Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nigel Fairest, a prisoner at HMP Lincoln, on 22 March 2020

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

Summary

1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Nigel Fairest, who was 72 years old, died in a hospice of heart disease on 22 March 2020, while a prisoner at HMP Lincoln. We offer our condolences to Mr Fairest's family and friends.

4. The clinical reviewer concluded that the care Mr Fairest received at HMP Lincoln was not equivalent to that which he could have expected to receive in the community. She made three recommendations.

5. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that if a prisoner is undergoing treatment for cancer, contact is made with the hospital responsible for delivering that treatment within 24 hours of their arrival at the prison.

- The Head of Healthcare should ensure that all prisoners receiving chemotherapy/palliative care are discussed at multidisciplinary meetings from the onset of their care, or as soon after their arrival at the prison as practicably possible.

- The Head of Healthcare should ensure that clear communication channels are in place to enable both healthcare and prison staff, to share information about the physical condition of terminally ill prisoners and any requests that they may have.

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Fairest's clinical care at HMP Lincoln.

7. The PPO investigator has investigated non-clinical issues, including Mr Fairest's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. One of the PPO's family liaison officers wrote to Mr Fairest's next of kin, his ex-wife, to explain the investigation. She did not respond to our letter.

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

Previous deaths at Lincoln

10. Mr Fairest was the fifth prisoner at Lincoln to die since March 2018. Of the previous deaths, two were self-inflicted, one was drug-related and one was from natural causes. There are no similarities between our findings in the investigation of Mr Fairest's death and the previous deaths.

Key Events

11. On 29 September 2017, Mr Nigel Fairest was sentenced to 40 months in prison for sexual offences. On 31 August 2018, he was released on licence but on 7 February 2019, he was recalled and sent to HMP Lincoln.

12. Mr Fairest had several pre-existing medical conditions, including heart disease (for which he had previously undergone quadruple heart bypass surgery) and malignant melanoma (an aggressive form of skin cancer for which he was receiving chemotherapy).

13. On 20 February, prison healthcare staff contacted Western Park Hospital, Sheffield, to find out when Mr Fairest's next chemotherapy session was due. No sessions had been arranged as the hospital had not been able to contact Mr Fairest about his previous chemotherapy session due on 21 January. The hospital scheduled a session for 21 March, which Mr Fairest attended. (He had not attended for chemotherapy since 24 December 2018.) On 27 March, Mr Fairest's care was transferred to Lincoln County Hospital.

14. Mr Fairest missed his chemotherapy session on 14 May, because no escorts were available to take him. It was rebooked for 4 June, and he attended.

15. On 3 February 2020, a prison GP reviewed Mr Fairest and noted that he was extremely unwell. The GP sent him to Lincoln County Hospital by emergency ambulance. Hospital staff diagnosed Mr Fairest with acute renal failure and a chest infection. He was admitted to hospital as an inpatient and treated with antibiotics. He was discharged back to Lincoln on 5 February.

16. On 20 February, Mr Fairest attended Lincoln County Hospital for an oncology review. Hospital staff told him that despite receiving chemotherapy treatment, his cancer had worsened. They told him there were no active treatment options left open to him and any further treatment would be palliative.

17. The following day, a nurse saw Mr Fairest. The nurse noted that Mr Fairest's condition had worsened. He suspected he had developed a chest infection. He sent him to Lincoln County Hospital by emergency ambulance. Hospital staff diagnosed him with kidney failure, a chest infection and a worsening of his cancer symptoms. He remained in hospital as an inpatient until 28 February.

18. On 9 March, Mr Fairest told a prison GP that he did not want to be taken to hospital should his condition deteriorate, or resuscitated if his heart or breathing stopped. He signed a DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) order the next day.

19. On 10 March, a nurse reviewed Mr Fairest. She noted that he was extremely unwell and had not eaten properly for the previous week. She noted in his careplan that routine reviews by healthcare staff should be increased from twice, to three times a day. She also spoke with the prison staff working on the wing who told her they were not aware of how ill he was. She told them to check on Mr Fairest throughout the night and alert healthcare staff if necessary.

20. A nurse reviewed Mr Fairest the following day. She noted his blood sugar level was low and that he was vomiting when he ate. She considered he required a further review and he was taken to Lincoln County Hospital by emergency

ambulance. Mr Fairest was diagnosed with an exacerbation of his cancer symptoms and admitted as an inpatient.

21. Mr Fairest's condition continued to deteriorate and on 20 March he was transferred to St Barnabas Hospice, Lincoln, to receive end of life care.

22. His condition continued to deteriorate and at 10.45am on 22 March, Mr Fairest died. A hospice doctor confirmed his death at 10.50am.

23. The Coroner gave Mr Fairest's cause of death as left ventricle failure (where the left side of the heart does not pump blood adequately), caused by ischaemic heart disease. Metastatic melanoma (skin cancer that has spread to other areas of the body) was listed as a contributory factor.

Lisa Burrell **December 2020**
Assistant Ombudsman