Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Graham Butterworth a prisoner at HMP Lincoln on 5 December 2017

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 I oversee can improve their work in the future.

Mr Graham Butterworth died in hospital on 5 December 2017 of legionella pneumonia while a prisoner at HMP Lincoln. Mr Butterworth was 71 years old. I offer my condolences to Mr Butterworth's family and friends.

Mr Butterworth was taken to hospital on the evening of 4 December after being found lying on the floor of his cell. He was admitted to intensive care and his condition deteriorated very quickly. The investigation found that healthcare staff did not properly assess and monitor Mr Butterworth's condition during the day on 4 December, and that an opportunity to identify earlier that Mr Butterworth had a life-threatening illness was missed.

It is very disappointing that Mr Butterworth was taken to hospital in restraints and that he continued to be restrained in hospital until shortly before he died even after he was admitted to the intensive care unit. I am not satisfied that the use of restraints was justified by an appropriate risk assessment that took into account the severity of Mr Butterworth's medical condition.

The investigation also found deficiencies in family contact and follow up support for staff which the prison 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.

Elizabeth Moody
Acting Prisons and Probation Ombudsman **May 2018**

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Summary

Events

1. In September 2016, Mr Graham Butterworth was sentenced to 11 years in prison for indecent assault. He was moved to HMP Lincoln on 21 September 2017. He had several long-term health conditions and used a walking stick.

2. Mr Butterworth fell out of bed several times overnight on 2 and 3 December. While a note was made on his electronic medical record, it was unclear whether healthcare staff examined him. A healthcare assistant told police that she had reviewed Mr Butterworth after a fall, but she could not remember the exact day and there is no record she took his clinical observations.

3. On 4 December, at around 10am, a healthcare assistant visited Mr Butterworth in his cell because he was constantly demanding assistance from other prisoners. Mr Butterworth said his hands were always shaking. The healthcare assistant witnessed this but did not consider the shaking was uncontrollable. There is no record that he took Mr Butterworth's clinical observations.

4. At around 7pm, during a roll check, an officer found Mr Butterworth lying on his cell floor. He called for assistance and entered the cell to find Mr Butterworth breathing and able to communicate. He asked another officer to alert healthcare staff and a nurse arrived within minutes. The nurse conducted a clinical assessment and requested an ambulance at 7.40pm. Paramedics took him to hospital. He was restrained with double handcuffs. He was diagnosed with pneumonia and an acute kidney injury and died in hospital on 5 December, at 7.08pm.

5. The post-mortem report concluded that Mr Butterworth had died of legionella pneumonia. Public Health England notified the prison that Mr Butterworth had tested positive for legionella shortly after his death and the Health and Safety Executive are investigating the presence of legionella bacteria in the prison's water system.

Findings

6. We consider that more comprehensive monitoring of Mr Butterworth's condition between 10am and 7pm on 4 December might have resulted in the earlier identification of a life-threatening condition and a hospital referral. We agree with the clinical reviewer that the care Mr Butterworth received at Lincoln was not equivalent to that which he could have expected to receive in the community.

7. We are concerned that the decision to use restraints when Mr Butterworth was taken to hospital did not take full account of his poor health and reduced mobility and how this affected his level of risk. We are also concerned that staff did not remove restraints until shortly before Mr Butterworth died, despite a request from a hospital staff.

8. We are concerned that the prison did not inform Butterworth's next of kin that he was seriously ill, or notify them of his death, in accordance with Prison Service instructions.

9. The investigation found that a prison manager did not debrief the escort staff on duty at the hospital when Mr Butterworth died.

Recommendations

- The Head of Healthcare should ensure that healthcare staff:
    - receive training to help detect and treat early warning signs of deterioration in prisoners;
    - take and record observations as required; and
    - record actions and decisions about prisoners' ongoing care in their medical records.
- 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 Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible.
- The Governor should ensure that a member of Prison Service staff informs a prisoner's next of kin of their death, in line with national guidance.
- The Governor should ensure that a debrief is held promptly after the death of a prisoner and that the staff involved are offered effective support.

The Investigation Process

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

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

12. The investigator interviewed six members of staff at HMP Lincoln on 24 January 2018.

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

14. We informed HM Coroner for Central Lincolnshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. The investigator wrote to Mr Butterworth's next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond to our letter.

