Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gareth Brear, a prisoner at HMP Garth, on 29 December 2020

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 I 020 7633 4100
F I 020 7633 4141

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*

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 Gareth Brear died of heart disease on 29 December 2020 at HMP Garth. He was 42 years old. I offer my condolences to Mr Brear's family and friends.

The clinical reviewer concluded that the healthcare Mr Brear received at Garth was equivalent to that which he could have expected to receive in the community.

The clinical reviewer did, however, identify some shortcomings in Mr Brear's care in relation to his medication. Although these did not contribute to Mr Brear's death, they are of concern because of his history of substance misuse.

I am concerned that the officer who conducted the welfare check on the morning of 29 December did not realise that Mr Brear was dead, and that the officer who later found him, did not immediately call a medical emergency code. These failings did not affect the outcome for Mr Brear as he had been dead for some time but could make a critical difference in other cases.

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 **December 2021**

Contents

Summary

Events

1. In September 2009, Mr Gareth Brear was remanded to HMP Leeds charged with murder. He subsequently received a life sentence with a tariff of nearly 26 years.

2. At his initial health screen, Mr Brear said that he had had a heart attack in November 2008. He was referred to hospital specialists and, in May 2010, he was diagnosed with an abnormal fast heartbeat. After he received hospital treatment, his condition improved, and he was discharged from hospital care in November 2011. He continued to receive regular reviews by prison healthcare staff.

3. In September 2018, Mr Brear transferred to HMP Garth. Healthcare staff continued to keep him under review, and he was referred to substance misuse services. In August 2020, he said he was drug free.

4. At about 8.30am on 29 November, an officer carrying out the morning welfare check saw Mr Brear apparently sitting on his bed. He assumed he was alive and did not try to obtain a verbal response from him.

5. At 8.55am, another officer went into his cell and found him sitting on his bed with no trousers on. She spoke to him, but he did not respond, so she asked another officer to check on him.

6. At 9.00am, the other officer entered the cell and checked for a pulse, but there was none. He immediately radioed a medical emergency code to summon help.

7. A nurse responded immediately. She considered that Mr Brear had been dead for some time and therefore she did not attempt CPR. Paramedics arrived at the cell at 9.10am and confirmed that Mr Brear had died.

8. The post-mortem report gave Mr Brear's cause of death as left ventricular hypertrophy (a thickening of the wall of the heart's main pumping chamber).

Findings

9. The clinical reviewer concluded that the clinical care Mr Brear received at Garth was equivalent to that which he could have expected to receive in the community.

10. The clinical reviewer did, however, identify some shortcoming in Mr Brear's care.

11. Prison GPs failed to complete a medication in possession risk assessment (MIPRA) on two occasions when Mr Brear's medication was changed and, on another occasion, a GP increased the dosage of Mr Brear's medication against his wishes. These issues did not contribute to Mr Brear's death but are of concern because of his history of substance misuse.

12. The clinical reviewer was also concerned that Mr Brear's prescription for co-codamol was not available to him over a weekend in July 2020. She considered that some prisoners might self-harm in these circumstances.

13. The officer who carried out the morning welfare check on 29 December 2020 did not try to obtain a verbal response from Mr Brear and therefore failed to realise that he was dead.

14. The officer who found Mr Brear unresponsive 25 minutes later did not call a medical emergency code and there was therefore a delay of around five minutes before the code was called. Although this made no difference in Mr Brear's case as he had been dead for some time, it could make a critical difference in other circumstances.

