

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Baby C, the child of a prisoner at HMP Foston Hall, on 16 October 2023

A report by the Prisons and Probation Ombudsman

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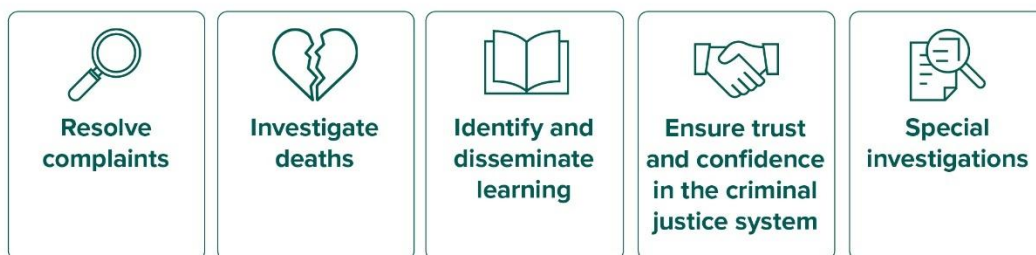
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OUR VISION

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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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 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.

Baby C died at the Royal Derbyshire Hospital on 16 October 2023, just over 24 hours after they were born. The baby's mother, Ms C, was admitted to hospital from HMP Foston Hall around seven hours before the birth. I offer my condolences to Ms C and her partner.

Ms C was in prison for just four days when she was admitted to hospital, having been 34 weeks pregnant when she was recalled to prison having breached her licence for a previous sentence. Her pregnancy was high-risk, and she had limited contact with maternity services in the community.

The clinical reviewers found that the pregnancy related care Ms C received at Foston Hall was not equivalent to that which she could have expected to receive in the community. Information about Ms C's high-risk pregnancy was not fully shared with relevant prison staff and clinical records lacked detail. The prison midwife was working in isolation, with little accountability or direct supervision. Following Ms C's recall, the prison midwife should have completed and recorded a full antenatal assessment and escalated her care to appropriate hospital specialists. There was also a delay in admitting Ms C to hospital before she gave birth, when she reported reduced fetal movement.

Just a few hours after she gave birth, prison bed watch staff inappropriately handcuffed Ms C.

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

May 2025

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Summary

Events

1. On 10 October 2023, Ms C was returned to prison, having breached her release licence, and was taken to HMP Foston Hall. She was approximately 34 weeks pregnant.
2. Ms C had a history of high-risk pregnancies, due to having a rare blood group. She also had a history of substance misuse and was prescribed methadone (an opiate substitute).
3. At around 11.15am on 14 October, Ms C told a nurse that her baby's movements had reduced. At around 4.00pm, she reported that the baby had not moved since the morning. Foston Hall contacted the Pregnancy Assessment Unit (PAU) for advice and Ms C was taken to hospital.
4. At 1.06am on 15 October, Ms C gave birth to Baby C. The baby had to be resuscitated, was noted to have numerous health complications and was unlikely to survive.
5. At 6.05am on 16 October, Baby C died.

Findings

6. The clinical reviewers found that Ms C's general nursing care was equivalent to that she could expect to receive in the community. They concluded that the standard of pregnancy care was not equivalent. Ms C's high-risk pregnancy and limited antenatal care in the community meant that she should have been urgently assessed by a fetal medicine consultant and/or a senior obstetrician. An urgent appointment was not made, and the first time Ms C went to hospital was when she gave birth.
7. Recording of midwifery care and observations at Foston Hall was poor with multiple different records used, which meant that information was not always accessible to those who needed it. Not all staff who worked with Ms C had received HMPPS training on pregnancy and perinatal care in prisons, and the training package available had some notable omissions.
8. On the day of her admission, Ms C's reduced fetal movements were not escalated as quickly as they should have been.
9. Handcuffs were inappropriately applied to Ms C within a few hours of her giving birth.

Recommendations

- NHS England should commission an independent review of the standard of midwifery care provided at HMP Foston Hall. The review should include the standard of midwifery documentation; the nature and content of clinical contacts;

referrals completed, communication and escalation pathways; and supervision of midwifery care at HMP Foston Hall.

- The Head of Healthcare should review the prison medical record to ensure that key information regarding a pregnancy and any associated care plans are easily accessible to all healthcare staff.
- NHS England should ensure that all relevant community and hospital records are provided for the purpose of a PPO investigation following the death of a baby.
- The Head of Healthcare should ensure that nurse prescribers are adequately informed regarding antidepressant medication, including what is safe to use in pregnancy, and the risks associated with immediately stopping prescribed medication.
- The Head of Healthcare should ensure that all bereaved prisoners who request antidepressant medication are seen by a GP and/or nurse prescriber in a timely manner.
- The Governor should ensure that all required observations, comments and summaries are recorded in a prisoner's Pregnancy Support Plan, in line with national and local guidelines.
- The Prison Group Director for the Women's Estate should review the current training package for staff working directly with pregnant prisoners, to ensure they receive training to equip them with the required skills and knowledge to care for pregnant prisoners safely. This training should include the importance of fetal movements and escalation pathways if a prisoner reports reduced fetal movements.
- The Governor should ensure that local policy regarding *Hospital Escorts – Prisoners Under Escort to Give Birth* is revised to include guidance to staff following a birth, including that:
 - Prisoners who have given birth are not restrained in hospital unless there are significant indicators of high risk of escape or to the public; and
 - The escort risk assessment is reviewed and revised before the prisoner returns from hospital, giving consideration to information about their current health and mobility.

