Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Harief Pearson, a prisoner at HMP Swaleside, on 1 June 2022

A report by the Prisons and Probation Ombudsman

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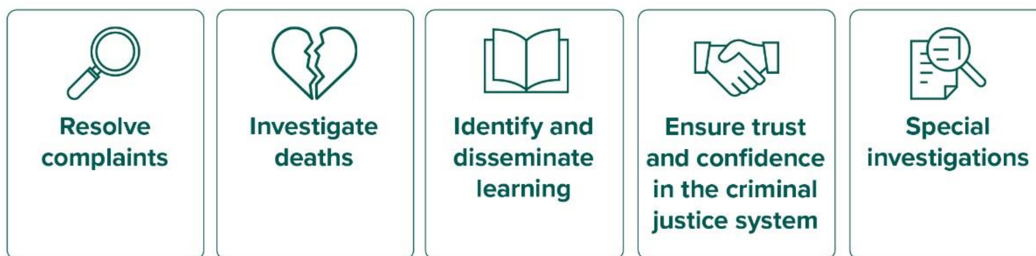
OUR VISION

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

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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.

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 Pearson died of acute cerebral and pulmonary oedema (excess fluid in the lungs and brain), in his cell on 1 June 2022 at HMP Swaleside. He was 25 years old. I offer my condolences to Mr Pearson's family and friends.

The post-mortem examination of Mr Pearson suggested that his death was due to drug use and evidence found in Mr Pearson's cell after his death supports this hypothesis. However, urine and blood samples taken after his death were of poor quality and nothing of toxicological significance was found. The coroner concluded that the underlying cause of Mr Pearson's death was unascertained.

As a result, my investigation could draw no definitive conclusions about the circumstances of Mr Pearson's death. A month before he died, staff suspected Mr Pearson of using illicit drugs and the evidence of contraband in his cell leads me to believe that in all likelihood illicit substance use was a factor in his death.

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 **June 2023**

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Summary

Events

1. Mr Harief Pearson was a 25-year-old Black British Caribbean man serving an 11-year sentence for causing grievous bodily harm with intent. On 5 September 2019, Mr Pearson was transferred to HMP Swaleside.

2. Mr Pearson had post-traumatic stress disorder (PTSD), insomnia and a history of cannabis use. He had limited contact with the substance misuse team while at Swaleside and was never officially referred to the service for treatment.

3. Between August 2021 and February 2022, Mr Pearson received counselling for trauma related to being stabbed. The counsellor did not note any signs of substance misuse and Mr Pearson did not seek support with it.

4. On 3 May, an officer thought Mr Pearson appeared to be under the influence of drugs but did not record many details of the event or take any follow up action.

5. Officers completed routine checks on Mr Pearson’s cell at 9.00pm on 31 May and 5.00am and 7.15am on 1 June and did not note any concerns. When officers unlocked Mr Pearson’s cell at around 10:30am, he was unresponsive. They radioed a medical emergency code blue, indicating a life-threatening situation, however Mr Pearson had already died. At 10.50am, doctors attended the cell and confirmed that Mr Pearson had died.

6. Tests were carried out on ripped pages within a notebook in Mr Pearson’s cell, and they identified that the paper contained traces of THC (the main psychoactive compound found in cannabis). Charred paper in the mouthpiece of a vape in Mr Pearson’s cell suggested he had been smoking the paper.

7. The post-mortem report concluded that the cause of Mr Pearson’s death was acute cerebral and pulmonary oedema (with unascertained causation). The pathologist recorded that Mr Pearson’s cause of death suggested substance use, but this could not be confirmed due to the poor quality of the blood and urine samples taken from Mr Pearson after his death. Although the toxicology report found nothing of significance, it did show that THC was present in Mr Pearson’s system, which shows he was likely using the vape in this way. Although it is possible to die from THC inhalation, it is uncommon.

