Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Harold Rushton, a prisoner at HMP Stafford, on 20 December 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

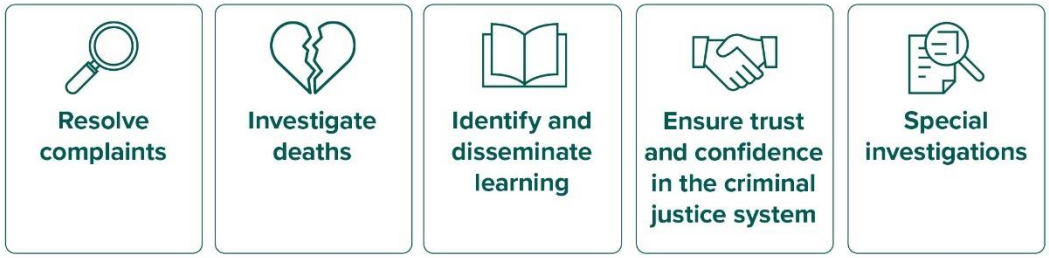
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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

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. 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.

3. In March 2019, Mr Harold Rushton was sentenced to 16 years in prison for rape. He died of cardiorespiratory failure on 20 December 2024, at HMP Stafford. He was 76 years old. We offer our condolences to Mr Rushton's family and friends.

4. The Ombudsman's office wrote to Mr Rushton's next of kin to explain the investigation and to ask if they had any matters, they wanted us to consider. Mr Rushton's next of kin did not ask any questions but asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer, to review Mr Rushton's clinical care at Stafford.

6. The clinical reviewer concluded that the clinical care Mr Rushton received at Stafford was of a good standard and equivalent to what he could have expected to receive in the community. She found that the healthcare team supported and cared for Mr Rushton very well. He was appropriately monitored and treated for his health conditions as his health naturally declined over the years. The clinical reviewer made recommendations not related to Mr Rushton's death that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Rushton's care. We make no recommendations.

Governor and Head of Healthcare to note

8. Staff initiated CPR on Mr Rushton due to uncertainty about whether a DNACPR order was in place for him. Once it was confirmed that he had an active DNACPR, resuscitation efforts were ceased immediately. During the immediate debrief, the Duty Governor suggested that DNACPR documentation should be more readily accessible, proposing that a copy be kept in the prisoner's cell.

9. The Safer Custody Manager reported that the DNACPR process was discussed in detail at the Prevention of Future Deaths meeting. While the idea of storing a copy of the DNACPR in the prisoner's cell was considered, it was ultimately rejected. Concerns were raised about confidentiality in shared cells and the impracticality of accessing documents stored in locked cupboards in the cell during emergencies.

10. The Head of Healthcare at Stafford informed us that the communication process around DNACPRs was also discussed. It was agreed that the prison would retain its existing pathway and remind staff of the procedures. Following Mr Rushton's death, a notice was issued to staff, reminding them where to access the list of prisoners with active DNACPR orders.

11. Given that the existing process has been retained, despite its failure in Mr Rushton's case, the Governor may wish to assure himself that the current system is fit for purpose. It is important that both prison and clinical staff are aware of which prisoners have DNACPR orders and can access this information promptly in an emergency.

12. Mr Rushton's family received a copy of the initial report. They did not make any comments.

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

14. Practice Plus Group also pointed out some factual inaccuracies with the clinical review. The investigator passed these onto the clinical reviewer who amended their report.

Adrian Usher **August 2025**
Prison and Probation Ombudsman

Inquest

At the inquest held on the 11 December 2025, the coroner concluded Mr Rushton died of natural causes.

Prisons & Probation Ombudsman
Independent Investigations

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