Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Henry Bottomley, a prisoner at HMP Hull, on 13 October 2021

**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 we oversee can improve their work in the future.

Mr Henry Bottomley died in hospital from sepsis caused by bronchopneumonia on 13 October 2021, while a prisoner at HMP Hull. He was 89 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that mostly, the healthcare that Mr Bottomley received at Hull was equivalent to that which he could have expected to receive in the community.

However, there were a number of aspects that were not equivalent. She identified some shortcomings in his care after he returned from hospital in May 2021. We are concerned that there is no evidence that staff completed a thorough clinical review, there was a lack of clinical observations, missed palliative care reviews, and healthcare staff failed to include Mr Bottomley in decisions about his care.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

**Kimberley Bingham**
**Acting Prisons and Probation Ombudsman** **April 2023**

# Contents

# Summary

## Events

1. On 21 February 2020, Mr Henry Bottomley was sentenced to eight years in prison for sexual offences and sent to HMP Hull.

2. Mr Bottomley had several long-term medical conditions. Healthcare staff prescribed appropriate medications and created care plans to manage his conditions.

3. Before he arrived in prison, Mr Bottomley had an order in place not to be resuscitated if his heart or breathing stopped. Healthcare staff at Hull failed to discuss this with him to ensure that they were clear about his wishes.

4. In May 2021, a prison GP referred him urgently to colorectal specialists under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. However, no one followed up this referral.

5. At the beginning of October, Mr Bottomley told healthcare staff that he felt unwell and dizzy. They sent him to hospital by emergency ambulance, unrestrained and escorted by two officers. His condition deteriorated, and he died in hospital on 13 October 2021.

6. A post-mortem examination established that Mr Bottomley died from sepsis caused by bronchopneumonia.

## Findings

7. The clinical reviewer concluded that mostly, the standard of care that Mr Bottomley received at Hull was equivalent to that which he could have expected to receive in the community. However, she identified that some aspects of his care were not of the required standard and were not equivalent.

8. Healthcare staff did not discuss Mr Bottomley's resuscitation wishes with him. They failed to note any involvement they had with him when arranging his care plans.

9. Prison healthcare staff did not follow up Mr Bottomley's referral to cancer specialists as they should have done.

10. When Mr Bottomley was unwell, healthcare staff did not always use the National Early Warning Score (NEWS2, a tool to assess unwell patients) or a sepsis screening tool as they should have done.

## Recommendations

- The Head of Healthcare should ensure that prisoners receiving palliative care are given the opportunity to discuss their wishes about resuscitation.

- The Head of Healthcare should ensure that there is a streamlined and robust system in place so that prisoners with current or previous cancer diagnoses receive appropriate follow-up care.

- The Head of Healthcare should ensure that clinical staff assess and manage prisoners effectively to enable good standards of care, including that:
    - all treatment is fully documented in prisoners' medical records to allow effective continuity of care;
    - clinical staff are aware of the triggers for escalation and when to organise further investigations;
    - prisoners with a palliative care plan who are discussed in complex care/Gold Standard Framework (GSF) meetings have regular reviews, and all actions are recorded in their medical records; and
    - palliative nursing plans are individualised and amended to reflect any medical changes.

## The Investigation Process

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

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

13. NHS England and NHS Improvement commissioned a clinical reviewer to review Mr Bottomley's clinical care in prison.

14. We informed HM Coroner for Hull of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.

15. The Ombudsman's family liaison officer contacted Mr Bottomley's next of kin, a friend, to explain the investigation and to ask if he had any matters that he wanted us to consider. He did not have any questions but asked for a copy of our report.

16. Mr Bottomley's friend received a copy of the initial report. He raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

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

# Background Information

## HMP Hull

18. HMP Hull is a local prison that holds up to 1,056 men in ten wings. City Healthcare Community Partnership (CHCP) provides health services at the prison. GP surgeries are held four days a week, with an out-of-hours service at other times.

## HM Inspectorate of Prisons

19. The most recent inspection of HMP Hull was in March 2022. Inspectors reported that healthcare services were failing in some critical areas. Inspectors were not confident that partnership working was providing sufficient oversight and governance. They found that there were serious risks and unmet needs which needed immediate attention. HMIP considered that healthcare services had ongoing staff shortages which had a negative impact on the delivery of safe patient care.

## Independent Monitoring Board

20. 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 February 2021, the IMB reported that the prison provided a full range of healthcare services. They found that elderly prisoners, some of whom were disabled, were well supported. They noted that staff had worked hard to maintain the provision under extreme pressure over the last year. However, the complexity of the health service complaints system had led the IMB to question whether the provision of care was equivalent to the community.

21. The IMB noted that in December 2020, the Care Quality Commission (CQC) had carried out an inspection of healthcare services and served a section 31 notice to CHCP. (A section 31 notice sets out that the CQC has reasonable cause to believe that there is a risk of harm, unless action is taken.) CHCP had begun work on an action plan. The IMB also noted that the most frequent concern raised in applications to them was about healthcare.

## Previous deaths at HMP Hull

22. Mr Bottomley was the fourteenth prisoner to die at Hull since October 2019. Of the previous deaths, six were from natural causes, six were self-inflicted and one was drug-related. There were no significant similarities between our investigation findings about Mr Bottomley's death and those about the previous deaths.

# Key Events

23. On 21 February 2020, Mr Henry Bottomley was sentenced to eight years in prison for sexual offences and sent to HMP Hull. Mr Bottomley had several pre-existing, long-term conditions, including bowel cancer (he had had surgery and used a colostomy bag), Barrett's oesophagus (a pre-cancerous condition, where there are abnormal cells lining the oesophagus), osteoarthritis, deep vein thrombosis and a pulmonary embolism. Healthcare staff created care plans and had regular contact with him to manage his conditions.