The Investigation Process

10. HMPPS notified us of Baby C's death on 16 October 2023.
11. The investigator issued notices to staff at HMP Foston Hall informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. The investigator visited Foston Hall on 23 October. She introduced herself to Ms C and explained the remit of the investigation. The investigator visited the remand unit and prison healthcare. She obtained copies of relevant extracts from Ms C's prison and medical records. She also obtained the HMPPS Early Learning Review, Post Incident Initial Review Report completed by Practice Plus Group, and relevant extracts from Ms C's Probation Service records.
13. NHS England commissioned a clinical reviewer to review Ms C's physical and mental healthcare at the prison and a consultant midwife to review Ms C's midwifery and obstetric care at Foston Hall. The investigator, together with the clinical reviewers, interviewed eleven members of prison and healthcare staff at Foston Hall. In addition, the investigator interviewed the Deputy Head of Dudley and Sandwell Probation Delivery Unit, and three officers from other establishments that undertook bed watch duties. The remit of this investigation does not include a review of the care Ms C received in the community or in hospital.
14. The investigator met Ms C again via a video link on 7 November to hear about her experience. The investigator and clinical reviewers attempted to meet with Ms C before she was released from prison but, due to her ongoing physical health issues, were unable to do so. They attempted to engage with her after she was released from prison, but Ms C did not attend a planned meeting, or respond to subsequent phone calls.
15. We informed HM Coroner for Derbyshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
16. The investigator also contacted Ms C's partner to explain the investigation and to ask if he had any matters he wanted us to consider. Ms C and her partner asked some questions outside the remit of our investigation, but asked the following questions relating to Ms C's time at Foston Hall and Baby C's death:
 - Why were restraints applied to Ms C shortly after giving birth and again in the labour ward before she returned to Foston Hall?
 - Why some bed watch staff made inappropriate and offensive comments?
 - Did Baby C have to be resuscitated after their birth?
17. Baby C's parents received a copy of the initial report. They did not identify any factual inaccuracies. The solicitor representing Baby C's parents wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

18. The prison also received a copy of the report. They did not identify any factual inaccuracies. We have issued a revised version of the clinical review report.

Background Information

HMP Foston Hall

19. HMP Foston Hall is a closed women's prison serving courts in the Midlands. It holds remanded and sentenced women. Practice Plus Group provides primary and mental healthcare services.
20. NHS England are responsible for commissioning maternity services in prisons, including midwifery services. Commissioning arrangements vary across the country, however women in prison have access to community midwifery services at all women's prisons. Diagnostic and obstetric services are available onsite or at local NHS Trusts subject to need. Health Visiting Services are commissioned by the Local Authority for the prison with health providers providing onsite care as appropriate.
21. At the time that Ms C was at Foston Hall, a midwife was employed to work 15 hours a week at the prison; she was employed by University Hospitals Derbyshire and Burton (UHDB). One midwife provided most of the midwifery care at Foston Hall. During Ms C's custody in June 2023, the midwife was on leave therefore midwifery care was provided by her colleagues from the midwifery team at UHDB (known as the Juno Team, who provide primary and secondary maternity care).

HM Inspectorate of Prisons

22. The most recent full inspection of Foston Hall was in November 2021. Inspectors found a deterioration in the regime and the provision of purposeful activity, and that safety outcomes were poor. Inspectors found that the support offered to newly arrived women was not good enough.
23. Inspectors noted that pregnant women received care from the local Trust's midwife who supported mothers through their pregnancy and postnatal period. The local midwife services prepared mothers to give birth and provided birthing plans and separation packs. The midwife visited the prison each week and discussed with the lead GP and a local nurse specialist the detoxification of pregnant women who misused substances. Two prison officers with appropriate training worked closely with the midwife to support these women. However, inspectors reported that not all staff knew the expected date of delivery for women in their care which did not meet expectations.
24. There was an established pathway to refer women to the Birth Companions charity which supported women during pregnancy and when they were separated from their babies. Women had access to support and counselling which reflected national guidance on support with miscarriage and bereavement.
25. Inspectors returned to Foston Hall in August 2022, to undertake a review of progress. They found that support for new arrivals had improved.

Independent Monitoring Board

26. 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 November 2023, the IMB reported that a new Governor took up post in October 2023 and that significant number of new staff had started. Training, mentoring and induction had been prioritised. The IMB noted that the regime was less restricted than the previous year.
27. IMB members reported that healthcare providers faced challenges with recruitment and retention, particularly the mental health team. They found that there was an increasingly joined up approach to perinatal care.

Key Events

28. On 1 June 2023, Ms C was charged with theft and a breach of bail and remanded to HMP Foston Hall. On 21 July, she was sentenced to 12 months imprisonment. Due to the length of time she had been on remand, and time monitored by an electronic curfew, she was released the same day. On 22 September, Ms C was recalled to custody as she had failed to attend probation appointments, reside as directed and for poor behaviour. She was arrested on 10 October and returned to Foston Hall.
29. Ms C has several physical health conditions, a long history of substance misuse and was prescribed methadone (an opiate substitute). She had previously given birth to four children, all of whom had survived.

