

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Denzil Pearce, a prisoner at HMP North Sea Camp, on 17 April 2021

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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Summary

1. 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.
2. Our office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Denzil Pearce, who was 72 years old, died from lung cancer on 17 April 2021, at HMP North Sea Camp. We offer our condolences to Mr Pearce's family and friends.
4. The clinical reviewer concluded that overall, the clinical care Mr Pearce received at North Sea Camp was equivalent to that which he could have expected to receive in the community. She made no recommendations.
5. However, we are concerned that when Mr Pearce was found unresponsive, staff tried to resuscitate him despite him having signed a Do Not Attempt Resuscitation (DNAR) Order. It is important that staff respect a prisoner's wishes not to be resuscitated.
6. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Recommendations

- The Governor and Head of Healthcare should ensure that staff are aware of prisoners with DNAR Orders in place and that they do not start CPR against a prisoner's wishes.

Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Pearce's clinical care at HMP North Sea Camp.
8. The PPO investigator has investigated the non-clinical issues in Mr Pearce's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
9. The PPO's family liaison officer wrote to Mr Pearce's next of kin, his daughter, to explain the investigation. She did not respond.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies.

Previous deaths at North Sea Camp

11. Mr Pearce was the 7th prisoner to die at North Sea Camp since April 2019. All the previous deaths were from natural causes. There are no significant similarities between those cases and Mr Pearce's.

Key Events

12. In December 1981, Mr Denzil Pearce was sentenced to life imprisonment for sexual offences. He was moved to HMP North Sea Camp on 17 October 2018.
13. Mr Pearce had been a heavy smoker and, in 2015, lung function tests suggested he could have chronic obstructive pulmonary disease (COPD - the term for a group of serious lung diseases). He did not require medication but had annual reviews.
14. In August 2020, a prison GP sent Mr Pearce for a chest X-ray as he was complaining of chest pain. He had a second X-ray in October, which indicated some worsening of his lungs. A prison GP requested further investigation with a CT scan (which takes X-rays from several different angles to give a more detailed picture than a standard X-ray).
15. At the beginning of the COVID-19 pandemic, and several times subsequently, Mr Pearce was advised to shield because of his age and suspected COPD. He declined to do so and signed a disclaimer to say he understood the risks and his choices. In December, Mr Pearce tested positive for the virus. Although he was asymptomatic, it delayed his visit to hospital for his tests, which were postponed to January 2021.
16. On 29 January, on a hospital visit, a doctor told Mr Pearce that the CT scan results indicated that he might have lung cancer. Further tests in February confirmed the diagnosis and that the cancer had also spread to his bones.
17. Mr Pearce's cancer was too far advanced to be cured and the only treatment was palliative (care with the focus on optimising the quality of life and reducing suffering). In view of this, the prison began consideration of early release on compassionate grounds (ERCG). A prison GP filled in paperwork for this on 5 March and estimated at that time that Mr Pearce had a year to live but said this was subject to confirmation from the hospital. Mr Pearce deteriorated quite quickly, but it was not possible to progress his ERCG as accommodation in an Approved Premises (probation hostel) could not be made available earlier than his release from prison which was due on 11 May.
18. On 5 February, Mr Pearce had his first COVID-19 vaccination. After he agreed to have palliative chemotherapy on 16 March, a hospital doctor asked for his second vaccination to be brought forward so he could have it before treatment began. He received his second vaccination on 23 March.
19. Mr Pearce had his first round of chemotherapy on 9 April, and he felt unwell in the following days.

20. On 17 April, Mr Pearce told a prison officer early in the morning that he was having a bad day and was feeling sick. The officer asked a nurse to visit Mr Pearce. The nurse gave him some medication and arranged to see him again the next day. Around 6.40pm, a prisoner alerted staff that they had found Mr Pearce collapsed and apparently unconscious on his cell floor.
21. An officer promptly called a code blue on their radio (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts staff to attend and to call an ambulance). Officers carried out cardiopulmonary resuscitation (CPR) until ambulance paramedics arrived. (There were no healthcare staff on duty at that time of the day.)
22. The ambulance crew arrived at around 7.00pm and pronounced Mr Pearce dead at 7.08pm.
23. The post-mortem examination found that Mr Pearce's death was caused by non-small cell lung cancer (the most common kind of lung cancer).

Non-Clinical Findings

Attempted resuscitation of Mr Pearce

24. On 26 February, Mr Pearce completed a ReSPECT form (the ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices) which said that although he was willing to be treated in hospital and to have pain relief, he did not want to be resuscitated in an emergency.
25. North Sea Camp told the investigator that the process for Do Not Attempt Resuscitation (DNAR) Orders is for a copy of the form to be kept in the unit office, for a copy to be displayed in the cell, and for staff to be briefed at morning meetings. Healthcare staff also retain a copy.
26. When officers attended the emergency on 17 April, there was no DNAR paperwork displayed in Mr Pearce's cell, so they started CPR.
27. Healthcare staff said that a copy was put up in Mr Pearce's cell. It is not known if it was taken down by him. However, even if it had been taken down by Mr Pearce, the information should have been immediately available to staff from the unit office. Mr Pearce had very recently moved units to go to a cell that could accommodate a hospital bed, and it is possible that there was some loss of continuity of process. This needs to be addressed. We recommend:

The Governor and Head of Healthcare should ensure that staff are aware of prisoners with DNAR Orders in place and that they do not start CPR against a prisoner's wishes.

Louise Richards
Assistant Ombudsman

September 2021

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