

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Foster, a prisoner at HMP Five Wells, on 19 March 2023

A report by the Prisons and Probation Ombudsman

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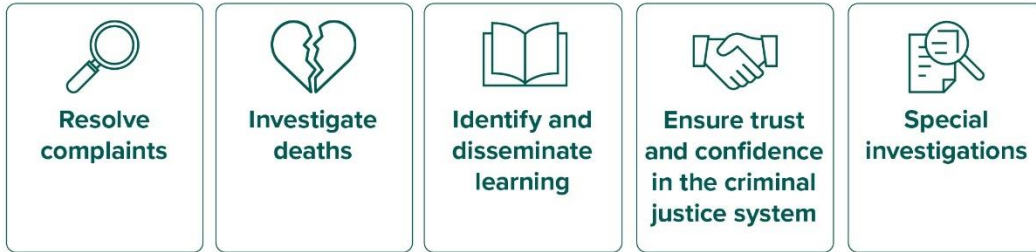
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OUR VISION

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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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. 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. Mr Anthony Foster died in hospital on 19 March 2023 of advanced colon cancer while a prisoner at HMP Five Wells. He was 74 years old. We offer our condolences to Mr Foster's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Foster received at Five Wells was equivalent to what he could have expected to receive in the community. The clinical reviewer made a recommendation about the use of NEWS2 (a nationally recognised clinical tool to detect deterioration in a patient).
5. We found no non-clinical issues of concern.

The Investigation Process

6. HMPPS notified us of Mr Foster's death on 20 March 2023.
7. NHS England commissioned an independent clinical reviewer to review Mr Foster's clinical care at Five Wells.
8. The PPO investigator investigated the non-clinical issues relating to Mr Foster's care.
9. The PPO family liaison officer wrote to Mr Foster's son to explain the investigation and to ask if he had any matters he wanted us to consider. He asked questions about Mr Foster's initial cancer diagnosis and his care, which have been addressed in the clinical review and this report.
10. Mr Foster's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Five Wells

12. Mr Foster was the second prisoner to die at Five Wells since it opened in 2022. The previous death was from natural causes. There are no similarities between our findings in the investigation into Mr Foster's death and our investigation findings for the previous death.

Key Events

13. On 10 June 2022, Mr Anthony Foster was sentenced to four years and six months imprisonment for sexual offences and was sent to HMP Peterborough.
14. Mr Foster had two pre-existing medical conditions, which were hypertension (high blood pressure) and type 2 diabetes. He received appropriate medications and was referred to the long term conditions clinic.
15. On 24 February 2023, Mr Foster was transferred to HMP Five Wells.
16. On his arrival, healthcare staff conducted an initial health screen and a secondary health screen on 25 February. Mr Foster complained of having abdominal pains, bowel issues and weight loss. He also said that he was not eating properly because when he ate it felt like his colon was getting full.
17. On 28 February, a paramedic at the prison completed a routine review with Mr Foster. The paramedic weighed Mr Foster and noted that he had lost three kilograms in the four days he had been at Five Wells. The paramedic arranged to discuss an urgent hospital referral for Mr Foster with a GP at the prison.
18. Later that day, a nurse at the prison noted that Mr Foster was frail, lethargic and grey in colour. She completed a plan for an urgent GP review to ensure that Mr Foster was referred urgently to hospital under the two week fast track referral process for suspected upper gastrointestinal cancer. Healthcare staff monitored Mr Foster. His observations were checked and were all within a normal range.
19. On 1 March, healthcare staff completed blood tests and a GP saw Mr Foster and sent him to hospital. Mr Foster discharged himself from hospital due to the long waiting times.
20. On 2 March, healthcare staff received Mr Foster's blood test results, and they were abnormal. Healthcare staff sent Mr Foster back to hospital. Two officers escorted him and he was not restrained.
21. In hospital, Mr Foster had a CT scan which showed that he had widespread cancer. Specialists told him that he would have palliative and end of life care. During his hospital admission, healthcare staff at Five Wells allocated a planned care lead for Mr Foster who consulted with the hospital. Healthcare and prison staff also held a multi-disciplinary meeting to discuss the practical arrangements in the event Mr Foster returned to Five Wells or obtained a hospice place.
22. On 10 March, healthcare staff visited Mr Foster in hospital. He told them that he did not want to return to Five Wells. Prison staff started an application for compassionate release. Mr Foster died before a final decision had been made.
23. Mr Foster's condition continued to deteriorate in hospital and on 19 March, it was confirmed that Mr Foster had died.

Cause of death

24. The coroner accepted the cause of death provided by a hospital doctor. The doctor gave Mr Foster's cause of death as advanced carcinoma of the sigmoid colon, with adrenal, liver, lung and bone metastases (colon cancer which had spread to other organs).

Adrian Usher
Prisons and Probation Ombudsman

December 2023

Inquest

At the inquest, held on 30 March 2026, the Coroner concluded that Mr Foster died from natural causes.

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