Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Matthew Pearson, a prisoner at HMP Ranby, on 8 January 2020

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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

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 Matthew Pearson was found hanged in his cell at HMP Ranby on 8 January 2020. He was 36 years old. I offer my condolences to his family and friends.

Staff at HMP Nottingham appropriately started Prison Service suicide and self-harm prevention procedures in December 2019 but we are concerned that they underestimated his level of risk. When he was later transferred to Ranby, Mr Pearson spent nearly all his time isolated in his cell. We are not satisfied that Ranby supported him properly, either through suicide and self-harm prevention or violence reduction procedures. His case reviews, which should have sought ways to reduce his risk of suicide and self-harm, were not multidisciplinary and did not put in place suitable plans to address his issues and reduce that risk.

On the night that he died, the night patrol officer did not follow national guidelines when Mr Pearson obscured his cell observation panel. We are particularly concerned with the quality of his final welfare check, which took place little over an hour before day staff found Mr Pearson with rigor mortis clearly established.

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 **August 2020**

Contents

Summary

Events

1. On 6 December 2019, Mr Matthew Pearson was sentenced to one year and nine months in prison. Staff at HMP Nottingham started Prison Service suicide and self-harm prevention procedures (known as ACCT) on his arrival, as he had tied a ligature around his neck in court cells and said he would "end it". Mr Pearson told staff that he did not believe his sentence was just and that he did not expect to be sent to prison. He was assessed as being at low risk of suicide and self-harm.

2. On 27 December, Mr Pearson was transferred to HMP Ranby. A prison nurse assessed him on arrival, recorded that he appeared "anxious and paranoid", and referred him to the mental health team. As the mental health team was understaffed, Mr Pearson was given the first available appointment which was in around three weeks' time.

3. A custodial manager held an ACCT case review on Mr Pearson's first night at Ranby. At Mr Pearson's request, he reduced the frequency of ACCT observations.

4. On 28 December, Mr Pearson told an officer that he intended to isolate himself. The officer completed a violence reduction referral (known as CSIP). Three days later, a supervising officer (SO) interviewed Mr Pearson. He took action that he thought had resolved Mr Pearson's issue and ended the CSIP. However, Mr Pearson continued to isolate himself for the remainder of his life.

5. On 2 January, Mr Pearson attended a substance misuse needs' assessment. The substance misuse nurse could not complete the assessment because of Mr Pearson's "unsettled" behaviour. She did not make an entry in his ACCT document.

6. On 3 January, an SO led an ACCT case review. He contacted the mental health team for input, and received a response from a nurse who did not know Mr Pearson and did not read his medical record. The SO recorded that Mr Pearson had "numerous issues" in prison but did not specify what they were and did not address them in the caremap.

7. On the night of 7 to 8 January, Mr Pearson blocked his cell observation panel. The night officer warned him, and he moved the blockage to leave a small gap at the top. At around 6.00am, the night officer completed an ACCT observation. He said that he saw Mr Pearson move and heard him grunt.

8. At 7.10am, an officer completed a welfare check of all prisoners. She found Mr Pearson's observation panel completely covered and said she could not see into the cell. The officer telephoned for assistance and, with colleagues, opened the cell. They found Mr Pearson hanged from a ligature, with rigor mortis established. The officers and the first nurse to arrive began cardiopulmonary resuscitation before a senior nurse stopped them.

Findings

Managing the risk of suicide and self-harm – HMP Nottingham

9. Prison staff appropriately started ACCT procedures when Mr Pearson arrived at Nottingham. However, despite his self-harming behaviour at court and statements that he intended to take his life, they assessed him as at low risk of suicide and self-harm.

Managing the risk of suicide and self-harm – HMP Ranby

10. A number of key aspects of ACCT procedures aimed at reducing risk, including holding multidisciplinary case reviews and setting meaningful caremap actions, were not fulfilled, and ACCT observations were reduced when it might not have been appropriate to do so.

Mr Pearson's isolation

11. Mr Pearson spent the last ten days of his life in isolation in his cell. The reasons for this were not properly investigated, and he was not supported in line with local policy requirements.

Mental health care

12. Mr Pearson's circumstances, including his risk of suicide and self-harm, were not considered when a mental health assessment was scheduled, and the appointment he was given was two weeks outside of the local target.

Medication

13. Toxicology tests identified that Mr Pearson had taken potentially fatal amounts of methadone and citalopram, both of which he was prescribed. While we cannot be sure how he obtained enough to take the amounts identified, it is most likely that he did not swallow the medication when it was issued and hoarded it for later use.

Night of 7 to 8 January 2020

14. The night patrol officer did not take appropriate action when Mr Pearson covered his observation panel. We are concerned about the quality of the observation he recorded at 6.00am, and we consider it is possible that Mr Pearson was dead at this time. We have asked Ranby to conduct a local investigation into these events and the officer's actions.

Emergency response

15. The officer, who found that Mr Pearson did not respond when requested to remove the blockage, did not radio for assistance. This would have been the quickest way of summoning support.

