

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

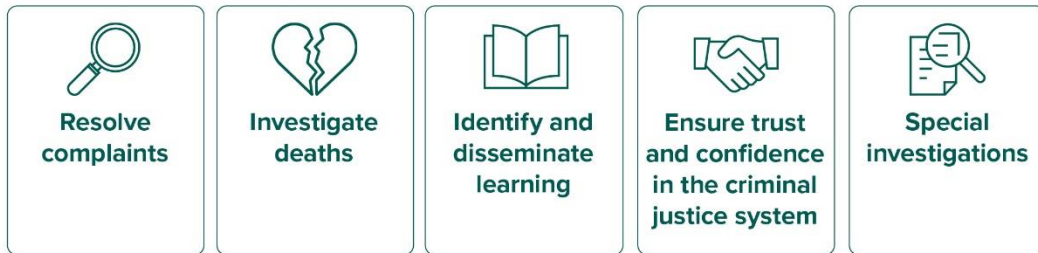
# **Independent investigation into the death of Mr John Botham, a prisoner at HMP Nottingham, on 13 January 2023**

**A report by the Prisons and Probation Ombudsman**

## 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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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.

If my office is to best assist HM Prisons 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.

Mr John Botham died in hospital on 13 January 2023, while a prisoner at HMP Nottingham. The cause of his death was heart disease. He was 60 years old. I offer my condolences to Mr Botham's family and friends.

I am satisfied that Mr Botham's clinical care at Nottingham was equivalent to that which he could have expected to receive in the community. However, in medical emergencies, healthcare staff must share key clinical details with control room staff, to assist the ambulance service to prioritise responses.

Mr Botham was in restraints while an inpatient in the intensive care unit and during intravenous treatment. The use of restraints in these circumstances was disproportionate and unacceptable.

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

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**November 2023**

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# Summary

## Events

1. Mr John Botham was convicted of harassment and breach of a restraining order and sentenced to nine months and six days imprisonment. He was sent to HMP Nottingham on 14 December 2022.
2. Mr Botham was dependent on alcohol and had been diagnosed with cirrhosis of the liver, as well as fluid in his abdomen. He completed a five-day alcohol detoxification programme.
3. On 31 December, Mr Botham had symptoms of dizziness and stomach pain, and healthcare staff found that his blood pressure was very low. An emergency ambulance was requested at 3.14pm and paramedics arrived at the cell at 5.25pm.
4. Mr Botham was taken to hospital, where he was admitted to the intensive care unit. He was initially treated for dehydration and low blood pressure. On 1 January 2023, he had surgery for internal bleeding.
5. In the early hours of 13 January, Mr Botham's breathing stopped. He was resuscitated and placed on a ventilator. However, at 11.55am that morning, his treatment was withdrawn, and Mr Botham died at 1.47pm.

## Findings

6. The investigation found that Mr Botham's clinical care was equivalent to that which he could have expected to receive in the community.
7. The clinical reviewer considered that healthcare staff should have shared the details of Mr Botham's blood pressure readings with control room staff. Had this information been passed to the ambulance service, the request for an ambulance might have been given higher priority, with a quicker response time.
8. Given Mr Botham's poor state of health when he left the prison, the use of handcuffs was disproportionate. It was unacceptable that he was restrained while receiving intravenous treatment and in the intensive care unit. Prison managers should have acted on the updates from the escort officers and reviewed Mr Botham's security risk sooner.

## Recommendations

- The Head of Healthcare should ensure that when requesting an emergency ambulance, healthcare staff share specific details of the prisoner's symptoms and the results of clinical observations, to be passed to the ambulance service.

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that in all cases:
  - healthcare staff fully complete the medical information section of the escort risk assessment to reflect how the prisoner's current clinical condition affects their ability to escape unaided;
  - the authorising manager confirms they have taken this information into account in decisions on the level of risk and the use of restraints; and
  - managers promptly review a prisoner's risk when circumstances change.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Nottingham informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Botham's prison and medical records.
11. NHS England commissioned an independent clinical reviewer to review Mr Botham's clinical care at the prison.
12. We informed HM Coroner for Nottingham City and Nottinghamshire of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
13. The Ombudsman's family liaison officer contacted Mr Botham's son to explain the investigation. Mr Botham's son had no specific matters for the investigation to consider.
14. We sent a copy of the initial report to Mr Botham's son. He made no comments.
15. The initial report was shared with HMPPS and they found no factual inaccuracies.

