

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Adrian Pearce, a prisoner at HMP Hewell, on 4 August 2020

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 Adrian Pearce died of heart failure on 4 August 2020 at HMP Hewell. This was caused by heart disease, which was in turn caused by morbid obesity. He also had chronic kidney disease and Type 2 diabetes which contributed to but did not cause his death. He was 70 years old. I offer my condolences to his family and friends.

The investigation found that the care that Mr Pearce received at Hewell for his heart failure was of a good standard and equivalent to that which he could have expected to receive in the community. However, the nursing care that he received for other aspects of his deteriorating health was not of the required standard and was not equivalent to that which he could have expected in the community.

There is no record that a social care referral had been made to support Mr Pearce with his daily activities or to obtain equipment to support him in his cell.

Mr Pearce frequently went to hospital in the months before he died and I am concerned that he was inappropriately restrained because prison managers did not take his chronic health conditions into account in their risk assessments. We have previously raised concerns about the inappropriate use of restraints at Hewell on elderly and ill prisoners. The Prisons Group Director for the West Midlands will need to address this continuing unacceptable and failure to use restraints appropriately.

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

Sue McAllister CB
Prisons and Probation Ombudsman

March 2021

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Summary

Events

1. On 14 May 2018, Mr Adrian Pearce was remanded to HMP Hewell. After a period at HMP Oakwood, he returned to HMP Hewell on 7 May 2019.
2. Mr Pearce was obese and had Type 2 diabetes, heart failure, leg oedema, leg ulcers and poor mobility.
3. On 23 December, a prison GP identified that Mr Pearce's diabetes was getting worse. He was prescribed medication but refused to take it.
4. On 24 February 2020, Mr Pearce went to hospital because he had breathing difficulties. He was restrained with a double cuff. He was diagnosed with a serious bacterial infection.
5. On 15 April, Mr Pearce went to hospital because the antibiotics he was taking were not working. While in hospital, he signed an order to say that he did not want to be resuscitated if his heart or breathing stopped.
6. On 20 June, Mr Pearce went to hospital because his blood test results were abnormal. He was restrained with a single cuff. On 25 June, a prison GP noted that blood tests showed that Mr Pearce had end-stage heart failure. On 9 July, he went back to Hewell.
7. On 19 July, Mr Pearce was unwell, and was admitted to hospital. He was restrained in hospital until 20 July when a prison manager authorised the removal of restraints. He returned to Hewell on 28 July.
8. At about 3.20pm on 4 August, a prisoner saw Mr Pearce lying on the floor of his cell and called prison staff. Officers saw through the observation panel that Mr Pearce was lying on the floor, with a pool of blood around his head. An officer radioed a medical emergency code red (which indicates that a prisoner is bleeding) and the officers went into the cell.
9. An officer saw that Mr Pearce had a cut above his right eye. The officer could hear that Mr Pearce was breathing. A prison paramedic went into the cell and at that time, Mr Pearce stopped breathing. The prison paramedic started chest compressions. An officer radioed a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing). A prison paramedic and a nurse tried to resuscitate Mr Pearce.
10. At 3.41pm, ambulance paramedics arrived at Mr Pearce's cell and a nurse confirmed that Mr Pearce had an order in place not to be resuscitated. Healthcare staff stopped resuscitation. At 3.42pm, an ambulance paramedic confirmed that Mr Pearce had died.

Findings

Clinical care

11. The clinical reviewer said that the care that Mr Pearce received at Hewell for his heart failure was of a good standard and equivalent to that which he could have expected to receive in the community.
12. However, the clinical reviewer found that the nursing care for other aspects of Mr Pearce's deteriorating health was not of the required standard and was not equivalent.

Social care

13. There is no record that Mr Pearce was referred to social care services for support with his daily activities and equipment to support him in his cell.

Emergency response

14. When Mr Pearce was seen on the floor of his cell, officers promptly entered Mr Pearce's cell and began first aid. A prison paramedic and healthcare staff promptly tried to resuscitate him until they became aware that he had an order in place not to be resuscitated.