16. Prison and healthcare staff unnecessarily tried to resuscitate Mr Pearson when rigor mortis was clearly present.

Recommendations

- The Governor of HMP Nottingham should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that case reviews consider all relevant information that affects risk.
- The Governor and Head of Healthcare of HMP Ranby should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that:
  - ACCT case reviews are multidisciplinary and include all relevant people involved in the prisoner's care, including healthcare staff where relevant.
  - Case reviews consider all relevant information that affects risk, address all issues through specific and meaningful caremap actions, and observations are only reduced when there has been a clear reduction in risk.
  - Conversations are carried out as directed and documented in the ongoing record.
  - All staff in contact with prisoners are trained in ACCT procedures and understand that they should record all relevant information about risk in the ongoing record.
- The Head of Healthcare should ensure that the mental health service has the capacity to provide appropriate care to prisoners judged to be at risk of suicide and self-harm.
- The Head of Healthcare should ensure that nurses safely issue medication to prisoners who do not keep and administer their own medication, and that reasonable checks are undertaken to ensure that the prisoner has taken the medication at the time of collection.
- The Governor should inform the Ombudsman of the findings of the internal investigation into the events on the night of 7 to 8 January, and of any action taken as a result, by 30 September 2020.
- The Governor should ensure that staff are aware of national guidance and understand their responsibilities when they find a cell observation panel obscured.
- The Governor should ensure that, subject to a risk assessment, staff enter cells as quickly as possible if there is reason to consider that a prisoner may be at risk.
- The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in line with European Resuscitation Council Guidelines.
- The Governor should ensure that a copy of this report is shared with CM A, SO A, SO B, Officer A and Officer B and that a senior manager discusses the Ombudsman's findings with them.

- The Head of Healthcare should share a copy of this report with Nurse A and Nurse B and share the Ombudsman's findings with them.

The Investigation Process

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

18. The investigator obtained copies of relevant extracts from Mr Pearson's prison and medical records. He interviewed 12 members of staff at Ranby between 24 and 26 February.

19. NHS England commissioned an independent clinical reviewer to review Mr Pearson's clinical care at the prison. He joined the investigator for interviews with clinical staff.

20. We informed HM Coroner for Nottinghamshire of the investigation. She gave us the results of the post-mortem examination and toxicology tests. We have sent the Coroner a copy of this report.

21. The Ombudsman's family liaison officer contacted Mr Pearson's next of kin to explain the investigation and to ask if she had any matters that she wanted us to consider. She raised the following issues:

    - On 30 December 2019, Mr Pearson told staff at Ranby that he was isolating himself as he did not feel safe at the prison.

    - Ranby's family liaison officer had told her that Mr Pearson was checked by a member of staff at 6.00am and found dead around an hour later. Mr Pearson's next of kin asked for clarification of the timeline of events.

22. We have addressed those questions in this report.

23. We shared our initial report with Mr Pearson's next of kin. She identified one factual inaccuracy, which we have amended in this report.

24. We also share the initial report with HM Prison and Probation Service. Their action plan is annexed to this report.

Background Information

HMP Ranby

25. HMP Ranby is a Category C prison in Nottinghamshire, holding over 1,000 men. Nottinghamshire Healthcare NHS Foundation Trust provides primary healthcare services.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Ranby was in June 2018. Inspectors reported that the number of prisoners choosing to isolate themselves had fallen since the last inspection, and processes for identifying and supporting them were good. However, they found that the regime for these prisoners was too restricted.

27. Inspectors also found that levels of self-harm had risen and were higher than comparable prisons. They reported that ACCT case management was poor, with case reviews often poorly attended and caremaps that often did not relate to the prisoners' identified needs. They also found that officers' recorded ACCT observations frequently lacked detail.

Independent Monitoring Board

28. 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 March 2019, the IMB reported that prisoners who chose to isolate themselves had an individual management plan to ensure they had access to relevant aspects of the daily regime.

29. The IMB also reported that the quality of ACCT case management had improved over the course of the year due to a focus on a single case manager model. They highlighted that case managers had received additional training on identifying risks and triggers and building effective caremaps.

Previous deaths at HMP Ranby

30. Mr Pearson was the second prisoner from Ranby to die since January 2018, and the first to take his own life. There are no significant similarities between the circumstances of the other recent death and that of Mr Pearson.

Assessment, Care in Custody and Teamwork

31. 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. 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.

32. 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.

Psychoactive Substances (PS)

33. PS (formerly known as 'new psychoactive substances' (NPS) or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for PS precipitating or exacerbating the deterioration of mental health, and they are linked to suicide or self-harm.

34. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time, NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.

35. HM Prison and Probation Service now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

Key Events

36. Mr Matthew Pearson spent time in prison from 2013 to 2015. Prison staff started ACCT procedures on three separate occasions in this time. Mr Pearson was released from his most recent sentence in 2015.

37. On 6 December 2019, Mr Pearson was sentenced to one year and nine months in prison for various offences including assault and affray. Court staff recorded that, following sentencing, Mr Pearson told them he would "end it" at his first chance to do so because prison would "break him". They also recorded that he tried to tie a ligature around his neck in a court cell. A Prisoner Custody Officer (PCO) completed a suicide and self-harm warning form, which travelled with Mr Pearson to Nottingham.