Findings

Clinical care

8. The clinical reviewer found that overall, the clinical care provided to Mr Pearson was equivalent to that which he could have expected to receive in the community.

Substance misuse

9. Mr Pearson's death appears to be substance misuse related. Some of the staff supporting Mr Pearson thought he and other prisoners had used cannabis on the wing. Others thought Mr Pearson had no issues with substance misuse in prison. The only recorded incident of suspected drug use was one month before Mr Pearson died. The record lacked detail and Mr Pearson was not referred to the substance misuse team.

10. When Mr Pearson was found unresponsive in his cell, staff found what looked like a rolled cigarette possibly containing cannabis or other drugs. The police confirmed that the item was not tested to see if it contained illicit substances.

11. It is disappointing that post-mortem toxicology tests could not provide a definitive cause of death for Mr Pearson; however, we consider that, in all likelihood, Mr Pearson died as a result of taking illicit substances.

Family liaison

12. There were no cover arrangements for the family liaison officer at Swaleside, who was on leave when Mr Pearson died. This appears to be common practice at the prison. As a result, Mr Pearson's mother was not offered ongoing contact and support after being informed of her son's death.

Unlock procedures

13. Staff did not complete a welfare check and obtain a response from Mr Pearson when unlocking his cell on 1 June 2022, despite national policy requirements instructing them to do so. While we accept that completing a welfare check would not have made any difference to the outcome for Mr Pearson, it may have an impact in future emergencies.

Recommendations

- The Governor should ensure that all instances of suspected illicit drug use are recorded and that referrals are made to the Forward Trust in line with Swaleside's local drug strategy.

- The Governor should ensure that staff understand their responsibilities, under national policy, to obtain a response from prisoners during unlock.

- The Governor should ensure that family liaison provision is in place at all times, so that families are given the appropriate support following a death in custody, in line with PSI 64/2011.

- The Governor should formally apologise to Mr Pearson's mother for the poor-quality family liaison she received.

The Investigation Process

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

15. The investigator visited HMP Swaleside on 16 August 2022. He obtained copies of relevant extracts from Mr Pearson's prison and medical records.

16. The investigator interviewed five members of staff and one prisoner at Swaleside on 16 August 2022.

17. NHS England commissioned an independent clinical reviewer to review Mr Pearson's clinical care at the prison. All interviews were completed jointly with the clinical reviewer.

18. We informed HM Coroner for Kent and Medway 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 family liaison officer contacted Mr Pearson's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted us to consider. She had some questions about the progress of our investigation which we answered in separate correspondence. She did not ask us any specific questions about the circumstances surrounding her son's death.

20. Mr Pearson's mother also requested redacted copies of all documents referred to in our investigation. Copies of these documents have been sent to Mr Pearson, alongside her copy of this report.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not identify any factual inaccuracies.

22. Mr Pearson's mother received a copy of the draft report. She responded but did not make any comments on the report itself.

Background Information

HMP Swaleside

23. HMP Swaleside, on the Isle of Sheppey, is part of the Long-Term and High Security estate. It houses up to 1,112 men serving sentences of four years or more. Integrated Care 24 Ltd provides primary healthcare. There is 24-hour nursing cover and a 17-bed inpatient unit. GPs work in the prison Monday to Friday, and Medway on Call Care provides an out of hours GP service. Oxleas NHS Foundation Trust provides mental health services. The Forward Trust provides substance misuse treatment.

HM Inspectorate of Prisons

24. The most recent published inspection of HMP Swaleside (a progress review) was in July 2022. Inspectors reported that the shortage of officers was worse than at their previous inspection in October 2021, leading to very limited time out of cells for most prisoners. However, good progress had been made in addressing inspectors' concerns about support during prisoners' early days at the prison and it was evident that a significant amount of effort had been put into creating a well-thought-out service. Despite this, inspectors reported that staffing levels were now at 'crisis point' and this was having an impact on all aspects of the regime.