Recommendations

- The Head of Healthcare should ensure that GPs complete a Medication in Possession Risk Assessment (MIPRA) when prescribing medication, in line with Safer Prescribing in Prisons: Guidance for clinicians - January 2019 (update).
- The Head of Healthcare should ensure that when a patient makes a specific request for a change of medication, particularly when the patient has a known drug dependency, the reason for this request is fully explored with the patient and the detail of this discussion recorded in his medical records.
- In discussion with GP services, the Head of Healthcare should ensure that medication reviews for pain relief prescriptions include discussion of wider treatment plans (including advice on physical activity or physiotherapy, sleep and support in achieving improvements in mental health and quality of life) in line with the Safer Prescribing in Prisons guidance.
- The Head of Healthcare should ensure that out of hours stock of medication is available and that there is appropriate medication available to prisoners if required over the weekend.
- The Governor should share this report with Officer B and arrange for a senior manager to discuss the Ombudsman's findings with her.

The Investigation Process

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

16. Due to restrictions in response to the COVID-19 pandemic, the investigator was unable to visit Garth. He obtained copies of relevant extracts from Mr Brear's prison and medical records by email.

17. NHS England commissioned an independent clinical reviewer to review Mr Brear's clinical care at the prison.

18. The clinical reviewer interviewed the Head of Healthcare at Garth via video conferencing on 7 May 2021.

19. We informed HM Coroner for Lancashire and Blackburn with Darwen of the investigation. The coroner gave us the results of the post-mortem investigation and toxicology results. We have sent the coroner a copy of this report.

20. Mr Brear'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.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended to reflect that. Their action plan is annexed to this report

Background Information

HMP Garth

22. HMP Garth holds up to 846 prisoners serving sentences of four years or longer or indeterminate sentences. Primary care services are provided by Bridgewater NHS Foundation Trust. Mental health and clinical substance misuse services are provided by Greater Manchester Mental Health NHS Foundation Trust and psychosocial substance misuse services are provided by Phoenix Futures.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Garth was in January 2019. Inspectors noted that several aspects of healthcare had improved since the previous inspection, but patients still waited too long for hospital appointments. Staffing levels had improved, but there were still vacancies. The management of long-term conditions had improved and patients received regular reviews and a good level of care. Substance misuse services were reasonably good, prescribing was safe and reviews took place regularly. A good range of psychosocial support was also available. Medicines were managed reasonably well and medicines administration had improved since the previous inspection, but governance and oversight needed to be enhanced.

Independent Monitoring Board

24. 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 July 2020, the IMB noted that the number of applications they had received in respect of healthcare matters had almost halved, from 31 in the previous reporting year to 16 during 2018/19. However, the issues that were raised were similar in subject to the previous year, such as the length of time waiting for appointments and disagreements in respect of medication.

Previous deaths at HMP Garth

25. Mr Brear was the 11th prisoner to die at Garth since December 2018. Of the previous deaths, four were from natural causes, one was a self-inflicted death and five were drug-related deaths. There have been two further deaths since Mr Brear's death, one from natural causes and one self-inflicted, which are currently under investigation.

26. We have made recommendations about the emergency response following some of our previous investigations into deaths at Garth.

Key Events

27. On 26 September 2009, Mr Gareth Brear was remanded into prison custody charged with murder. He was sent to HMP Leeds. In March 2010, he received a life sentence with a tariff of 25 years and 5 months.

28. At his initial health screen, a prison nurse noted that Mr Brear had a history of substance misuse, including heroin, cocaine and alcohol. He also told the nurse that he had had a heart attack in November 2008 and was awaiting a hospital cardiology appointment. However, despite numerous enquiries, the hospital had no record of Mr Brear having been referred to them and a new referral was made. Mr Brear was reviewed by the hospital's cardiac department in May 2010. He was diagnosed with SVT (supraventricular tachycardia, an abnormally fast heartbeat). Hospital staff adjusted Mr Brear's prescription medication and planned further reviews.

29. In June, Mr Brear transferred to HMP Full Sutton. His history of substance misuse and SVT were noted, he was referred to hospital specialists and he was placed under the care of a specialist cardiac clinic at the prison to manage his condition.

