

**The death in custody of a woman at
HMP Foston Hall - 2 June 2004**

**Report by the Prisons and Probation Ombudsman for England and
Wales**

3 November 2004

Foreword

This is the report of an investigation into the circumstances of the death of a married woman who died on 2 June 2004 while in the custody of HMP Foston Hall. She was serving a life sentence at Foston Hall at the time of her death.

All deaths of prisoners in custody are investigated, including those due to natural causes. The responsibility for carrying out these investigations traditionally fell to the Prison Service itself, but has now been passed to the Prisons and Probation Ombudsman (PPO) to bring independence and greater consistency to the task. In this case, the investigation has been carried out by one of my Assistant Ombudsmen.

An independent clinical review was commissioned jointly by Derbyshire Dales and South Derbyshire PCT and HMP Foston Hall in April 2004. They were requested to examine the standards of care received by the woman during her stay in the Health Care Centre at HMP Foston Hall and as an in patient at nearby hospital.

My colleagues and I would like to extend our condolences to the family for their loss. We would also like to thank the Governor of Foston Hall, and the other members of her staff who assisted us during the investigation. We found all the staff at Foston Hall most helpful, in particular the PA to the Governor, who organised our visits and gathered together all the documentation we required.

Stephen Shaw
Prisons and Probation Ombudsman

3 November 2004

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Summary

This woman died of renal failure at the age of 62 at a hospital in Burton-on-Trent. She had been a life sentence prisoner for 17 years and had been at HMP Foston Hall since 13 May 2003.

The woman had complex health needs. She suffered from diabetes, and several of its complications, including retinopathy, vascular disease and renal failure. The clinical review of her care while at Foston Hall described the prison's Health Care Centre as not being designed, staffed or equipped to meet this woman's needs.

She left a son and two daughters who recognised that 17 years of institutionalisation had taken its toll on their mother. However, they felt that the prison staff were helpful and had done what they could for her.

There are a number of lessons to be learned from this death, in particular, about how prisoners with complex healthcare needs are cared for by the Prison Service, communication between hospitals and prison Health Care Centres and the issue of compassionate release of prisoners with terminal illness.

This version of my report, published on my website, has been amended to remove the name of the deceased and the names of any staff or prisoners who were involved in this investigation.

Investigation process

All the indications were that this was a death from natural causes. In accordance with the Terms of Reference for investigating deaths, my approach in cases of apparent natural cause deaths has been to conduct an initial review to determine if a full investigation is justified. In this case, there has already been a full clinical review covering the period 1 January 2004 to 3 April 2004. The team also examined the records up to 2 June 2004 and they concluded that the Health Care Centre at Foston Hall was not sufficiently equipped to care for prisoners with such complex health needs as this woman. They made a number of recommendations to be followed should Foston Hall take on prisoners with these needs in the future. There had also been some communication failures between the hospital and the prison and that these had increased during the period from April to June 2004. I decided in the circumstances that I did not require a further full investigation.

The investigators visited Foston Hall and had a very helpful discussion with the Governor as well as with the Healthcare Manager, a doctor, an officer, the representative of the Prison Officers Association (POA), and the Chair of the Independent Monitoring Board.

They were given access to all the woman's records, including her medical records, and we were given copies of everything requested.

The investigator spoke to the woman's son, who said that he would like to thank all the staff at Foston Hall for the care given to his mother.

The Stafford Coroner noted that he had no particular worries about the circumstances of this death and listed the inquest to take place on 15 July 2004. This was later adjourned, due to other inquest schedules, and is to be listed again.

Events Leading up to the Death

The woman was admitted to a hospital in Burton-on-Trent on 7 April 2004, suffering with hypoglycaemia and a problem of recurrent vomiting. It was also noted that she had a decrease in kidney function. The hospital noted that 'her management and monitoring have been complicated by the fact that she has refused on several occasions to have blood tests taken' and therefore they were unable to closely monitor her kidney function.

On 13 May 2004, the Consultant Renal Physician wrote stating that in his opinion Mrs Ali had quite severe chronic renal failure due to her diabetes. He noted also that, due to her very weak condition and multiple complications related to the diabetes, she would not be able to tolerate any form of dialysis treatment. 'It is therefore likely that her kidney function will continue to deteriorate and that she will die from kidney failure.'

From 11 May 2004, the hospital were trying to discharge the woman, as there was no further treatment they could give for her renal failure. The prison were reluctant to have her returned and were trying very hard to secure compassionate release for her into a hospice.

The woman was eventually returned from hospital to Foston Hall on 27 May 2004 where her condition was recorded as 'okay', until the night of 30 May 2004 when she deteriorated and was returned to the nearby hospital.