Use of restraints

15. Mr Pearce was an obese 70-year-old man, with chronic pre-existing health conditions and poor mobility. We do not consider that the use of restraints was proportionate to the risk he posed. The completion of the risk assessment process for the use of restraints was variable and there were times when the authorising officer did not have information about Mr Pearce's current medical condition. It is not the first time we have made recommendations about the inappropriate use of restraints at Hewell.

Recommendations

- The Governor and Head of Healthcare should review the social care referral process to ensure that roles and responsibilities are clear, and referrals are made promptly.
- The Governor and Head of Healthcare should ensure that:
 - all staff undertaking risk assessments for prisoners taken to hospital understand the legal position;
 - healthcare staff complete the healthcare section of the risk assessment form and provide information about the prisoner's current state of health and whether this affects his mobility and ability to escape; and
 - escort risk assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Prisons Group Director for the West Midlands should write to the Ombudsman, within four weeks of receipt of this report, to set out what is being done to address

the prison's continuing failure to use restraints appropriately when prisoners are escorted to hospital.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
17. The investigator obtained copies of relevant extracts from Mr Pearce's prison and medical records.
18. The investigator interviewed two members of staff on 2 and 16 November.
19. NHS England commissioned a clinical reviewer to review Mr Pearce's clinical care at the prison. The investigator jointly interviewed three members of staff with the clinical reviewer between 14 October and 4 November.
20. All the interviews were conducted by telephone because of the COVID-19 restrictions
21. We informed HM Coroner for Worcestershire of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
22. The Ombudsman's family liaison officer wrote to Mr Pearce's son to explain our investigation. He did not respond.
23. We shared the initial report with the Prison Service. There was one factual inaccuracy and this report has been amended accordingly and their action plan has been appended to this report.

Background Information

HMP Hewell

24. HMP Hewell is a secure local prison. Practice Plus Group provides health services and there is a 20-bed inpatient unit.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Hewell was in June 2019. Inspectors reported that all new arrivals received a comprehensive initial health screen by a registered nurse, who reviewed risks and made onward referrals. A GP or nurse prescriber was available during the evening for complex cases, although late arrivals often missed out on this provision.
26. Inspectors noted that external hospital appointments were managed well but that some appointments had been cancelled to facilitate the large number of emergency admissions. Inspectors also noted that the number of appointments that had breached the NHS 18-week rule for non-urgent consultant treatment had been minimal in recent months.

Independent Monitoring Board

27. 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 September 2019, the IMB reported that they were concerned by the slow progress in modernising inadequate accommodation. They noted that prisoners with disabilities continued to have problems accessing the showers and that wheelchair access was poor. They also noted that there had been a lack of coordination between healthcare and prison staff in making referrals to the local authority for social care.

Previous deaths at HMP Hewell

28. In the two years before Mr Pearce's death, there were five deaths from natural causes, three self-inflicted deaths and one drug-related death at Hewell. We have made recommendations about the inappropriate use of restraints three times in the past two years. In those cases, we found that authorising managers did not take into account the health of a prisoner when deciding that they should be restrained.