HMP Nottingham

38. A Supervising Officer (SO) started ACCT procedures when Mr Pearson arrived at Nottingham. As well as the information recorded at court, the SO noted that Mr Pearson said that he had "a problem with [PS]" and did not know how he would cope in custody.

39. A nurse completed a health assessment. She recorded that Mr Pearson said that he had depression and paranoia, and referred him to the mental health team. She also recorded that Mr Pearson said that he used heroin, crack cocaine and PS in the community. Mr Pearson tested positive for opiates. A prison GP prescribed a course of methadone (opiate substitute medication).

40. An officer completed a first night interview. She recorded that Mr Pearson appeared extremely agitated and angry to be in prison. She noted that he was open about having previously harmed himself and said that he had had a problem with this for many years because of "mental health reasons".

41. Prison staff allocated Mr Pearson a single cell. They assessed him as high risk of sharing a cell because of a previous conviction of arson but noted that he could share with a prisoner who had not committed the same offence.

42. On 7 December, a SO interviewed Mr Pearson as part of the ACCT procedures. He recorded that Mr Pearson thought his sentence was unjust as he had been expecting a fine. Mr Pearson also spoke about his substance misuse and mental health issues. The SO recorded that Mr Pearson gave no indication of any intent to harm himself.

43. A SO then led the first ACCT case review, with another SO and a nurse from the mental health team. He recorded that Mr Pearson spoke about his conviction and that he thought he had been "set up". Mr Pearson said that this had made him feel like harming himself at the time but he had no current thoughts of doing so. Mr Pearson also said that he had an issue with another prisoner in the induction unit. The SO added two caremap actions: for Mr Pearson to see the mental health team and for him to move to another wing. He concluded that Mr Pearson was at low risk of self-harm (on a scale of low, raised or high), and set ACCT observations at a minimum of one per hour.

44. On 8 December, Mr Pearson chose not to eat lunch or dinner. An officer recorded that Mr Pearson said he was doing this "to get back at the judge".

45. On 9 December, a prison GP prescribed a course of propranolol (medication for anxiety) in line with Mr Pearson's prescription in the community.

46. A nurse then completed a triage mental health assessment. He recorded that Mr Pearson reported a history of depression, self-harm and attempted suicide. He referred Mr Pearson for a full mental health assessment.

47. On the same day, Mr Pearson was due to move to another wing. On arrival, he refused to share a cell and prison staff therefore returned him to his previous wing.

48. On 10 December, a SO led an ACCT case review, with a nurse of the mental health team. The SO recorded that Mr Pearson was angry with the court and the judge who had sentenced him. Mr Pearson said he was on "hunger strike" because he thought he had been harshly sentenced. The SO advised Mr Pearson that the best course of action would be to contact his solicitor to discuss appealing his sentence, and Mr Pearson said that he had begun this process. He recorded that Mr Pearson had no current thoughts of self-harm. The SO recorded that Mr Pearson was at low risk of suicide and self-harm. He lowered ACCT observations to a minimum of one every two hours, with prison staff to hold a quality conversation with Mr Pearson every morning and afternoon.

49. On 11 December, a nurse visited Mr Pearson in his cell to assess his food refusal. He recorded that he found evidence in the cell that Mr Pearson had eaten part of his meals, as well as snacks, and that his blood glucose level was within the normal range. The nurse concluded that Mr Pearson was not refusing food.

50. On 12 December, Mr Pearson blocked his cell door observation panel. Prison staff recorded that he refused to take down the blockage when asked, and they therefore opened the cell and removed it.

51. On 13 December, a prison GP prescribed citalopram (antidepressant medication) in line with Mr Pearson's community prescription.

52. On 17 December, a Custodial Manager (CM) led an ACCT case review, with a nurse from the mental health team, and a resettlement worker. The CM recorded that Mr Pearson was no longer on hunger strike but that he said he would be suicidal if required to share a cell. Mr Pearson also said that he wanted to transfer to HMP Ranby. The CM signed the caremap actions as completed, and concluded that Mr Pearson was at low risk of suicide and self-harm. He recorded ACCT observations as a minimum of one per hour during the night, with at least three quality conversations during the day.

53. On 18 December, a substance misuse worker completed a substance misuse assessment. She recorded that Mr Pearson said that he had used PS on previous prison sentences and continued this in the community but that he had not used it during his current sentence. She recorded that Mr Pearson was stable on his methadone prescription.

54. On 20 December, Mr Pearson covered his observation panel and refused to remove the obstruction when asked. The night manager attended, and he and other staff went into Mr Pearson's cell and removed the obstruction.

55. On 24 December, a CM led an ACCT case review, with a nurse from the mental health team. He recorded that Mr Pearson said he only wanted to die in prison, and that if released, he would not even think of it. The nurse recorded in the medical record that Mr Pearson was "furious" that he was in prison. The CM concluded that Mr Pearson was at low risk of suicide and self-harm, and did not change the level of ACCT observations.

