medication, mirtazapine, due to continued low mood and difficulty sleeping. A GP increased the dose from 15mg to 30mg and changed the administration time from 4.00pm to 8.00pm to help improve Mr Pierson's mood and ability to sleep. Although Mr Pierson received mirtazapine up to 19 September, he did not receive any on the evenings of 20, 21 or 22 September.

67. The administration of medication at 8.00pm meant that it was taking place during night state when there were minimal staff on duty. Healthcare staff need to be escorted by prison staff to the prisoner's cell to administer the medication. While we appreciate that night-time medication administration may cause some challenges as opposed to administering medication during the day, we consider that all staff should be clear of their roles and responsibilities to ensure that prisoners receive their medication as prescribed. Furthermore, if a prisoner's medication is not

administered, we would expect to see this clearly documented including the reasons why it was missed. This did not happen for Mr Pierson.

68. From interviews and prison records, we consider that Mr Pierson was frustrated that his medication was not being given to him at 8.00pm. He drew this to the attention of staff and, given that this was medication to help with his mood and his sleep, it is not surprising that he felt he was not being listened to. While we cannot be sure of his reasons for taking an overdose of his verapamil medication, he allegedly indicated to his cellmate that he hoped staff would listen to him and give him his medication. While waiting for the ambulance, he also told healthcare staff that he did not want to die. It is therefore possible that Mr Pierson took the overdose so that healthcare staff would take notice of his plight, rather than as a deliberate attempt to end his life. We make the following recommendation:

The Head of Healthcare should develop an agreed local policy for medication management during night state, which should set out:

- **responsibilities for the prescriber, pharmacy, Head of Healthcare, the night healthcare team and where applicable, night prison staff;**
- **how evening medications are to be accessed and administered;**
- **what action to take in the event of missed medication, including incident reporting (i.e. Datix) and advising the prescribing clinician or team; and**
- **the audit process to ensure compliance.**

Mental health care

69. Mr Pierson was appropriately referred to the mental health team when he arrived at Bullingdon. As he was immediately placed under ACCT monitoring, he was seen by a member of the mental health team at each ACCT review. Given that Mr Pierson was placed on Nurse A's caseload from 6 June, we would expect to see evidence of a formal care plan and some individual sessions with Mr Pierson outside of the ACCT process but this did not happen.

70. When ACCT monitoring stopped on 30 July, Mr Pierson did not have any further documented contact with Nurse A or anyone else from the mental health team. Nurse A did, however, attempt to see him for a full mental health assessment on 20 August but he was not available due to being at work. It is not clear if he knew that Nurse A was due to be assessing him. Nurse A noted that she would rebook the assessment for the following week, but no follow-up had taken place by the time Mr Pierson died. Furthermore, we found no evidence that the mental health team had any plans in place to support Mr Pierson in the days surrounding his sentencing, which was due to take place on 27 September. We consider that the support received from the mental health team was inadequate and we make the following recommendation:

The Head of Healthcare should review the mental health process to ensure that prisoners are not lost to follow-up and that upcoming important dates are highlighted and appropriately escalated.

Inquest

71. At the inquest, held from 22 to 26 June 2026, the jury reached a narrative conclusion:

> "Garrick Gerald Pierson died on 23rd September 2024 at the John Radcliffe Hospital, Oxford from a self-inflicted act of taking verapamil. However, it is not possible to safely discern his intent. It is probable that the inadequate process for the management and monitoring of his medication contributed to his death. It is possible that insufficient formal support to Garrick Gerald Pierson following his solicitor's visit on the 19th of September 2024 may have also contributed to his death. Therefore, we have come to a narrative conclusion due to the conflicting and unclear evidence of his intent."

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