25. HMIP's inspection in October 2021 reported that in order to combat the supply of illicit items, the security team had implemented: enhanced searching on entry to the prison for staff and visitors, testing of incoming mail for illicit substances and a dedicated search team. Mandatory drug testing had been reintroduced (after being halted during the COVID-19 pandemic) in July 2021 but was sometimes dropped off if staff were needed elsewhere in the prison. Prisoners who were suspected of using illicit substances were referred to the Forward Trust for support. Inspectors note that Swaleside's drug strategy was up to date and there was good attendance at drug strategy meetings, which provided oversight of local issues.

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 April 2021, the IMB found the prison had had a difficult year coping with the COVID-19 pandemic – at one point 150 staff were off work. Although they felt as a whole the prison had still managed to forge ahead and make some improvements regarding physical repairs and collaborative working, they remarked on the lack of meaningful activity/work available for prisoners which had been necessary to keep staff and prisoners safe.

Previous deaths at HMP Swaleside

27. Mr Pearson was the 13th prisoner at Swaleside to die since June 2020. Six of the previous deaths were from natural causes, five were self-inflicted and one was drug related. We found some similarities in our investigation findings following a previous self-inflicted death at Swaleside on 1 August 2021. Staff did not refer a prisoner with

drug problems to the Forward Trust until ten months after he arrived at Swaleside. Also, staff shortages and COVID-19 protocols affected the prison's ability to facilitate key work in both this case and another death which occurred just five days after Mr Pearson on 6 June 2022.

Key Events

Background

28. On 17 December 2018, Mr Harief Pearson was remanded to HMP Wormwood Scrubs charged with causing grievous bodily harm with intent. On 5 July 2019, he was sentenced to 11 years imprisonment with a two-year licence period. Mr Pearson was British and Caribbean, and he was 25 years old when he died.

29. Mr Pearson had a diagnosis of post-traumatic stress disorder (PTSD) after being stabbed outside prison. He experienced insomnia and had a history of cannabis use.

HMP Swaleside

30. On 5 September 2019, Mr Pearson was transferred to HMP Swaleside.

31. On 20 October, Mr Pearson provided a urine sample for a mandatory drug test and tested negative. Later that month, Mr Pearson met his Prison Offender Manager (POM), who recorded sentence plan targets including drug work with The Forward Trust (the substance misuse treatment service) due to his history of cannabis use, and work to address trauma. Mr Pearson's POM did not make a referral to The Forward Trust.

32. On 9 January 2020, Mr Pearson did not attend his scheduled mental health review. The mental health team closed the referral and wrote to Mr Pearson with advice on how to access psychological therapies.

33. On 15 April, Mr Pearson self-referred for psychological therapy with the in-reach team. Staff placed him on a waiting list for counselling with the Bradley Therapy Service (BTS) and completed regular welfare checks in the meantime.

34. On 29 July, the substance misuse team completed their six-month review of Mr Pearson, to check how he was feeling. No concerns were raised, and no follow-up appointments were made.

35. On 23 August, Mr Pearson attended his first trauma counselling session with a worker in the prison counselling team. In interview, the worker told us that Mr Pearson described nightmares linked to being stabbed and nervousness if he could not see other prisoners' hands. She did not have any serious concerns about Mr Pearson.

36. On 27 August, Mr Pearson's mother telephoned the prison safer custody welfare line and said that her son was feeling stressed and anxious. The message was passed on to staff on A Wing where Mr Pearson was located. However, it is unclear from records whether staff completed a welfare check or any follow-up action.

37. On 23 November 2021, Mr Pearson was involved in an incident that resulted in a general alarm being raised on his wing. He ignored several instructions from staff to disperse and was subsequently downgraded from 'standard' level privileges to

‘basic’. This meant he had the lowest entitlement to privileges such as letters and visits. He returned to standard level in December but continued to receive regular negative entries in his prison file.

