Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Frederick Butcher a prisoner at HMP Elmley on 10 May 2018

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 Frederick Butcher died in hospital on 10 May 2018 of heart failure while a prisoner at HMP Elmley. He was 80 years old. I offer my condolences to Mr Butcher's family and friends.

I am satisfied that Mr Butcher received a good standard of care and support at Elmley, equivalent to that which he could have expected to receive in the community.

However, I am concerned that the decision to use restraints on Mr Butcher when he was taken to hospital in March 2018 was clearly unjustified, and did not take account of his advanced age and serious ill-health. It is disappointing to have to raise this matter with the prison yet again. This issue needs to be addressed urgently by the Prison Group Director of Kent, Surrey and Essex Group.

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 **January 2019**

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Summary

Events

1. In January 2017, Mr Frederick Butcher was remanded to custody charged with attempted murder, and sent to HMP Elmley. (He was sentenced to 13 years and three months in prison on 23 March 2018.)

2. Mr Butcher suffered from several long-term conditions including heart disease and chronic obstructive pulmonary disease (COPD – a collection of lung diseases including chronic bronchitis and emphysema). Nurses and prison GPs monitored Mr Butcher's medical conditions frequently.

3. On 30 March, a nurse examined Mr Butcher and found his oxygen saturation level was 86% (a normal level would be 95-100%) and sent him to hospital. He was accompanied by two prison officers who restrained him with an escort chain. Mr Butcher was treated with oxygen therapy for an exacerbation of COPD. Further investigations found he had heart failure and a mass on his right kidney. Mr Butcher was returned to the prison's inpatient unit on 11 April.

4. The next day, a prison GP noticed that Mr Butcher's condition had deteriorated and sent him back to hospital, where he was treated for pneumonia. He was returned to the prison's inpatient unit on 23 April.

5. On 2 May, a nurse examined Mr Butcher and found he had an oxygen saturation level of 80-82% and looked unwell. The nurse sent him to hospital where he was treated for an exacerbation of COPD. Mr Butcher's health deteriorated rapidly and he died in hospital on 10 May, with his family present.

Findings

6. We agree with the clinical reviewer that Mr Butcher received a good standard of clinical care at Elmley, equivalent to that which he could have expected to receive in the community.

7. However, we are concerned that the decision to use restraints when Mr Butcher was taken to hospital on 30 March did not take full account of his advanced age and poor health, and how this affected his level of risk. We are also concerned that the prison was unable to tell us whether they restrained Mr Butcher during his hospital transfer on 12 April. We have raised the unjustified use of restraints with Elmley on numerous occasions and urgent action is now required to address this issue.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff completing and authorising risk assessments justifying the use of restraints on prisoners taken to hospital understand the legal position; and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Prison Group Director of Kent, Surrey and Essex Group should assure himself that meaningful action is taken to ensure that this happens.

The Investigation Process

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

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

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

11. We informed HM Coroner for Mid Kent and Medway District of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. The investigator wrote to Mr Butcher's daughter 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.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Elmley

14. HMP Elmley serves the courts in Kent and holds up to 1,252 men, remanded and sentenced, in six houseblocks, with a mixture of single, double and triple cells. Integrated Care 24 Ltd provides 24-hour primary healthcare services, with input from Minster Medical Group. The prison's healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Elmley was in November 2015. Inspectors reported that healthcare services at the prison had improved since the last inspection in June 2014 and were generally good. The inpatient unit provided good care for prisoners with the most acute needs, though general access to healthcare services remained a problem. They also found that prisoners sometimes missed routine external hospital appointments because of competing prison priorities for escort staff.

Independent Monitoring Board

16. 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 31 October 2017, the IMB reported that the overall care for prisoners located in the inpatient unit was of a high standard. They reported that the outpatient department remained very busy and that despite every effort from staff, the number of complaints by prisoners remained high.