30. In November, test results showed that Mr Brear had developed mild to moderate left ventricular impairment (the left ventricle is the chamber of the heart which pumps the blood around the body). He had a cardiac ablation procedure in August 2011 to help restore his normal heart rhythm. His condition improved and in November 2011, he was discharged from hospital cardiac care but remained under regular review by prison healthcare staff.

31. In March 2015, Mr Brear transferred to HMP Wakefield. His cardiac history was noted, and he was referred to secondary care providers to ensure the continuity of his care. His care plans were updated, and his care was managed by a specialist cardiac clinic at the prison. In August, Mr Brear saw a prison GP after complaining of chest pain. An ECG was carried out, which showed nothing of note.

32. Mr Brear was also referred to the substance misuse service (SMS) at Wakefield. In June 2018, he tested positive for psychoactive substances PS). He was also suspected of displaying drug-seeking behaviour when he attempted to get a prescription for medication for ADHD (Attention Deficit Hyperactivity Disorder), a condition he did not have. He also requested medication to support him to detox from codeine, although a blood test showed that he had no codeine in his system at the time.

HMP Garth

33. In September 2018, Mr Brear transferred to HMP Garth.

34. A nurse carried out an initial health screen. Mr Brear said that he had not taken any drugs recently, but he did feel that he still had a problem with drugs. He was therefore referred to the SMS when he arrived at HMP Garth. He initially agreed to engage with them but subsequently said he did not feel he needed any help from the SMS.

35. The nurse also noted Mr Brear's ongoing cardiac concerns. Mr Brear was referred to specialist clinics at the prison, and his care plans were reviewed and updated. In November, Mr Brear underwent a routine review by the prison's specialist cardiac care clinic. He continued to have regular ECGs and blood tests to monitor his condition.

36. In October, Mr Brear was seen by a prison GP after he reported severe headaches. He was diagnosed with migraine and prescribed 30/500mg co-codamol (opioid based pain relief).

37. In January 2019, Mr Brear told a prison GP that his current prescription for co-codamol was not effective for his migraines. The GP increased the volume of Mr Brear's prescription for co-codamol, to be held in-possession, and made a referral to a hospital neurology department.

38. In August, during a routine check, Mr Brear was unable to account for 48 co-codamol tablets that he should have had in his possession. As a result, a prison GP suspended Mr Brear's medication and later prescribed him an alternative (etoricoxib). Mr Brear was angry and unhappy about this and said he only wanted opioids.

39. In December 2019, Mr Brear told a prison GP that etoricoxib was not as effective as co-codamol. The GP agreed to re-prescribe him a reduced dosage of 15/500mg of co-codamol. The GP also told Mr Brear that he was on a final warning in relation to the medication audits and that if he did not comply his medication would be stopped.

40. In February 2020, a prison GP saw Mr Brear to discuss adjustments to his pain relief medication. Mr Brear did not agree with the GP's suggested increase to his prescription from 15/500mg of co-codamol to 30/500mg. He told the GP he felt his current level of medication was effective. However, Mr Brear's medication was increased against his wishes.

41. In July, Mr Brear's prescription for co-codamol was not available to him over a weekend as a repeat prescription had not been agreed by a GP. Mr Brear told staff he was being forced to suffer withdrawal symptoms and he threatened to self-harm. However, following discussion with healthcare staff, Mr Brear agreed to wait, and he received his co-codamol on the Monday morning.

42. Later that month, Mr Brear asked a prison GP if he could be prescribed just codeine, but the GP told him that the combination of codeine and paracetamol would be better for him.

43. In August, Mr Brear was assessed by the SMS for a role as a Recovery Peer (where someone who has been on a drug recovery journey is employed to support others with their journeys). He said that he was enjoying being drug free. He was subsequently seen for a one to one 'check in' once a fortnight to discuss any concerns he might have about his health and wellbeing. In October, he was accepted as a Recovery Peer and said he was optimistic about his future with a treatment goal of abstinence.