38. On 8 February 2022, the worker from the prison’s counselling team completed Mr Pearson’s final counselling session. She told us that Mr Pearson engaged well in the sessions and reported having learned useful techniques to manage his anger.

39. On 21 February, Mr Pearson self-referred for further counselling sessions. He said he wanted someone to talk to about feeling stuck in the prison system. BTS staff discussed Mr Pearson’s self-referral. They concluded that counselling would not be useful because further sessions would be covering the same issues. Mr Pearson was encouraged to use the skills he had already learnt.

40. Mr Pearson continued to receive regular negative entries in his prison file for refusing orders, being late to return to his cell and delaying the regime. he was downgraded to the basic level of privileges on 14 April and remained on that level until his death.

41. On 15 April, Mr Pearson submitted another referral to the Mental Health Team requesting further counselling. The BTS service team were tasked to consider the referral.

42. On 22 April, a member of the BTS team completed a welfare check on Mr Pearson. They assessed that Mr Pearson was managing well but said he would appreciate a further welfare check.

43. On 4 May, an officer recorded in Mr Pearson’s file that he had been found ‘under the influence’ the previous day. The record provided no further detail.

44. On 11 May, a BTS counsellor wrote to Mr Pearson to explain that she had been unable to see him on the wing due to the dangerous behaviour of another prisoner. She explained that efforts were being made to resolve the situation and signposted Mr Pearson to other support services, such as Samaritans and the Chaplaincy, in the meantime. The session was due to be rebooked but did not take place due to BTS staff sick leave.

45. On 31 May, at around 9.00pm, an OSG (Operational Support Grade) completed a routine check of prisoners on A Wing. He looked through Mr Pearson’s cell door observation panel and raised no concerns.

1 June

46. At around 5.00am on 1 June, the OSG completed the first routine check of prisoners on A Wing that morning, including Mr Pearson, and raised no concerns.

47. At around 7.15am, Officer A completed the second morning check of prisoners on A Wing. In interview, the officer told us that he looked through Mr Pearson’s cell observation panel and saw him lying in his bed. He thought Mr Pearson was asleep, had no concerns, and so did not attempt to gain a response.

48. At around 7.45am, a Supervising Officer (SO) completed the morning briefing for staff on A Wing staff. She assigned Officer B, who was completing his second duty at Swaleside having been temporarily deployed there from another prison, to work on Mr Pearson's landing.

49. At around 9.00am, two prisoners on A Wing were suspected of using illicit substances and healthcare staff were called to assess them.

50. At around 10.25am, Officer B began unlocking the basic regime prisoners on the landing. He went to Mr Pearson's cell to unlock it and thought that Mr Pearson was asleep. The SO had not told the officer, and he said that it was not standard practice at his usual prison, to complete a welfare check on prisoners who were on the basic regime when unlocking their cells.

51. Officer B decided not to unlock Mr Pearson's cell and instead to wait for him to press his cell bell when he woke up.

52. At 10.28am, a prisoner alerted Officer B to the fact that Mr Pearson's door was still locked. The officer thought Mr Pearson had woken up, but he looked through the cell observation panel and saw that he still appeared to be asleep. He asked for support from Officer A, who knew Mr Pearson well. At around 10.30am, both officers attended Mr Pearson's cell and Officer A shouted loudly four or five times, but Mr Pearson did not reply.

53. Another prisoner offered to wake Mr Pearson. He entered the cell and shook him, but quickly realised something was wrong. The officers ushered the prisoner out of the cell and Officer B radioed a medical emergency code blue at 10.34am, which triggered the control room to call an ambulance. Officer A began cardiopulmonary resuscitation (CPR).

54. Around two minutes later, three nurses arrived and observed that Mr Pearson was immovable with rigor mortis and was cold to the touch. They brought a defibrillator (a device that can give a high energy shock to someone who is in cardiac arrest) with them but did not use it as it was clearly too late. Two prison GPs attended the cell and confirmed that Mr Pearson had died at 10.50am. Paramedics arrived at the cell moments afterwards but were told Mr Pearson had already been pronounced dead.