Previous deaths at HMP Elmley

17. Mr Butcher was the 21st prisoner to die at Elmley since May 2015. Of the previous deaths, 16 were due to natural causes, two were self-inflicted and two were drug-related. There has been one death since, the cause of which is not yet known. We have made recommendations about ensuring staff properly justify the use of restraints on prisoners taken to hospital in several previous investigations, most recently in October 2017 when we made a recommendation to the Director of Kent and Essex Prisons. We raise the inappropriate use of restraints yet again in this case.

Key Events

18. On 28 January 2017, Mr Frederick Butcher was remanded to custody having been charged with attempted murder and was sent to HMP Elmley.

19. Mr Butcher was aged 79 and had several long-term health conditions including, high blood pressure, heart disease and chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases such as chronic bronchitis and emphysema). He had a pacemaker fitted (a device placed in the chest to control abnormal heart rhythms) and was an ex-smoker. Healthcare staff created multiple care plans and saw Mr Butcher for reviews at the prison's complex needs clinic. Doctors prescribed inhalers and nebulisers to ease his COPD symptoms and reviewed his medication as required.

20. On 5 June, a visiting consultant respiratory physician saw Mr Butcher for an examination and diagnosed moderate to severe COPD. Healthcare staff reviewed Mr Butcher frequently over the next four months and despite presenting short of breath on occasion, his COPD symptoms remained relatively stable. Records show that Mr Butcher was verbally aggressive to staff on occasion and that he sometimes refused to take his medication.

21. On 2 November, Mr Butcher was moved to Thornford Park Hospital, Berkshire, for a psychiatric assessment ordered by the Court to assess whether any psychiatric condition may have affected his decision making, such as a depressive episode. The assessment, undertaken by a consultant forensic psychiatrist, concluded that Mr Butcher was not clinically depressed and did not suffer from a psychotic illness. The consultant considered that the prison's mental health team could sufficiently manage Mr Butcher and recommended bereavement counselling, as he appeared to be suffering from the effect of his wife's recent death.

22. On 12 February 2018, Mr Butcher was moved back to Elmley. A nurse conducted an initial reception screen and referred him to the prison's inpatient unit for monitoring, as he reported thoughts of self-harm prior to leaving Thornford Park Hospital. On 23 March, Mr Butcher was sentenced to 13 years and three months in prison and was returned to Elmley.

23. On 30 March, a nurse saw Mr Butcher for a review after prison staff called an emergency medical code blue (which indicates that a prisoner is unconscious or has breathing difficulties). She found his oxygen saturation levels were 86% (a normal level would be 95-100%) and sent him to Medway Maritime Hospital. Two officers escorted him and restrained him with an escort chain (a long chain with a handcuff at each end, one of which is attached to a prison officer). Mr Butcher was admitted and treated for an exacerbation of COPD. Further investigations found that he had heart failure and a mass on his right kidney, which renal specialists decided to treat palliatively (a medical approach that specialises in care for life-limiting illnesses). Mr Butcher was returned to the prison's inpatient unit on 11 April.

24. On 12 April, a prison GP examined Mr Butcher and noted that his condition had deteriorated since his return from hospital. He recorded that Mr Butcher had low blood pressure (94/58 mmHg) and an oxygen saturation level of 90%, and sent

him to hospital by emergency ambulance. Mr Butcher was admitted and treated for pneumonia (an inflammatory condition of the lung usually caused by a bacterial infection). During his stay, Mr Butcher told hospital staff that he did not wish to be resuscitated if his heart or breathing stopped and signed an order to that effect. He was returned to the prison's inpatient unit on 23 April and healthcare staff continued to monitor him frequently.

25. On 2 May, a nurse saw Mr Butcher for a review and recorded that he had an oxygen saturation level of 80-82%. He administered a nebuliser and sent Mr Butcher to hospital by emergency ambulance. Two escort officers went with him and did not use restraints. Mr Butcher was admitted and treated for an exacerbation of COPD. Prison healthcare staff kept in regular contact with the hospital for updates on his condition. Mr Butcher's health deteriorated rapidly and he died in hospital at 12.01am on 10 May, with his family present.

