Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Butterworth, a prisoner at HMP Cardiff, on 13 February 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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 Butterworth died in hospital from sepsis on 13 February 2020, while a prisoner at HMP Cardiff. He was 53 years old. I offer my condolences to Mr Butterworth's family and friends.

I am satisfied that the care Mr Butterworth received at Cardiff was equivalent to that which he could have expected to receive in the community.

I make no recommendations.

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 **July 2020**

Contents

Summary

Events

1. On 4 September 2018, Mr Anthony Butterworth was remanded in custody, charged with supplying class A drugs, and sent to HMP Cardiff. He was later sentenced to five years in prison.

2. Mr Butterworth had several long-term health conditions including chronic liver disease and hepatitis C. He was located on the prison's healthcare wing.

3. During 2019, Mr Butterworth had recurrent urinary tract infections, which were treated with antibiotics.

4. On 13 February 2020, Mr Butterworth pressed his emergency cell bell and told an officer that he had pains in both his arms and he was struggling to breathe. The officer went to try to find a nurse, but when he could not find one, he called a medical emergency code over his radio. The control room did not respond so he used his radio to ask for a nurse to attend Mr Butterworth's cell.

5. A nurse responded and went to Mr Butterworth's cell. She assessed him and asked for an ambulance to be called. At 9.43am, the control room called an ambulance but it did not arrive at the prison until 11.37am. When the paramedics arrived, they said that Mr Butterworth needed to go to hospital.

6. Mr Butterworth was taken to University Hospital Wales. His health rapidly deteriorated and a few hours later he died.

7. A hospital doctor recorded Mr Butterworth's cause of death as sepsis caused by pneumonia.

Findings

8. We are satisfied that Mr Butterworth received appropriate care and treatment for his health conditions. The clinical reviewer considered that the standard of care he received at Cardiff was equivalent to that he could have expected to receive in the community.

9. The clinical reviewer noted that the delay in the ambulance arriving may have been a contributory factor in Mr Butterworth's death. We are satisfied that this was outside the control of the prison. Ambulance service delays are outside the remit of our investigation.

10. The control room did not respond to the medical emergency code. The prison said that there were no problems with the radio system on that day and they do not know why this happened. We are satisfied that this was a one-off glitch in the system and did not make any difference to the outcome for Mr Butterworth.

The Investigation Process

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

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

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

14. We informed HM Coroner for South Wales of the investigation. The coroner sent us the cause of death. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Butterworth's daughter to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. She did not respond.

16. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Cardiff

17. HMP Cardiff holds around 800 men, mostly from south-east Wales. Many of the prisoners come from local courts on remand. Cardiff and Vale University NHS Health Board is responsible for delivering primary, physical and mental health services at the prison. The prison healthcare department has a 22-bed inpatient facility for prisoners with increased healthcare needs, with 24-hour nursing care.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Cardiff was in July 2019. Inspectors reported that the physical environment of the 22-bed inpatient unit had improved and patients received good, responsive care. They could participate in an extensive therapeutic regime that included education, work and regular visits to a well-maintained garden area. Staffing was generally appropriate, although healthcare staff were periodically called away to attend to other duties. Prison staff knew patients well and sought to promote a positive ward culture.

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 August 2018, the IMB reported that the fabric of the health care unit had been improved including actions taken to deal with the damp in the building. There had also been improvements to the clinic areas with waiting rooms being refurbished and a change in escorting practice so men had to spend less time in the waiting areas for appointments.

20. There had been staffing problems within the healthcare unit partly due to a lack of progression available to staff. A workforce review had been taking place for much of 2019. Despite the shortages, nursing staff continued to provide a professional service in a difficult area of work.

Previous deaths at HMP Cardiff

21. Mr Butterworth was the seventh prisoner to die at Cardiff since February 2018. Of the previous deaths, four were from natural causes and two were self-inflicted.

Key Events

22. On 4 September 2018, Mr Anthony Butterworth was remanded in custody charged with supplying class A drugs. He was sent to HMP Cardiff. He was later sentenced to five years in prison.

23. A nurse completed the initial reception health screen. He noted that Mr Butterworth had several long-term health conditions, including hepatitis C and chronic liver disease. He also noted that Mr Butterworth was withdrawing from excessive alcohol use and had substance misuse issues. Mr Butterworth was given appropriate medication and located on the prison healthcare wing.