16. 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 Lincoln

17. HMP Lincoln houses up to 729 remanded and convicted men. It serves the courts of Lincolnshire, Nottinghamshire and Humberside. It has four residential wings, which includes a vulnerable prisoners' unit. Nottingham Healthcare NHS Trust provides health services and there is 24-hour nursing cover. There is no inpatient unit at Lincoln.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Lincoln was in January and February 2017. Inspectors reported that the prison remained overcrowded, which, along with the age of the prison, meant there were significant challenges in keeping conditions decent for those held. They reported that healthcare vacancies had an impact on service delivery but, overall, a dedicated team provided prisoners a reasonably good service.

Independent Monitoring Board

19. 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 January 2017, the IMB reported that throughout the year, there had been an ongoing number of nurse vacancies in general healthcare which had some impact on delivery of services although the service provider was proactive in recruiting to vacant posts.

Previous deaths at HMP Lincoln

20. Mr Butterworth was the fifth prisoner to die at Lincoln since January 2017, the fourth from natural causes. We have previously made a recommendation about staff support.

Key Events

21. On 2 September 2016, Mr Graham Butterworth was sentenced to 11 years imprisonment for indecent assault and sent to HMP Lincoln. He was moved to HMP Rye Hill on 9 May 2017 and returned to Lincoln on 21 September. Mr Butterworth suffered from several long-term health conditions, including high blood pressure, high cholesterol and diabetes. He had poor mobility and used a walking stick to get around.

22. At an initial reception screen, a nurse noted that Mr Butterworth required an easily accessible cell. Over the next two months, healthcare staff reviewed Mr Butterworth frequently and prison GPs prescribed appropriate medication.

23. On 3 December, at 7.38am, a nurse put an entry in Mr Butterworth's electronic medical record, dated 2 December, stating that he had fallen out of bed three times overnight and that prison staff had encouraged him to get back into bed unaided. There is no record that healthcare staff attended. At 7.41am, he made another entry, dated 3 December, stating that Mr Butterworth had fallen out of bed on four occasions during the night and that prison staff had attended to him. In her statement to the police, a healthcare assistant, said that she reviewed Mr Butterworth after hearing over her radio that he had fallen, but could not remember whether it was on 2 or 3 December. She stated that she saw Mr Butterworth lying on the floor when she arrived and that he did not report any injury or concern about his health. She said she helped get him back into bed. There is no record that she took his clinical observations.

24. On 4 December, at around 10am, prison staff arranged for a healthcare assistant to speak to Mr Butterworth about his constant demands for assistance from other prisoners. He saw Mr Butterworth in his cell and noted that he immediately started asking him to do things, such as sit him up in bed and get him a cup of water. He refused. He told the investigator that he did not want to take away Mr Butterworth's independence and watched him stand up unassisted. He enquired about his requests for help and Mr Butterworth said that his hands were always shaking. At this point his hands started to shake, but the healthcare assistant was not convinced the shaking was uncontrollable. He advised prison staff that Mr Butterworth only required assistance with mopping his floor and made an adult social care referral. There is no record that he took any clinical observations.

25. Later that day, at around 7pm, an officer escorted some prisoners from the gymnasium to the wing and assisted with the roll check. He looked through the observation hatch on Mr Butterworth's cell and saw him lying on the floor. The officer's radio had run out of power so he shouted for assistance and entered the cell. He noticed that despite signs of distress, Mr Butterworth was breathing and able to communicate. He asked another officer to radio for immediate healthcare assistance and a nurse arrived within minutes.

26. The nurse noted that Mr Butterworth was alert and orientated and assisted prison staff to sit him upright. His clinical observations indicated that he had low blood pressure (119/45mmHg) and a rapid breathing rate (42 breaths per minute – normal for resting adults is between 12 and 20 breaths per minute). She could

not accurately obtain Mr Butterworth's oxygen saturation level due to poor blood circulation and estimated it to be 80-88% (normal being 95-100%). She gave him 15 litres of oxygen via a mask and completed a National Early Warning Score assessment (NEWS – a scoring system to assess clinical deterioration in patients). Based on Mr Butterworth's observations, she scored him '6' (medium clinical risk) and at 7.40pm, she requested an ambulance.

