

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Luke Pearce, a prisoner at HMP/YOI Swinfen Hall, on 6 April 2023

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 Luke Pearce was found hanging in his cell on 6 April 2023, at HMP/YOI Swinfen Hall. Staff tried to resuscitate him but were unsuccessful. Mr Pearce was 21 years old. I offer my condolences to his family and friends. Mr Pearce was the first prisoner to take his life at Swinfen Hall in almost six years.

Mr Pearce gave no indication to staff that he was at risk of suicide or self-harm in the months leading up to his death. I am satisfied that staff could not have foreseen his actions.

When staff saw Mr Pearce hanging, there was a delay in them removing the ligature and starting CPR. We cannot say whether the delay made a difference to the outcome for Mr Pearce, but we know that in a medical emergency, any delay could be critical. The Governor has told us that staff have been reminded of their responsibilities during medical emergencies.

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

January 2024

Contents

Summary	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	6
Findings	10

Summary

Events

1. In January 2019, Mr Luke Pearce, then aged 17, was sentenced to life imprisonment for murder. He was moved to HMP/YOI Swinfen Hall on 30 April.
2. Staff started suicide and self-harm prevention procedures (known as ACCT) for Mr Pearce on two occasions. The first was when he arrived at Swinfen Hall as staff were concerned about Mr Pearce's young age and long sentence. The second was in July 2020, when Mr Pearce told staff that he was going to hang himself. Later that day, he told staff that he had only said that to annoy them as he was frustrated with the COVID-19 restrictions. There were subsequently no concerns that Mr Pearce was at risk of suicide or self-harm.
3. On 22 April 2022, a prison chaplain saw Mr Pearce following the news that his grandmother had died. Mr Pearce was close to his grandmother and was upset. The chaplain offered support and arranged for Mr Pearce to watch a recording of his grandmother's funeral.
4. Shortly after 5.30am on 6 April 2023, during a routine check, an officer found that Mr Pearce had covered the observation panel in his cell door. The officer called to Mr Pearce but got no response. He looked through the crack of the door and saw Mr Pearce with a ligature around his neck. The officer radioed for assistance. An Operational Support Grade (OSG) attended and briefly entered Mr Pearce's cell before coming out again.
5. When another officer attended, the first officer and OSG told her that she should not enter the cell as it was a crime scene. She contacted a custodial manager for permission to go in and then cut the ligature and lowered Mr Pearce to the floor. The officer and OSG waited outside and did not assist. At 5.40am, more staff arrived and the control room staff called an ambulance. Staff started CPR at 5.42am. Ambulance paramedics arrived at 5.59am and took over CPR. At 6.30am, they pronounced that Mr Pearce had died.
6. Mr Pearce left a note addressed to his mother, in which he apologised and said he was not coping with the pain he was feeling. He said that ever since his grandmother died, he had not felt the same. He said he was so far from home and did not get to see anyone.

Findings

7. Mr Pearce gave no indication to staff that he was at risk of suicide or self-harm in the months leading up to his death. We are satisfied that staff could not have foreseen his actions.
8. There was a delay in staff entering the cell, removing the ligature and starting CPR. We cannot say whether the delay affected the outcome. The Governor told us that he had issued a notice to staff setting out the correct process to follow during a medical emergency. However, the officer who found Mr Pearce was clearly still unaware of the correct process when interviewed which indicates that the notice to

staff was ineffective. Staff wrongly believing that they are unable to enter a cell alone during a medical emergency is an issue we see time and again in our investigations. HMPPS should consider reviewing their routine training of staff to ensure that this is adequately covered.

Recommendations

- The Executive Director for Transforming Delivery and the Operational Security Group Director should ensure that relevant training and guidance equips staff to understand when and how to enter a cell in a medical emergency, including the priority that must be given to acting quickly to preserve life, whilst maintaining their own safety.

