Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Arif Butt, a prisoner at HMP Littlehey, on 29 October 2021

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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

Summary

1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Arif Butt died in hospital on 29 October 2021 of a stroke, while a prisoner at HMP Littlehey. Mr Butt was 58 years old. I offer my condolences to Mr Butt's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Butt received at HMP Littlehey was equivalent to that which he could have expected to receive in the community. She made one recommendation about offering prisoners further opportunities to have regular checks of long-term conditions when they have the mental capacity to make decisions about their own care. We repeat the recommendation about this below.

5. We did not find any non-clinical issues of concern.

Recommendation

- The Head of Healthcare should ensure that when a prisoner with capacity declines an assessment and/or intervention for a long-term health condition, the associated risk of continued refusal is discussed with the prisoner at all future contacts and the discussion outcome is clearly recorded in the SystmOne records.

The Investigation Process

6. NHS England commissioned a clinical reviewer to review Mr Butt's clinical care at Littlehey.

7. The PPO investigator has investigated the non-clinical issues in Mr Butt's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. Our family liaison officer wrote to Mr Butt's next of kin, his daughter, to explain the investigation. Mr Butt's daughter did not have any specific questions or concerns but asked for a copy of our report.

Previous deaths at HMP Littlehey

9. Mr Butt was the 29th prisoner to die at HMP Littlehey since October 2019. Of the previous deaths, 27 were from natural causes and one was self-inflicted.

10. There are no similarities between our findings in the investigation into Mr Butt's death and our investigation findings for the previous deaths.

Key Events

11. On 14 July 2017, Mr Arif Butt was sentenced to 13 years in prison for a sexual offence. In July 2019, he transferred to HMP Littlehey.

12. Mr Butt was previously diagnosed with high cholesterol, and he took appropriate medication for his condition.

13. During his first and second stage health screening at Littlehey, it was recorded that Mr Butt had no significant previous or current medical issues. Over the years that followed, he had little significant contact with healthcare staff at Littlehey.

14. On 18 July 2019, Mr Butt had a medicines reconciliation assessment. He refused a blood test to check his cholesterol level. Healthcare staff respected his decision as there was no reason to suspect that he did not have the capacity to make this decision at the time. There is no evidence in his medical records to show that he was offered further cholesterol checks.

Events of 27 October 2021

15. On 27 October, Mr Butt was in an education class at the prison. A prisoner in the class told a teacher that Mr Butt was unwell. She and the prisoner called out to an officer (who was on duty in the education wing) for help.

16. When the officer entered the classroom, he saw Mr Butt slumped in a chair and the left side of his body was drooping. He suspected that Mr Butt had had a stroke. He radioed a 'code blue' (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Control room staff called an ambulance immediately.

17. The officer stayed with Mr Butt while the teacher got him some water. Another prisoner helped hold Mr Butt upright. The officer gave information to the control room to be relayed to the ambulance service. The ambulance service gave a response time of up to four hours.

18. A Custodial Manager (CM) attended. He was followed by two nurses. Both nurses believed that Mr Butt had either had, or was still having, a stroke, and that he needed emergency intervention that was beyond their ability to provide in a prison setting. They asked prison staff to update the ambulance service. The call was made at 4.28pm, and the waiting time for an ambulance was decreased to 90 minutes. Both nurses stayed with Mr Butt.

19. At 5.36pm, the ambulance arrived at the prison and at 5.45pm, Mr Butt was taken to Peterborough City Hospital.

20. At approximately 11.30pm, hospital staff told bedwatch officers that Mr Butt had a bleed on his brain and his condition was very serious and advised that his next of kin should be contacted. Shortly after this, a manager contacted Mr Butt's next of kin, his daughter, to inform her that her father had been taken to hospital. However, they were not able to make contact until 6.10am the next day as the calls were not answered as his daughter was asleep.

21. On 28 October, the prison appointed a CM as the Family Liaison Officer (FLO). He contacted Mr Butt's daughter and agreed to meet her at the hospital.

22. Mr Butt's health continued to deteriorate in hospital and at 7.50am on 29 October, it was confirmed that Mr Butt had died.

23. The FLO contacted Mr Butt's daughter to offer his condolences and continued support.

24. Mr Butt's funeral took place on 1 December 2021. In line with Prison Service instructions, the prison contributed towards the cost of the funeral.

Post-mortem report

25. The pathologist gave Mr Butt's cause of death as intraventricular and subarachnoid haemorrhage (a stroke), caused by bilateral cerebral infarction with haemorrhagic transformation (occurs following a stroke) and atrial fibrillation (abnormally fast heart rate).

Sue McAllister CB
Prisons and Probation Ombudsman **May 2022**

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