Key Events

29. On 14 May 2018, Mr Adrian Pearce was remanded to HMP Hewell for breaching a sexual offences prevention order. On 5 September, he was transferred to HMP Oakwood. On 7 May 2019, he returned to HMP Hewell.
30. When Mr Pearce arrived at Hewell in May 2019, a nurse identified at his initial and second health screen that he had Type 2 diabetes, heart failure and leg oedema (fluid retention causing swollen feet and ankles). He also had poor mobility and was obese. She made an urgent referral to a prison GP and for a hospital appointment to review his leg ulcers. A nurse re-prescribed his medication.
31. On 2 December, Mr Pearce was sentenced to fourteen years in prison for sex offences.
32. On 23 December, a prison GP reviewed blood tests for Mr Pearce's blood sugar levels and saw that his diabetes was getting worse. He prescribed metformin for Type 2 diabetes and asked that Mr Pearce have a diabetic diet. Mr Pearce refused to take the medication.
33. On 24 February 2020, Mr Pearce went to hospital because he had breathing difficulties. A consultant microbiologist found that Mr Pearce had a serious bacterial infection which probably came from his leg cellulitis (a potentially serious infection of the layers of the skin).
34. Before Mr Pearce went to hospital, prison staff completed an escort risk assessment. There is no record that the medical section of the risk assessment was completed. A custodial manager recommended that Mr Pearce should be double cuffed because he was an unsentenced prisoner. The Head of Safety, authorised that he should be escorted by two officers and double cuffed.
35. While Mr Pearce was in hospital, a prison manager reviewed the level of restraints and noted that his cellulitis made it difficult for him to walk and that Mr Pearce was on intravenous antibiotics so was not able to move from his bed. Due to Mr Pearce's size, the manager authorised that he should be restrained with a Goliath (extra large) cuff. On 3 March, Mr Pearce returned to Hewell with antibiotics.
36. On 4 March 2020, the prison GP referred Mr Pearce to the hospital's cardiology department for assessment and management of suspected heart failure. (The referral was previously delayed because prison GPs thought that Mr Pearce might be released from custody.)
37. On 15 April, Mr Pearce went to hospital because the antibiotics for his cellulitis were not working. While in hospital, he signed an order to say that he did not want anyone to resuscitate him if his heart or breathing stopped. The prison GP spoke to Mr Pearce about the order and ensured that he understood it.
38. Before Mr Pearce went to hospital, prison staff completed an escort risk assessment. There is no record that the medical section was completed. A security collator assessed Mr Pearce as a medium risk to females and to hospital

- staff. The Head of Operations authorised that Mr Pearce should be restrained with a single cuff or an escort chain. He noted that because Mr Pearce had significant mobility issues and had a heavy build, a Goliath cuff was required for his wrist.
39. On 16 April, a prison manager reviewed the level of restraint. A prison paramedic completed the medical section and noted that Mr Pearce had heart failure. She did not object to the use of restraints. The Head of Reducing Reoffending authorised that Mr Pearce should be restrained by an escort chain in hospital and a single cuff for transportation. On 18 April, Mr Pearce returned to Hewell.
 40. On 1 May, Mr Pearce was short of breath and had a high temperature. He was sent to hospital.
 41. On 2 May, after Mr Pearce was admitted to hospital, prison staff completed an escort risk assessment. A nurse completed the medical section and did not object to the use of restraints but noted that Mr Pearce had a heart condition and had signed an order not to be resuscitated if his heart or breathing stopped. A prison manager authorised that Mr Pearce should be restrained with an escort chain.
 42. On 6 May, Mr Pearce went back to Hewell and was told to drink 1.5 litres of fluid a day. A nurse gave him a fluid balance chart, but Mr Pearce refused to complete the chart. On 20 May, the prison GP noted that Mr Pearce's condition was gradually worsening, that he was short of breath on exertion and had worsening pain in his right leg. He prescribed him antibiotics.
 43. On 29 May, Mr Pearce attended a tissue viability appointment, where healthcare staff started compression bandaging on his leg.
 44. On 12 June, a prison GP, saw Mr Pearce for heart and possible renal failure. Mr Pearce told him that he felt unwell, was dizzy, vomiting, had reduced urination and was not eating well. The doctor sent him to hospital for assessment. There is no record of the escort risk assessment for this hospital visit. On 14 June, Mr Pearce went back to Hewell.
 45. On 20 June, Mr Pearce went to hospital because he had abnormal blood test results. On 25 June, the prison GP noted that the blood tests showed that Mr Pearce had end-stage heart failure. The hospital cardiology team reviewed Mr Pearce.
 46. Before Mr Pearce went to hospital, prison staff completed an escort risk assessment. A nurse completed the medical section and noted that Mr Pearce was a wheelchair user, that he had a heart condition and had signed an order not to be resuscitated. The Head of Reducing Reoffending authorised that Mr Pearce should be restrained with an escort chain or single cuffs and that due to his size, the cuffs could not be removed without the permission of the duty governor or in a medical emergency. On 9 July, Mr Pearce went back to Hewell.
 47. On 19 July, Mr Pearce was unwell, and was admitted to hospital. Before he left for hospital, prison staff completed an escort risk assessment. The medical section was not completed. A senior manager authorised that Mr Pearce should

be restrained by an escort chain which could only be removed if his condition deteriorated and with the permission of the duty governor.

