Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Busfield, a prisoner at HMP Stafford, on 19 January 2021

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 Anthony Busfield died on 19 January 2021 of heart failure at HMP Stafford. He was 84 years old. I offer my condolences to Mr Busfield's family and friends.

Mr Busfield had a number of long-term heart conditions which left him at high risk of sudden death. The clinical reviewer found that, although there were some shortcomings, the standard of healthcare that Mr Busfield received at Stafford was good and at least equivalent to that which he could have expected to receive in the community.

Prion staff responded quickly when Mr Busfield slipped on a residential landing. Healthcare staff were present when he became unconscious and quickly began resuscitation attempts.

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 **October 2021**

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Summary

Events

1. On 5 March 2020, Mr Anthony Busfield was sentenced to ten years in prison for sexual offences. He transferred to HMP Stafford in November 2020.

2. Mr Busfield had a long and complicated medical history of heart conditions and was considered to be at high risk of sudden death. Healthcare staff saw him frequently to monitor his conditions and prescribe his medications.

3. At around 9.00am on 19 January, Mr Busfield slipped on a landing. He told staff he was not injured. They helped him up, contacted healthcare staff and asked them to come and check Mr Busfield. Nurses attended and, as they helped Mr Busfield into his cell, he collapsed. He then lost consciousness. An officer radioed a medical emergency. More nurses and officers arrived to assist.

4. Nurses began resuscitation attempts. Paramedics and an air ambulance doctor arrived and, at 10.17am, they confirmed that Mr Busfield had died.

5. The Coroner gave Mr Busfield's cause of death as heart failure.

Findings

6. The clinical reviewer was satisfied that the care Mr Busfield received at Stafford was equivalent to that which he could have expected to receive in the community.

7. The clinical reviewer did, however, identify some shortcomings in Mr Busfield's care.

8. Mr Busfield suffered from significant heart problems which healthcare staff monitored and ensured he was prescribed appropriate medications. However, on his arrival at Stafford, healthcare staff missed his falls risk assessment which had been completed at his previous prison. Care plans lacked sufficient detail and it was unclear whether Mr Busfield was involved in the care planning process. Also, some entries in his medical record were not clear.

Recommendations

- The Head of Healthcare should ensure that, in line with NICE guidelines and PSO 3050 Continuity of Healthcare for Prisoners, healthcare staff check the previous care given to the prisoner.

- The Head of Healthcare should ensure that prisoners at risk of falling have a regularly reviewed falls risk assessment, in line with NICE guidelines.

- The Head of Healthcare should ensure that care plans are individualised and are completed with the prisoner.

- The Head of Healthcare should ensure that when prisoners refuse to take critical medications (whether continuously or on separate occasions):
    - a senior member of healthcare staff speaks to the prisoner and documents this in the medical record;
    - a medication in-possession risk assessment is carried out and the outcome is recorded in the medical record; and
    - the prisoner's mental capacity is assessed, and the outcome is recorded in the medical record.
- The Head of Healthcare should ensure that all staff understand their professional requirement in record keeping, to make clear, accurate, timely and contemporaneous notes in prisoners' medical records.

The Investigation Process

9. 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.

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

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

12. We informed HM Senior Coroner for Staffordshire South of the investigation. He gave us the cause of death. We have sent the Coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Busfield's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter. However, at the time of Mr Busfield's death, she asked the prison about the circumstances surrounding his death. Her question has been addressed in this report.

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

Background information

HMP Stafford

15. HMP Stafford is a medium security prison in Staffordshire for adult sex offenders. It can hold around 750 prisoners across seven wings. Care UK provides healthcare services. Nurses are on duty daily between 7.30am and 5.30pm and there is a weekday GP service, with on-call doctors outside these hours.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Stafford was conducted in January 2020. Inspectors found the range of primary care services available at the prison was appropriate, and access to nurses and GPs was good. Inspectors considered the care of those patients who had been diagnosed with long-term conditions, was also well managed. Healthcare reviews with such prisoners were reliably scheduled and comprehensive care plans were used to manage their care needs.

Independent Monitoring Board

17. 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.

18. In its report for the year to April 2020, the IMB noted that the health and well-being needs of prisoners at Stafford were well met. The IMB noted that there had been instances of prisoners receiving the wrong doses of medication, or, on very rare occasions, being given the wrong medication. The Board recognised that errors could be made but were reassured that every effort was being made to avoid such mistakes.

