Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Keith Fairbrother, a prisoner at HMP Wakefield, on 4 June 2022

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

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 Keith Fairbrother died of a coronary artery thrombosis (blood clot in the heart) on 4 June 2022 at HMP Wakefield. He was 59 years old. I offer my condolences to Mr Fairbrother's family and friends.

Mr Fairbrother had been in prison for less than two months, and at Wakefield for only ten days when he died. He arrived with several pre-existing conditions, including high blood pressure.

On the morning of 3 June, Mr Fairbrother complained of chest pain and a nurse diagnosed acid reflux. When a nurse reviewed Mr Fairbrother on the morning of 4 June, he said he still had chest pain. The nurse found his clinical observations were normal. A few hours later, staff found Mr Fairbrother unresponsive in his bed. Staff and paramedics tried to resuscitate him but were unsuccessful.

The clinical reviewer found that the care Mr Fairbrother received at Wakefield was not equivalent to that which he could have expected to receive in the community.

The clinical reviewer found that on both occasions when Mr Fairbrother complained of chest pain, healthcare staff failed to carry out a full clinical assessment. They also failed to carry out an ECG (a test to check the heart's rhythm). The clinical reviewer was concerned that these were missed opportunities to assess the reasons for Mr Fairbrother's chest pain.

The clinical reviewer also found that Mr Fairbrother's reception screen was not carried out properly, that he was not referred for blood pressure monitoring and appropriate care plans were not put in place. His repeat medications were also not continued at Wakefield.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **April 2023**

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Summary

Events

1. On 6 April 2022, Mr Keith Fairbrother was remanded in prison custody, charged with sexual offences. He was subsequently sentenced to 17 years imprisonment and was moved to HMP Wakefield on 26 May.

2. Mr Fairbrother had several long-term health conditions, including high blood pressure.

3. On 3 June, at around 4.30am, a nurse saw Mr Fairbrother as he was complaining of chest pain and vomiting. The nurse took Mr Fairbrother's clinical observations, which were normal. The nurse thought the symptoms were due to acid reflux as Mr Fairbrother had not taken his medication.

4. A nurse saw Mr Fairbrother in his cell on the morning of 4 June. He said he still had chest pain. The nurse was unable to take his blood pressure as the equipment was not working so she said she would do it later. She took his other clinical observations which were normal, apart from a slightly fast breathing rate.

5. At 12.15pm, while conducting the lunchtime roll check (a count of prisoners), an officer realised that Mr Fairbrother was unresponsive in his bed. She did not have a radio and so called to another officer to call a medical emergency code blue. She too did not have a radio so called to a third officer who was also on the wing and called the code blue at 12.16pm.

6. Officers started CPR and healthcare staff provided support when they arrived a few minutes later.

7. At 12.30pm, paramedics arrived and took over CPR. They were unsuccessful in resuscitating Mr Fairbrother and declared his death at 12.44pm.

8. The post-mortem report concluded that Mr Fairbrother died of coronary artery thrombosis (a blood clot in an artery in the heart).

Findings

9. The clinical reviewer found that the care Mr Fairbrother received at Wakefield was not equivalent to that which he could have expected to receive in the community.

10. The clinical reviewer found that Mr Fairbrother's reception health screen was not completed properly, he was not referred for blood pressure monitoring and no second health screen was completed. Also, he was not prescribed his repeat medication.

11. The clinical reviewer also found that nurses did not carry out a full clinical assessment when Mr Fairbrother complained of chest pain or carry out an ECG (to check the heart's rhythm). She was also concerned that nurses gave Mr Fairbrother adrenaline during the emergency response which was not appropriate.

Recommendations

- The Head of Healthcare should ensure that staff carrying out reception health screens:
    - Complete the screening template in full so that all relevant information, such as medication and mobility issues, are recorded.
    - Refer prisoners to the clinic for long-term conditions where appropriate.
    - Arrange follow up appointments, if necessary, for example, where there is a high blood pressure reading.
- The Head of Healthcare should ensure that all clinical staff are trained and competent in managing GP2GP degraded entries to support with continuity of care.
- The Head of Healthcare should ensure that care plans are initiated, reviewed and updated for any active medical or mobility issue.
- The Head of Healthcare should ensure that staff carry out a full clinical assessment of a prisoner with chest pain, in line with National Institute for Health and Care Excellence (NICE) guidance CG95 on recent-onset chest pain of suspected cardiac origin.
- The Head of Healthcare should ensure that all clinical staff are aware of their responsibilities in managing medical devices and the escalation processes in place when equipment is faulty or not available.
- The Head of Healthcare should review the events that led to the incorrect administration of adrenaline during the emergency response and consider whether additional training is needed.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Wakefield informing them of the investigation and asking anyone with relevant information to contact her. One person responded.

