Investigation into the death of a woman in February 2006 whilst in the custody of HMP Foston Hall

Report by the Prisons and Probation Ombudsman for England and Wales

November 2006

This is the report of an investigation into the circumstances of the death of a woman who died in Queen Elizabeth Hospital, Birmingham in February 2006. The woman died from bronchopneumonia (a chest infection) which she developed after complications during complex and difficult abdominal surgery. At the time of her death, she was on compassionate temporary release from HMP Foston Hall. She was 45 years of age.

I would like to extend my personal condolences to the woman's family and to all those touched by her death.

Both my investigator and I would like to thank the Governor of Foston Hall and her staff for their cooperation during this investigation. I am also grateful to Derbyshire Dales and South Primary Care Trust who carried out a clinical review of the care the woman received during her time in custody and whilst at hospital.

I conclude that the clinical care the woman received during her time at Foston Hall was satisfactory in terms of the management of her condition on a reactive basis. However, the healthcare team missed opportunities to be more proactive – although this would probably not have altered the outcome.

This report makes three clinical recommendations.

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Prisons and Probation Ombudsman **November 2006**

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Summary

The woman was remanded into the custody of HMP Brockhill in October 2005. After sentencing, she moved to HMP Foston Hall in November 2005.

The woman suffered from Crohn's disease. On reception to HMP Brockhill, she was noted as being underweight and requiring medical attention. She was seen by the prison doctor.

On 1 November, the woman required medical attention during the night as she was in pain and discomfort. She told the nurse that she had previously been treated at Queen Elizabeth Hospital in Birmingham for the management of her Crohn's disease. This had included surgery on her colon. She was then seen by the prison doctor on 3 November. He sent an urgent referral letter to Queen Elizabeth Hospital. In the meantime, he prescribed medication to ease the symptoms. A letter confirming an appointment for 21 December was sent on 17 November. By this time, the woman had transferred to HMP Foston Hall, but the appointment was forwarded.

Despite the woman requiring healthcare attention for her illness during December, she refused to attend her hospital appointment on 21 December. Although healthcare staff succeeded in persuading her to change her mind, it became too late for her to be able to attend. The appointment was rescheduled for 16 January 2006. She was taken by prison escort to Queen Elizabeth Hospital for her appointment on 16 January. Two officers initially accompanied her as a bedwatch escort and she was required to wear restraints.

The woman was admitted on a ward and seen by a doctor. It was assessed that she had a 'mass' in her stomach and she was taken for an x-ray and scan. The woman was kept in hospital whilst awaiting the results. She was visited frequently by prison and healthcare staff. Significant efforts were made at this stage to identify her next of kin. These were unsuccessful as information in her prison and probation records was inaccurate.

The woman was very unhappy about remaining in hospital and did not like having to wear the restraints. Her behaviour towards both prison and hospital staff was at times difficult and abusive.

The woman's condition began to worsen. On 24 January, she was informed that she required keyhole surgery. The woman was frightened of surgery and did not consent until 27 January. The operation was scheduled for 30 January.

During the evening of 27 January, the woman was released on temporary licence and the restraints were removed.

Keyhole surgery towards the end of January revealed that the woman required urgent further surgery. The operation was scheduled for the weekend and her consent was needed. Her health continued to deteriorate. She still had not consented to the further surgery. A psychiatric assessment took place to ascertain her capability to make the decision. It was concluded that she was able to decide for herself.

Early in February, she was granted compassionate release on temporary licence and the bedwatch escort was removed.

Foston Hall discussed the possibility of early compassionate release if the woman was discharged from hospital. The search for her adoptive family continued to no avail, despite having enlisted the help of the police.

The woman moved to the intensive care unit. She agreed to have surgery, and this was scheduled for the following day. Complications during surgery resulted in a collapsed lung. Her condition deteriorated rapidly and some time later she passed away from bronchopneumonia, as a result of the collapsed lung.

Staff at Foston Hall succeeded in tracing the woman's adoptive parent. A memorial service was held at the prison chapel on 2 March. Her family were invited, but chose not to attend.

The clinical review concludes that the woman's care at Foston Hall was satisfactory in terms of managing her condition on a reactive basis, until she was admitted to hospital on 16 January 2006. However, there were missed opportunities for the healthcare unit to be more proactive in the management of her needs**.**

The investigation process

The investigation was opened at HMP Foston Hall a few days after the woman's death. My investigator arranged with the Governor to visit the prison on 2 March. The Governor made the deceased's prison and medical records available for examination. Notices of the investigation were displayed in the prison informing staff and prisoners of the process.