The Investigation Process

9. HMPPS notified us of Mr Pearce's death on 6 April 2023.
10. The investigator issued notices to staff and prisoners at HMP/YOI Swinfen Hall informing them of the investigation and asking anyone with relevant information to contact him. Three prisoners contacted the investigator.
11. The investigator visited Swinfen Hall on 9 June 2023. He obtained copies of relevant extracts from Mr Pearce's prison and medical records.
12. The investigator interviewed three members of staff and three prisoners at Swinfen Hall on 9 June. The remaining two interviews took place over telephone on 24 and 25 August 2023.
13. NHS England commissioned an independent clinical reviewer to review Mr Pearce's clinical care at the prison.
14. We informed HM Coroner for South Yorkshire East of the investigation. He gave us Mr Pearce's cause of death. We have sent the Coroner a copy of this report.
15. The Ombudsman's family liaison officer contacted Mr Pearce's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

Background Information

HMP/YOI Swinfen Hall

16. HMP/YOI Swinfen Hall holds around 600 remanded and sentenced young adult men aged 18 to 28 across nine wings. Healthcare services are provided by Practice Plus Group (PPG) and the mental health services are provided by Midlands Partnership NHS Foundation Trust (MPFT). Healthcare services are available from 7.30am to 7.30pm Monday to Thursday, and 7.30am to 5.30pm Friday to Sunday.

HM Inspectorate of Prisons

17. HM Inspectorate of Prisons carried out an inspection of Swinfen Hall in June and July 2021. Although levels of self-harm had reduced, they were still higher than similar prisons, and self-harm rates among the young adult population remained higher than their older peers. Inspectors found the Safer Prisons Team provided good support for prisoners being supported through the ACCT process. Progress in developing positive staff-prisoner relationships had stalled in the last year and the delivery of quality key work was too limited. Security was well managed and had a good flow of intelligence, which was analysed swiftly by the newly developed regional intelligence team. The prison had worked hard to reduce the availability of illicit substances.

Independent Monitoring Board

18. 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 the most recent published report for the year to 30 April 2022, the Board noted that a disproportionate number of self-harm incidents arose from a small number of individuals experiencing crisis. Key worker sessions had been ad hoc with high numbers being provided in January and February, then trailing off slightly in the following months. The Board also noted that intelligence-led searches had resulted in an increase in drug-related finds.

Previous deaths at HMP/YOI Swinfen Hall

19. Mr Pearce was the first prisoner at Swinfen Hall to die since May 2017.

Key worker scheme

20. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the scheme should work are set out in HMPPS's Manage the Custodial Sentence Policy Framework. This says:
 - All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.

- Key workers must have completed the required training.
 - Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
21. Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.
22. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

23. On 27 August 2018, Mr Luke Pearce, then aged 17, was remanded in prison, charged with murder, and sent to HMP/YOI Feltham. It was his first time in prison. In January 2019, he was sentenced to life imprisonment with a minimum term of 17 years.
24. On 30 April, Mr Pearce was moved to HMP/YOI Swinfen Hall. Staff started suicide and self-harm prevention procedures (known as ACCT) because they were concerned about Mr Pearce's young age (he had recently turned 18), the length of his sentence and that he said he punched walls when he got angry. The next day, a mental health assessment found no issues and Mr Pearce said he had family support and no concerns, so staff stopped ACCT procedures.
25. On 29 May, Mr Pearce was caught in possession of fermenting liquid (which as well as being drunk as alcohol, can also be used to extract psychoactive substances (PS) that have been impregnated into paper or clothing). He told staff that he was being bullied but refused to give names.
26. On 2 April 2020, a letter addressed to Mr Pearce tested positive for PS.
27. On 10 July, Mr Pearce told prison staff that he was "going to string up". Staff started ACCT procedures. At the ACCT case review later that day, Mr Pearce told staff that he said he was going to hang himself to annoy staff as he felt frustrated about the COVID-19 regime and lack of visits. He also said he had felt disrespected by staff as when he rang his emergency cell bell to ask for paper so he could write to his parents, they told him it was not an emergency. Staff discussed with Mr Pearce how he could manage his anger and frustration and stopped ACCT procedures.
28. On 1 January 2022, Mr Pearce assaulted another prisoner. Three days later he assaulted an officer. He was managed using a Challenge, Support and Intervention Plan (CSIP – a process to manage prisoners who are violent) and spent a period of time in the Care and Separation Unit (CSU, the segregation unit).
29. On 17 January, Mr Pearce was moved from the CSU to G Wing.
30. On 30 January, an officer noted that he discussed Mr Pearce's recent poor behaviour with him during a key worker session. This was his last recorded key worker session.
31. On 22 April, a prison chaplain saw Mr Pearce following his grandmother's death (his family had broken the news to him). Mr Pearce was close to his grandmother and was upset. The chaplain offered support.
32. On 18 May, Mr Pearce attended the chaplaincy to view a recording of his grandmother's funeral (which took place in Finland).
33. In May and July, Mr Pearce assaulted the same prisoner twice. This prisoner had previously been on Mr Pearce's wing but had moved to F Wing. Intelligence indicated that the prisoner had a history of being assaulted for being in debt.
34. On 22 March 2023, staff smelled cannabis smoke coming from Mr Pearce's cell.

35. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. The investigator listened to the calls Mr Pearce made from his in-cell telephone in the two weeks before his death.
36. Between 25 March and 4 April, Mr Pearce made several calls to friends during which they talked about the receipt and movement of money. He made no calls to his family. During one call, Mr Pearce said that he owed somebody £350 and that he would give them goods amounting to £250 so he would owe £100. He did not appear to be concerned about this.
37. At around 8.00pm on 5 April, Mr Pearce made his last telephone call to a friend. They spoke for almost an hour about times they spent together, people they knew, prison life and some frustrations. Mr Pearce said his 22nd birthday was coming up. Mr Pearce complained about losing contact with some of his friends, when they had changed their telephone numbers and not told him. They discussed selling vape capsules for 'food' (a slang term for drugs) but did not discuss any money issues. Nothing was said during the calls that indicated that Mr Pearce was distressed or contemplating suicide.

Events of 6 April 2023

38. At 5.34am on 6 April, during a routine check, Officer A found that Mr Pearce had covered his observation panel with a cloth. In his statement, Officer A said that he knocked on the door several times and then switched the cell light on and off while calling out to Mr Pearce but got no response.
39. Officer A looked through the crack of the door and saw Mr Pearce with a ligature around his neck with his body hanging above his bed. The ligature was made from a dressing gown cord and shoelaces. Mr Pearce had attached the ligature to a vent and his notice board.
40. Officer A radioed, "Urgent message. Immediate threat to life." The control room said that staff were on their way and asked for more information. Officer A told them that there appeared to be a ligature around the cell occupant's neck.
41. At 5.36am, an Operational Support Grade (OSG) attended. He looked through the crack of the door and could see what he thought was Mr Pearce's torso, with mottled flesh. The OSG told the investigator that he immediately turned to Officer A and said that they needed to go into Mr Pearce's cell. CCTV footage shows that at 5.37am, the OSG entered the cell briefly and then came out again. Officer A remained in the doorway of the cell.
42. At 5.38am, Officer B attended. She told the investigator that Officer A and OSG told her that she should not enter the cell as it was a crime scene. She thought this was incorrect and radioed the custodial manager (CM) to check and get authorisation to cut Mr Pearce down. The CM gave authorisation.
43. Officer B went into Mr Pearce's cell. Officer B said she could not find a pulse for Mr Pearce, and he had mottled legs and arms, but was still warm.
44. Officer B cut the ligature around Mr Pearce's neck and lowered him to the floor. She told the investigator that she struggled to lift him down by herself. Officer A and the

OSG did not assist her. She said that by the time she got Mr Pearce to the floor, she heard the CM arrive. CCTV footage shows that he arrived at 5.40am, along with Officer C. At 5.40am, control room staff called an ambulance.