Events of 29 December

44. A routine roll check (count) of prisoners was carried out at about 5.30am on 29 December, and the night officer said he saw nothing unusual.

45. At 08.30am, Officer A carried out welfare checks on the landing where Mr Brear lived. He said that when he looked into Mr Brear's cell, he saw Mr Brear sitting upright on his bed, with his back against the wall and his feet flat on the floor. Given his position, the officer said he assumed Mr Brear was alive and well, so he did not attempt to gain a verbal response from him. He signed a document in the wing office to indicate that he had carried out the welfare checks.

46. At about 8.55am, Officer B went to Mr Brear's cell to give him a fresh set of work clothes. In her police statement she said looked through the observation panel of his cell door and saw that he was sitting upright on his bed. She walked into the cell and realised that he had no clothes on from the waist down. She immediately left the cell. She called his name through the open door, but he did not respond. She said she was concerned for Mr Brear's wellbeing and therefore asked Officer C who was nearby to check on him.

47. At 9.00am, Officer C entered the cell and called Mr Brear's name, but he did not respond. He touched his arm and noted it was cold to the touch and he could not feel a pulse. He immediately radioed a medical emergency code blue to summon help. An ambulance was called immediately.

48. A nurse, who was already nearby, responded immediately. She checked Mr Brear for signs of life but found none. She noted evidence of blood pooling indicating that Mr Brear had been dead for some time and therefore decided it would not be appropriate to attempt CPR.

49. Paramedics arrived at the cell at 9.10am and immediately confirmed that Mr Brear had died.

Contact with Mr Brear's family

50. At 10.00am, the prison appointed a family liaison officer (FLO).

51. She telephoned Mr Brear's ex-partner, who he had listed as his next of kin, and informed her of Mr Brear's death. She explained that ordinarily she would have attended her address in person to break the news, but due to the COVID-19 restrictions, she was unable to do so. She offered her condolences and support.

52. The FLO remained in contact with Mr Brear's next of kin until his funeral which was held on 22 January. The prison contributed to the funeral costs in line with national instructions.

Support for prisoners and staff

53. The prison posted notices informing other prisoners of Mr Brear'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 his death.

54. After Mr Brear's death, the staff involved in the incident were given the opportunity to discuss any issues arising, and they were also offered support by the staff care team.

Post-mortem report

55. The pathologist gave Mr Brear's cause of death as left ventricular hypertrophy (a thickening of the wall of the heart's main pumping chamber).

56. Toxicology tests found that Mr Brear had taken pregabalin shortly before his death (although not enough to contribute to his death). Pregabalin is prescribed for epilepsy, anxiety and nerve pain and can be abused for its euphoric effects. Mr Brear was not prescribed pregabalin.

Findings

Clinical care

57. The clinical reviewer concluded that the care Mr Brear received at Garth was of a reasonable standard and was, in the main, at least equivalent to that which he could have expected to receive in the community.

58. She noted that a care plan was in place for Mr Brear's historical heart complaint and that he was seen and reviewed in accordance with this care plan. She noted, however, that Mr Brear's last cardiac review had taken place in March 2019 and he had not had an annual review in 2020.

59. The clinical reviewer found that Mr Brear was well supported by the substance misuse team and mental health team. She also noted that in previous prisons, he had on occasion chosen not to fully engage with healthcare staff. However, the clinical reviewer considered that good efforts were made by healthcare staff at Garth which encouraged Mr Brear to engage with them.

60. The clinical reviewer did, however, identify some shortcomings in Mr Brear's care.

In possession medication risk assessments and review

61. Mr Brear had a history of substance misuse and apparent drug-seeking behaviour. Against that background, the clinical reviewer was not satisfied that the prescription of Mr Brear's medication was always appropriately assessed or managed at Garth.

62. She was concerned that when a prison GP increased the volume of Mr Brear's prescription for co-codamol in January 2019, and when another GP re-prescribed him a reduced dosage of 15/500mg of co-codamol in December 2019, neither updated Mr Brear's medication in possession risk assessment (MIPRA) to reflect the change, as they should have done.

