Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Hartshorne, a prisoner at HMP Stafford, on 14 February 2023

A report by the Prisons and Probation Ombudsman

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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

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.

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.

Mr John Hartshorne died in hospital from a brain stem stroke on 14 February 2023, while he was a prisoner at HMP Stafford. He was 74 years old. I offer my condolences to Mr Hartshorne's family and friends.

The clinical reviewer concluded that the healthcare Mr Hartshorne received at Stafford was of a good standard and was equivalent to that which he could have expected to receive in the community. However, she highlighted some issues which the Head of Healthcare will need to address.

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

Adrian Usher
Prisons and Probation Ombudsman **September 2023**

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Summary

Events

1. On 6 May 2022, Mr John Hartshorne was convicted of sexual offences and sentenced to 30 months imprisonment. On 19 May, he was moved to HMP Stafford.

2. Mr Hartshorne had several health conditions including bradycardia (slow pulse) and hypotension (low blood pressure). He was also obese. At a health check in August, a nurse carried out a QRisk assessment which showed that Mr Hartshorne had a high risk (over 20% chance) of a heart or circulation problem within the next ten years.

3. On 9 January 2023, Mr Hartshorne said he felt unwell with abdominal pain. A nurse took his clinical observations and undertook an electrocardiogram (ECG, a test to check the heart's rhythm) as she was concerned about Mr Hartshorne's slow pulse. A GP reviewed the result the next day and assessed that Mr Hartshorne needed a heart scan. He referred Mr Hartshorne to a cardiologist (heart specialist) at the hospital.

4. On 12 January, a GP recorded that Mr Hartshorne's QRisk score had increased to over 25%. The GP noted that Mr Hartshorne had already been referred to a cardiologist.

5. During January, Healthcare Champions (prisoners trained to carry out basic clinical tasks) recorded pulse and blood pressure readings for Mr Hartshorne. A nurse then transferred these readings to Mr Hartshorne's medical record.

6. At 12.55am on 1 February, Mr Hartshorne's cellmate found him collapsed on the floor of their cell. He pressed his emergency cell bell to alert staff. An Operational Support Grade (OSG) responded and when she saw Mr Hartshorne on the floor, she called a medical emergency code. A nurse and healthcare assistant arrived within a few minutes and noted that Mr Hartshorne was unresponsive but breathing.

7. At 2.10am, an ambulance arrived at Stafford. Around 20 minutes later, paramedics took Mr Hartshorne to hospital.

8. A hospital doctor assessed that Mr Hartshorne had a blood clot on his brain, so he was taken into surgery to have this removed. After his surgery, he was moved to the Intensive Therapy Unit (ITU) and he was put on a ventilator to help him breathe.

9. Over the next two weeks, Mr Hartshorne's health deteriorated, and he was unable to breathe without the support of a ventilator.

10. On 14 February at approximately 12.30pm, Mr Hartshorne died after his life support was withdrawn.

11. A hospital doctor recorded Mr Hartshorne's cause of death as a brain stem stroke. The doctor listed atrial fibrillation (a condition that causes an irregular and often fast heartbeat) as a contributing factor.

Findings

12. The clinical reviewer found that the care Mr Hartshorne received at Stafford was of a good standard and was equivalent to that which he could have expected to receive in the community. However, she identified that there was no nursing care plan in place for the management of Mr Hartshorne's bradycardia and hypotension.

Recommendations

- The Head of Healthcare should ensure that all patients with long term conditions have evidence of an appropriate nursing care plan within their medical record.

The Investigation Process

13. HMPPS notified us of Mr Hartshorne's death on 14 February 2023.

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

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

16. NHS England commissioned an independent clinical reviewer to review Mr Hartshorne's clinical care at the prison. The investigator and clinical reviewer interviewed two members of healthcare staff at Stafford on 13 April 2023.

17. We informed HM Coroner for Staffordshire of the investigation. We have sent the Coroner a copy of this report.

18. The Ombudsman's family liaison officer contacted Mr Hartshorne's son to explain the investigation and to ask if he had any matters he wanted us to consider. He asked whether prison protocols were followed when Mr Hartshorne collapsed and about the clinical care Mr Hartshorne received at Stafford. These issues have been addressed in our report and in the clinical review. Mr Hartshorne's son also asked questions which were outside the remit of our investigation which have been addressed in a separate letter.

19. Mr Hartshorne's son received a copy of the draft report. He raised three questions that do not impact on the factual accuracy of this report which have been addressed through separate correspondence.