55. In interview, Officer A told us that he noted a "half-smoked joint of some description" on the floor of Mr Pearson's cell, which was reported to the police when they arrived to investigate Mr Pearson's death. Staff also found other drug paraphernalia in Mr Pearson's cell, including a vape and a notebook, the pages of which were later found to contain traces of THC (the main psychoactive compound found in cannabis).

Contact with Mr Pearson's family

56. At 10.50am, staff asked the chaplain at HMP Elmley (which is part of the same cluster group of prisons as Swaleside and is located nearby) to take on the role of family liaison officer, as Swaleside's designated family liaison officer was unavailable.

57. The chaplain arrived at Swaleside at 11.30am and met a Custodial Manager (CM), who explained to him what had happened. They decided that a home visit to Mr Pearson's family to break the news would be appropriate. However, while they were completing a risk assessment for the visit, Mr Pearson's mother, his next of kin, telephoned Swaleside saying she had been told her son was not breathing. It transpired that her daughter had been contacted by an unknown person.

58. As the distance to Mr Pearson's mother's home was around a two-hour drive, the Duty Governor agreed that the chaplain could speak to Mr Pearson's mother on the telephone and break the news to her. At 12.40pm, the chaplain telephoned Mr Pearson's mother and told her that her son had died.

59. Swaleside contributed to the costs of Mr Pearson's funeral, in line with Prison Service instructions.

Support for prisoners and staff

60. After Mr Pearson's death, a Custodial 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.

61. The prison posted notices informing other prisoners of Mr Pearson's death and offering support.

Post-mortem report

62. The post-mortem report concluded that the cause of Mr Pearson's death was acute cerebral and pulmonary oedema (with unascertained causation).

63. The pathologist said that Mr Pearson's cause of death suggested substance use, but post-mortem tests did not find anything of toxicological significance in his samples. The pathologist noted, however, that the urine and blood samples taken from Mr Pearson's body after he died were of poor quality which limited the extent of the testing undertaken.

64. Although the toxicology report found nothing of significance, it did show that THC (the main psychoactive compound found in cannabis) was present in Mr Pearson's system.

Findings

Clinical care

65. The clinical reviewer found that, overall, the clinical care provided to Mr Pearson was equivalent to that which he could have expected to receive in the community.

Substance misuse

66. The ‘Incident Reporting’ section of Swaleside’s local drug, alcohol and substance misuse strategy states that if a prisoner is found to be under the influence of psychoactive substances (PS), they should be automatically referred to the substance misuse service (the Forward Trust) and mental health in-reach team.

67. Mr Pearson’s death appears to be the result of substance misuse. Mr Pearson had a history of cannabis use, which he disclosed when he arrived at Swaleside, but he was not referred to the substance misuse team.

68. A SO told us that staff knew prisoners on A Wing used cannabis and that staff ‘knew’ Mr Pearson had smoked cannabis a few times. However, she was unsure if they had documented this. There were no entries in Mr Pearson’s prison file related to suspected drug use other than on 3 May 2022, one month before he died. The record for this incident was very limited and did not provide detail on the type of drug staff suspected Mr Pearson was using or whether any follow up action should or would be taken.

69. The worker from the prison’s counselling team told us that Mr Pearson had never mentioned any issues with drugs. Officer A said there were no signs that Mr Pearson was in debt or had drug issues, which seems to contradict the SO’s observations.

70. The underlying cause of Mr Pearson’s death was not determined by the coroner, but staff found what appeared to be a half-smoked rolled cigarette (or joint) on Mr Pearson’s cell floor when they found him unresponsive. This was referred to the police, who confirmed that the item was not tested to see if it contained illicit substances.