45. The CM found that Mr Pearce's skin was still soft and warm. Body Worn Video Camera (BWVC) footage shows that he started CPR at 5.42am. Officer C collected a defibrillator. Officer B took over chest compressions while the CM set up the defibrillator.
46. At 5.44am, the defibrillator indicated no shockable heart rhythm. The CM delivered chest compressions, and Officer B delivered rescue breaths. This continued until the ambulance staff arrived at the cell at 5.59am. Paramedics then took over CPR.
47. At 6.30am, paramedics stopped CPR and confirmed that Mr Pearce had died.
48. Mr Pearce left a note in his cell addressed to his mother, in which he apologised and said he was not coping with the pain he was feeling. He said that ever since his grandmother died, he had not felt the same. He said he was so far from home and did not get to see anyone.

Contact with Mr Pearce's family

49. On 6 April, the prison appointed a family liaison officer (FLO). Mr Pearce's mother lived in Southampton so the FLO asked staff at HMP Winchester to assist.
50. A FLO from HMP Winchester and the regional safety lead visited Mr Pearce's mother and told her of Mr Pearce's death.
51. The Head of Safety at Swinfen Hall contacted Mr Pearce's stepfather by telephone and informed him that Mr Pearce had died.
52. The FLO kept in contact with Mr Pearce's family over the following days, offering support and advice.
53. Mr Pearce's workshop instructor had a close relationship with Mr Pearce and was a pallbearer at his funeral. The prison contributed to the costs of Mr Pearce's funeral in line with national policy.

Support for prisoners and staff

54. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case by case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.
55. After Mr Pearce's death, a prison manager individually 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.

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

Post-mortem report

57. No post-mortem was undertaken. The Coroner recorded Mr Pearce's cause of death as hanging.

Findings

Assessment of Mr Pearce's risk of suicide and self-harm

58. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that should be followed when a prisoner is identified as being at risk of suicide and self-harm. It sets out the risk factors and triggers that could indicate increased risk.
59. Staff supported Mr Pearce using ACCT on two occasions. When he arrived at Swinfen Hall in April 2019 and in July 2020. Mr Pearce did not require the support of ACCT after that.
60. In the lead up to his death, Mr Pearce gave no indication to staff that he was at risk of suicide or self-harm. We are satisfied that staff could not have foreseen Mr Pearce's death.
61. Mr Pearce's grandmother died in April 2022. The approaching anniversary of her death could have been a factor in Mr Pearce's decision to end his life. We are satisfied that the prison provided appropriate support to Mr Pearce when his grandmother died and that he gave no indication that he was struggling in the lead up to the anniversary of her death.
62. There were some indicators that Mr Pearce might have been involved in the drugs trade at Swinfen Hall. He discussed the movement of money during telephone calls to friends and selling vapes for drugs, he mentioned that he owed money, and he assaulted another prisoner who was known to be in debt. Two weeks before Mr Pearce died, staff smelt cannabis smoke coming from his cell.
63. Another prisoner told us that he had heard that Mr Pearce was in debt for drugs. However, other prisoners and staff told us that they were not aware of any debts or other issues with Mr Pearce. Even if Mr Pearce was in debt, we found no evidence that he was being threatened or that it was causing Mr Pearce distress. It would appear from his telephone calls that he had access to funds so there was no indication that he was unable to repay his debt.
64. There was no indication that Mr Pearce was at increased risk of suicide and self-harm due to his possible involvement in the drugs trade at Swinfen Hall.

Emergency response

65. PSI 03/2013 Medical Emergency Response Codes says that all Governors should have a Medical Emergency Response Code protocol in place that enables staff to quickly convey the nature of the medical emergency. This should ensure that staff take the relevant equipment to the incident and that an ambulance is called immediately. Swinfen Hall uses the emergency codes 'code blue' (to indicate unconsciousness) and 'code red' (to indicate heavy bleeding).
66. When Officer A found Mr Pearce hanging at 5.36am on 6 April, he used his radio to say that there was an immediate threat to life, but he did not call a code blue. When

the control room asked what was wrong, he said that the cell occupant had ligatured. He remained outside the cell while waiting for other staff to arrive.