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

Background Information

HMP Stafford

21. HMP Stafford is a category C training prison for prisoners convicted of sexual offences. It holds 751 male prisoners. The physical health care provider is Care UK Health and Rehabilitation Services Ltd.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Stafford was in January 2020. Inspectors reported that waiting times for most healthcare clinics were short and there was a clear application system, with nursing staff triaging potentially urgent issues. Patients with long-term conditions were managed well by a practice nurse and the GP. Reviews of these conditions were reliably scheduled, and care plans were in place. Additional health checks relating to long-term conditions were carried out as required. Inspectors also found arrangements within the prison to provide a rapid response to medical emergencies were sound and resuscitation equipment was checked and maintained regularly. They found that prison and health services staff were clear about how to obtain ambulance support if required, although not all prison staff knew the location of the defibrillators.

Independent Monitoring Board

23. 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 ending 30 April 2022, the IMB reported that the quality of care delivered by the patient-facing staff was often praised and certainly on par with what could be expected in the community.

Previous deaths at HMP Stafford

24. Mr Hartshorne was the twenty-fourth prisoner to die at Stafford since February 2020. Of the previous deaths, 21 were from natural causes and two were self-inflicted. We have previously made recommendations about the use of NEWS2 and about calling an ambulance immediately when a medical emergency code is used.

Key Events

25. On 6 May 2022, Mr John Hartshorne was convicted of sexual offences and sentenced to 30 months imprisonment. On 19 May, he was moved to HMP Stafford.

26. Mr Hartshorne had a number of health conditions, including bradycardia (slow pulse) and hypotension (low blood pressure). He was prescribed appropriate medication for his health conditions.

27. On 9 August, a nurse undertook a health check review with Mr Hartshorne. The nurse recorded that his Body Mass Index (BMI) was 30.08kg/m^2, which put him in the obese range. The nurse also took his blood pressure and completed a QRISK2 assessment. (A QRISK2 assessment identifies potential risk of cardiovascular (heart and blood vessel) related diseases.) Mr Hartshorne's QRisk score was 21.71%, which meant that he was at high risk of having a heart or circulation problem in the next ten years (more than a 20% chance).

28. On 9 January 2023, a nurse saw Mr Hartshorne after he said he was feeling unwell with abdominal pain. She took his clinical observations but there is no record that she calculated a NEWS2 score. (National Early Warning Score (NEWS2) is a clinical tool used to assess clinical deterioration in adult patients.) Mr Hartshorne's pulse was slow and his respiratory rate slightly fast. She carried out an electrocardiogram (ECG, a test to check the heart's rhythm). Mr Hartshorne said he was feeling a bit better after taking an indigestion tablet. He reported no chest pain or dizziness.

29. The next day, a GP at Stafford reviewed Mr Hartshorne's ECG test result. He found that Mr Hartshorne's heart rhythm was bradycardic (slow) and assessed that he needed a heart scan. The GP referred Mr Hartshorne to a cardiologist (a heart and blood vessel specialist) at a local hospital.

30. On 12 January, a GP recorded that Mr Hartshorne's QRisk score had increased to over 25%. He noted that Mr Hartshorne had already been referred to a cardiologist.

31. Over the next few weeks, the prison's Healthcare Champions (prisoners trained to undertake basic clinical tasks) took Mr Hartshorne's observations regularly. This included his blood pressure and pulse. They recorded the readings and then a nurse entered them onto Mr Hartshorne's electronic medical record several days later.

32. On 31 January, a nurse reviewed the clinical observations that had been taken by the Healthcare Champions. She noted that Mr Hartshorne had low blood pressure, so she asked for him to be seen by the GP for further blood pressure tests.

Events of 1 February 2023

33. At 12.55am on 1 February, Mr Hartshorne's cellmate found Mr Hartshorne collapsed on the floor of their cell. He said that he tried to wake Mr Hartshorne, but he could not get a response. He pressed his emergency cell bell to alert staff.

34. At 12.56am, an Operational Support Grade (OSG) answered the cell bell. She saw Mr Hartshorne lying unresponsive on the cell floor, so she called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Approximately three minutes later, a nurse and a healthcare assistant attended Mr Hartshorne's cell. The nurse monitored Mr Hartshorne and took clinical observations while they waited for paramedics to arrive.

35. At 1.02am, an OSG rang the emergency services. The call handler asked her if the patient was breathing, but she did not know, as she had not been given any information on his condition.

36. At 2.10am, an ambulance arrived at Stafford. Paramedics attended Mr Hartshorne's cell and took over his treatment. Around 20 minutes later, the ambulance left Stafford and took Mr Hartshorne to a local hospital.

