Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Catherine Botwright, a prisoner at HMP New Hall, on 18 May 2024

A report by the Prisons and Probation Ombudsman

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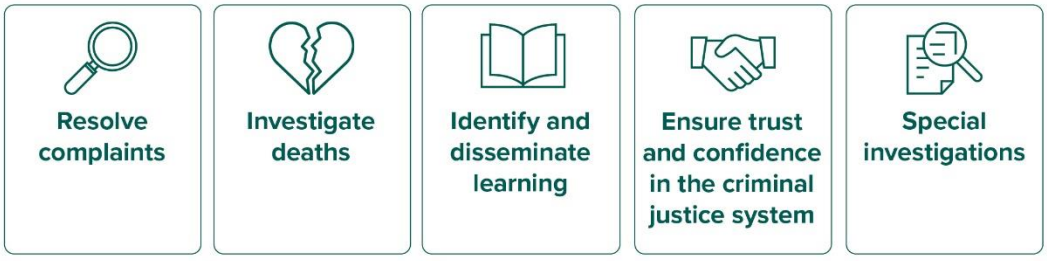
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. In August 2011, Ms Catherine Botwright (previously known as Catherine Hodges) was sentenced to life imprisonment for murder. She died in a hospice from cervical cancer on 18 May 2024, while a prisoner at HMP New Hall. She was 62 years old. We offer our condolences to Ms Botwright's family and friends.

4. The Ombudsman's office contacted Ms Botwright's husband and sister to explain the investigation and to ask if they had any matters they wanted us to consider. They raised concerns about Ms Botwright's healthcare, including missed hospital appointments, which have been addressed in the clinical review. They also raised concerns about delays with the early release on compassionate grounds (ERCG) application which we address below.

5. The PPO investigator investigated the non-clinical issues relating to Ms Botwright's care. We did not find any non-clinical issues of concern.

6. The prison started preparing an ERCG application in 2023, but at that time, Ms Botwright would not have met the criteria for ERCG as her prognosis was more than three months. The prison submitted an application on 15 April 2024, but it was refused on 1 May, despite the Governor of New Hall and probation staff supporting the application. The Public Protection Casework Section (PPCS) of HMPPS concluded that Ms Botwright's risk could not be effectively managed in the community. The remit of the PPO does not extend to reviewing decisions made by PPCS. We note that the prison arranged for Ms Botwright to be released on temporary licence to a hospice and they resubmitted an ERCG application on 14 May, which was not considered before Ms Botwright died. We consider that the prison did all they could to pursue early release for Ms Botwright.

7. NHS England commissioned an independent clinical reviewer to review Ms Botwright's clinical care at HMP New Hall.

8. The clinical reviewer concluded that the clinical care Ms Botwright received at New Hall was of a good standard and equivalent to that which she could have expected to receive in the community. She made two recommendations, one of which we repeat here:

   The Head of Healthcare should ensure that all external hospital appointment locations are cross referenced against referral information/hospital confirmation letters to ensure patients are taken to the correct appointment location.

9. We shared our initial report with HMPPS and with the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies. Practice Plus Group provided an action plan which is annexed to this report.

10. We sent copies of our initial report to Ms Botwright's husband and sister. They did not notify us of any factual inaccuracies.

11. The inquest, held on 5 June 2024, concluded that Ms Botwright died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman **October 2024**

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