19. The Board also noted that the resident full-time doctor had reduced his working week to three days and an agency doctor had been appointed to cover the shortfall.

Previous deaths at HMP Stafford

20. Mr Busfield was the tenth prisoner to die at Stafford since January 2019. The previous nine deaths were all from natural causes. Since Mr Busfield's death there have been three deaths from natural causes. There are no similarities between our findings in the investigation of Mr Busfield's death and the other deaths.

Key Events

21. On 5 March 2020, Mr Anthony Busfield was sentenced to ten years in prison for sexual offences. He was sent to HMP Dovegate.

22. Mr Busfield had a complicated medical history of irregular and fast heartbeat, left ventricular systolic dysfunction (a complication of a heart attack that leads to increased risk of sudden death and heart failure), biventricular failure (heart failure to the left and right side of the heart), pacemaker with a cardiac resynchronisation therapy-defibrillator (CRTD) device (a special device for heart failure patients who are at high risk of sudden death), ischaemic heart disease (where the blood vessels supplying the heart are narrowed or blocked), diverticular disease (digestive conditions that affect the large intestine), hyperlipidaemia (elevated lipids in the blood), pre-diabetes (a high blood sugar level indicating likelihood of developing type 2 diabetes), gout (an arthritic type of joint pain), arthritic shoulder and neck pain and an enlarged prostate.

23. While at Dovegate, Mr Busfield had a falls risk assessment, which noted that he was at high risk of falling. A referral was made for social care. However, Mr Busfield transferred to HMP Stafford three days later on 9 November, so the referral was not followed up.

24. While on his way to Stafford, Mr Busfield's pacemaker started making a noise. When he arrived at the prison, healthcare staff attempted to contact hospital specialists in the cardiology department for advice but were unable to reach them. They contacted the out of hours doctor, who advised them that there was no evidence of dysfunction but that Mr Busfield should be monitored and, if there was any deterioration in his health, he should be taken to hospital. Nurses completed his clinical observations which were all normal.

25. When he arrived at Stafford, Mr Busfield self-isolated for 14 days in line with the COVID-19 guidelines for prisons. He was not required to shield after 14 days because healthcare staff assessed him as a moderate risk of complications due to COVID-19.

26. Healthcare staff completed two reception screens. They noted all Mr Busfield's medical conditions and arranged for a pacemaker care plan and a hypertension care plan to be created. No-one noted that Mr Busfield was a high falls risk or that a social care referral was outstanding.

27. On 10 November, the hospital cardiac pacing team told prison healthcare staff that the pacemaker noise was not typical. Healthcare staff continued to monitor Mr Busfield and no further problems were reported. Prison GPs prescribed appropriate medications.

28. On 12, 14 and 19 January 2021, Mr Busfield refused to take his medications. No reasons for his refusal were noted in his medical record.

Events on 19 January 2021

29. At approximately 9.00am, Mr Busfield was walking on the landing of his residential unit when he slipped. Two officers heard a noise and saw him lying

on the floor. Mr Busfield told them that he had fallen but was fine. An officer asked colleagues to contact healthcare staff to come and check Mr Busfield. Staff helped him into a wheelchair and took him back to his cell. Mr Busfield sat on a chair outside his cell.

30. At approximately 9.15am, officers radioed for healthcare assistance. A nurse and a trainee nurse attended. They asked Mr Busfield to stand up so they could help walk him into his cell. Mr Busfield was able to stand but then he lowered himself to the floor. He was alert and conscious but had been incontinent of urine. He lost consciousness. The nurses placed him in the recovery position. An officer radioed a medical emergency code blue (indicating that a prisoner is unresponsive or having difficulty breathing) and staff in the communications room called an ambulance immediately.

31. The nurse radioed for the advanced nurse practitioner to attend and asked a prison officer to get the defibrillator machine. Staff moved Mr Busfield out onto the landing. The nurse noted that there were no vital signs. The advanced nurse practitioner began chest compressions. A nurse prepared the defibrillator, and another nurse prepared the airway equipment and oxygen. The defibrillator administered one shock and staff followed the defibrillator instructions and continued with chest compressions.