HMP Ranby

56. On 27 December, Mr Pearson was transferred to Ranby. A nurse assessed him on arrival. He recorded that Mr Pearson appeared "anxious and paranoid" and referred him to the mental health team and substance misuse team. Mr Pearson continued to be prescribed methadone and citalopram at Ranby. The nurse assessed that he should collect these each day and take them in front of a nurse.

57. An officer conducted a first night interview. She recorded that Mr Pearson was happy to have been allocated a single cell and had no concerns about being at Ranby. She also recorded that Mr Pearson said that he had no thoughts of suicide or self-harm.

58. CM A then led an ACCT case review. Other than Mr Pearson, no one else was present. The CM recorded that Mr Pearson was happy to be at Ranby. He also noted that Mr Pearson had spoken to his solicitor about appealing his sentence. Mr Pearson asked for the ACCT procedures to be closed, and the CM recorded that he told Mr Pearson that he would keep them open while he settled into the prison. He agreed to Mr Pearson's request to reduce the level of observations at night as Mr Pearson said that he had not liked staff at Nottingham waking him every hour. The CM told us that Mr Pearson had a relaxed and calm demeanour, was happy to be at Ranby rather than Nottingham, and that he thought that lowering the level of observations overnight would be beneficial to Mr Pearson. He concluded that Mr Pearson was at low risk of suicide and self-harm, and set a minimum of three ACCT observations overnight and three quality conversations during the day.

59. In line with local protocols, Mr Pearson was allowed an advance of up to £20 to spend in the prison shop (known as 'canteen') on his first night in prison. CM A told us that this was a new initiative at Ranby, designed to ensure that prisoners did not miss out on a weekly order due to transfer. Mr Pearson spent the full amount.

60. On 28 December, a nurse considered Mr Pearson's mental health referral. He concluded that Mr Pearson should be assessed, and an appointment was subsequently booked for 17 January 2020. He told us that the mental health team was short-staffed at the time and that all referrals were booked into the first available assessment slot.

61. On the same day, Mr Pearson told an officer that some prisoners were trying to take his watch. Mr Pearson told the officer that he intended to isolate himself. The officer completed a Challenge, Support and Intervention Plan (CSIP) referral. (CSIP is a Prison Service violence reduction tool used to identify and manage prisoners at raised risk of harming others.) Two days later, the safer custody team forwarded the CSIP to SO A to investigate.

62. On the early morning of 30 December, a CM recorded that Mr Pearson had covered his cell observation panel. He recorded that Mr Pearson "said he was okay", and

he did not record whether he asked Mr Pearson to remove the blockage or took any further action.

63. On 31 December, an officer spoke to Mr Pearson. He recorded that Mr Pearson said that problems in his private life had upset him which he thought would make him an easy target for bullies. Mr Pearson also said that he did not feel safe on his current wing, and that this was why he had chosen to isolate himself. The officer recorded that Mr Pearson seemed very confused and worried about his near future.

64. On the same day, SO A spoke to Mr Pearson as part of the CSIP process. He told us that Mr Pearson's only issue was that he was concerned that his watch might be stolen. Mr Pearson told him that no one had tried to take the watch from him, but that he had a "feeling" that people were watching him and might try to take it. SO A suggested to Mr Pearson that he could store the watch with his property, so that he did not have to keep it with him in his cell. Mr Pearson agreed to this. SO A told us that he believed that this had resolved the issue. He did not speak to Mr Pearson about whether he would now stop isolating himself. He recorded that no further action was required and closed the CSIP.

65. Later that day, Mr Pearson moved to Houseblock 2. On arrival, he told staff that he would isolate himself. There is no record that anyone asked Mr Pearson why he had chosen to isolate.

66. On 2 January 2020, Nurse A saw Mr Pearson for a substance misuse needs assessment. She recorded that Mr Pearson was "unsettled", unable to sit still in the waiting room, and repeatedly said he wanted to see the chaplain as he was "the only one who understands me". She noted that she was unable to complete the assessment due to Mr Pearson's presentation. She did not make an entry in Mr Pearson's ACCT ongoing record. She told us that in the five months she had worked at Ranby, she had never made an entry in an ACCT document.

67. On 3 January, SO B led an ACCT case review. No one else was present, although SO B noted that he had received a verbal report from a nurse of the substance misuse team. (SO B also noted that another SO was present but told us that this was incorrect.) The nurse told us that she had never met Mr Pearson and asked a colleague about him, who said that there were "no concerns". Neither the nurse nor her colleague read Mr Pearson's medical record or documented their conversation or that with SO B.

68. SO B recorded that Mr Pearson said that he had numerous issues in his life and in jail. He did not expand on this in the notes, nor did he add anything to the caremap. SO B told us that Mr Pearson's main concern was that he was upset about the sentence he had been given, and that he spoke about trying to appeal it. He said that Mr Pearson also stated that his flat had been burgled, and spoke about an (unidentified) issue with his medication, about which SO B advised him to speak to healthcare staff at his next appointment. SO B said that Mr Pearson also explained that he was isolating because he felt more comfortable by himself than around other people. SO B said that he told Mr Pearson that he could work towards attaining a move to a smaller houseblock at Ranby.