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

14. NHS England commissioned a clinical reviewer to review Mr Fairbrother's clinical care at the prison.

15. We informed HM Coroner for Wakefield of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Fairbrother's son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not raise any issues but asked for a copy of our report.

17. We shared our initial report with HM Prison and Probation Service (HMPPS). They did not find any factual inaccuracies.

18. We sent a copy of our initial report to Mr Fairbrother's son. He did not identify any factual inaccuracies.

Background Information

HMP Wakefield

19. HMP Wakefield is a high security prison and holds up to 750 men. Practice Plus Group provides healthcare. Service provision for psychiatry, recovery and psychology services are contracted from the Midlands Partnership Foundation Trust.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Wakefield was in June 2018. Inspectors found that clinical governance had improved since the last inspection and prisoner consultation at a monthly patient forum influenced service improvement. They noted that access to healthcare services was good and staffing levels were reasonable to support primary care, although there had been some delays with social care assessments.

Independent Monitoring Board

21. 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 30 April 2021, the IMB reported their concerns that the Governor's ability to influence healthcare delivery was constrained by the outsourcing of healthcare provision to an external contractor, and that as a result, some prisoners do not experience an equivalent level of care to that which might reasonably be expected in the community.

Previous deaths at HMP Wakefield

22. Mr Fairbrother was the seventeenth prisoner at Wakefield to die since June 2020. Of the previous deaths, three were self-inflicted, and the rest were from natural causes. We have previously made a recommendation to Wakefield about the initiation of care plans.

Key Events

23. On 6 April 2022, Mr Keith Fairbrother was remanded in prison custody, charged with sexual offences, and sent to HMP Lewes. On 9 May, he was sentenced to 17 years imprisonment. He was moved to HMP Wakefield on 26 May.

24. Mr Fairbrother had several long-term health conditions, including asthma, deep venous thrombosis (a condition in which blood clots form in veins located deep inside the body) and hypertension (high blood pressure). He also had poor mobility due to an osteoporotic vertebral fracture (which occurs when the small bones in the spine weaken due to a fall or trauma), and which caused him chronic back pain.

25. At around 4.30am on 3 June, Mr Fairbrother told staff he had chest pain and was vomiting. Prison officers asked healthcare staff to see him. A nurse took Mr Fairbrother's clinical observations, which were all normal. The nurse concluded that Mr Fairbrother's symptoms were due to acid reflux as he had not taken his medication (lansoprazole, used to reduce stomach acid).

26. At around midday, an advanced nurse practitioner was asked to review Mr Fairbrother as his repeat medication had not been prescribed. He recorded that he was unable to prescribe the medication on repeat due to '168 GP2GP degraded entries' on his medical record. (GP2GP is a new Government Information Technology system that allows GP records to be transferred to other GP practices, allowing for better continuity of care for prisoners when they arrive and leave prison. Degraded entries are old entries that have been transferred. They require immediate attention to promote continuity of care.) He noted that he would resolve the issue on Monday 6 June.

27. On the morning of 4 June, a nurse saw Mr Fairbrother in his cell for a welfare review. He said he still had chest pain. She recorded that she was unable to take a blood pressure reading 'due to equipment' so would do it later. She took his other clinical observations which were all normal, except for a slightly fast breathing rate.

28. At 12.15pm, while conducting the lunchtime roll check (a count of prisoners), an officer noticed that Mr Fairbrother was on his bed, with his head slightly to the left and with his eyes opened. She opened the cell door and shouted Mr Fairbrother's name and shook his leg, but he did not respond. In her statement, she said Mr Fairbrother appeared grey and that she could not see any movement in his chest. She did not have a radio, so she called to another officer, who was locking up the opposite side of the landing and asked her to call a medical emergency code blue.

29. The other officer also did not have a radio, so she called to a third officer, who called the code blue at 12.16pm, while making her way to Mr Fairbrother's cell. Two officers started CPR on Mr Fairbrother. Healthcare staff arrived at Mr Fairbrother's cell and supported the officers giving CPR. They also administered adrenaline.

30. At 12.30pm, paramedics arrived and took over CPR, but they were unsuccessful in resuscitating Mr Fairbrother and declared his death at 12.44pm.

Contact with Mr Fairbrother's family

31. A prison manager identified that Mr Fairbrother's next of kin, his son, lived too far from HMP Wakefield for one of the Wakefield family liaison officers to visit him.

