Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Pearson, a prisoner at HMP Holme House, on 24 October 2022

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T l 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr John Pearson died of a stroke caused by a bleed on the brain on 24 October 2022 while a prisoner at HMP Holme House. He was 66 years old. I offer my condolences to Mr Pearson's family and friends.

The clinical reviewer concluded that the clinical care Mr Pearson received at Holme House was good and equivalent to what he could have expected to receive in the community. The clinical reviewer identified a number of areas of good practice. She also made two recommendations about the lack of clarity around the clinical escalation process and improvements to ensure entries in medical records are timely and detailed.

Mr Pearson died before the compassionate release process was completed because probation staff refused to follow the process.

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 **March 2024**

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Summary

Events

1. Mr John Pearson was serving a sentence of 24 years in prison for sexual offences. On 31 August 2018, he was transferred to HMP Holme House.

2. Mr Pearson had several long-term medical conditions. Healthcare staff had frequent contact with Mr Pearson as they monitored and supported him through the long-term conditions clinics.

3. In June 2022, Mr Pearson began to lose weight.

4. On 27 September, Mr Pearson slipped in his cell. He reported this to staff the next morning and healthcare staff examined him. A healthcare assistant noted that apart from scrapes on his elbows, Mr Pearson was mobilising around his cell without any problems.

5. On 2 October, Mr Pearson complained of a headache. A nurse arranged for him to transfer to the prison's inpatient unit so that healthcare staff could monitor him as she noted that he was unable to respond to some questions.

6. In the early hours of 3 October, a nurse noted that Mr Pearson appeared to be deteriorating and he was less responsive. The nurse arranged an ambulance to take Mr Pearson to hospital. Two officers escorted him, and he was not restrained.

7. The hospital diagnosed Mr Pearson with a large bleed on the brain and an aneurysm (a bulge in a blood vessel). Mr Pearson remained in hospital and specialists treated him.

8. On 19 October, hospital specialists told prison staff that Mr Pearson's life expectancy was less than four weeks. Prison staff started the compassionate release process. However, probation staff refused to engage in the process and Mr Pearson died before the application was completed.

9. Mr Pearson died in hospital on 24 October with his family present.

Findings

10. When it was clear that Mr Pearson had a very limited life expectancy, probation staff at Redcar, Cleveland and Middlesbrough Probation Delivery Unit (PDU) refused to engage fully with the compassionate release process because they did not understand their obligations under the HMPPS policy. As a result, Mr Pearson's compassionate release application was not processed before he died.

11. The clinical reviewer concluded that healthcare staff at Holme House provided Mr Pearson with good care that was equivalent to what he could have expected to receive in the community. Improvements were needed in relation to recording and noting clinical observations.

Recommendations

- The National Probation Service Divisional Director for the Northeast should add training for compassionate release applications to the Probation Delivery Unit training plan for all staff and ensure that any staff involved in requests for reports as part of the compassionate release process understand their responsibility in accordance with the ERCG Policy Framework.

- The Head of Healthcare should ensure that all staff complete a full set of clinical observations, including a NEWS2 score and the Glasgow Coma Scale when attending a prisoner who has been reported as being unwell or has had a fall, to ensure that patients who are deteriorating, or at risk of deteriorating have a timely initial assessment by a competent clinical decision maker.

The Investigation Process

12. HMPPS notified us of Mr Pearson's death on 24 October 2022.

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

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

15. The investigator interviewed five members of staff on 23 November and 7 December 2022 through Microsoft Teams.

16. NHS England commissioned a clinical reviewer to review Mr Pearson's clinical care at the prison. She conducted joint interviews with the investigator on 23 November 2022.

17. We informed HM Coroner for Teesside and Hartlepool of the investigation. The Coroner gave us the cause of death. We have sent the Coroner a copy of this report.

18. The Ombudsman's family liaison officer contacted Mr Pearson's wife to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Pearson's wife said that her concerns about Mr Pearson falling in his cell were ignored by prison staff and asked if earlier intervention by healthcare staff could have changed the outcome. We have addressed these concerns in the clinical review report and in our report.

19. Mr Pearson's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies. The head of the Probation Delivery Unit made a number of observations that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Holme House

21. HMP Holme House is a category C training prison holding over 1,200 men. Spectrum Community Health CIC provides primary care health services at the prison.