71. After Mr Pearson’s death, prison staff identified that some of the pages of a notebook found in Mr Pearson’s cell had been ripped. They tested the notebook on their Ion scanner (used to detect illegal substances) and found that it contained traces of THC. Charred paper was present in the mouthpiece of a vape found in Mr Pearson’s cell, which suggests Mr Pearson was tearing off pieces of paper from the notebook, putting them into the mouthpiece of the vape and smoking it. Although the toxicology report found nothing of significance, it did show that THC was present in Mr Pearson’s system, which suggests he was likely using the vape in this way. Although it is possible to die from THC inhalation, it is uncommon.

    The Governor should ensure that all instances of suspected illicit drug use are recorded and that referrals are made to the Forward Trust in line with Swaleside’s local drug strategy.

Unlock procedures

72. PSI 75/2011, *Residential Services*, contains requirements on unlock procedures for prisons. It says:

> "Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight … but staff unlocking them have not noticed that the prisoner had died. This is not acceptable."

> "The appropriate arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock. … Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

73. At around 10.25am, Officer B went to unlock Mr Pearson's cell, but decided to leave it locked as he was still asleep. He did not check Mr Pearson's welfare or get a response from him. Around five minutes later, staff found Mr Pearson unresponsive. Rigor mortis was present, indicating that Mr Pearson had been dead for some time.

74. In interview, staff appeared unaware that they should be completing welfare checks on prisoners and obtaining a response from them when unlocking them for the regime. Officers told us they had not been told to complete welfare checks at unlock. This is a national policy requirement and, while completing a welfare check would not have made any difference to the outcome for Mr Pearson, it may do in other situations in the future. We make the following recommendation:

The Governor should ensure that staff understand their responsibilities, under national policy, to obtain a response from prisoners during unlock.

Family liaison

75. Chapter 13 of Prison Service Instruction (PSI) 64/2011 'Safer Custody' contains mandatory requirements for family engagement and liaison following a death in custody, including that the family liaison officer will maintain contact with the family and provide information and support where appropriate.

76. When Mr Pearson died on 1 June, Swaleside's allocated prison family liaison officer was on leave. The chaplain at neighbouring HMP Elmley was asked to take over and travelled to Swaleside immediately. During his preparations to visit Mr Pearson's next of kin, his mother, she contacted the prison. Mr Pearson's mother said that her daughter had been told by an unknown person that her son was not breathing. Mr Pearson's mother lived around two hours' drive from Swaleside, so a decision was taken to break the news of his death over the phone. We consider that this was reasonable, in the circumstances.

77. Mr Pearson's mother spoke to the chaplain about visiting Swaleside to meet the Governor and see her son's cell. The prison said they would contact her to confirm potential dates for the visit. However, when we spoke to Mr Pearson's mother during our investigation, she told us that she had not heard from Swaleside since their initial telephone call on 1 June, and that no one from the prison had visited or written to her. Mr Pearson's mother said she had emailed the Governor, who told

her that someone would be in touch. However, this was not followed up. She said she felt that her family had been treated very badly by the prison.

78. On 29 June, the Ombudsman's investigator contacted Swaleside urging them to make contact with Mr Pearson's mother and update her as soon as possible. The investigator did not receive a response, so sent a follow up email. Mr Pearson's mother did not hear from Swaleside until 9 August, when a newly assigned family liaison officer made contact and arranged a visit.

79. The family liaison officer told us there were no cover arrangements in place at Swaleside in the event that the nominated family liaison officer was on leave at the time of a prisoner's death. This resulted in additional distress for Mr Pearson's family and a breach of policy. We make the following recommendations:

The Governor should ensure that family liaison provision is in place at all times so that families are given the appropriate support following a death in custody, in line with PSI 64/2011.

The Governor should formally apologise to Mr Pearson's mother for the poor-quality family liaison she received.

Inquest

80. The inquest, held on 4 to 8 March 2024, recorded an open conclusion. The jury concluded that not providing adequate direction to the detached prison officer in respect of the regime in place at Swaleside concerning the welfare check at unlock was a failure, however it did not contribute to the death.

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