48. On 20 July, the level of restraints was reviewed. A prison paramedic noted that Mr Pearce had chronic congestive heart failure, ischaemic heart disease, diabetes, leg ulcers and chronic kidney disease. The Head of Reducing Reoffending authorised that Mr Pearce's restraints should be removed. Mr Pearce remained in hospital until 28 July.

Events of 4 August 2020

49. At about 3.20pm on 4 August, a prisoner went to Mr Pearce's cell to collect his meal choice slip. He saw that Mr Pearce was lying on the floor of his cell and called prison staff. An officer went to the cell and saw through the cell door observation panel that Mr Pearce was lying on the floor, with a pool of blood around his head. The officer radioed a medical emergency code red (indicating that a prisoner has serious bleeding). An officer went to the cell and he and the other officer went into the cell.
50. One of the officers saw that Mr Pearce had a cut above his right eye and put a towel over the cut and applied pressure to it. He said that he could hear that Mr Pearce was breathing, moving his head from side to side and moaning. An officer went into the cell and the two officers tried to move him into the recovery position. Mr Pearce's breathing became shallower.
51. A prison paramedic went into the cell and an officer said that Mr Pearce stopped breathing at this point. The prison paramedic and the officers turned Mr Pearce over and the prison paramedic said that it was obvious that he was in cardiac arrest. The prison paramedic started chest compressions and put the towel over Mr Pearce's head to cover his mouth and nose. (The prison paramedic said that the COVID-19 guidelines state that when carrying out chest compressions, a covering should be placed over the face and nose to reduce aerosol contamination.)
52. An officer radioed a medical emergency code blue (indicating that a prisoner is unconscious or not breathing).
53. The prison paramedic used a defibrillator and continued chest compressions. A nurse, who was wearing personal protective equipment (PPE) suitable for carrying out life support, took over chest compressions and the prison paramedic put on the same level of PPE. He inserted an airway and gave Mr Pearce oxygen.
54. A custodial manager told the prison paramedic that Mr Pearce had an order in place not to be resuscitated. The prison paramedic told her that he had to see the original document before he stopped resuscitation attempts.
55. At 3.41pm, ambulance paramedics arrived at Mr Pearce's cell and a nurse brought the order not to be resuscitated from the healthcare department. The prison healthcare staff who were present checked the document and stopped resuscitation. At 3.42pm, an ambulance paramedic confirmed that Mr Pearce had died.

Contact with Mr Pearce's family

56. On 20 July, a custodial manager Wilde appointed an officer as the family liaison officer and, a chaplain, as the deputy family liaison officer. On 21 July, the officer telephoned Mr Pearce's next of kin and told them that Mr Pearce was ill in hospital.
57. On 4 August, after Mr Pearce died, the officer telephoned Mr Pearce's next of kin (in line with the COVID-19 policy) and told him that Mr Pearce had died. She offered her condolences.
58. Mr Pearce's funeral took place on 24 August. The prison contributed to its cost in line with national instructions.

Support for prisoners and staff

59. After Mr Pearce's death, the Head of Residential Safety, 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.
60. The prison posted notices informing other prisoners of Mr Pearce'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 Pearce's death.

Post-mortem report

61. A post-mortem examination established that Mr Pearce died of congestive cardiac failure (heart failure) caused by decompensated left and right ventricular hypertrophy (a form of heart disease), which in turn was caused by morbid obesity. He also had chronic kidney disease and Type 2 diabetes which contributed to but did not cause his death.