Redcar, Cleveland and Middlesbrough Probation Delivery Unit (PDU)

22. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise stakeholders. They have links with local partnerships to whom, where appropriate, they refer people for resettlement services.

23. Redcar, Cleveland and Middlesbrough PDU is one of seven PDUS within the North East Region of the Probation Service.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Holme House was in March 2023. Inspectors reported that there was good healthcare delivery, strengthened by first rate collaboration between a number of teams and organisations, including good joint working between the healthcare workers and prison staff.

25. Inspectors reported that complex patients were reviewed regularly through a strong multidisciplinary approach. Palliative care arrangements were excellent. An experienced palliative care nurse provided compassionate and skilled care alongside the GP and other staff. Good links were established with the local hospice and Macmillan nurses.

HM Inspectorate of Probation

26. The first inspection of probation services in Redcar, Cleveland and Middlesbrough Probation Delivery Unit (PDU) was in December 2022. Inspectors reported that there was an impressive leadership team who were proactive in their approach, and there was a stable workforce across all grades who worked towards the delivery of quality probation work. However, this had not translated into the quality of practice.

27. Inspectors said that improvement was needed in the quality of work to assess and manage the risks that people on probation may present to the wider community.

28. Inspectors gave ratings of 'requiring improvement' under organisational delivery for leadership and services, and 'inadequate' for assessments, implementation and delivery and 'requiring improvement' for planning and reviewing.

29. Inspectors noted that the coordination of multi-agency working to manage the risk of harm was poor in a lot of cases and information sharing between agencies needed to improve. Their recommendation included prioritising training to enhance workforce skills.

Independent Monitoring Board

30. 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 December 2022, the IMB reported that in working with prisoners with terminal conditions, prison staff supported the families during the final days of the prisoner's life.

31. The Board noted that end of life prisoners were treated with compassion and support and they observed improvements in the healthcare provision due to staffing changes and improvements, with bank and agency nurses covering any shortfalls.

Previous deaths at HMP Holme House

32. Mr Pearson was the tenth prisoner to die at HMP Holme House since October 2020. Of the previous deaths, six were from natural causes and three were self-inflicted. Up to the end of 2023, there have been nine deaths at the prison since Mr Pearson's death. Eight were from natural causes and one was drug related. There are no similarities between our findings in the investigation of Mr Pearson's death and the other deaths.

Key Events

33. On 16 May 2018, Mr John Pearson was convicted of sexual offences and sentenced to 24 years imprisonment. He was 62 years old. Mr Pearson was sent to HMP Durham. On 31 August 2018, he transferred to HMP Holme House.

34. Mr Pearson had several long-term medical conditions which included type 2 diabetes, liver cirrhosis (long term liver damage from scarring), headaches, anxiety and depression. While in prison, Mr Pearson was diagnosed with chronic obstructive pulmonary disorder (COPD - a lung condition that causes breathing difficulties), leukaemia in 2019 (he did not require treatment but was on a watch and observe plan with hospital specialists) and oesophageal varices (enlarged veins in the oesophagus due to cirrhosis) in 2022.

35. Healthcare staff noted Mr Pearson's complicated medical history at his first and second reception screens. They had frequent contact with Mr Pearson as they monitored and reviewed his conditions and offered him support through the long-term conditions clinics. On 14 November 2021, healthcare staff added Mr Pearson to the complex care register, and he was discussed monthly at a multi-disciplinary team (MDT) forum consisting of prison staff and a range of healthcare staff. Staff appointed a prison buddy (a designated prisoner to assist him with his daily needs e.g., delivering his meals and offering him support when needed).

2022

36. In June 2022, Mr Pearson's wife reported he was losing significant amounts of weight. Mr Pearson had lost one stone and six pounds in eight months and said that he had occasional abdominal pain, but no other major symptoms were noted. Healthcare staff monitored his weight and noted that it continued to decline each week.

37. In September, Mr Pearson told his hospital haematologist about his weight loss and said that he had numbness in his feet. The haematologist was concerned that this indicated leukaemia progression and requested blood tests.

Events from 27 September 2022

38. During the night of 27 September, Mr Pearson slipped in his cell. The next morning on 28 September, Mr Pearson told an officer about his fall and said that he had hit his head. The officer notified the duty nurses, noted the details in the wing observation book and completed an injury to prisoner form (referred to as form F213).