32. Paramedics and an air ambulance doctor arrived and continued with resuscitation attempts. At 10.17am, the ambulance doctor confirmed that Mr Busfield had died.

Contact with Mr Busfield's family

33. On 19 January, the prison appointed a Senior Officer (SO) to act as family liaison officer (FLO). She telephoned Mr Busfield's nominated next of kin to inform her of his death. Mr Busfield's next of kin asked about the circumstances surrounding his death. The SO remained in contact with Mr Busfield's next of kin to offer support.

34. Mr Busfield's funeral took place on 15 February. The prison contributed towards the cost of the funeral in line with national guidance.

Support for prisoners and staff

35. After Mr Busfield's death, the duty manager and deputy governor 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.

36. The prison posted notices informing other prisoners of Mr Busfield'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 Mr Busfield's death.

Cause of death

37. The Coroner accepted the cause of death provided by the attending clinicians and no post-mortem examination was carried out. The clinicians gave Mr

Busfield's cause of death as severe left ventricular systolic dysfunction (a form of heart failure) caused by ischaemic heart disease.

Findings

Clinical care

38. The clinical reviewer concluded that the care and treatment Mr Busfield received at Stafford was of a good standard and was equivalent to that which he could have expected to receive in the community. The clinical reviewer noted that Mr Busfield had complex heart conditions and was at risk of sudden death due to left ventricular systolic dysfunction (weakness on the left side of the heart).

39. The clinical reviewer did, however, identify some concerns.

Continuity of care and care plans

40. National Institute for Health and Clinical Excellence (NICE) guidelines and Prison Service Order (PSO) 3050 *Continuity of Healthcare for Prisoners* set out the expectation that prisons ensure continuity of care for prisoners on transfer. This includes considering relevant clinical information and carrying out a general health assessment, equivalent to a primary care assessment when registering with a new GP in the community.

41. Mr Busfield had been identified as a high falls risk at Dovegate which meant that he might have needed help with his mobility. Although he received detailed screenings when he arrived at Stafford, healthcare staff did not identify that Mr Busfield was a falls risk or that a falls risk assessment had been completed at Dovegate, or that a referral for social care was still outstanding. We make the following recommendations:

    The Head of Healthcare should ensure that, in line with NICE guidelines and PSO 3050 *Continuity of Healthcare for Prisoners*, that healthcare staff check for information about previous care.

    The Head of Healthcare should ensure that prisoners at risk of falling have a regularly reviewed falls risk assessment, in line with NICE guidelines.

42. The clinical reviewer found that Mr Busfield's pacemaker care plan and his hypertension care plan lacked sufficient detail about his complicated heart conditions. They were not individualised and did not indicate whether Mr Busfield had any input into the process as they should have done. We recommend:

    The Head of Healthcare should ensure that care plans are individualised and completed with the prisoner.

Non-compliance with medication

43. Shortly before Mr Busfield's death, there were three occasions in January when he did not take his medication. Healthcare staff should have had recorded discussions with Mr Busfield to ensure that he understood the consequences of not taking the medication as prescribed. Best practice requires careful documentation of the prisoner's decision, regular review and evidence that the

consequences of not taking prescribed medication have been explained to the prisoner and that alternative treatment has been explored.

44. The clinical reviewer found that healthcare staff at Stafford only investigated continuous instances of missed medication and not separate instances of missed medication. She considers that the prison's definition of non-compliance with medication should be reviewed. Healthcare staff should have had a discussion with Mr Busfield to understand why he was not taking his medication, but they failed to do so. We make the following recommendation:

The Head of Healthcare should ensure that when prisoners refuse to take critical medications (whether continuously or on separate occasions):

- **a senior member of healthcare staff speaks to the prisoner and documents this in the medical record;**
- **a medication in-possession risk assessment is carried out and the outcome is recorded in the medical record; and**
- **the prisoner's mental capacity is assessed, and the outcome is recorded in the medical record.**

Record keeping

45. Some of the entries in Mr Busfield's medical record were unclear. For example, some of the GP daily entries used abbreviations which made it difficult to follow the chronology of events. The clinical reviewer noted the importance of making clear notes to assist with good clinical record keeping. We recommend:

The Head of Healthcare should ensure that all staff understand their professional requirement in record keeping, to make clear, accurate, timely and contemporaneous notes in prisoners' medical records.

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