

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Burnley, a prisoner at HMP Stafford, on 7 November 2021

A report by the Prisons and Probation Ombudsman

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



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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 John Burnley died on 7 November of a heart attack at HMP Stafford. Mr Burnley was 59 years old. I offer my condolences to Mr Burnley's family and friends.

Mr Burnley had a complex medical history and was prescribed 23 medications for various conditions. The clinical reviewer concluded that only some of Mr Burnley's clinical care was equivalent to that he could have expected to receive in the community. While he had appropriate care plans for some of his conditions, these were absent for the management of his heart condition, diabetes and obesity.

The clinical reviewer was also concerned about the management of Mr Burnley's medication. There is no record that healthcare staff changed Mr Burnley's diabetic medication at the request of a specialist. I am also concerned that there was not a follow up medication review when the pharmacist highlighted a potential adverse drug interaction.

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

July 2022

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Summary

Events

1. On 4 October 2016, Mr John Burnley was remanded to HMP Peterborough charged with sexual offences. In November, he was sentenced to 13 years imprisonment. Mr Burnley moved between several prisons until he transferred to HMP Stafford in January 2020.
2. Mr Burnley's complex medical history and medications were reviewed and assessed during his initial health screen. He had several serious long-term conditions that required monitoring by specialist consultants. These conditions included diabetes, hypertension (high or raised blood pressure), cardiac concerns, asthma, sleep apnoea (a sleeping disorder that disrupts breathing), prolapsed discs and deep vein thrombosis (a blood clot in a vein, usually the leg).
3. Mr Burnley was subject to several medication changes, some of which were not followed up and were significant in managing his diabetes. On 17 October 2021 and 27 October, the prison pharmacist and prison GP both separately recorded concerns about the combination of his prescription medications potentially being harmful.
4. At 8.55am on 7 November, a prisoner found Mr Burnley unresponsive in his cell. Staff radioed an emergency code, healthcare staff responded and administered CPR. An air ambulance crew confirmed at 9.55am that Mr Burnley had died.
5. The pathologist concluded that Mr Burnley's cause of death was a heart attack caused by angina (chest pain caused by reduced blood flow to the heart).

Findings

6. The clinical reviewer concluded that only some of the care that Mr Burnley received at Stafford was equivalent to that he could have expected to receive in the community. He had appropriate care plans in place for the management of his diabetes and asthma. However, care planning in relation to Mr Burnley's heart condition, hypertension and obesity were inadequate.
7. There were also serious deficiencies in his medication management. Significant changes in medication to manage Mr Burnley's diabetes were delayed or not actioned following the request of a specialist. Healthcare staff also failed to appropriately assess and review the possible negative effects of Mr Burnley's complex combination of prescribed medication.

Recommendations

- The Head of Healthcare should review current practice and ensure that appropriate, consistent processes are in place for assessing, managing and prescribing for long-term conditions.

- The Head of Healthcare should complete an immediate medication management review, focusing on patients who take multiple medications in line with the Royal Pharmaceutical Society's (RPS) Professional Standards for Optimising Medicines for people in Secure Environments.
- The Head of Healthcare should ensure that there is a robust system in place for safe prescribing, a patient focused approach to medicines use and that any discrepancies are followed up.
- The NHS England and NHS Improvement Commissioner for the West Midlands region should write to the Ombudsman setting out what she is doing to satisfy herself that HMP Stafford has a robust system for managing medication safely and that prisoners with long-term conditions have appropriate care plans in place.

The Investigation Process

8. 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. The Chair of the Independent Monitoring Board contacted the investigator as a result.
9. The investigator obtained copies of relevant extracts from Mr Burnley's prison and medical records. NHS England commissioned an independent clinical reviewer to review Mr Burnley's clinical care at the prison.
10. The investigator jointly interviewed four members of healthcare staff with the clinical reviewer by video conference on 16 December 2021, 17 December 2021 and 4 January 2022. She also had a video conference discussion with the Chair of the Independent Monitoring Board. One member of staff requested for interview was not available, as he no longer works at HMP Stafford.
11. We informed HM Coroner for Staffordshire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Burnley's family, to explain the investigation and to ask if they had any matters, they wanted the investigation to consider. We did not receive a response.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Stafford

14. HMP Stafford is a medium security prison in Staffordshire for adult men convicted of sexual offences. It can hold around 750 prisoners. Practice Plus Group (previously known as 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

15. 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 that the care of those patients who had been diagnosed with long-term conditions was well managed. Healthcare reviews with such prisoners were reliably scheduled and comprehensive care plans were used to manage their care needs.
16. They found that medicine services had improved but there were still some serious outstanding problems. The volume of activity, as well as inefficient systems, resulted in disruption to prescribing regimes, and too many patients had experienced gaps in treatment.