24. Before he arrived in prison, Mr Bottomley had an order in place not to be resuscitated if his heart or breathing stopped. There is no evidence that healthcare staff discussed this order with him or updated it while he was at Hull.

25. Healthcare staff arranged for Mr Bottomley to attend hospital appointments with colorectal specialists to monitor for any return of the cancer.

26. Mr Bottomley's palliative care plan was discussed at a Gold Standard Framework (GSF) meeting which the prison and secondary providers attended. There is no evidence that Mr Bottomley had any input to the meeting.

**2021**

27. Mr Bottomley had a routine blood test. On 20 May, a prison GP saw him to discuss the test results which were abnormal. He noted that Mr Bottomley had declining haemoglobin levels and a history of bowel cancer. He referred him to colorectal specialists under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. However, the referral was never completed because hospital specialists queried whether they were the most suitable hospital for the referral. Healthcare staff did not follow this up.

28. On 22 September, Mr Bottomley felt light-headed and dizzy. Nurses visited him in his cell and checked his observations and urine which were within a normal range. Healthcare staff told prison staff to contact them if his condition deteriorated.

29. On 29 September, Mr Bottomley saw a prison dentist after complaining of a toothache and was prescribed antibiotics.

30. On 5 October, another prison GP saw Mr Bottomley because he was still feeling nauseous and dizzy. Mr Bottomley did not attend a scheduled dental appointment because he felt too unwell. The GP noted that his blood test results were abnormal and sent him to hospital, unrestrained and with two officers.

31. The hospital diagnosed Mr Bottomley with a dental abscess and labyrinthitis (an inner ear infection that affects balance). He returned to Hull that day, with prescribed medication for nausea.

32. On 6 October, a nurse completed Mr Bottomley's observations. She noted that his blood pressure was low and that he refused to sit up or drink fluids. Healthcare staff did not complete his observations for the rest of the day. The next day, healthcare staff sent him to hospital because his medication was not working, and he was still feeling nauseous and dehydrated.

33. Hospital specialists diagnosed Mr Bottomley with pneumonia and a dental abscess. His condition continued to deteriorate in hospital and Mr Bottomley died on 13 October.

## Contact with Mr Bottomley's family

34. On 5 October 2021, the prison appointed a family liaison officer (FLO). He contacted Mr Bottomley's friend (whom he had listed as his emergency contact) to advise him that Mr Bottomley was on his way to hospital. The FLO maintained contact with Mr Bottomley's friend by telephone over several days to advise him that Mr Bottomley was seriously ill in hospital, and he arranged for his friend to visit him. When Mr Bottomley died, the FLO contacted his friend to offer his condolences and support. The prison contributed towards the cost of Mr Bottomley's funeral in line with national instructions.

## Support for prisoners and staff

35. After Mr Bottomley's death, the duty governor debriefed the escorting staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

36. The prison posted notices informing other prisoners of Mr Bottomley's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Bottomley's death.

## Post-mortem report

37. The coroner concluded that Mr Bottomley died from sepsis caused by bronchopneumonia. He also had a dental abscess, acute myeloid leukaemia, ischaemic heart disease (narrowing of the arteries) and chronic kidney disease which did not cause but contributed to his death.

# Findings

38. The clinical reviewer concluded that, overall, Mr Bottomley's care was reasonable and equivalent to that which he could have expected to receive in the community. However, she found some shortcomings in his care and concluded that there were many aspects that were not equivalent.

## Continuity of care

39. The clinical reviewer found that there was a lack of continuity with Mr Bottomley's cancer care provision because referrals to secondary care under the two-week cancer pathway were not managed effectively. We recommend that:

**The Head of Healthcare should ensure that there is a streamlined and robust system in place so that prisoners with current or previous cancer diagnoses receive appropriate follow-up care.**

40. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners gives guidance on the clinical management of prisoners and emphasises the importance of continuity in the success of clinical interventions and treatment. Mr Bottomley had already completed an order not to be resuscitated at Hull if his heart or breathing stopped. Healthcare staff failed to discuss Mr Bottomley's resuscitation wishes with him and to keep it under review as they should have done. We make the following recommendation:

**The Head of Healthcare should ensure that prisoners receiving palliative care are given the opportunity to discuss their wishes about resuscitation.**

41. The clinical reviewer found that there was no record of a palliative care review, there was poor communication with Mr Bottomley when discussing his diagnosis and there is no evidence that healthcare staff ensured that his needs and preferences were taken into account.

42. The clinical reviewer also found that despite having low blood pressure and refusing to drink fluids on 6 October, healthcare staff failed to use NEWS2 (which should be used routinely when a prisoner is unwell). A sepsis screening tool was not completed, a care plan and fluid balance chart were not initiated, and Mr Bottomley's clinical observations were not checked as they should have been. We recommend that:

**The Head of Healthcare should ensure that clinical staff assess and manage prisoners effectively to enable good standards of care, including that:**

- **all treatment is fully documented in prisoners' medical records to allow effective continuity of care;**
- **clinical staff are aware of the triggers for escalation and when to organise further investigations;**
- **prisoners with a palliative care plan who are discussed in complex care/GSF meetings have regular reviews, and all actions are recorded in their medical records; and**

- **palliative nursing plans are individualised and amended to reflect any medical changes.**

43. The clinical reviewer made other recommendations about clinical observations and clinical staff training which do not relate to Mr Bottomley's death, and we do not repeat here but which the Head of Healthcare will need to address.

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