

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Clifford Fairhurst a prisoner at HMP Whatton on 20 March 2019

**A report by the Prisons and Probation Ombudsman**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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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 Clifford Fairhurst died of an intraparenchymal haemorrhage (bleeding within the brain tissue in hospital on 20 March 2019 while a prisoner at HMP Whatton. Mr Fairhurst was 83 years old. I offer my condolences to his family and friends.

The clinical care that Mr Fairhurst received at Whatton was equivalent to that which he could have expected to receive in the community.

However, I am concerned that Mr Fairhurst was briefly restrained when he was transferred to hospital as an emergency on 18 March 2019. The decision to restrain him was unjustified, and did not take account of his age, mobility and serious ill-health.

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**

**June 2020**

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# Summary

## Events

1. On 11 May 2016, Mr Fairhurst was sentenced to seven years in prison for sexual offences and sent to HMP Lincoln. He was transferred to HMP Whatton on 21 December.
2. On 18 March 2019, Mr Fairhurst was found lying on the floor in the shower. He was conscious but incoherent and staff radioed a medical emergency code.
3. Mr Fairhurst was initially restrained when he was transferred to hospital but when his health deteriorated in the ambulance, his restraints were removed permanently.
4. At hospital, a scan showed that Mr Fairhurst had bleeding on the left side of his brain that he would not survive.
5. Mr Fairhurst died in hospital on 20 March at 3.50pm.

## Findings

6. The care that Mr Fairhurst received at HMP Whatton was of a good standard and equivalent to that which he could have expected to receive in the community.
7. We are concerned that the risk assessment which the prison undertook when Mr Fairhurst went to hospital on 18 March 2019 did not consider medical information. Mr Fairhurst was an 83-year-old man in poor health and with poor mobility, and there is no evidence that the decision making about whether or not to restrain him was appropriate or proportionate.

## Recommendations

- **The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**

## The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Whatton informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. She obtained copies of relevant extracts from Mr Fairhurst's prison and medical records.
10. NHS England commissioned an independent clinical reviewer to review Mr Fairhurst's clinical care at the prison.
11. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Fairhurst's next of kin to explain the investigation and to ask if he had any matters that he wanted the investigator to consider. He did not respond.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.

## Background Information

### HMP Whatton

14. HMP Whatton in Nottinghamshire is a medium security prison holding up to 841 prisoners convicted of sex offences. MITIE Care and Custody Health provides healthcare services. The healthcare centre is open on weekdays from 7.30am to 6.30pm and at weekends and Bank Holidays from 8.00am to 1.30pm. There is an out-of-hours service at other times. There is also a palliative care suite in the healthcare centre for end-of-life care.

### HM Inspectorate of Prisons

15. The most recent inspection of HMP Whatton took place in August 2016. Inspectors reported that the quality of health and social care was good, and waiting times for treatment were reasonable. Inspectors found that healthcare services were provided by a mix of appropriately skilled staff in well-integrated teams, and that their interactions with their patients were polite and professional. There was high demand for routine hospital appointments but an increase in the number of available escort officers had significantly reduced the number of cancellations.

### Independent Monitoring Board

16. 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 May 2018, the IMB reported that healthcare remained a major concern. They reported that in January 2018, NHS England issued a rectification notice to address the healthcare concerns and increased funding to recruit additional nursing and administrative staff. The IMB noted that at the end of the reporting year, this rectification action had not yet been completed and some specialist nursing clinics had not been held. However, they noted a slight improvement during the last two months of the reporting year. The IMB said that healthcare staff had worked hard to deliver a quality service, and GPs received high praise from prisoners and staff. The IMB also considered that the healthcare contract did not adequately take into account the needs of HMP Whatton's population, including a high proportion of older prisoners and those with complex health conditions. They noted that this resulted in a sub-standard provision of care.

### Previous deaths at HMP Whatton

17. Mr Fairhurst is the thirteenth prisoner to die of natural causes at HMP Whatton since March 2017. Since Mr Fairhurst's death, two prisoners died of natural causes. In our investigation into the death of a prisoner in February 2019, a month before Mr Fairhurst's death, we recommended that staff should

understand the legal position on the use of restraints and that escort risk assessments take into account the health of a prisoner and the risk the prisoner presents at the time. While we accept that Whatton has since agreed to implement our recommendation, it is disappointing that the use of restraints was again an issue in our investigation into Mr Fairhurst's death.

## Key Events

18. Mr Fairhurst's medical history included prostate cancer, high blood pressure and glaucoma, all diagnosed in 2005 and he had surgery to remove a tumour from his pancreas in 2015.
19. On 11 May 2016, Mr Fairhurst was sentenced to seven years in prison for sexual offences and sent to HMP Lincoln.
20. On 21 December, Mr Fairhurst was transferred to HMP Whatton. A nurse completed his initial health screen and noted his medical history. She assessed Mr Fairhurst as suitable to keep his medication in his cell and administer it himself. His medication was prescribed the next day. Mr Fairhurst lived in a single cell on a standard wing for men with mobility issues.
21. Healthcare staff regularly reviewed Mr Fairhurst's blood pressure, managed his medication for high blood pressure in line with his pressure levels, completed blood tests to check for prostate cancer and gave him injections for his glaucoma.