69. SO B concluded that Mr Pearson was at low risk of suicide and self-harm and made no change to the level of ACCT observations. He told us that Mr Pearson said he always had "background thoughts" of self-harm but had no current thoughts. SO B

said that Mr Pearson appeared to be in good spirits and had a plan to deal with his issues which he was focused on achieving.

70. On 4 January, an officer recorded that Mr Pearson told her that other prisoners on Houseblock 2 "think he is a rapist". The officer told us that Mr Pearson was "waffling" and did not make much sense. She said that Mr Pearson did not say why he thought this, and he did not say that he had been approached or threatened by other prisoners.

71. On 6 January, Mr Pearson attended the substance misuse clinic for his rearranged appointment with Nurse A. She recorded that Mr Pearson appeared calmer than previously but she could not start the assessment as he seemed to be "responding to external stimuli" and did not answer any of her questions. Nurse A told us that instead, Mr Pearson complained about various aspects of prison life. She cancelled the appointment. Nurse A said that she spoke to a member of the mental health team afterwards to confirm that Mr Pearson had been referred to them and had an upcoming appointment.

72. On 7 January, an officer recorded that Mr Pearson told her that he felt good that morning, and that he seemed to be in high spirits. In the afternoon, she recorded that he was again in good spirits and thanked her multiple times for her assistance.

Night of 7 to 8 January 2020

73. Officer A worked overnight on Houseblock 2 on the night of 7 January. Prison records show that Mr Pearson pressed his cell bell at 8.19pm, and that Officer A answered it promptly. In the ACCT document, Officer A recorded that this occurred at 9.00pm, and that Mr Pearson had covered his observation panel. He recorded that Mr Pearson asked for a breakdown of what he had spent in the prison shop, which he could not provide at night. Officer A recorded that Mr Pearson moved the blockage over his observation panel "after a few minutes [of] moaning", and that he issued him with a warning under the prison's Incentives and Earned Privileges (IEP) scheme (which aims to encourage and reward responsible behaviour in prisons).

74. At interview, Officer A said that he could not remember whether the observation panel was covered when he first went to Mr Pearson's cell.

75. Telephone records show that, at around 9.35pm, Mr Pearson twice tried to call the Samaritans from his in-cell telephone. He was unable to connect the call, and his records stated that the number was unavailable. The Head of Safety told us that the ability to call the Samaritans from in-cell telephones was introduced in the week that Mr Pearson died. (Previously, prisoners had to ask prison staff to allow them to call the Samaritans from a dedicated telephone.) She told us that the telephone number that prisoners had to dial from an in-cell telephone was different to the usual Samaritans' number (which Mr Pearson tried to call). She told us that the process for calling the Samaritans had been advertised to prisoners but she speculated that it was likely that Mr Pearson was not aware as the facility was new.

76. At 9.44pm, Mr Pearson pressed his cell bell again. Officer A answered the bell within two minutes. In the ACCT document (recorded as at 10.00pm), Officer A recorded that Mr Pearson said that he had pressed the cell bell to tell him that he had submitted an application to see a chaplain. Officer A recorded that he advised Mr Pearson to speak to wing staff about this the next day, and that it was not a

reason to use the cell bell. He recorded that he told Mr Pearson that he would issue another IEP warning if he continued to misuse the cell bell. He did not make a record about the observation panel.

77. At interview, Officer A told us that the cell observation panel was covered the second time that he went to Mr Pearson's cell. He said that he asked Mr Pearson to remove the cover, and Mr Pearson replied, "It's all right when you want me to do something, but when I ask you it's a 'no'." Officer A said that Mr Pearson moved the blockage down so that the panel was partially blocked but he could see in over the top. He said that he could see the whole of the cell and that he was satisfied with what Mr Pearson had done. He said that Mr Pearson did not say anything about trying to contact the Samaritans, nor did he expand on why he wanted to speak to a chaplain.

78. At 12.00am, Officer A returned to Mr Pearson's cell to complete an ACCT observation. He recorded that Mr Pearson's observation panel was covered "with a small gap at the top", and that he could see Mr Pearson lying on his bed, watching television. He recorded that Mr Pearson was "clearly acting like a petulant child as he didn't get what he wanted earlier".

79. At interview, Officer A told us that Mr Pearson had moved the blockage up slightly from earlier but he could see over the top of it and also through a gap in the side of the door. He said that there was sufficient light to see in the cell as the cell light and television were both on, and that he could see Mr Pearson walking around the cell. Officer A said he did not speak to Mr Pearson or ask him to remove the blockage. He told us that his entry about Mr Pearson "acting like a petulant child" referred to the earlier conversation he had with Mr Pearson at around 10.00pm, and acknowledged that this was not an appropriate entry to make.

80. At 6.00am, Officer A returned to Mr Pearson's cell to complete an ACCT observation. He recorded that Mr Pearson was "laid on back, movement noted".