39. At approximately 10.00am, a healthcare assistant visited Mr Pearson in his cell and noted that he was mobilising around the cell, was not in pain but did have scrapes to both elbows. There is no evidence that healthcare staff recorded any clinical observations including a NEWS2 score (which monitors clinical deterioration) or Glasgow Coma Scale (measures the level of consciousness) following his fall.

40. On 2 October, officers were concerned about Mr Pearson and asked for a member of the healthcare team to visit him. Mr Pearson had vomit on his clothing and

bedding, and he complained of a headache. A nurse completed an assessment and arranged for Mr Pearson to transfer to the prison's inpatient unit. The nurse noted that Mr Pearson was helped back into bed, but he was unable to respond to some questions. His NEWS2 score was three (indicating a low to medium clinical risk and recommended further assessment). Nurses completed two further reviews at hourly intervals and noted that Mr Pearson's NEWS2 score had reduced.

41. In the early hours of 3 October, a nurse noted that Mr Pearson appeared to be deteriorating as he had vomit on his clothes, was urine incontinent, his sitting and standing balance was poor and he was less responsive. His NEWS2 score was four. The nurse requested an ambulance at approximately 12.20am. However, ambulance delays meant that paramedics arrived at 2.40am to take Mr Pearson to hospital. Two officers escorted him, and he was not restrained.

42. Hospital specialists reviewed Mr Pearson in hospital. A CT scan identified a large bleed on the brain and aneurysm (bulge in the blood vessel). Mr Pearson had surgery to stem and drain the blood and was placed on a ventilator. Healthcare staff at Holme House contacted the hospital for updates. When Mr Pearson was taken off the ventilator, hospital staff told prison staff that Mr Pearson's prognosis was poor. Mr Pearson was transferred to James Cook University Hospital for urgent surgery and treatment.

Application for compassionate release

43. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from prison before their sentence has expired. On 18 October, the Head of Safety asked prison staff to consider starting the paperwork for temporary release and then compassionate release as hospital specialists had said Mr Pearson was in the final stages of his life with possibly hours or at most a few weeks left to live.

44. On 19 October, healthcare staff received a hospital consultant letter saying that Mr Pearson's life expectancy was fewer than four weeks. As Mr Pearson had not yet been allocated a Community Offender Manager (COM - because he was not close enough to release), Mr Pearson's Prison Offender Manager (POM) emailed a Senior Probation Officer (SPO) at Redcar, Cleveland and Middlesbrough Probation Delivery Unit (PDU) and asked him to appoint a COM to contribute to the assessment for Mr Pearson's compassionate release application, and said it was urgent. The SPO refused to allocate a COM. Prison staff contacted HMPPS headquarters for advice and were told that a COM must be allocated because their report formed part of the risk management and release plan needed for a compassionate release application.

45. In an email to the POM, the SPO said that they acknowledged the complexities of the case and the significant health issues but were concerned about the shift of management from the prison to the community. The SPO said that he had consulted his manager for advice as there was a limit as to what probation could do if Mr Pearson was released on licence. They noted he would be unable to engage with appointments, understand or consent to any restrictions or licence conditions and that they would be responsible for the risk of the case without any real risk management strategies that could be put in place.

46. The SPO suggested that the POM seek advice about transferring Mr Pearson to a secure hospital as in his opinion, this would remove the need for prison officer presence, allow for family not to have to contend with the challenge of having prison officers present, but would remain true to the original sentence imposed by the court and remain mindful of the impact on victims.

47. In response, the POM told the SPO that Mr Pearson met the criteria for Early Release on Compassionate Grounds (ERCG) and therefore, it was something the prison must do. Secure hospitals hold prisoners with mental health issues and not those needing end of life care. Holme House did not have the healthcare facilities to meet Mr Pearson's needs and was the reason for his transfer to a hospital. The POM made it clear that they would not be making an application for ERCG unless Mr Pearson was suitable and eligible. Probation staff at Redcar, Cleveland and Middlesbrough PDU refused to complete their section of the compassionate release application as they should have done, and the matter was still unresolved at the time of Mr Pearson's death.

48. Mr Pearson died in hospital on 24 October with his family present.

Contact with Mr Pearson's family

49. The prison appointed two family liaison officers (FLOs) when Mr Pearson was first admitted to hospital. One contacted Mr Pearson's wife and told her that Mr Pearson was unwell in hospital. Both FLOs provided regular updates and arranged for his family to attend the hospital. When Mr Pearson was transferred to another hospital for urgent surgery, both FLOs travelled to the hospital to offer support and information to his family. They visited the hospital often as Mr Pearson's health deteriorated.