63. She was also concerned that the GP increased Mr Brear's co-codamol dosage to 30/500mg in February 2020, against his wishes and that Mr Brear's reasons for wanting his medication to remain unchanged were not fully discussed with him.

64. The clinical reviewer also said that when Mr Brear asked for a codeine only prescription in July 2020, she would have expected the GP to have found his request suspicious and to have explored Mr Brear's reasons with him.

65. We make the following recommendations:

The Head of Healthcare should ensure that GPs complete a Medication in Possession Risk Assessment (MIPRA) when prescribing medication, in line with *Safer Prescribing in Prisons: Guidance for clinicians* – January 2019 (update).

The Head of Healthcare should ensure that when a patient makes a specific request for a change of medication, particularly when the patient has a known drug dependency, the reason for this request should be fully

explored with the patient and the detail of this discussion recorded in his medical records.

In discussion with GP services, the Head of Healthcare should ensure that medication reviews for pain relief prescriptions include discussion of wider treatment plans (including advice on physical activity or physiotherapy, sleep and support in achieving improvements in mental health and quality of life), in line with *the Safer Prescribing in Prisons* guidance.

Availability of prescribed medications

66. When Mr Brear's prescription for co-codamol was not available over a weekend in July 2020, Mr Brear said he was suffering withdrawal effects and threatened to self-harm. The clinical reviewer was concerned that, although Mr Brear did not harm himself, other prisoners might in these circumstances. We recommend:

The Head of Healthcare should ensure that out of hours stock of medication is available and that there is appropriate medication available to prisoners if required over the weekend.

Other matters

67. The clinical reviewer also made recommendations about reception screening and record keeping which we do not repeat here but which the Head of Healthcare will need to address.

Welfare checks

68. Prison Service Instruction (PSI) 75/2011, *Residential Services*, says:

> "Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight, apparently from natural causes, 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 wellbeing of prisoners during or shortly after unlock. For example, if a prisoner is expected to leave their cell for an activity shortly after being unlocked, then it will be sufficient for there to be a check on any prisoner who does not do so. 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."

69. When Officer A carried out the welfare check on the morning of 29 December, he said he did not try to get a verbal response when he saw Mr Brear sitting on his bed because he assumed he was alive. However, it is clear that Mr Brear was dead when Officer A checked on him.

70. This illustrates the importance of staff following PSI 75/2011 and obtaining a response from prisoners when they conduct welfare checks. In this case it is clear that Mr Brear had been dead for some time and Officer A's failure to check him properly therefore made no difference to the outcome. However, in other circumstances such a failure could be critical.

71. The Head of Safer Prisons at Garth told us that she had spoken to Officer A after Mr Brear's death and given him advice and guidance. She said she thought this was an appropriate action given the position Mr Brear was in when Officer A carried out his check.

72. She also told us that, following Mr Brear's death, the prison had issued a revised Staff Information Notice (SIN 21.06) reminding staff that they must have full sight of each prisoner and obtain a verbal response when they carry out welfare checks.

73. We are satisfied that the prison has taken appropriate action and we have not, therefore, made any recommendations.

Emergency response

74. When Officer B entered Mr Brear's cell at 8.55am she found him semi-naked and unresponsive. She asked Officer C to check on him because she was concerned about him and he entered the cell and immediately realised Mr Brear was dead and called a medical emergency code at 9.00am.

75. We understand that Officer B did not want to enter the cell again for decency reasons, but we consider that she should have called the code blue herself when she could not get a response from Mr Brear. Instead there was a delay of around five minutes. This made no difference to the outcome for Mr Brear as he had been dead for some time, but it could make a critical difference in other circumstances. We recommend:

The Governor should share this report with Officer B and arrange for a senior manager to discuss the Ombudsman's findings with her.

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