81. At interview, Officer A told us that the observation panel was covered in the same manner as at 12.00am but it was harder to see in the cell because the light and television were now off. He said that he had to shine his torch over the blockage and through the gap in the side of the door, and that it took a while to see Mr Pearson. He said that Mr Pearson was lying on his back on the bed. He said that he could not get a response from Mr Pearson until he tapped the door with his foot, at which point Mr Pearson turned over and "grunted". In a statement submitted to the police by email, the officer wrote that he spent several minutes at the cell door trying to observe movement or get a response from Mr Pearson.

Emergency response

82. At around 7.10am, Officer B began a welfare check of all prisoners. She told us that she found Mr Pearson's observation panel fully covered and she could not see in at all. She knocked on the door but received no response. She then ran to the staff office to confirm that Mr Pearson was being managed under ACCT procedures and to telephone a CM, the duty manager, for permission to enter his cell. She then returned to the cell, with another officer, and opened the cell. They found Mr Pearson hanged from a ligature made from a bedsheet attached to the curtain rail. An officer who arrived at the cell as Officer B was going in, radioed a medical

emergency code blue, indicating a life-threatening situation. The control room operator telephoned for an ambulance immediately.

83. Officer B cut the ligature. She told us that she thought that Mr Pearson was clearly dead, as his limbs and jaw were stiff. She began cardiopulmonary resuscitation.

84. Nurse B responded to the radio message and was the first member of healthcare staff to arrive at Mr Pearson's cell. She continued the resuscitation. Nurse B told us that rigor mortis had clearly established but she was uncomfortable to stop resuscitation efforts without a senior nurse present. A nurse, the clinical matron, arrived shortly afterwards and ordered them to stop.

Contact with Mr Pearson's family

85. A prison family liaison officer (FLO) and a deputy FLO visited Mr Pearson's next of kin on the morning of 8 January, and informed her of his death. Ranby contributed to the costs of Mr Pearson's funeral in line with Prison Service instructions.

Support for prisoners and staff

86. After Mr Pearson's death, the Governor 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.

87. The prison posted notices informing other prisoners of Mr Pearson'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 Pearson's death.

Post-mortem report

88. The post-mortem examination found that the cause of death was hanging. A toxicology examination also identified that Mr Pearson had taken potentially fatal amounts of methadone and citalopram (both of which he was prescribed).

Findings

Management of risk of suicide and self-harm

89. Prison staff appropriately started ACCT procedures when Mr Pearson was sentenced and arrived at Nottingham. However, we are concerned that some of these procedures were poorly managed and did little to support him. We cannot say whether this would have affected the eventual outcome for Mr Pearson but it might have helped prison managers and staff produce a co-ordinated and effective care plan, aimed at addressing his issues and reducing his risk.

HMP Nottingham

90. Prison Service Instruction (PSI) 64/2011 contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. It states that the first case review must agree the level of risk posed by the prisoner to themselves, taking into consideration all available sources of information. The level of risk must be reviewed at all subsequent case reviews.

91. At the first ACCT case review on 7 December, the SO concluded that Mr Pearson was at low risk of self-harm. The previous day, he had tried to tie a ligature around his neck at court, and he told court staff that he would "end it" if sent to prison. On arrival at Nottingham, an officer recorded that Mr Pearson was "extremely agitated and angry".

92. Guidance in the ACCT document is that risk is raised when there are previous, especially recent, suicide attempts, or current self-harming behaviour, or the situation experienced is painful but with no impending crisis. As well as his behaviour at court, Mr Pearson had other risk factors for suicide and self-harm, including that he had newly arrived in prison and had an apparent issue with another prisoner. We consider that the SO should have assessed Mr Pearson's risk of suicide and self-harm as at least raised at the first case review.

93. At the case review on 10 December, Mr Pearson said that he was now on "hunger strike". On 24 December, he spoke of wanting to die in prison. On both occasions, no change was made to the level of risk and it remained low. We consider that Mr Pearson's level of risk could have been assessed as raised on these occasions too. We make the following recommendation:

    The Governor of HMP Nottingham should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that case reviews consider all relevant information that affects risk.

HMP Ranby

94. PSI 64/2011 requires ACCT case reviews to be multidisciplinary where possible. Only Mr Pearson and a manager attended his two ACCT case reviews at Ranby. A SO consulted healthcare staff before the case review on 3 January but the staff who responded did not know Mr Pearson or review his medical notes.

95. PSI 64/2011 highlights that transfer between prisons is a known risk factor for suicide and self-harm. We appreciate that CM A intended to help Mr Pearson by lowering his ACCT observations on his first night at Ranby. However, a nurse had earlier identified him as "anxious and paranoid". It would have been more appropriate to keep the observations at the same level, or to consider increasing their frequency, on Mr Pearson's first night at Ranby and until he had settled into the prison.