Findings

Clinical care

62. The clinical reviewer found that the care that Mr Pearce received for his heart failure was of a good standard and equivalent to that which he could have expected to receive in the community.
63. The clinical reviewer said that Mr Pearce's long-term conditions of heart failure, kidney failure and diabetes were regularly reviewed by prison GPs. She said that prison GPs acted promptly when Mr Pearce had acute heart failure and cellulitis and sent him to hospital for emergency medical treatment.
64. However, the clinical reviewer found that the nursing care that Mr Pearce received at Hewell for some aspects of his deteriorating health was not fully of the required standard and was therefore not equivalent to that which he could have expected to receive in the community.
65. The clinical reviewer found that a wound care plan was not created until six months after it was identified in May 2019 that Mr Pearce's leg ulcers would require daily treatment. Mr Pearce had compression bandaging treatment to manage his leg ulcers but there is no record that a Doppler assessment (an ultrasound test that estimates the blood flow through the blood vessels) took place and no record that the assessment, required before compression bandaging therapy could start, had been undertaken. Only two of the four nurses who applied compression bandages were trained to do so. There is no record in the wound care plan to reflect the management of Mr Pearce's bacterial infection.
66. The clinical reviewer has made several recommendations which are not directly related to Mr Pearce's death but which the Head of Healthcare will need to address.
67. The emergency response was prompt and the clinical reviewer found that healthcare staff appropriately continued resuscitation attempts until they saw the original signed order not to resuscitate Mr Pearce.

Social care

68. After Mr Pearce was identified as very high risk of developing pressure sores, prison GPs asked for him to have a different chair and pressure relieving equipment. There is no record that action was taken to provide this equipment.
69. Mr Pearce's cell was described as being in a poor condition. There is no record that there was a social care referral to support him with his daily activities or for equipment to assist him in his cell.
70. The Head of Healthcare, said that the Safer Custody Team was responsible for the contract for social care. A safety hub manager said that Mr Pearce lived in the inpatient unit where healthcare staff would predominantly complete the referral for social care or notify the Safer Custody Team if a referral was needed. She said that the Safer Custody Team were not notified that Mr Pearce needed to be referred for social care and they did not therefore complete a referral for

him. She was also not aware that Mr Pearce required any pressure-relieving equipment or assistance aids.

71. We make the following recommendation:

The Governor and Head of Healthcare should review the social care referral process to ensure that roles and responsibilities are clear and referrals are made promptly.

Use of restraints

72. When prisoners leave prison (for example, to go to hospital), staff complete a risk assessment to determine the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public which must be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as the prisoner's health and mobility.
73. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. The judgment indicated that medical opinion about a prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
74. Between February and July 2020, Mr Pearce frequently went to hospital for assessment and treatment and frequently stayed in hospital for weeks at a time.
75. On 24 February, when Mr Pearce went to hospital, healthcare staff were aware that he had heart failure, leg oedema, Type 2 diabetes and was obese but the medical section was not completed. Mr Pearce was restrained by a double cuff because a prison manager said that he was an unsentenced prisoner, although in fact Mr Pearce had been sentenced on 2 December 2018. When cellulitis made it difficult for him to walk in hospital and he was not able to move from his bed, a prison manager authorised that he should be restrained with a Goliath cuff.
76. Each time that Pearce went to hospital, he was restrained and because of his size, which reduced his ability to escape, prison managers said that he should be restrained with the Goliath cuff. Mr Pearce's health deteriorated, and it was not until 20 July, during his final stay in hospital, that a prison manager authorised that the restraints be removed.
77. Mr Pearce was an obese 70-year-old man, with chronic pre-existing health conditions and poor mobility. He was assessed as a medium risk to females and to hospital staff but a low risk of escape. The completion of the risk assessment process was variable and there were times when the authorising officer did not have information about the current state of his health. We consider that it was inappropriate, uncomfortable and disproportionate for Mr Pearce to have been restrained while in hospital. We recommend that:

The Governor and Head of Healthcare should ensure that:

- **all staff undertaking risk assessments for prisoners taken to hospital understand the legal position;**
- **healthcare staff complete the healthcare section of the risk assessment form and provide information about the prisoner's current state of health and whether this affects his mobility and ability to escape; and**
- **escort risk assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**

78. We have previously expressed concerns about the inappropriate use of restraints on sick and elderly prisoners at HMP Hewell, and the prison has committed on each occasion to address these failings. It is, therefore, a cause of real concern that restraints are still being used inappropriately at the prison, and we make the further recommendation:

The Prisons Group Director for the West Midlands should write to the Ombudsman, within four weeks of receipt of this report, setting out what is being done to address the prison's continuing failure to use restraints appropriately when prisoners are escorted to hospital.

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