1 June to 21 July 2023

30. When Ms C first arrived in custody on 1 June 2023, a test confirmed she was pregnant. A nurse completed her initial health screen and recorded Ms C's clinical observations, which were all normal. A urine test confirmed that Ms C was positive for using opiates, methadone and cocaine, and an alcohol assessment showed that she was drinking at a harmful level. Ms C disclosed that she had used heroin and crack.
31. On 2 June, Ms C told a mental health nurse that she was diagnosed with Post Traumatic Stress Disorder (PTSD - a mental health condition caused by very stressful, frightening or distressing events) and Emotionally Unstable Personality Disorder (EUPD - this is a pervasive pattern of unstable and intense interpersonal relationships, self-perception, and moods. Impulses are poorly controlled). Ms C was referred for a mental health assessment.
32. A Registered Midwife (RM) recorded that she had arranged an antenatal scan for Ms C on 9 June. The RM did not see Ms C in person on this date, and a full antenatal assessment was not completed.
33. During this time at Foston Hall, the substance misuse team monitored Ms C every day.
34. On 4 June, a mental health nurse assessed Ms C. She told the nurse that she was focussed on her baby and hoped to be released from court when she next appeared. The nurse noted that Ms C should be reassessed after her next court appearance, to determine what support she may need with her pregnancy, but that she was currently coping well. She also provided Ms C with information about taking methadone while pregnant.
35. On 7 June, a nurse recorded in Ms C's medical record that a potentially clinically significant red cell antibody had been detected. She documented that the prison midwife was to review Ms C. Later that morning, another RM met Ms C, as the previous RM was on leave. The RM recorded clinical observations and that Ms C gave consent for blood and urine tests. She recorded details about Ms C's previous pregnancies and deliveries.

36. On 9 June, Ms C attended the local hospital for her pregnancy scan. The expected date of delivery was confirmed as 21 November, making her 16 weeks pregnant. A GP at Foston Hall noted that Ms C's fetal RHD screen (a blood test to identify fetal rhesus disease status, a condition where antibodies in a pregnant woman's blood destroy her baby's blood cells) showed an abnormal result. He sent an urgent task to the RM to make her aware of the need for enhanced fetal screening.
37. After she returned from her scan, Ms C told staff that she had been advised by the hospital to have the pregnancy terminated as she had a history of deep vein thrombosis, she was a drug user, and because she had a rare blood type and a potential she could have rhesus disease. (This condition had been detected in two earlier pregnancies for Ms C.) Ms C told staff that she wanted to keep the baby.
38. On 14 June, a nurse recorded in Ms C's medical record that she had seen the prison midwife and been told that her baby had an increased risk of Down's Syndrome. (A scan on 28 June confirmed that this risk was low.) Later, an RM recorded that Ms C was upset about the diagnostic testing and she advised her that if she continued with the pregnancy there was a high chance that intrauterine transfusions (a medical procedure where substances are introduced directly into the uterus) would be required, as with her previous pregnancies, and that those appointments would be arranged at short notice as they would be directly related to her blood results.
39. On 16 June, Ms C met a mental health nurse. They discussed the possibility that the baby would potentially have additional needs. The nurse noted that Ms C was calm and relaxed and trying to process this news. Ms C asked if she could restart antidepressant medication and the nurse advised her to book a GP appointment.
40. On 19 June, Ms C attended an appointment in the fetal medicine department at Royal Derby Hospital. She had blood tests and was advised she would have to wait for the results and a follow up appointment. The next day, Foston Hall held a multidisciplinary perinatal meeting attended by prison and healthcare staff. They discussed Ms C's pregnancy and the concerns around her baby's health. They recorded that Ms C was waiting for her test results. The RM was assigned to liaise with the antenatal team to establish a plan for Ms C.
41. On 21 June, an RM recorded that Ms C was generally well. They discussed the normal pattern for fetal movements and the RM provided Ms C with information on normal fetal movement pattern and fetal development. Ms C asked to start antidepressants as she said she was a 'bit up and down'.
42. On 22 June, Ms C did not attend an appointment with the GP. It is likely this appointment was to discuss antidepressant medication, but it is not recorded in the health records what the purpose of this appointment was.
43. On 27 June, Ms C attended an appointment with the fetal medicine team. When she returned to Foston Hall, Ms C told the nurse that she had received positive news at the hospital, and she showed him a scan of the baby. The next day, an RM recorded in Ms C's medical record that there was a strong possibility of the need for intrauterine transfusions, and Ms C would need regular scans to ensure that any fetal anaemia was detected early.

44. On 29 June, Ms C met a GP at Foston Hall and said that she was struggling with her mood and was not sleeping. The GP recorded that she would prescribe sertraline (an antidepressant).
45. On 6 July, Ms C attended hospital for a scan and met a specialist drug and alcohol midwife. In an email forwarded by the hospital midwife to the prison midwife, it was noted that during Ms C's hospital appointment she disclosed she had been experiencing some withdrawal symptoms in the evenings. The specialist midwife suggested a small increase in Ms C's methadone to reduce the negative impact withdrawal symptoms could have either on the baby's growth, or the possibility that this could trigger miscarriage/premature labour. (This was implemented later that week.)
46. On 14 July, Ms C attended an outside hospital appointment for a scan. She told a nurse on her return to Foston Hall that she was concerned about the continuity of her antenatal care as she could soon be released from prison when she next attended court. The RM was notified.
47. On 17 July, the RM recorded that the recent scan results showed there was no evidence of hydrops fetalis (severe swelling in an unborn baby).
48. On 19 July, the RM completed a maternity assessment and recorded no concerns. Ms C asked the RM to contact the hospital to transfer her care if she was released from court and the RM emailed the hospital to alert them to her possible release from Foston Hall. The RM recorded that she sent an email to Ms C's local hospital and Royal Derby Hospital to update plans.
49. On 21 July, Ms C appeared in court and was sentenced to 12 months in prison. Due to the time she had spent on remand, she was released directly from court.
50. On 26 July, Ms C contacted the RM to say she was concerned about her baby's movements and that she was not on the correct dose of methadone. The RM advised her to contact the Pregnancy Assessment Unit (PAU) at her local hospital and gave Ms C their telephone number. There was no further contact from Ms C to the RM before her return to custody.