### 18 March 2019

22. On 18 March 2019, a prisoner told an officer that Mr Fairhurst had fallen over in the shower. The officer responded immediately and found Mr Fairhurst lying on his back on the floor. At 9.56am, the officer radioed a medical emergency code blue (used to indicate that a prisoner is unconscious or having breathing difficulties) as Mr Fairhurst was conscious but confused and could not respond to questions.
23. Staff covered Mr Fairhurst with blankets to keep him warm. Healthcare staff completed his observations, which were within the normal range, except for a slightly raised blood sugar level. His pupils were recorded as equal and reactive to light. Healthcare staff were unable to complete another set of observations as Mr Fairhurst was in too much pain.
24. At 10.17am, paramedics arrived and at 11.05am, they transferred Mr Fairhurst to a hospital in Nottingham.
25. Mr Fairhurst was initially restrained when he was transferred to hospital, but his health deteriorated while he was in the ambulance, and his restraints were permanently removed at 11.15am on his way to hospital.
26. A hospital scan showed that Mr Fairhurst had a bleed to the left side of his brain that he would not survive. He was placed on an end-of-life care pathway and prison healthcare staff checked Mr Fairhurst's condition on a daily basis.
27. Mr Fairhurst died in hospital on 20 March at 3.50pm.

### Contact with Mr Fairhurst's family

28. Mr Fairhurst's next of kin lived approximately 50 miles from the prison.
29. At 5.15pm on 18 March 2019, the Head of Security contacted Mr Fairhurst's next of kin by telephone to inform him that he had been taken to hospital as an

emergency and was in a critical condition. Mr Fairhurst's next of kin asked to be kept updated by telephone.

30. On 19 March, the Governor telephoned Mr Fairhurst's next of kin with an update, and told him that an officer had been allocated as the family liaison officer (FLO). That day, the Governor and FLO visited Mr Fairhurst in hospital and the FLO later updated Mr Fairhurst's next of kin about his condition.
31. Mr Fairhurst died the next day at 3.50pm. At 4.00pm, the FLO telephoned his next of kin and left a message, asking him to call her back. At 4.30pm, the FLO told Mr Fairhurst's next of kin that Mr Fairhurst had died and offered her condolences and support.
32. Mr Fairhurst's funeral took place on 29 April 2019. The prison contributed to its cost, in line with national instructions.

### **Support for prisoners and staff**

33. The prison posted notices informing other prisoners of Mr Fairhurst'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 Fairhurst's death.

### **Post-mortem report**

34. A post-mortem examination was not conducted. A hospital doctor confirmed Mr Fairhurst's death and the Coroner accepted the cause of death as intraparenchymal haemorrhage (bleeding within the brain tissue).

# Findings

## Clinical care

35. The clinical reviewer concluded that the care that Mr Fairhurst received was of a good standard and equivalent to that which he could have expected to receive in the community.
36. The clinical reviewer found that Mr Fairhurst's medical history was clearly documented and that his medical conditions were monitored and treated appropriately. She identified that Mr Fairhurst was reviewed monthly for his blood pressure and when it was elevated, healthcare staff made a further appointment for him to have it rechecked. When it became consistently elevated, his medication was increased and he was reviewed and had further blood tests taken.
37. The clinical reviewer also identified that entries in Mr Fairhurst's medical record were clear and concise.

## Restraints, security and escorts

38. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account a prisoner's health and mobility.
39. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
40. On 18 March 2019, the Head of Operation, concluded that two officers should escort Mr Fairhurst to hospital, using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) and that the restraints should only be removed for medical treatment or in emergencies with prior approval. Mr Fairhurst was assessed as posing a low risk to the public, of hostage taking, escape potential, outside assistance, to females and to hospital staff. The medical section noted that his limited mobility affected his ability to escape.
41. We acknowledge that Mr Fairhurst's restraints were removed after his health deteriorated while he was in the ambulance, ten minutes after they were applied. However, we are concerned that the approach that the Head of Operations initially applied to using restraints was inconsistent with the provisions of the High Court judgement and that it is not the first time that we have identified an issue with the decision-making process for the use of restraints at Whatton. Mr Fairhurst was 83 years old, in poor health, had poor mobility and was assessed as posing a low risk. In this context, we do not consider that the decision-making

process was in line with the requirements of case law and there is no evidence to explain how restraining Mr Fairhurst was proportionate to the risk he posed, especially as he was escorted by two officers. Staff did not consider his risk at the time and the impact of his poor health on his risk. While we recognise that Whatton has agreed to implement our previous recommendation about the use of restraints, we repeat it here:

**The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**

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