37. A hospital doctor diagnosed a blood clot on the brain and Mr Hartshorne was taken into surgery to have this removed. After his surgery, he was moved to the Intensive Therapy Unit (ITU), and he was put on a ventilator to help him breathe.

38. Over the next two weeks, Mr Hartshorne's health deteriorated, and he was unable to breathe without the support of a ventilator. On 14 February, at approximately 12.30pm, Mr Hartshorne died after his life support was withdrawn.

Contact with Mr Hartshorne's family

39. A prison manager contacted Mr Hartshorne's family on 1 February to let them know that he had been taken to hospital. On the day of Mr Hartshorne's death, the prison appointed a family liaison officer (FLO). The same day, the FLO went to the hospital to introduce herself to Mr Hartshorne's family, explain her role, and offer support. She remained in contact with the family to ensure their questions were answered and that Mr Hartshorne's belongings were returned to them.

Support for prisoners and staff

40. After Mr Hartshorne's death, a prison manager debriefed the staff who were present at the hospital at the time of Mr Hartshorne's death to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

41. The prison posted notices informing other prisoners of Mr Hartshorne's death and offering support.

Post-mortem report

42. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The hospital doctor recorded Mr Hartshorne's cause of death as basilar artery thrombus (brain stem stroke). Atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate) was listed as a contributing factor.

Findings

Clinical care

43. The clinical reviewer found that the care Mr Hartshorne received at Stafford was of a good standard and was equivalent to that which he could have expected to receive in the community. However, she identified some issues.

44. The clinical reviewer found that when a nurse identified Mr Hartshorne as having bradycardia and hypotension, she took appropriate action to assess, monitor and ensure that he was referred to a cardiologist. However, there was no nursing care plan in place for the management of Mr Hartshorne's hypotension or bradycardia. We recommend:

    The Head of Healthcare should ensure that all patients with long term conditions have an appropriate nursing care plan within their healthcare record.

Head of Healthcare to note

45. The clinical reviewer found that Mr Hartshorne's hypotension and bradycardia were monitored by Healthcare Champions. Although the readings were reported back to qualified nurses, the clinical reviewer found that there was a delay in the recording of these results into Mr Hartshorne's medical record. At interview the Head of Healthcare said that this concern had already been noted and was being addressed by the healthcare team.

46. The clinical reviewer found that the Healthcare Champions took clinical observations using a battery-operated blood pressure machine, which also recorded a pulse. The clinical reviewer noted that these machines were not suitable for monitoring irregular pulses, for example in those with atrial fibrillation. She noted that this reading should be taken manually by a qualified nurse who could correctly identify irregularity in a pulse. The clinical reviewer also found that there was no record of a physical review of the Healthcare Champion's assessment by a qualified nurse. These are issues that the Head of Healthcare will need to consider.

47. The clinical reviewer found that when Mr Hartshorne became unwell on 9 January 2023, the nurse who assessed him did not record a NEWS2 score. Inconsistent use of NEWS2 by staff at Stafford is an issue that we have raised before. In May, we were told that NEWS2 training was due to be delivered to healthcare staff by the end of August 2023. The Head of Healthcare may wish to consider spot checks in the meantime to ensure that NEWS2 is being used consistently.

Governor to note

Emergency response

48. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, says that when a code blue is called, the control room should call an ambulance immediately.

49. There was a delay of six minutes between the code being called, and the control room ringing the emergency services. This did not affect the outcome for Mr Hartshorne given that there was an hour wait for the ambulance, but such a delay could be critical in a future medical emergency.

50. Prison Service Instruction (PSI) 03/2013 says that the member of staff using the medical emergency code must also provide relevant information about the condition of the prisoner to the control room staff, so that they can pass it on to the ambulance service for use in the triage process.

51. When the OSG called the code blue, she did not provide sufficient information on Mr Hartshorne's condition to the control room. As a result, the OSG in the control room was unable to answer the emergency services call handler's question "Is the patient breathing?". Although this did not affect the care Mr Hartshorne received, or delay the arrival of the ambulance, we are concerned that if the control room are not given sufficient information about the nature of the emergency and the patient's condition, it could result in the wrong category of ambulance being sent to somebody. The Governor and Head of Healthcare will want to consider how to ensure staff are aware of their responsibilities in a medical emergency.

Inquest

52. At the inquest, held on 29 July 2025, the Coroner concluded that Mr Hartshorne died from natural causes.

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