## **Background Information**

### **HMP Nottingham**

16. HMP Nottingham is a resettlement and local prison serving the courts of Nottinghamshire and Derbyshire. It has capacity for approximately 900 men. Nottinghamshire Healthcare NHS Foundation Trust provides healthcare services.

### **HM Inspectorate of Prisons**

17. The most recent inspection of HMP Nottingham was in May and June 2022. Inspectors said that it was a challenging prison to run and, although it was improving from the low base of previous recent inspections, progress was still required in many areas.
18. Inspectors found that health services were well led but had become stretched since their last inspection in 2020 and that staff shortages were affecting service delivery. However, most essential provision continued, and governance and oversight arrangements were robust with good processes to identify and mitigate risk. They said the management of long-term conditions was good.

### **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 28 February 2022, the IMB reported that the prison was gradually returning to a normal regime following the COVID-19 pandemic. This included prisoners having more face-to-face appointments with healthcare staff.

### **Previous deaths at HMP Nottingham**

20. Mr Botham was the fourteenth prisoner at Nottingham to die since January 2020. Ten were from natural causes, two were self-inflicted and one was due to substance misuse. We have previously raised the issue of risk assessments and the use of restraints.

## Key Events

21. Mr John Botham was convicted of harassment during a suspended sentence and breach of a restraining order. On 14 December 2022, he was sentenced to nine months and 6 days in prison and sent to HMP Nottingham. It was not his first time in prison.
22. A nurse completed Mr Botham's initial health screen, including clinical observations. Mr Botham had been diagnosed with cirrhosis of the liver, ascites (fluid in the abdomen), portal hypertension, enlarged or swollen veins in the lining of the oesophagus and anxiety. He disclosed that he was dependent on alcohol and an alcohol screen audit indicated severe alcohol dependence. The nurse referred him to both the substance misuse and mental health services.
23. A GP at the prison reviewed Mr Botham immediately after the health screen and noted that he appeared to be withdrawing from alcohol. Mr Botham then began a five-day alcohol detoxification programme.
24. On 15 December, a care plan was created to manage Mr Botham's liver disease. The next day, a nurse conducted a second-stage health assessment. After completing his detoxification, Mr Botham had no other significant contact with healthcare staff until 31 December.

## Events of 31 December and Mr Botham's admission to hospital

25. In the early hours of 31 December, a wing officer informed a night nurse that Mr Botham had snapped a wisdom tooth. The nurse advised that he could get pain relief from the medication hatch later that morning.
26. Just after 11.00am, a nurse gave Mr Botham paracetamol for his toothache. During the course of the day, the nurse noted that he asked for further painkillers and appeared to be in pain. She asked if he had any health issues and he mentioned ascites, so she arranged for another nurse to examine him.
27. A nurse reviewed Mr Botham at approximately 3.00pm. He felt unwell with symptoms of dizziness, toothache and stomach pain, as well as unsteadiness on his feet. His blood pressure was very low, scoring five on the National Early Warning Score 2 (NEWS2 – a tool to detect clinical deterioration in patients). The score indicated that he should be urgently assessed by a clinician experienced in acute illness.
28. A code blue emergency was called, and an ambulance was requested at 3.14pm. The ambulance service initially estimated a waiting time of up to eight hours. The prison updated the details of Mr Botham's condition and healthcare staff monitored him while waiting. Paramedics arrived at Mr Botham's cell at 5.25pm.
29. Shortly after 6.00pm, Mr Botham was taken to Queens Medical Centre, Nottingham. He was escorted by two prison officers and handcuffed. The escort officers regularly updated the prison's operational manager. Mr Botham received intravenous treatment for dehydration and, late evening, he was moved to the intensive care unit.