32. The manager sought assistance from prisons closer to Mr Fairbrother's next of kin. HMP East Sutton Park agreed to inform Mr Fairbrother's next of kin, which they did later that day.

Support for prisoners and staff

33. After Mr Fairbrother's death, a prison 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.

Post-mortem report

34. The post-mortem report concluded that Mr Fairbrother died of right coronary artery thrombosis (a blood clot in an artery in the heart) as a result of right coronary artery atherosclerosis (when fats, cholesterols and other substances collect on the inner walls of the heart arteries). The post-mortem also showed that hypertension (high blood pressure) and hyperlipidaemia (abnormally high levels of fats in the blood) contributed to but did not cause Mr Fairbrother's death.

Findings

Clinical care

35. The clinical reviewer found that the care Mr Fairbrother received at HMP Wakefield was not equivalent to that which he could have expected to receive in the community.

Reception health screen

36. We had a number of concerns about Mr Fairbrother's reception screen. The reception nurse failed to record whether Mr Fairbrother had arrived with seven days of his prescribed medication (it was later confirmed that he had) and failed to record his mobility issues. Also, we are concerned that although the blood pressure reading taken at Mr Fairbrother's reception screen was high, no appointment was made to check it again. However, we recognise that the clinical reviewer noted that when Mr Fairbrother's blood pressure was taken again on 3 June, it was within normal range. We are also concerned that Mr Fairbrother was also not referred to the clinic for long-term conditions for monitoring of his asthma and hypertension.

37. We recommend:

The Head of Healthcare should ensure that staff carrying out reception health screens:

- **Complete the screening template in full so that all relevant information, such as medication and mobility issues, are recorded;**
- **Refer prisoners to the clinic for long term conditions where appropriate.**
- **Arrange follow up appointments, if necessary, for example, where there is a high blood pressure reading.**

Medication

38. Mr Fairbrother's repeat medications were not continued at Wakefield. When an advanced nurse practitioner was asked to review Mr Fairbrother on Thursday 3 June, he noted that he was unable to prescribe his repeat medication due to '168 GP2GP degraded entries' on his medical record. The nurse noted that he would resolve the issue on Monday 6 June.

39. The clinical reviewer was concerned that the 'degraded entries' in Mr Fairbrother's medical record were not corrected immediately, which caused further delay in Mr Fairbrother being prescribed his regular medication. We recommend:

The Head of Healthcare should ensure that all clinical staff are trained and competent in managing GP2GP degraded entries to support with continuity of care.

Care plans

40. The clinical reviewer was concerned that Mr Fairbrother did not have any care plans for his active clinical problems, including his hypertension, and mobility issues. We recommend:

    The Head of Healthcare should ensure that care plans are initiated, reviewed and updated for any active medical or mobility issue.

Assessing Mr Fairbrother's chest pain

41. The clinical reviewer considered that there were two occasions when healthcare staff did not fully assess Mr Fairbrother's complaints of chest pain. The first was on 3 June at around 4.30am when healthcare staff were called to Mr Fairbrother's cell. The nurse who responded diagnosed acid reflux but did not carry out a detailed clinical assessment as he should have done, including a description of the pain, whether it radiated to other parts of the body and how long Mr Fairbrother had had the pain. He also did not carry out an ECG (a test to check the heart's rhythm).

42. Again, on the morning of 4 June, a nurse did not properly assess Mr Fairbrother's chest pain or carry out an ECG as she should have done. She also noted that she could not take a blood pressure reading 'due to equipment'. We make the following recommendations:

    The Head of Healthcare should ensure that staff carry out a full clinical assessment of a prisoner with chest pain, in line with NICE guidance CG95 on recent-onset chest pain of suspected cardiac origin.

    The Head of Healthcare should ensure that all clinical staff are aware of their responsibilities in managing medical devices and the escalation processes in place when equipment is faulty or not available.

Emergency response

43. The clinical reviewer was concerned that prison healthcare staff administered adrenaline before the paramedics arrived. The clinical reviewer found that at Wakefield, adrenaline can only be given when the patient is in acute anaphylaxis (an immune system response where blood pressure drops suddenly and the airways narrow, blocking breathing). Mr Fairbrother was not in acute anaphylaxis and therefore the use of adrenaline was inappropriate. We recommend:

    The Head of Healthcare should review the events that led to the incorrect administration of adrenaline during the emergency response and consider whether additional training is needed.

Inquest

44. The inquest, heard on 22 to 23 February 2023, concluded that Mr Fairbrother died from natural causes.

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