10 October 2023 - return to custody

51. At around 3.30pm on 10 October, Ms C arrived at Foston Hall having been arrested following her recall. The reception process was completed, and staff noted that Ms C was approximately 34 weeks pregnant and did not raise any concerns. Ms C reported that she had only attended one midwifery appointment in the community since her release in July.
52. An officer, the Pregnancy, Mother and Baby Liaison Officer (PMBLO – the key purpose of the role is to enable early identification, contact and signposting to support services for pregnant women and mothers) met Ms C in Reception. She noted that Ms C was in good spirits. The officer recorded that the expected date of delivery was 21 November, and they discussed arranging authorisation to visit for Ms C's birthing partner in case of an early labour. The officer contacted the RM to advise her that Ms C was back in custody and arranged for an appointment with the RM the next day.

53. At 3.37pm, a nurse completed the initial health screen and noted Ms C's physical and mental health history. All clinical observations were within the normal range. Ms C said that she no longer received a methadone prescription and was buying approximately 40mls a day. She reported using opiates and benzodiazepines daily. Ms C tested positive for methadone, cocaine and benzodiazepines. Ms C said that she never drank alcohol. She told the nurse that the baby was moving well and that she had no concerns. Ms C said that she had only attended one antenatal appointment in the community since her discharge from court. Ms C disclosed she was awaiting a hip and knee replacement and the nurse noted she had a constant limp and used crutches to help her mobilise.
54. At 4.10pm, an advanced nurse practitioner (they can assess, diagnose, manage, and care for patients with complex clinical issues) met Ms C. The nurse detailed Ms C's substance misuse history and noted some signs of withdrawal. She started Ms C on a methadone maintenance programme and pregnancy vitamins. (Ms C's methadone prescription was 10mls each morning, evening and night for the first two days, increasing to 15mls morning, evening and 10mls at night. Between 13-23 October, Ms C was prescribed 20mls each morning and evening.) Ms C told the nurse that she had engaged with her antenatal care in the community but went on to say that 'they'll say I haven't'.
55. Ms C arrived with a supply of sertraline, but the nurse did not prescribe it as it was not recorded on Ms C's summary care record (an electronic summary of key clinical information), and she wanted to check it was safe to prescribe during pregnancy. An appointment was booked for Ms C to meet the prison midwife the following day. The nurse created a care plan for the management of Ms C's substance misuse. The nurse recorded that Ms C needed crutches due to hip problems.
56. Staff allocated Ms C a single cell on the induction unit. A Pregnancy Support Plan was started, and Ms C signed a compact giving permission to share relevant information about her pregnancy with other organisations. Because Ms C was in her third trimester, prison staff were to observe her hourly and record comments each morning and afternoon. (Staff completed the observations, but most of the conversations were left blank).

11-13 October

57. At 8.25am, an HCA completed Ms C's secondary health screen. He noted her medical history, including Ms C's pregnancy, and that she had Hepatitis C (an infectious disease affecting the liver, often acquired through intravenous drug use) but could not start treatment until after the birth.
58. At around 9.30am, another HCA, substance misuse team, assessed Ms C. The HCA recorded that Ms C showed no signs of toxicity and all her clinical observations were within the normal range.
59. At 2.10pm, the RM met Ms C and recorded that she had not had any antenatal care since 8 August. The RM noted that Ms C showed signs of drug withdrawal and looked 'very thin'. She made an appointment for Ms C with the hospital fetal medicine team for 18 October. The RM noted that Ms C's pregnancy was high risk and confirmed that she had the contact details for the PAU on her in-cell phone. She also recorded that they discussed vigilance on fetal movements. There was no

mention of rhesus immunisation or an antenatal care plan in the RM's medical record entry. Although Ms C consented to having blood and urine samples taken there is no evidence in her medical record to confirm that these were taken and there are no subsequent results recorded.

60. At around 3.50pm, a psychosocial substance misuse recovery worker, who is also the perinatal lead for that team, met Ms C and introduced herself as her key worker. Ms C said she was feeling the effects of withdrawal and asked for her methadone to be increased. The recovery worker explained that it could not be increased at that time (she did not record why) but that hopefully she should start to feel better.
61. At 5.00pm, the prison pharmacist completed a medicines reconciliation review and confirmed that Ms C could be prescribed sertraline. However, there is no evidence in Ms C's medical record that it was prescribed to her.
62. At around 8.50am on 12 October, an HCA assessed Ms C, who told her that she was not sleeping and felt stressed and worried about the baby. Ms C said she was experiencing cold sweats, felt sick and had back ache. The HCA encouraged Ms C to continue taking her symptomatic medication for nausea and general aches and recorded that all her clinical observations were normal. The HCA assessed Ms C again in the afternoon, and although she reported still feeling achy said she felt better than she had earlier. All Ms C's clinical observations were within normal parameters.
63. On 13 October, a multi-disciplinary team meeting was held (where pregnant prisoners are discussed); this is not recorded in Ms C's health records. However, at this meeting, the Operational Head of Perinatal Health completed a Mother Care and Management Plan (MCMP) for Ms C as the PMBLO was on annual leave. There is no record of who attended this meeting. In the MCMP, Ms C's details and EDD were recorded and that social services and the prison midwife had been informed she had arrived at Foston Hall. In the healthcare section, the Operational Head of Perinatal Health noted that Ms C was detoxing and had been referred for a prescription of aspirin. No mental health needs were identified, and it was noted that Ms C would receive support from Birth Companions (a charity to support pregnant women and mothers in prison) each Tuesday. There was nothing recorded about Ms C having a high-risk pregnancy in the healthcare or additional comment sections.
64. In the afternoon, an HCA completed a substance misuse assessment and noted that Ms C had no signs of sedation or toxicity. Ms C reported that she had achy bones and had been sick. She was advised to ask for symptomatic medication.