Post Incident Response

On Wednesday 2 June 2004 the Governor broke the news of the death to staff and the Muslim Minister. On afternoon unlock, residential staff informed the woman's close friends.

At association the same day, prisoners on each wing were gathered in their association room, with Listeners on stand-by, and told of the woman's. They were allowed an extra half hour association and the Chapel and Multi-faith room were made available.

On Thursday 3 June 2004, the woman's son, visited the prison for a time, talked to the Governor and staff, and collected his mother's property.

The funeral was held on Friday 4 June 2004. Three staff attended and flowers were sent from prisoners and staff at Foston Hall. These we are told, were particularly welcomed by the family.

On 10 June 2004 a memorial service was led by the Muslim Minister at Foston Hall. This was well attended by both staff and prisoners.

Later the Governor found some photographs of the woman at the 2003 Eid celebrations, and she sent them to her son on 12 July 2004.

Level of Compliance

Standards of health care in prisons are intended to mirror those available in the outside community. Because of concerns about the woman's care during her recent stay in the in-patient bed at the Health Care Unit at Foston Hall, a clinical review was commissioned jointly by Derbyshire Dales and South Derbyshire PCT and Foston Hall. The review team were:

The Clinical Governance Lead from Derbyshire Dales, South Derbyshire PCT
The Clinical Governance Manager from, Derbyshire Dales, South Derbyshire PCT

And a representative from East Midlands Prison Health Task Force.

However, the review team have made a number of recommendations relating to the health care at Foston Hall and the hospital in Burton all of which I endorse.

Release on Compassionate Grounds

The Head of Resettlement and Lifer Governor at Foston Hall wrote to the Senior Medical Officer on 12 March 2004. She asked whether the woman met the criteria for early release on compassionate grounds. The Deputy Healthcare Manager verbally confirmed that the woman was very ill and that a doctor would support the application.

The Head of Resettlement wrote again on 11 June 2004 stating that she had submitted an application for early release on compassionate grounds to the Parole Board, Lifer Unit and Area Office, on 19 April 2004. She stressed that the application was urgent as this woman was very poorly. A member from the Lifer Unit, e-mailed a governor grade at the prison on the same day. He said that: 'Unfortunately, as a lifer, the Secretary of State will not consider such an application unless there are 2 medical reports, including 1 from the outside consultant, giving a prognosis/diagnosis of death within the next 3 weeks.' He recommended bringing forward the parole process.

On 13 May 2004 the governor grade received a report from the hospital consultant confirming the woman's chronic renal failure and suggesting that her survival was suspected to be a few weeks to a few months. They supported early release.

On 28 May 2004 the parole dossier was sent to Lifer Unit but the governor grade was unable to obtain the requirement of 2 doctors giving a prognosis of death within 3 weeks.

On 2 June 2004, just after 11.00 hrs, HMP Foston Hall were notified that the woman had died. At 13.07 on the same day, they received a fax from the consultant at the hospital stating that he would be surprised if the woman lived for another 12 months.

Prison Service Order 6000 (12.4) covers the requirements for granting early release on medical grounds. This has been a consistent issue arising with terminally ill prisoners and in due course, I hope to bring together my findings on all the difficulties encountered by staff trying to secure release on compassionate grounds.

Findings

The woman died of natural causes as a result of renal failure. The clinical review team found that 'Foston Hall's Health Care Centre was not designed, staffed or equipped to meet her complex health needs.' They found that the Centre was not equipped to monitor diabetes and its complications satisfactorily, and staff had major responsibilities to other prisoners, which meant that they could not give the woman their full attention.

The communication difficulties in trying to return the woman from hospital to the Health Care Centre, when they felt under equipped to cope with her needs, must have been stressful for both staff and the woman.

Difficulties encountered in trying to secure compassionate release from prison were frustrating and distressing for both staff and doctors.

Conclusions

Despite being a difficult patient, the woman was well cared for at Foston Hall. However, I support the recommendations of the clinical review which detail the reforms needed at Foston Hall if they are to care adequately for patients with similar complex healthcare needs.

Recommendations

I fully support the recommendations detailed in the clinical review.

I also recommend that the Prison Service should review the processes for agreeing compassionate release of terminally ill prisoners whose risk to the public has been reduced to nil by the nature of their infirmity, and ensure these processes are communicated to all establishments.

Good Practice

I would like to commend the Governor's handling of the announcement of the death. I found this to have been sympathetic to the emotional needs of the prison as a whole.

Stephen Shaw CBE
Prisons and Probation Ombudsman