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. The Chair of the IMB at Stafford spoke to the investigator. He felt that the concerns raised in the annual report were particularly relevant to Mr Burnley's healthcare at Stafford.
18. In its report for the year to April 2021, the IMB noted that its greatest concern was about medicine management. This had been highlighted from a Care Quality Commission (CQC) Inspection, HMIP inspection and previous PPO investigations. The Board was pleased to note there had been an improvement in supervision at the medication hatches by prison staff.
19. Aside from the ongoing medication concerns, the Board said that prisoners at Stafford continue to benefit from a "calm, safe and well-ordered environment".

Previous deaths at HMP Stafford

20. In the two years before Mr Burnley's death, there had been ten deaths due to natural causes at Stafford, two of which were related to COVID-19. There have been four deaths due to natural causes since Mr Burnley's death, one of which was related to COVID-19.
21. In December 2020, we recommended that long-term care plans were put in place for conditions as soon as they were diagnosed. This was accepted by the Head of

Healthcare in April 2021. In September 2020 and October 2020, our recommendations to ensure that appropriate systems were in place for prescribed medication were accepted. However, the management of both long-term conditions and prescribed medication remain significant areas of concern in this investigation.

Key Events

22. On 4 October 2016, Mr John Burnley was remanded to HMP Peterborough, charged with sexual offences. On 24 November, he was sentenced to 13 years in prison and taken to HMP Norwich. Mr Burnley was diagnosed with numerous complex physical health issues including diabetes, hypertension (high or raised blood pressure), cardiac concerns including historical bypass surgery and a heart attack, asthma, sleep apnoea (a sleeping disorder that disrupts breathing), prolapsed discs and deep vein thrombosis (a blood clot in a vein, usually the leg).
23. In January 2020, Mr Burnley transferred to HMP Stafford. His health needs were assessed, and the healthcare team continued to monitor and manage his physical health conditions. Mr Burnley's history of heart conditions and diabetes were noted, and he was under the care of a consultant diabetologist (diabetic specialist).
24. On arrival at Stafford in January and following a temporary prison transfer in September 2021, the prison doctor completed a health assessment and checked that Mr Burnley's medications were up to date. Mr Burnley was prescribed 23 different medications to manage his long-term health conditions. His medication In Possession (IP) risk assessment was completed and highlighted no concerns with him keeping low risk medication in his cell.
25. Mr Burnley's care plan for long-term management for diabetes and asthma were completed in accordance with National Institute for Health and Care Excellence (NICE) guidelines.
26. On 31 March 2021 and 23 June 2021, Mr Burnley's diabetic medication was reviewed by a diabetic consultant at Airedale Hospital, using video consultation. On both occasions, the consultant asked for Mr Burnley to be given double the dose of his diabetic medication, Liraglutide. On 23 June, he also asked that his insulin (Toujeo) was increased from 180 to 200 units per day.
27. On 16 September, Mr Burnley told a nurse during a medication review that his Liraglutide medication was not correct. She amended his prescription to reflect the dose of Liraglutide that the consultant had instructed. Mr Burnley continued to be prescribed 180 units of insulin per day.
28. Mr Burnley had regular blood tests and medication reviews to ensure that the combination of his medicines was safe. On 17 October, a prison pharmacist noted that he was concerned about Mr Burnley's medication. He recorded that the mix of medications he was taking was known to increase the risk of breathing problems and unexpected death when used by patients with sleep apnoea. There is no record that this was addressed, or a plan of action made. It was not possible to interview the pharmacist, as he no longer worked at the prison.
29. On 27 October 2021, a prison GP referred Mr Burnley to a cardiologist and haematologist, as he was concerned about the possible interactions of medications on his heart health.
30. On 7 November, a prisoner went to see Mr Burnley in his cell at about 9.00am. He was a carer for Mr Burnley and casually assisted him with daily living tasks, including delivering him meals. He found Mr Burnley in bed unresponsive and

immediately pressed the cell bell. This alerted an officer, who was on the wing. The officer went to the cell and on seeing Mr Burnley, radioed a code blue (an emergency code indicating that a prisoner is not breathing or is having difficulty breathing) and started CPR. Staff in the control room immediately requested an ambulance.