Events from 14 October

65. At around 11.15am, Ms C told a nurse that the baby's movements had reduced. He advised her to monitor the movements and if they continued to reduce or stop then she should contact the healthcare team and they may need to escalate to the PAU. The nurse told Ms C that she would be checked again later that afternoon when she collected her methadone. The nurse recorded in Ms C's medical record that her clinical observations were normal, although she was showing mild withdrawal symptoms.

66. At around 4.00pm, the nurse completed the planned welfare check with Ms C. She told him that she was concerned as she had not felt any movements since the morning, and she had some lower chest wall pain. The nurse recorded that he obtained Ms C's consent and examined her stomach. He noted that he thought the baby's foot was positioned under Ms C's ribcage and he told her that this may have been the cause of her discomfort. An HCA contacted the PAU, and the midwife that he spoke to also spoke directly to Ms C. She was advised to attend the hospital.
67. At 6.15pm, Ms C left Foston Hall by car, escorted by two prison officers. Prison staff completed an escort risk assessment, which noted that Ms C was a low risk of escape and low risk to the public, and that at least one of the escorting officers had to be female. Healthcare staff noted that they did not have any medical objection to restraints being applied but that Ms C was a 'pregnant prisoner'. Ms C was not restrained.
68. At around 6.40pm, Ms C arrived at the Royal Derbyshire Hospital, and staff at the PAU assessed her.
69. Foston Hall attempted to telephone Ms C's mother, her nominated next of kin, to inform her that she had been taken to hospital, but the calls were not answered. Ms C provided her partner's telephone number, and he was informed of the situation.
70. At 7.45pm, two officers from other prisons arrived to take over the bed watch. Officers from Foston Hall gave a handover to these staff, which was noted in the Person Escort Record (PER - a document that accompanies all prisoners when they move between police stations, courts, hospitals, and prisons which sets out the risks they pose).
71. At 11.15pm, after a period of assessment and monitoring at the hospital, a doctor told Ms C that her baby would have to be delivered by caesarean section. Around an hour later, she was taken into theatre.
72. At 1.06am on 15 October, Baby C was delivered by caesarean section, but was not breathing. Hospital staff started neonatal resuscitation and after 25 minutes they established a heartbeat. Baby C was moved to intensive care. The baby had numerous health problems, and hospital staff recorded that the baby was unlikely to survive.
73. The bed watch staff were traumatised by events. They contacted Foston Hall to ask if they could be replaced. At 2.30am, two officers from Foston Hall took over the bed watch duty. Ms C was able to visit her baby in intensive care before moving to a ward.
74. At 7.20am, when day shift staff took over from the night bed watch staff, they found that the current bedwatch staff had applied standard handcuffs. There is no record of who applied restraints, at what time, or whether this was authorised by a manager. The Head of Safety and Equalities later told us that a CM (the duty night manager) had authorised use of handcuffs.
75. At 8.15am, the bedwatch staff contacted The Head of Safety and Equalities and a CM, as a nurse on the maternity ward had raised concerns with the bed watch staff

about Ms C being in handcuffs. They authorised that the restraints were removed immediately.

76. Hospital staff kept Ms C informed about Baby C's health and treatment and prison staff continued to provide support. Ms C was able to visit her baby in the neonatal care unit and was told that if Baby C stabilised they might be moved to Queen Elizabeth Hospital in Nottingham. (This did not happen as Baby C was not well enough to be transferred.) Foston Hall arranged a taxi for Baby C's father to travel to the hospital. He was allowed to stay with Ms C throughout her time in hospital.
77. At 3.45pm, the prison chaplain and the hospital chaplain blessed Baby C. The Operational Head of Perinatal Health arranged for photographs to be taken of Baby C (at Ms C and her partner's request), and foot and handprints were taken. Over the next few hours, Baby C underwent several clinical procedures.
78. At 6.05am on 16 October, Baby C died.