96. A caremap must be completed at the first case review for all prisoners subject to ACCT monitoring. PSI 64/2011 says that the caremap should reflect the prisoner's needs, the triggers of their distress, and must aim to address the issues identified at the assessment interview and at later case reviews. The caremap should set time-bounded actions and be aimed at reducing prisoners' risk to themselves. At the case review on 3 January, SO B recorded that Mr Pearson had "numerous issues" within his life and in prison. He did not record what they were, nor did he make any additions to the caremap to identify how to address them and to support Mr Pearson through the process.

97. On both 2 January and 6 January, Nurse A identified issues that might have indicated deteriorating mental health or an increase to Mr Pearson's risk of suicide and self-harm. She appropriately recorded these incidents in the medical record and discussed them with a member of the mental health team. However, Nurse A did not make an entry in the ACCT document. Along with the failure to provide proper healthcare input to the case review, this meant that the incidents were not known to the ACCT case manager. Nurse A told us that she had never made an entry in an ACCT document during her time at Ranby, nor had she received mandatory Prison Service suicide and self-harm prevention training. This is a serious omission.

98. PSI 64/2011 states that staff must follow the level of observations and conversations noted on the ACCT document and must record these immediately or as soon as is practical. It also states that staff must actively engage with the prisoner, encouraging them to talk and participate in activities where appropriate. While prison staff usually recorded three interactions with Mr Pearson per day, most of these interactions were brief and not the good quality conversations required of ACCT monitoring. Mr Pearson spent nearly all his time at Ranby isolated in his cell and, in these circumstances, it was particularly important that staff should have tried to engage with him. We make the following recommendation:

The Governor and Head of Healthcare of HMP Ranby should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that:

- **ACCT case reviews are multidisciplinary and include all relevant people involved in the prisoner's care, including healthcare staff where relevant.**
- **Case reviews consider all relevant information that affects risk, address all issues through specific and meaningful caremap actions, and observations are only reduced when there has been a clear reduction in risk.**
- **Conversations are carried out as directed and documented in the ongoing record.**

- **All staff in contact with prisoners are trained in ACCT procedures and understand that they should record all relevant information about risk in the ongoing record.**

Mr Pearson's isolation

99. Ranby's local policy on Isolated Prisoners, issued in June 2019, states that when staff identify that a prisoner is isolating himself, they should complete a CSIP referral. A residential SO must then investigate the reasons for the self-isolation, and create a plan to encourage re-engagement with the regime. The prisoner should then be supported and monitored daily using a residential management plan, including offering activities, when appropriate. The plan is closed when the prisoner begins to engage with the regime and any issues are resolved.

100. An officer appropriately completed a CSIP referral when Mr Pearson said that he intended to isolate himself. SO A investigated the reasons, and told us that he thought that placing Mr Pearson's watch in his stored property had resolved the issue. However, Mr Pearson continued to isolate for the remainder of his life. No one created a residential management plan, and no one investigated or reported the reasons why he continued to isolate, or reported this to the safer custody team.

101. We obtained month-end figures for the number of prisoners isolating themselves at Ranby, from August 2019 to January 2020. These ranged from 35 to 48 prisoners choosing to isolate, at an average of around four per cent of the population. These numbers are very high. In March 2020, Ranby issued a new policy for managing and supporting isolated individuals and for reducing isolation levels. We therefore make no recommendation. However, the prison must continue to identify and support isolated individuals and recognise the additional risk of suicide and self-harm that this raises.

Mental health care

102. A nurse appropriately referred Mr Pearson to the mental health team on his arrival at Ranby. A nurse considered the referral the next day and booked Mr Pearson into the first available slot for assessment, which was not for around three weeks and considerably outside the local target of five working days. The nurse told us that the mental health team was short-staffed at the time and they did not therefore have the capacity to consider the individual circumstances of each referral.

103. The clinical reviewer was concerned that Mr Pearson's referral was considered without any review of his current ACCT and recent use of a ligature in the court cells, which should have suggested he be prioritised. The clinical reviewer concluded that the mental healthcare that Mr Pearson received at Ranby was of a poor standard. We make the following recommendation:

The Head of Healthcare should ensure that the mental health service has the capacity to provide appropriate care to prisoners judged to be at risk of suicide and self-harm.

Medication

104. Toxicology tests identified that there were potentially fatal amounts of methadone and citalopram in Mr Pearson's blood, above the usual therapeutic range for each. The toxicologist found evidence that Mr Pearson had taken the drugs a few hours before his death.

105. Mr Pearson was prescribed both methadone and citalopram. Prison staff assess prisoners to determine whether it is safe for them to keep medication in their cells, taking into account the risk of the prisoner not taking the medication, over-medicating, or passing on medication to other prisoners. A nurse assessed that Mr Pearson should collect his medication each day and take it in front of a nurse. We are satisfied that this was an appropriate assessment. (Methadone is a controlled drug, which means that no prisoners are allowed to keep it in their possession.)