31. A healthcare assistant responded to the emergency code and got to Mr Burnley's cell within 2 minutes. She assessed Mr Burnley and assisted the officer with CPR. Two nurses arrived four minutes later and assisted with Mr Burnley's care. All healthcare staff involved told the investigator that Mr Burnley was warm to the touch and floppy. They said that they were unable to open Mr Burnley's mouth to insert an oxygen tube and his jaw seemed rigid.
32. Paramedics arrived at 9.14am and took over CPR until the air ambulance arrived at 9.54am. At 9.55am, the air ambulance doctor confirmed that Mr Burnley had died.

Contact with Mr Burnley's family

33. On 7 November, following Mr Burnley's death, the prison appointed a family liaison officer (FLO). At approximately 4.00pm, the FLO and an officer arrived at Mr Burnley's son's address and informed him that Mr Burnley had died. Mr Burnley's son also told Mr Burnley's partner about his death, in the presence of the FLO and officer. The officers offered their condolences and support.
34. Mr Burnley's funeral took place on 5 December 2021. Stafford offered a contribution to the cost, in line with national instructions.

Support for prisoners and staff

35. After Mr Burnley's death, a custodial 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.
36. The prison posted notices informing other prisoners of Mr Burnley'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.

Post-mortem report

37. The pathologist concluded that Mr Burnley died of a myocardial infarction (heart attack) caused by angina (chest pain caused by reduced blood flow to the heart). He also had obstructive sleep apnoea (soft tissue causes a blockage in the airway during sleep), a coronary artery bypass graft (a surgical procedure to restore normal blood flow to an obstructed artery), diabetes, hypertension, obesity and deep vein thrombosis which did not cause but contributed to his death.

Findings

Clinical Findings

38. The clinical reviewer concluded that only some of the care Mr Burnley received at HMP Stafford was of a reasonable standard and equivalent to that which he could have expected to receive in the wider community. The main concerns in relation to Mr Burnley's death were the lack of long-term care planning and medication management. The clinical reviewer also identified a number of significant issues which are not directly relevant to Mr Burnley's death and which we have not repeated here. However, the Head of Healthcare will also need to address these concerns.

Long-term care planning

39. The clinical reviewer concluded that Mr Burnley's asthma and diabetes were reviewed on a regular basis and care plans were in place. This was in line with NICE guidelines.
40. Mr Burnley was also appropriately prescribed medication for his hypertension, obesity and history of heart failure. However, we share the clinical reviewer's concern that there were no care plans in place for the long-term management of these conditions. This is not in line with NICE guidance. In particular, Mr Burnley was not under the care of a cardiologist. A referral to cardiology was not made until October 2021, despite his history of heart surgery. This is extremely concerning.
41. In April 2021, following a previous death at Stafford, the Head of Healthcare accepted our recommendation to put long-term care plans in place for conditions as soon as they were diagnosed. We make the following recommendation:

The Head of Healthcare should review current practice and ensure that appropriate, consistent processes are in place for assessing, managing and prescribing for long-term conditions.

Medication Management

42. At the time of his death, Mr Burnley was prescribed 23 different medications. GPs were aware of this and he received some medication reviews, although the clinical reviewer notes that these were not regular or thorough. However, it was not until October 2021 that a pharmacist recorded concerns about the combination of medications Mr Burnley was prescribed. There is no record that he took any action as a result of this.
43. Later that month, eleven days before Mr Burnley's death, a GP also recorded concerns about the potentially dangerous effects of Mr Burnley's combination of medication and referred him to a cardiologist and haematologist.
44. We have previously made two recommendations following deaths at Stafford to ensure that appropriate systems were in place for prescribed medication. These were accepted in September and October 2020. We make the following recommendation:

The Head of Healthcare should complete an immediate medication management review, focusing on patients who take multiple medications in line with the Royal Pharmaceutical Society’s (RPS) Professional Standards for Optimising Medicines for people in Secure Environments.

45. The clinical reviewer also concluded that other aspects of Mr Burnley’s medication management were inadequate. In particular, that one of the requests made by a consultant to change Mr Burnley’s diabetic medication to better control his diabetes was not implemented for nearly six months and the other requested change was not made at all. We endorse the clinical reviewer’s recommendation that:

The Head of Healthcare should ensure that there is a robust system in place for safe prescribing, a patient focused approach to medicines use and that any discrepancies are followed up.

46. Given our repeated recommendations to improve medication management and long-term care planning at Stafford, along with the concerns of HMIP and the IMB, we make the following recommendation:

The NHS England and NHS Improvement Commissioner for the West Midlands region should write to the Ombudsman setting out what she is doing to satisfy herself that HMP Stafford has a robust system for managing medication safely and that prisoners with long-term conditions have appropriate care plans in place.

Inquest

47. The inquest, held on 24 April 2023, concluded that Mr Burnley died from natural causes.

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