Care for Ms C following Baby C's death

79. While Ms C was in hospital her partner was allowed to remain with her. As well as the support she received from Foston Hall bed watch officers, she was visited regularly by various staff, including the Operational Head of Perinatal Health, an RM, and the PMBLO. Ms C told the investigator that she was very grateful for the support she received.
80. On 19 October, Ms C was discharged from hospital and escorted back to the prison; handcuffs were applied. The PMBLO authorised additional vapes, PIN phone credit and writing materials so Ms C could maintain contact with her partner when she returned to Foston Hall. SAND, a baby loss helpline number, was added to her in-cell phone contacts. Ms C asked the PMBLO to tell her friends on the wing that her baby had died, as she did not want to face questions on her return. The PMBLO arranged for fresh bedding and clothes for Ms C when she arrived back at Foston Hall and, at her request, Ms C was allocated a single cell.
81. A nurse met Ms C on her return and noted that she was tearful, but grateful to have had the opportunity to spend time with her baby. The nurse recorded that she had referred Ms C to the mental health team, and that she could contact the healthcare team at any time for support. Ms C asked for her anti-depressant medication to be prescribed.
82. Ms C continued to receive regular contact from the mental health team and the prison chaplain to support her with her bereavement, as well as support from wing staff. In addition, Ms C had regular contact with Birth Companions.
83. The PMBLO and RM helped Ms C plan the funeral arrangements. Birth Companions supported Ms C during these arrangements and provided an outfit for Baby C. The PMBLO left her role in mid-November but ensured that Ms C was made aware of her departure in good time and that all information was handed over to the new PMBLO.
84. Baby C's funeral was held on 29 November, and the prison contributed to the costs, in line with national guidance. Ms C attended. At her request, prison staff also

attended the service. Foston Hall also held a blessing ceremony in the prison chapel on 15 December.

Support for prisoners and staff

85. The staff care team and trauma risk management (TRiM) were made available to staff who were involved with Ms Cs care and most said they felt well supported. However, the RM did not feel supported by Foston Hall or the Royal Derbyshire Hospital. The RM said she felt that she had done her best to care for Ms C but felt pulled between the prison and hospital and felt that 'nothing was good enough'.

Post-mortem report

86. The pathologist concluded that Baby C died from meconium aspiration (occurs when a new born breathes a mixture of meconium and amniotic fluid into the lungs around the time of delivery), leading to hypoxic ischaemic encephalopathy (a lack of oxygen to the brain before or shortly after birth), causing fetal distress (a baby's heart rate gets faster or slower before birth and is a sign they may not be getting enough oxygen) and hydrops fetalis (severe swelling in an unborn baby).
87. Toxicology tests showed that Baby C had a very low concentration of total morphine (which is morphine itself and its metabolites), which may reflect medical intervention or the prior exposure to a compound containing or metabolised to morphine (such compounds include morphine sulphate, heroin, and codeine). The pathologist noted that a review of Baby C's medical notes would determine if morphine or a compound metabolised to morphine was administered during his care.
88. There was evidence of exposure to methadone. The concentration of methadone was very low; however, some respiratory depressant and sedative effects could not be ruled out.

Findings

Clinical care

89. The clinical reviewers found that the general nursing care, including Ms C's physical health and management of her substance misuse, were equivalent to that she could expect to receive in the community. However, they concluded that the standard of pregnancy care was not equivalent. The clinical reviewers have made recommendations not directly related to Baby C's death, which we have not included in our report, but which the Head of Healthcare will need to address.

Prison midwifery care – return to HMP Foston Hall

90. The clinical reviewers found that despite the RM's awareness of Ms C's rhesus isoimmunisation and the extremely high-risk nature of this condition, there was no specific mention of the rhesus isoimmunisation and the implications for the unborn baby in her documentation on Ms C's medical record. There was no evidence that a full antenatal assessment had been completed when she returned to Foston Hall in October, neither had information been formally passed to prison staff (including healthcare staff) about the high-risk nature of her pregnancy. The clinical reviewers considered these to be significant omissions by the midwife as, on her return to prison on 10 October, Ms C required urgent referral back to the fetal medicine team at the hospital without delay.
91. The consultant midwife clinical reviewer considered that arrangements should have been made for Ms C to be seen urgently when she returned to Foston Hall, particularly as she had had limited antenatal care in the community after she was discharged from prison in July. The RM contacted the hospital, and an appointment was made for 18 October, despite the high-risk circumstances of her pregnancy. The details of the RM's call to the hospital are not recorded in the medical record. The clinical reviewers concluded that the RM should have escalated Ms C's care to a consultant or senior obstetrician and discussed Ms C's pregnancy with her line manager or another senior midwife.

Prison midwifery care – record keeping and service provision

92. The clinical reviewers found that, overall, the entries made in Ms C's prison medical record by the RM were very limited and lacked detail. There was no template for recording a full antenatal check and the RM did not use sufficient detail using free text. The RM did not document a full antenatal assessment when Ms C returned to prison and although she assessed the fetal heart rate, the results were not recorded. The RM explained at interview that she was required to record her contacts on three different systems: SystmOne (prison medical record), Lorenzo (UHDB - hospital record) and the patient's own handheld maternity records. The clinical reviewers found that the requirement to document clinical care/findings in three separate locations was a significant concern and the recording of pregnancy care on the prison medical record was not fit for purpose.
93. The investigation identified that much of the communication described by prison and healthcare staff, including the prison midwife, relied on conversations, telephone calls and emails. There was an over-reliance on individual contacts and

established relationships between staff, with little documentation on the prison or medical records. A lack of recorded and accessible information to those who needed to understand Ms C's pregnancy was a potential risk.