106. We do not know how Mr Pearson obtained enough methadone and citalopram to take the amounts identified by the toxicology tests. As he was self-isolating, the most likely explanation is that he did not swallow his medication when it was issued, or that he regurgitated it later, and hoarded it in his cell. This would suggest that Mr Pearson had planned to overdose. We make the following recommendation:

    The Head of Healthcare should ensure that nurses safely issue medication to prisoners who do not keep and administer their own medication, and that reasonable checks are undertaken to ensure that the prisoner has taken the medication at the time of collection.

Night of 7 to 8 January 2020

107. We are concerned about the actions of Officer A on the night that Mr Pearson died. Ranby does not have a local policy to tell staff what to do if they find a cell observation panel obscured. An HMPPS Safety Briefing on Observation Panels, issued in February 2018, states that when staff discover that a panel has been blocked, and the prisoner does not comply with instructions to remove the blockage, they must take immediate action to remove the obstruction and check on the prisoner's welfare. In such circumstances, we would usually expect staff who cannot see or speak to a prisoner to radio for help from other staff and remain at the cell door. If they believe the prisoner may be at risk, they should assess the risk of opening the cell door before help arrives, particularly if the prisoner is subject to ACCT monitoring.

108. Officer A's accounts of the events he recorded in the ACCT document differed from those he gave at interview. However, it is apparent that Mr Pearson had blocked his cell observation panel at least once early in the night, and that it was still covered at midnight. Officer A told us that there was a small gap at the top of the blockage and that he could see Mr Pearson through this gap and through a gap in the side of the cell door.

109. When he returned to the cell at around 6.00am, Officer A told us that the panel was blocked as previously but it was now harder to see in as the lights in the cell were off. He said he spent several minutes at the cell and told us that Mr Pearson eventually rolled over and grunted.

110. There is CCTV coverage of the landing on which Mr Pearson lived, but the spur at the end of the landing on which his cell was located is completely obscured by a staircase. It is not therefore possible to see what happened. However, we are concerned by the quality of Officer A's observations, particularly at 6.00am. Around an hour and a quarter later, Mr Pearson was found hanged with rigor mortis clearly established. The clinical reviewer notes that rigor mortis can begin to occur from one to six hours after death, depending on a broad range of circumstances. It is therefore likely that Mr Pearson was already dead when Officer A completed the observation at 6.00am, which raises questions about the credibility of his account.

111. It is always important that staff can clearly see into a cell to ensure the welfare of the occupants. This is particularly important for prisoners who are being monitored under ACCT procedures and are therefore judged to be at risk of suicide or self-harm. We note that Officer B told us that she could not see in Mr Pearson's cell at all when she went to it at 7.10am. This also raises questions about the credibility of Officer A's account that he saw Mr Pearson roll over and grunt at 6.00am.

112. Our view is that Officer A should have taken action to ensure that Mr Pearson's cell observation panel was fully clear, including calling the night manager and, if necessary, opening the cell to remove the blockage and check his welfare.

113. We are also concerned by Officer A's entry at 12.00am, in which he recorded that Mr Pearson was "behaving like a petulant child". Prison staff should not use such language to describe a prisoner at any time, and it is particularly worrying that Officer A chose to write this when he did not engage with Mr Pearson at the time he made the entry and Mr Pearson was simply lying on his bed, watching television.

114. We have asked Ranby to conduct a local investigation into the events of 7 to 8 January. This investigation is currently ongoing. We make the following recommendations:

The Governor should inform the Ombudsman of the findings of the internal investigation into the events on the night of 7 to 8 January, and of any action taken as a result, by 30 September 2020.

The Governor should ensure that staff are aware of national guidance and understand their responsibilities when they find a cell observation panel obscured.

Emergency response

Opening the cell

115. When Officer B identified that Mr Pearson had obscured his observation panel and could not get a response from him, she left the cell to telephone for permission to open it. We consider that she should have acted with more urgency, especially as Mr Pearson was on an ACCT. Our view is that Officer B should have radioed for assistance and considered immediately trying to open Mr Pearson's cell. We make the following recommendations:

The Governor should ensure that, subject to a risk assessment, staff enter cells as quickly as possible if there is reason to consider that a prisoner may be at risk.

Cardiopulmonary resuscitation

116. In September 2016, the National Medical Director at NHS England, wrote to Heads of Healthcare for prisons, introducing new guidance to support staff on when not to perform cardiopulmonary resuscitation. This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in a prison and was taken from the European Resuscitation Council Guidelines 2015 which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile."

117. Officer B, who discovered Mr Pearson, said he was clearly dead, and described signs of rigor mortis. Nurse B also told us that rigor mortis was clearly present. She said, however, that she was uncomfortable stopping the resuscitation efforts without a senior nurse being present.

118. We recognise that both Officer B and Nurse B are relatively new in service, and understand the commendable wish to attempt and continue resuscitation until death has been formally recognised by a senior clinician. However, staff should understand that they are not required to carry out resuscitation in these circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in line with European Resuscitation Council Guidelines.

The Governor should ensure that a copy of this report is shared with CM A, SO A, SO B, Officer A and Officer B and that a senior manager discusses the Ombudsman's findings with them.

The Head of Healthcare should share a copy of this report with Nurse A and Nurse B and share the Ombudsman's findings with them.

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