67. PSI 24/2011, Management and Security of Nights, says that under normal circumstances authority to unlock a cell at night must be given by the night orderly officer and no cell will be opened unless two or three (subject to local risk assessment procedures) members of staff are present, one of whom should be the night orderly officer. However, it says that the preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff should do a dynamic risk assessment to decide whether it is safe to enter a cell alone.
68. Officer A told the investigator that he had been trained to wait for additional staff support and could only go into a cell at night if he felt it was urgent. Once the OSG arrived, Officer A still did not go in. It was not until 5.38am, that Officer B went in and cut the ligature.
69. It is not possible to say whether the delay in the emergency response impacted on the outcome for Mr Pearce, but we know that in a medical emergency, a delay of a few minutes could be critical. Officer A was very new to the service and was inexperienced. The Governor told us that the delay in the emergency response had been identified as an area for learning and that measures had been taken to remind staff of their responsibilities during medical emergencies.
70. On 27 April, Swinfen Hall issued a notice to staff setting out the correct procedures for calling a medical emergency and entering a cell during night state. However, at his interview in June, Officer A still maintained that he could not go into a cell at night without three staff present. This demonstrates that notices to staff are not effective ways to communicate correct practices or change staff behaviours. Staff not understanding that they can enter cells alone, or with fewer staff than standard, in order to preserve life is an issue we see time and time again in our investigations. We recommend:

The Executive Director for Transforming Delivery and the Operational Security Group Director should ensure that relevant training and guidance equips staff to understand when and how to enter a cell in a medical emergency, including the priority that must be given to acting quickly to preserve life, whilst maintaining their own safety.

Location

71. In his note to his mother, Mr Pearce said that he was far from home and did not get to see anyone. Mr Pearce's family lives in Hampshire but they had visited him at Swinfen Hall up to August 2022. Other prisoners suggested that Mr Pearce had asked his family to stop visiting him because that might help him get moved to a prison closer to them.
72. Mr Pearce had received his category C status and staff were exploring the possibility of him moving to a prison closer to his family home. However, Mr Pearce was serving a life sentence and still had a long time to serve. It would have been

challenging at that stage of his sentence for him to fit the criteria for the category C prisons located close to his family's home.

Key work

73. All prisoners in the male closed estate are supposed to receive weekly key worker sessions. However, Mr Pearce did not receive any key worker sessions after January 2022. He had received regular key worker sessions up to June 2021 but none in the 14 months before his death.
74. The Governor of Swinfen Hall told the investigator that delivering key worker sessions to prisoners had been difficult due to staffing levels. There was a high staff attrition rate and reduced staffing meant that running the prison regime had had to be prioritised over the routine delivery of key work. Key worker sessions were delivered only to prisoners in vulnerable groups (which Mr Pearce was not).
75. The Governor said a lot of work had been done to try to improve the retention of staff, by creating a more supportive environment. This was starting to have an impact as the attrition rate had fallen from 26% to under 10% and there were now 139 officers in post against a target of 146.
76. It is difficult to say whether Mr Pearce would have shared how he was feeling with a key worker. Mr Pearce's workshop instructor, who had a close relationship with Mr Pearce, said that Mr Pearce did not show his emotions. It is possible therefore that key worker sessions would have made no difference to the outcome for Mr Pearce. Nevertheless, key worker sessions are important in establishing good relationships between prisoners and staff and should be resumed as soon as staffing levels allow.

Clinical care

77. Mr Pearce had little contact with healthcare staff during his time at Swinfen Hall. The clinical reviewer concluded that the care Mr Pearce received at the prison was equivalent to that which he could have expected to receive in the community.

Good practice

78. We consider that the actions of Officer B showed considerable professionalism. Despite reluctance from her colleagues already at the cell, she went in, cut the ligature and single-handedly supported Mr Pearce to the floor. The Governor should commend her for her actions.

Inquest

79. The inquest, held from 14 to 16 May 2024, concluded that Mr Pearce died by suicide.

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