27. Healthcare staff monitored Mr Butterworth's condition frequently while they waited for an ambulance and his NEWS score fluctuated between 7-10 (high clinical risk). Paramedics arrived at 8.40pm and took Mr Butterworth to hospital. Two prison officers went with him and restrained him by using double handcuffs.

28. On 5 December, at 1.26am, a nurse spoke to a hospital doctor and noted that a computerised tomography (CT) scan had shown that Mr Butterworth had signs of pneumonia. At 10.30am, hospital staff moved him to the Intensive Care Unit where he was treated for pneumonia and an acute kidney injury (damage to the kidneys, usually as a complication of another serious illness). Mr Butterworth's condition deteriorated and he died at 7.08pm.

Contact with Butterworth's family

29. At 7.15pm, on 5 December, the prison appointed an officer as the family liaison officer and he obtained an address for Mr Butterworth's friend, his nominated next of kin, but no telephone number. At 8.45pm, a prison manager and the deputy governor, decided that a visit should take place the following morning.

30. On 6 December, at 10.40am, the family liaison officer, deputy governor and a prison chaplain, arrived at Mr Butterworth's friend's address in Leicester. There was no answer so they tried a neighbour and a local golf club. About an hour later, after it became apparent that Mr Butterworth's friend had booked a prison visit for that afternoon, they returned to Lincoln. At 1.15pm, the deputy governor phoned Mr Butterworth's friend using a number staff had located and confirmed that he still intended to visit. At 2.15pm, the deputy governor and prison chaplain escorted Mr Butterworth's friend and his partner into a quiet room. The family liaison officer broke the news of his death and offered their condolences and support.

31. The family liaison officer provided ongoing support to Mr Butterworth's friend and attended Mr Butterworth's funeral, which took place on 3 January. The prison contributed towards the cost, in line with national policy.

Support for prisoners and staff

32. The prison posted notices informing other prisoners of Mr Butterworth'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 Butterworth's death.

33. There is no record that managers debriefed the escort officers present at the hospital to review what had happened and to offer them support.

Post-mortem report

34. A post-mortem examination found that Mr Butterworth died of legionella pneumophilia pneumonia (a severe lung infection caused by inhaling tiny droplets of water containing legionella bacteria). The post-mortem report noted that a synthetic cannabinoid was found in Butterworth's blood but did not cause or contribute to his death in any way.

Events after Mr Butterworth's death

35. On 6 December, the prison received notification from Public Health England that a urine sample taken while Mr Butterworth was in hospital had tested positive for legionella bacteria. The prison liaised with the relevant agencies and the Health and Safety Executive are investigating the presence of legionella bacteria in the prison's water system.

Findings

Clinical care

36. On 2 and 3 December, officers informed healthcare staff that Mr Butterworth had fallen out of bed several times. Although a healthcare assistant told police that she had reviewed him on at least one occasion, there is no record that any healthcare staff took his clinical observations or checked his medical record for a history of falls. The clinical reviewer considered that healthcare staff should have taken Mr Butterworth's clinical observations and watched him perform simple tasks, particularly as he had not fallen before.

37. The clinical reviewer considered that there was a missed opportunity to monitor Mr Butterworth between 10am and 7.15pm on 4 December, during which time his condition declined significantly. Typical symptoms of legionella pneumonia include shortness of breath, cough, fever, muscle aches, headaches, diarrhoea and vomiting. The clinical reviewer noted that loss of coordination and tremors are also seen and that Mr Butterworth's claim that his hands were always shaking was consistent with the symptoms associated with legionella pneumonia. He stated that although prison nurses would not have been expected to diagnose legionella pneumonia, healthcare staff did not show a suitable level of professional enquiry when faced with symptoms of recurrent falls and shaking.

38. The clinical reviewer concluded that healthcare staff failed to manage Mr Butterworth's deteriorating condition appropriately and that more comprehensive monitoring on 4 December might have led to earlier intervention and a hospital referral. We cannot be sure whether earlier hospitalisation would have prevented Mr Butterworth's death, but taking routine observations may have led to earlier identification of a life-threatening condition. The clinical reviewer found that Mr Butterworth's clinical care was not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff:

    - **receive training to help detect and treat early warning signs of deterioration in prisoners;**
    - **take and record observations as required; and**
    - **record actions and decisions about their ongoing care in their medical records.**

Restraints, security and escorts

39. 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. 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

40. When Mr Butterworth was taken to hospital on 4 December, a prison manager, authorised two officers to escort him using double handcuffs. Double cuffing entails the prisoner having his hands handcuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. This is usually required for moving category A or category B prisoners in good health. A written comment on the risk assessment states an escort chain (a long chain with a handcuff at each end, one of which is attached to an officer) would be appropriate if required in the ambulance. The prison manager told the investigator that she believed escort officers used an escort chain, but she could not be sure. Escort records indicate that officers removed one handcuff at 9.53pm, following a request from hospital staff, which would suggest that double handcuffs were used.