50. When Mr Pearson died, one of the FLOs telephoned Mr Pearson's wife to offer her condolences and update her on the arrangements that were in place.

51. The prison contributed towards Mr Pearson's funeral in line with national guidance.

Support for prisoners and staff

52. After Mr Pearson's death, a 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.

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

Cause of death

54. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Pearson's cause of death as subarachnoid haemorrhage (a stroke) caused by ruptured anterior communicating artery aneurysm (burst blood vessel causing bleeding on the brain).

Findings

Compassionate release

55. The criteria for early release for determinate sentenced prisoners are set out in the Early Release on Compassionate Grounds (ERCG) Policy Framework. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family.

56. All requests for ERCG are made to the Public Protection Casework Section (PPCS) of the Ministry of Justice who consider applications on behalf of the Secretary of State for Justice. As part of the application, a Community Offender Manager (COM) must complete section 5 of the application form. There must be evidence from a medical specialist (usually a consultant) outlining the condition and prognosis, and any planned treatment for the prisoner.

57. Due to Mr Pearson's length of sentence, he did not have a Community Offender Manager (COM) and no resettlement arrangements had been agreed. His Prison Offender Manager (POM) was responsible for Mr Pearson's sentence management. However, as Mr Pearson's health deteriorated, his POM had to contact the Probation Service so a COM could be allocated to complete the appropriate resettlement checks and reports for consideration of compassionate release.

58. The investigator spoke to HMPPS sentence calculation policy unit who said that where there is not an allocated COM for the prisoner, a duty COM should help in the completion of the application. If the application is successful and ERCG is granted, a COM should then be allocated to the case as outlined in paragraph 4.67 of the ERCG Policy Framework.

59. For ill health, the COM (or duty COM) is asked to provide details of their understanding of the prisoner's health and/or social care requirements and to what extent relatives/friends are aware of the prisoner's condition, care arrangements if released, details of how the prisoner will be managed in the community, their assessment of potential risk of re-offending (particularly concerns regarding violent/sexual offending), any known victim issues and any additional licence conditions.

60. It was clear that the community probation team did not understand the ERCG Policy Framework, or their responsibilities under it. Mr Pearson had a terminal illness. Community Probation staff should have followed the policy and engaged with the application process.

61. Interviews with probation staff confirmed this was not a situation that they had encountered before. In such circumstances, reference to the Policy Framework would have clarified the expectations and the arrangements needed. Probation staff's lack of understanding of the process and consequent refusal to engage impacted the prison's ability to progress the compassionate release application in a timely manner. We recommend:

The National Probation Service Divisional Director for the Northeast should add training for compassionate release applications to the Probation Delivery Unit training plan for all staff and ensure that any staff involved in requests for reports as part of the compassionate release process understand their responsibility in accordance with the ERCG Policy Framework.

Clinical Findings

62. The clinical reviewer concluded that Mr Pearson's clinical care at Holme House was of a good standard and equivalent to what he could have expected to receive in the community. She found evidence of good practice in relation to support from the healthcare team for monitoring and observation of his long-term conditions.

63. The clinical reviewer concluded that she could not say if there was any direct link between Mr Pearson's fall on 27 September and his brain haemorrhage but had been made aware that sub-arachnoid haemorrhages were either spontaneous (occurring without cause) or traumatic in nature. The clinical reviewer found that there was no evidence to suggest that Mr Pearson experienced a head trauma following his fall.

64. However, the clinical reviewer found that there was no evidence that healthcare staff recorded any clinical observations including NEWS2 scores and Glasgow Coma Scale scores to assess whether there was a deterioration in Mr Pearson's health. We recommend:

    The Head of Healthcare should ensure that all staff complete a full set of clinical observations, including a NEWS2 score and the Glasgow Coma Scale when attending a prisoner who has been reported as being unwell or has had a fall, to ensure that patients who are deteriorating, or at risk of deteriorating have a timely initial assessment by a competent clinical decision maker.

65. The clinical reviewer also made a recommendation about record keeping, which we do not repeat here but which the Head of Healthcare will need to address.

Good practice

66. Staff at Holme House recognised that there was a small window for Mr Pearson to be granted compassionate release before his death and they should be commended for their prompt efforts in trying to achieve this.

Inquest

67. The inquest, held on 7 May 2024, concluded that Mr Pearson died from natural causes.

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