94. At the time Ms C was at Foston Hall, the midwife was contracted to work 15 hours a week at the prison. We understand that consideration is being made to increase this to 25 hours a week. We were given conflicting information about what cover was provided when the RM was on leave or absent from work. The RM said that when she is in Foston Hall she meets weekly with all pregnant prisoners in the second trimester onwards (14 – 26 weeks pregnant). She said the Juno Team provide support when she is on leave as/when requested by the pregnant prisoners. During Ms C's first period at Foston Hall, between 1 June – 21 July (Ms C was recorded as 16 weeks pregnant on 9 June), the RM made entries in Ms C's medical record on 28 June, 6 July (added by a healthcare administrator), 17, 18 and 19 July. Another RM made entries on 7, 14 and 21 June. None of these entries refer to Ms C's pregnancy being high risk.
95. The clinical reviewers found that the RM was working in isolation at Foston Hall, with little accountability and no direct supervision. We make the following recommendations:

NHS England should commission an independent review of the standard of midwifery care provided at HMP Foston Hall. The review should include the standard of midwifery documentation; the nature and content of clinical contacts; referrals completed, communication and escalation pathways; and supervision of midwifery care at HMP Foston Hall.

The Head of Healthcare should review the prison medical record to ensure that key information regarding a pregnancy and any associated care plans are easily accessible to all healthcare staff.

96. Despite the clinical reviewers repeated and escalated requests for access to Ms C's relevant maternity hospital records from UHDB, and Baby C's neonatal records, they were not provided until the PPO's initial report was issued for consultation (they never received Ms Cs hand held maternity records). The clinical reviewers said that this hindered their review of the care received which then necessitated amendments to their clinical review report. We make the following recommendation:

NHS England should ensure that all relevant community and hospital records are provided for the purpose of a PPO investigation following the death of a baby.

Reduced fetal movements on 14 October

97. When Ms C told a nurse that the baby's movements had reduced, he did not think it was necessary to contact the prison midwife and/or the PAU. The clinical reviewers noted that fetal movements are the single most important indicator of fetal wellbeing and any reduction in fetal movements should cause concern and should prompt immediate escalation to the PAU for review. The nurse is not a midwife, and he did not have the expertise to decide not to escalate Ms C's report of reduced fetal movements to a midwife and/or PAU.

98. The nurse recorded in Ms C's medical record that he had examined her. In interview, the nurse clarified that he did not examine Ms C, but when she lifted her top, with her permission, he felt her abdomen with his hand and gave an opinion that he thought her discomfort could be because the baby's foot was pushing up if the head was engaged.
99. The clinical reviewers raised their concerns about the nurse's actions immediately after his interview. They noted that all registered nursing staff must recognise the limitations of their professional registration and practice within their scope of professional practice. The clinical reviewers referred the nurse to the Nursing and Midwifery Council (NMC - independent regulator for nurses and midwives in the UK, and nursing associates in England). As these concerns are now being investigated by the NMC we do not make a separate recommendation.

Medication

100. Ms C was prescribed an anti-depressant (sertraline) when she was previously at Foston Hall. When she returned to Foston Hall on 10 October, a nurse recorded that Ms C had arrived with this medication but that it was not recorded on her summary care record, and she incorrectly noted that there were prescribing risks as Ms C was pregnant.
101. The clinical reviewers found that the prescribed anti-depressant, which is safe during pregnancy, was abruptly discontinued, contrary to best practice. This was despite Ms C having been recalled to prison, at an advanced stage of pregnancy, and that she was exhibiting opiate withdrawal symptoms. The sudden cessation of anti-depressant medication can lead to a return of symptoms and/or the possibility of a 'psychiatric emergency' and can potentially be dangerous to the baby's health during the third trimester of pregnancy. The nurse did not seek immediate advice on prescribing sertraline during pregnancy.
102. On 19 October, when Ms C returned to Foston Hall after the birth of Baby C, during her re-admission assessment, she asked to be prescribed her anti-depressant and an appointment was booked with the prison GP. This appointment was not for five days. Ms C was bereaved and had a history of depression. The clinical reviewers concluded that the management of Ms C's anti-depressant medication was of a poor standard. We make the following recommendation:

The Head of Healthcare should ensure that nurse prescribers are adequately informed regarding antidepressant medication, including what is safe to use in pregnancy, and the risks associated with immediately stopping prescribed medication.

The Head of Healthcare should ensure that all bereaved prisoners who request antidepressant medication are seen by a GP and/or nurse prescriber in a timely manner.

Supporting pregnant prisoners

103. Supporting Women Experiencing Pregnancy, Mother and Baby Units, and Maternal Separation from Children up to the Age of Two in Women's Prisons – Operational Guidance issued on 20 September 2021 and re-issued on 17 May 2023, together

with the Policy Framework issued in September 2021, provide guidance for prison staff at all levels and is a reference for prisons to develop their own local policies and partnerships with other agencies. The guidance sets out that a trauma-informed responsive person-centred approach should be taken and based on the individual's specific circumstances and needs.

104. Pregnant Mother and Baby Liaison Officers are required to meet with a pregnant prisoner within five days of their arrival. The PMBLO met Ms C in Reception on the day she arrived and informed the midwife and social services, which was in line with guidance and good practice. She ensured wing staff were aware of the need to monitor Ms C hourly, using the Pregnancy Support Plan, as she was in her third trimester. Staff completed the observations hourly, but the requirement to write a comment/summary each morning and afternoon by wing staff were not completed, and these omissions were not identified during quality assurance checks. We make the following recommendation:

The Governor should ensure that all required observations, comments and summaries are recorded in a prisoner's Pregnancy Support Plan, in line with national and local guidelines.