41. On 5 December, at 10.30am, a hospital consultant requested the removal of Mr Butterworth's restraints. An escort officer contacted the prison manager who at 11.35am, having checked Mr Butterworth's risk assessment, advised that the restraints should be kept in place. He told the investigator that he did not know the seriousness of Mr Butterworth's condition and that as the duty manager, he would not have gone out to see him in hospital.

42. The same day, a prison manager reviewed Mr Butterworth's risk assessment and authorised the use of an escort chain for his hospital admission. The assessment indicated that Mr Butterworth presented a low risk of escape and a medium risk to the public. A note indicates his location in the Intensive Care Unit, but the medical section states he had full mobility. At interview, the manager told us that she made her decision based on the risk assessment and did not see Mr Butterworth in person. She said that a manager would normally review deteriorating prisoners in hospital, but there is no record this took place.

43. At 6.30pm, an escort officer informed another prison manager that hospital staff did not expect Mr Butterworth to live much longer and he authorised the removal of restraints.

44. While we are satisfied that the prison manager made the appropriate decision to remove the restraints shortly before Mr Butterworth died, we are concerned that Mr Butterworth went to hospital in double handcuffs and that he remained restrained for so long after his hospital admission. Mr Butterworth was an elderly and frail man who, at the time, was clearly very seriously ill. The risk assessment appears to have been based primarily on his offence, with little consideration of his actual risk or how his health affected this risk, as the 2007 High Court judgment requires. Whenever restraints are used, the risk assessments must accurately reflect the risk posed at that time to ensure proportionality and to maintain human dignity. We make the following recommendation:

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.

Informing Mr Butterworth's next of kin

45. Mr Butterworth was taken to hospital by ambulance on 4 December. He had rapid breathing, high blood pressure and a NEWS score indicative of a high medical risk. A CT scan showed acute kidney injury and signs of pneumonia and hospital staff transferred him to the Intensive Care Unit because he was so ill. However, no one from the prison informed Mr Butterworth's next of kin of his admission to hospital.

46. Prison Rule 22 requires that when a prisoner is seriously ill, the governor should tell the prisoner's spouse or next of kin "at once". Lincoln should have contacted Mr Butterworth's next of kin as soon as he was taken to hospital. We make the following recommendation:

The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible.

47. Prison Rule 22 also requires that the governor should inform families at once when a prisoner dies. Prison Service Instruction (PSI) 64/2011 requires that wherever possible, the family liaison officer and another member of staff visit the next of kin or nominated person to break the news of the death. It notes that time will be of the essence in order to try to ensure that the family do not find out about the death from another source. If the next of kin live a long distance away, consideration must be given to requesting the assistance of a family liaison officer from the nearest prison.

48. Mr Butterworth's next of kin lived approximately 70 miles from the prison. The prison manager told the investigator that he and the deputy governor decided a visit should take place the following morning as it was getting late and Mr Butterworth's friend was elderly. While we recognise that Mr Butterworth's friend was elderly, we do not consider 8.45pm too late for a visit. Lincoln should have sent an officer that evening or considered using a family liaison officer from a nearer prison to save travel time. We make the following recommendation:

The Governor should ensure that a member of Prison Service staff informs a prisoner's next of kin of their death, in line with national guidance.

Support for staff

49. PSI 64/2011 requires a manager to hold a debrief after a prisoner's death, for all staff involved, including healthcare staff. It does not differentiate between prison and hospital deaths. The purpose is to offer support, allow staff to support each other and to discuss any lessons from how the situation was handled.

50. Our investigation found that a prison manager did not hold a debrief following Mr Butterworth's death. We make the following recommendation:

The Governor should ensure that a debrief is held promptly after the death of a prisoner and that all staff involved are offered effective support.

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