Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr George Butterfield, a prisoner at HMP Moorland, on 1 June 2022

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

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 George Butterfield died in hospital of heart failure on 1 June 2022, while a prisoner at HMP Moorland. He was 74 years old. We offer our condolences to Mr Butterfield's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Butterfield received at Moorland was equivalent to that which he could have expected to receive in the community. However, the clinical reviewer found that prison healthcare staff were inconsistent in the use of NEWS2 (a tool used to assess clinical deterioration in adult patients) in the days leading up to Mr Butterfield's hospital admission.

5. The Head of Healthcare at Moorland told the clinical reviewer that not all healthcare staff were recording NEWS2 scores on the correct template, which meant they were not always visible in the medical records.

6. We are also concerned that Moorland has not yet settled an invoice for Mr Butterfield's funeral expenses. The investigator asked the family liaison officer (FLO) on several occasions about the delay, but he did not provide an explanation.

Recommendations

- The Head of Healthcare should audit the use of NEWS2 and ensure all staff use the correct templates to record observations.

- The Governor should ensure funeral expenses are paid promptly after receiving an invoice and explain delays to the PPO when requested.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Butterfield's clinical care at HMP Moorland.

8. The PPO investigator investigated the non-clinical issues relating to Mr Butterfield's care, including Mr Butterfield's location, the security arrangements for his hospital escorts and liaison with his family.

9. The PPO family liaison officer wrote to Mr Butterfield's next of kin, his daughter, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Moorland

11. Mr Butterfield was the tenth prisoner to die at Moorland since June 2020. Of the previous deaths, eight were from natural causes and one was drug-related. There are no similarities between our findings in the investigation into Mr Butterfield's death and our findings from the previous deaths.

Key Events

12. On 16 May 2018, Mr George Butterfield was convicted of sexual offences and sentenced to nine years imprisonment. He was sent to HMP Leeds.

13. On 2 September 2020, Mr Butterfield was moved to HMP Moorland. Mr Butterfield had already been diagnosed with several long-term conditions including angina (chest pain caused by reduced blood flow to the heart), atrial fibrillation (irregular heart rate), diabetes and chronic obstructive pulmonary disease (COPD – a group of lung conditions which affect breathing).

14. On 29 May 2022, a prison officer asked a nurse to see Mr Butterfield as he was short of breath. The nurse completed clinical observations and helped Mr Butterfield take his prescribed inhalers, which helped calm his breathing. The nurse saw him later that day and checked his blood oxygen level, which was within normal range. On both occasions, there is no record the nurse used the National Early Warning Score (NEWS2) tool. (NEWS2 is a tool used to assess clinical deterioration in adult patients. Each clinical observation, which includes pulse, blood pressure, blood oxygen level, breathing rate, temperature and consciousness level, is given a score and the total score determines whether emergency treatment or further monitoring is needed.)

15. On the morning of 30 May, a prison nurse saw Mr Butterfield as he continued to complain of shortness of breath. The nurse completed observations which were all within normal range. There is no record the nurse used NEWS2.

16. That afternoon, the nurse completed further observations on Mr Butterfield and recorded a NEWS2 score of 1 (a score of 1 means further monitoring is required) due to a low blood oxygen level. The nurse completed further observations in the evening, when Mr Butterfield's blood oxygen level was back within normal range. The nurse recorded a NEWS2 score of zero (which meant no further action was required).

17. On 31 May at 9.05am, a prison nurse saw Mr Butterfield, who said his shortness of breath had worsened. She completed observations and recorded a NEWS2 score of 10 (which indicated that Mr Butterfield needed urgent treatment). She requested an emergency ambulance for Mr Butterfield. At 9.31am, paramedics arrived and took Mr Butterfield to hospital.

18. At 3.09pm, a prison nurse requested an update from the hospital on Mr Butterfield's condition. The hospital told her Mr Butterfield had been moved to the resuscitation unit after he went into cardiac arrest (where the heart suddenly stops pumping blood around the body) and was resuscitated. Following this, Mr Butterfield said he did not want anyone to resuscitate him if his heart or breathing stopped again and signed an order to that effect.

19. Mr Butterfield's condition deteriorated and at 9.10am on 1 June, he died in hospital.

Post-mortem report

20. The post-mortem report concluded that Mr Butterfield died of congestive cardiac (heart) failure caused by ischaemic heart disease.

Non-Clinical Findings

Payment of funeral expenses

21. When a prisoner dies, the family of the deceased are entitled to financial support of up to £3,000 towards funeral expenses from the prison. Prison Service Instruction (PSI) 64/2011 says that any funeral expenses should be paid directly by the prison to the funeral directors once an original invoice is received.

22. Mr Butterfield's funeral was held on 1 July, and the funeral directors issued an invoice two weeks before. The prison FLO told the investigator that Mr Butterfield's funeral invoice had not yet been paid. The investigator asked the FLO on several occasions about the delay, but he did not provide an explanation.

23. While PSI 64/2011 does not provide specific timescales on paying a funeral invoice, we would expect a prison to deal with this promptly, so the process is not unnecessarily prolonged for the family of the deceased.

24. We would also expect the prison to provide the PPO investigator with an explanation about delays in paying funeral invoices when requested. We recommend:

    The Governor should ensure funeral expenses are paid promptly after receiving an invoice and explain delays to the PPO when requested.

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