Training

105. There is an eLearning training package, HMP Pregnancy and Perinatal Care in Prisons, which takes around 45 minutes to complete. This training has three modules and a course evaluation form: Supporting pregnancy in Prisons; An Introduction to Mother and Baby Units in Prison and; Mother and Baby Unit, which staff working in female prisons are expected to complete but is not mandatory. There is no other training which we identified for staff working with pregnant prisoners, beyond this eLearning package. Many staff we spoke to during our investigation were aware there was an online training package, but not all had completed it. The PMBLO had completed this training, but the perinatal lead for the substance misuse team had not.
106. We were told that after the death of Baby C, the RM supplied posters which included information on 'red flags' during pregnancy, including reduced fetal movements, and which were displayed around the prison. However, many of the staff did not know where these posters were and could not describe the content or purpose of the posters and they did not know who the posters were aimed at (e.g. staff or prisoners). No communication or further training regarding the information on these posters was provided.
107. The investigator completed the eLearning and found that the information provided does not include information on reduced fetal movements, a high-risk indicator for any pregnancy.
108. We therefore make the following recommendations:

The Prison Group Director for the Women's Estate should review the current training package for staff working directly with pregnant prisoners, to ensure they receive training to equip them with the required skills and knowledge to care for pregnant prisoners safely. This training should include the

importance of fetal movements and escalation pathways if a prisoner reports reduced fetal movements.

Restraints, security and escorts

109. 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. 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 suffering from a serious medical condition. It said that 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.
110. Foston Hall's Local Security Strategy, *Hospital Escorts – Prisoners Under Escort to Give Birth* states that physical restraints must not be applied during the escort to the hospital and may be applied on the return journey if the child is not present. In addition, on 12 November 2021, Foston Hall issued a Staff Information Notice that stated any pregnant prisoner would not be restrained when attending a medical appointment and that there must be significant evidence to inform a decision to apply restraints. Both instructions formed part of the escort risk assessment booklet that travelled with prison staff to the hospital.
111. When Ms C was discharged to hospital the escort risk assessment notes that her escape risk was low and that she was a low risk to the public. Other than identifying that Ms C was pregnant, there were no other comments about other physical issues which were pertinent when assessing Ms C's level of escape risk, including her poor mobility. In line with policy, restraints were not used when Ms C went to hospital.
112. The bed watch occurrence log shows that restraints were applied on 15 October, only hours after Ms C had given birth. We were not able to determine exactly when restraints were applied. The Head of Safety and Equalities said that this was a mistake and speculated that it may have been because the duty manager was used to working within the male prison estate and had not experienced working with pregnant women.
113. When Ms C was returned to Foston Hall, restraints were applied. Ms C told the investigator that she was told that restraints would not be applied until they were at the entrance of the hospital, but said they were applied in the ward. At 1.40pm, there is an entry in the bedwatch log 'cuffs to be applied' and Ms C arrived back at Foston Hall at 2.50pm. There was no entry made in the bed watch log as to the specific time/place restraints were applied and no indication that the escort risk assessment was reviewed or revised.
114. We recognise that many factors must be considered in determining whether restraints should be applied. However, Ms C had undergone a caesarean section, and her baby was gravely ill; she also had physical health needs which restricted her movement, which were not recorded. She was assessed as a low risk of escape

and to the public. The decision to restrain her at any point, especially within hours of giving birth, was not proportionate to her risk and was not in accordance with the pregnant prisoner protocol. We note that the current policy refers to 'pregnant' women, which could have caused confusion in Ms C's situation as she was no longer pregnant when restraints were applied. We therefore make the following recommendation:

The Governor should ensure that local policy regarding *Hospital Escorts – Prisoners Under Escort to Give Birth* is revised to include guidance to staff following a birth, including that:

- **Prisoners who have given birth are not restrained in hospital unless there are significant indicators of high risk of escape or to the public; and**
- **The escort risk assessment is reviewed and revised before the prisoner returns from hospital, giving consideration to information about their current health and mobility.**

Staff conduct during bed watch

115. Ms C told the investigator that hospital bed watch staff did not behave appropriately, and she made several allegations about their conduct. The staff involved were not from Foston Hall, but staff from other prisons who had volunteered to undertake bed watch duties (when a prison do not have sufficient staff to complete the role internally).
116. We told the prisons where these officers are based about the allegations, and they subsequently conducted local investigations. As a result, two staff were given advice and guidance, and one officer received a verbal warning. We are satisfied that the respective prisons have taken appropriate action.

Inquest

117. The inquest into Baby C's death concluded on 25 September 2026. The medical cause of death was recorded as: 1a Meconium Aspiration leading to Hypoxic Ischaemic Encephalopathy (occurs when a newborn aspirates meconium, a thick and sticky substance from the first bowel movements, into the airway which can lead to a lack of oxygen and blood flow), 1b Foetal Distress (usually due to insufficient oxygen or nutrient supply during late pregnancy or labour), 1c Immune Hydrops Fetalis, 1d Haemolytic disease of the foetus and newborn (where the mother's antibodies attack foetal red blood cells, leading to anaemia and jaundice), and 2 Prematurity at 34+5 weeks.
118. The Coroner concluded that Baby C died due to complications of severe immune hydrops fetalis because of untreated haemolytic disease. The Coroner found that if Baby C had received the in-utero treatment that had been planned for him when it was assessed as needed, it is highly unlikely that he would have died.
119. The Coroner also found that Baby C's death was contributed to by Baby C's mother's personal circumstances and difficulties after returning to her home area

which likely affected her ability to engage and therefore probably more than minimally contributed to Baby C's death.



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