30. On 1 January 2023, a prison manager conducted a management check at the hospital and reviewed the security risk assessment. He authorised removal of the restraints due to Mr Botham's lack of mobility, short sentence and low risk on all security factors and instructed the escort staff not to re-apply them if Mr Botham's health improved. The restraints were removed at 8.40am. Later that day, Mr Botham had surgery for internal bleeding.
31. Healthcare staff tried to obtain daily updates, but there was often no answer from the ward. On 8 January, Mr Botham was moved from the intensive care unit to a general ward.
32. In the early hours of 13 January, Mr Botham's breathing stopped. He was resuscitated, sedated and placed on a ventilator in the intensive care unit. At 11.55am, the hospital withdrew treatment and removed Mr Botham's ventilation. His death was confirmed at 1.47pm.

### **Contact with Mr Botham's Family**

33. During the management check on 1 January, a prison manager asked Mr Botham for the name and contact details of his next of kin. Mr Botham said this was a friend (but it was later established that the person he named was his son).
34. Just after 4.00pm on 1 January, a prison manager informed Mr Botham's son that Mr Botham was in hospital and, although his condition had initially been stable, he had since deteriorated and needed surgery. The next day, the manager gave permission for Mr Botham's two sons to visit him in hospital.
35. The prison assigned a family liaison officer when Mr Botham's condition further deteriorated on 13 January. She made several calls to both sons to give updates from the hospital.
36. After Mr Botham's death, the family liaison officer telephoned Mr Botham's sons immediately to break the news and offer support. The prison arranged and paid for Mr Botham's funeral.

### **Support for prisoners and staff**

37. The prison posted notices informing staff and prisoners of Mr Botham's death and offering support.

### **Post-mortem report**

38. The post-mortem report concluded that the cause of Mr Botham's death was ischaemic heart disease, due to severe coronary artery atheroma and cardiomegaly (a build-up of fatty material in the arteries and an enlarged heart). Alcoholic liver disease, portal hypertension, duodenal ulcer and peripheral vascular disease also contributed to, but did not cause his death.

# Findings

## Clinical care

39. The clinical reviewer concluded that Mr Botham's clinical care was of a satisfactory standard and equivalent to that which he could have expected to receive in the community.
40. The clinical reviewer made a recommendation about the need for healthcare staff to review a patient's medical records before planned appointments. As this was unrelated to Mr Botham's cause of death, we have not repeated it in this report, but the Head of Healthcare will need to consider it.

## Emergency response

41. The clinical reviewer noted that healthcare staff did not share details of Mr Botham's blood pressure readings with control room staff. She considered that if this information had been provided to the Ambulance Service, the request might have been assigned higher priority with a quicker response time. We recommend:

**The Head of Healthcare should ensure that when requesting an emergency ambulance, healthcare staff share specific details of the prisoner's symptoms and the results of clinical observations, to be passed to the ambulance service.**

## Security risk assessments and the use of restraints

42. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.
43. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. The judgment indicated that a medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
44. These requirements are reflected in the HMPPS' Prevention of Escape – External Escorts Policy Framework, on the use of restraints. The policy encourages sensitive handling to ensure that the needs of security are balanced against the clinical needs of a seriously ill prisoner and makes clear that restraints should not be used, "... if the prisoner's medical condition or advanced age or physical impairment renders restraints inappropriate ... unless there is intelligence to suggest that an escape attempt might be made".

45. The medical section of the security risk assessment for Mr Botham's journey to hospital indicated an objection to the use of restraints, but the reasons were not recorded. There is no evidence that the objection was taken into account, albeit the risk assessment concluded that Mr Botham was low risk on all the specific aspects of concern, such as the risk of escape and the likelihood of outside assistance to escape.
46. Given Mr Botham's poor condition when he left the prison, we are not persuaded that the use of restraints was justified for the journey to hospital, and it was unacceptable that he was restrained while in the intensive care unit and during intravenous treatment. We acknowledge that the restraints were removed within a day, but given the frequent updates to the prison, there was ample opportunity to review the risk assessment sooner. We recommend:

**The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that in all cases:**

- **healthcare staff fully complete the medical information section of the escort risk assessment to reflect how the prisoner's current clinical condition affects their ability to escape unaided;**
- **the authorising manager confirms they have taken this information into account in decisions on the level of risk and the use of restraints; and**
- **managers promptly review a prisoner's risk when circumstances change.**

## **Inquest**

47. The inquest, held on 22 November 2023, concluded that Mr Botham died from natural causes.

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