24. During 2019, Mr Butterworth had frequent urinary tract infections, which were treated with antibiotics.

25. On 10 February 2020, Mr Butterworth told a nurse that he was self-isolating in his cell because he had diarrhoea. The following day he said that he still had diarrhoea and a headache. A stool sample was taken.

26. On 13 February, at 9.10am, Mr Butterworth pressed his emergency cell bell. An officer said that when he got to the cell, he saw Mr Butterworth lying on his bed. The officer said that Mr Butterworth appeared to be hyperventilating and he had very little colour in his face, so he went to the office to try to find a nurse. There was no nurse in the office so he tried to call them on the telephone. No one answered, so he called a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties). The control room did not respond, so he called over the radio for a nurse to attend Mr Butterworth's cell.

27. At approximately 9.30am, a nurse responded to the radio call. She found Mr Butterworth conscious and breathing, and took his clinical observations. His blood pressure was very low and she decided that he needed an ambulance. At 9.43am, prison staff called an ambulance. The nurse stayed with Mr Butterworth while they waited for the ambulance to arrive. She continued taking his observations and updated the ambulance control by telephone. She noted that Mr Butterworth was talking and was fully conscious throughout, although he appeared confused.

28. Prison staff called the ambulance service several times, to find out why the ambulance had not arrived. At around 11.15am, the nurse noted that Mr Butterworth was deteriorating and she called the ambulance service to say that he was in a potentially life-threatening condition. The ambulance eventually arrived at 11.37am. Paramedics assessed that Mr Butterworth needed to go to hospital. He was escorted to University Hospital Wales by two officers, using the single cuffing method (when the prisoner's wrist is attached to a prison officer's wrist by a set of handcuffs). At 12.25am, the ambulance arrived at the hospital.

29. At 1.10pm, a prison manager told officers to remove all restraints as Mr Butterworth was clearly very unwell. Over the next two hours his health quickly deteriorated and at 3.56pm, he died.

Contact with Mr Butterworth's family

30. On 13 February, when Mr Butterworth was taken to hospital, a prison manager appointed an officer as the family liaison Officer (FLO). Mr Butterworth's next of kin, his daughter, was a prisoner at HMP Eastwood Park. The FLO contacted Eastwood Park and told them that Mr Butterworth was very ill. Eastwood Park said that that they would arrange for Mr Butterworth's daughter to be taken to the hospital to see him. However, before the prison could escort her to the hospital, Mr Butterworth died.

31. The FLO visited Mr Butterworth's daughter at Eastwood Park and offered her support, and help with the funeral arrangements.

32. The prison arranged and paid for Mr Butterworth's funeral in line with national guidelines. The funeral took place on 13 March.

Support for prisoners and staff

33. After Mr Butterworth's death, a prison manager debriefed the staff involved in Mr Butterworth's care to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

34. The prison posted notices informing other prisoners of Mr Butterworth's death, and offered 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.

Cause of death

35. The coroner accepted the cause of death provided by the hospital and no post-mortem examination was conducted. The hospital recorded Mr Butterworth's cause of death as sepsis caused by pneumonia.

Findings

Clinical Care

36. Mr Butterworth had several health conditions including hepatitis C and chronic liver disease. The prison made sure that all care plans were in place and when Mr Butterworth's health deteriorated he was cared for appropriately. He was located in the healthcare unit where he received 24-hour nursing care.

37. When Mr Butterworth became unwell on 13 February, it took almost two hours for an ambulance to arrive. The clinical reviewer commented that the delay in the ambulance arriving and in Mr Butterworth being taken to hospital, may have contributed to his death.

38. The delay in the ambulance arriving was outside the control of the prison and ambulance service delays are not within the remit of our investigation. We are satisfied that the prison did all they could. They called the ambulance control regularly, and gave updates on Mr Butterworth's condition.

39. We are satisfied that Mr Butterworth received appropriate care and treatment at Cardiff. The clinical reviewer considered the standard of care was equivalent to that he could have expected to receive in the community.

Emergency Response

40. When the officer called a code blue, the control room operator did not acknowledge with a response. The officer called again but the control room still did not respond. It appears that there was a glitch in the system and the code blue call did not go through. When the investigator spoke to a prison manager, he said that this was not a regular occurrence and it was not due to any black spots in the prison. He said that if the radio network stopped working, there was a contingency in place and mobile phones would be used instead.

41. This appeared to be a one-off incident and even though it caused a short delay in the ambulance being called, I am satisfied it did not affect the outcome for Mr Butterworth.

42. We make no recommendations.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141