Contact with Mr Butcher's family

26. On 31 March, the prison appointed a prison manager as family liaison officer. Mr Kennett phoned Mr Butcher's son, his named next of kin, to inform him that Mr Butcher had been admitted to hospital. On 4 April, Mr Butcher's daughter became the main point of contact and a prison chaplain arranged for her to visit Mr Butcher in hospital.

27. On 8 May, the chaplain phoned Mr Butcher's daughter to advise her that his condition had deteriorated and that hospital staff suggested she attend. Later that day, he and a prison manager met Mr Butcher's daughter at the hospital to offer support. On 10 May, at around 12.15am, the chaplain and one of his colleagues went to see Mr Butcher's daughter at the hospital and offered their condolences and support.

28. The chaplain provided ongoing support to Mr Butcher's daughter and attended his funeral on 8 June with the prison Governor and another member of staff. Mr Butcher had a pre-paid funeral plan therefore the prison was not required to contribute towards the cost.

Support for prisoners and staff

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

30. The prison posted notices informing other prisoners of Mr Butcher'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 Butcher's death.

Cause of death

31. The coroner accepted the cause of death provided by the hospital and did not ask for a post-mortem examination. The hospital recorded that Mr Butcher died of heart failure caused by COPD. Renal cell carcinoma (a type of kidney cancer) was a contributory factor.

Findings

Clinical care

32. Mr Butcher was an elderly man who had several long-term health conditions including COPD and heart disease. Healthcare staff monitored and reviewed him frequently and doctors prescribed appropriate medication. The clinical reviewer considered that healthcare staff managed Mr Butcher's health conditions well and sent him to hospital when appropriate. He concluded that Mr Butcher's care and treatment in prison was of a good standard and equivalent to that which he could have expected to receive in the community. We are satisfied that Mr Butcher received appropriate clinical care at Elmley.

Restraints, security and escorts

33. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

34. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

35. Mr Butcher was restrained with an escort chain when he was taken to hospital on 30 March. At 9.45am, on 31 March, a prison manager authorised the removal of Mr Butcher's restraints and they were not reapplied while he remained in hospital. Prison staff told us they used a previous risk assessment to speed up the process, but they could not tell us which one. The risk assessment used must have been at least five months old, as Mr Butcher had not been to hospital from Elmley since October 2017.

36. Prison staff told us that they again used a previous risk assessment for Mr Butcher's hospital transfer on 12 April, but could not tell us which one. While records show that Mr Butcher was not restrained from 10pm, when officers started a bedwatch log, we have been unable to establish if restraints were used for his transfer to hospital.

37. While we recognise that the prison manager made the appropriate decision to remove the restraints on 31 March, we consider that the initial use of an escort chain was not justified. Mr Butcher was a very elderly and frail man who, at the time he was taken to hospital, was clearly very ill. It seems the risk assessment used was based on the prison's view of his offence with little consideration of how his age, health and mobility affected his risk of escape, as the 2007 High Court judgment requires. Mr Butcher's condition had deteriorated and although we recognise the need for urgency, we are concerned that decisions appear to have been based on a risk assessment completed several months earlier.

38. We have made findings on the inappropriate use of restraints in numerous previous investigations into deaths at Elmley. Urgent action is needed to address this. We therefore make the following recommendations:

The Governor and Head of Healthcare should ensure that all staff completing and authorising risk assessments, justifying the use of restraints on prisoners taken to hospital, understand the legal position; and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Prison Group Director of Kent, Surrey and Essex Group should assure himself that meaningful action is taken to ensure that this happens.

Compassionate release

39. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

40. Elmley started the compassionate release process on 4 May and a prison GP completed the medical section of the application indicating that Mr Butcher had a life expectancy of approximately two months. However, the prison was unable to complete the process before Mr Butcher died. We are satisfied that the prison appropriately considered early release.

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