My investigator contacted Her Majesty's Coroner to discuss the nature and scope of this investigation. Although the woman had died in a Birmingham hospital, it was decided that the Derbyshire Coroner would hold the inquest as she was in the custody of a prison in his jurisdiction at the time. My investigator requested a copy of the post mortem report. Two post mortems took place, an external and a full internal. Copies of both were made available for examination.

On 6 April, my investigator revisited Foston Hall to formally interview six members of staff, both uniformed and healthcare.

Derbyshire Dales and South Primary Care Trust conducted a clinical review of the medical care and treatment that the woman received during her time at Foston Hall. They also interviewed members of staff at the prison.

One of my Family Liaison Officers spoke with the woman's family and offered to meet with them. They did not wish to meet but were grateful for contact being made. The family raised a number of questions:

- What illnesses was the woman suffering from?
- When was she diagnosed with these illnesses?
- Did she have an operation shortly before her death?

The clinical review and two post mortems provide answers to the family's questions surrounding her medical care. The Governor of Foston Hall has been in touch with the woman's family regarding the return of her property.

Crohn's disease

Crohn's disease is mainly a disease of the small intestine, but it can affect any part of the bowel. Symptoms of Crohn's disease are:

- fever
- diarrhoea
- pain in the abdomen
- loss of appetite and weight
- feeling generally unwell
- rectal bleeding; and
- a feeling of fullness and pain in the lower part of the abdomen.

There may be long periods where the condition is inactive, but flare-ups are always liable to occur and can be helped by appropriate treatment. This can involve medication to manage the disease. In cases where the disease frequently flares up and is difficult to control, drugs that influence the immune system might be used. Surgery might be required to remove damaged parts of the bowel. However, surgery usually prompts a flare-up of the disorder and repeated operations, usually on the same area, are often required.

HMP Foston Hall

Foston Hall is a closed female prison. It was originally a hunting estate. The present Hall was built in 1863, but the estate is 14th Century and many parts of the 17th Century house remain. The Prison Service acquired the Hall and grounds in 1953. In 1996, it was closed for major refurbishment and building work before being re-opened in its present guise on 31 July 1997.

The prison has six wings: A, B, C, D, E and Fwings. A, B & C each hold 40 prisoners. The cells are referred to as rooms. Each has integrated toilet and shower room. D wing is the induction wing. Accommodation on this wing comprises double and triple-bedded rooms, holding a total of 44 prisoners. Each room has integral sanitation. E wing comprises three rooms holding a total of 10 prisoners. This wing is for enhanced prisoners requiring minimal supervision. F wing in the voluntary testing unit (VTU).

The prison has a healthcare centre with two sites, one on the remand side and one on the sentenced side. Both have 24 hour nursing, and Derby Medical Service provides GP cover. There is an inpatient facility on the sentenced side with five beds in three rooms. These beds are largely reserved for prisoners with mental health problems and tend to be used as single occupancy rooms. In these circumstances, the inpatient capacity is reduced from five beds to three.

Facilities for patients with disabilities on the healthcare centre are both inadequate and inappropriate. However, there are plans to improve these facilities in accordance with recommendations made in Her Majesty's Chief Inspectorate of Prisons' report of August 2004.

In addition to 24 hour nursing care, there are 25 members of discipline staff with current first aid training. This is proportionate to the number of prisoners, which stands at 274 at full operational capacity.

Events leading up to the death of the woman

The woman was remanded into custody at HMP Brockhill in October 2005. On reception at Brockhill, she asked to be allocated a single cell as she required privacy due to her Crohn's disease. This was allowed and she was given a single cell on a flat location on D wing.

Part of the reception process into prison before being moved to a wing is to have a first screen health check. A nurse conducted the healthscreen. During the assessment, the woman told the nurse that she had Crohn's disease, osteoporosis and rheumatoid arthritis. She also said that she was asthmatic, had chest pain and suffered from tuberculosis. The nurse noted that the woman was underweight (45kg, 7 stones) and gave specific instructions to the kitchen staff to provide her with extra milk and sandwiches. Sandwiches were something the woman said she had less trouble digesting. Additional sanitation provisions were provided for her Crohn's disease. The nurse referred the woman to the prison doctor for a second healthscreen. Unfortunately this assessment is not dated and appears incomplete.

On 24 October, the woman was seen by the Mental Health Team clinical manager at Brockhill. The woman said she was a paranoid schizophrenic and heard voices. She also discussed her history of substance misuse which included taking heroin intravenously. The clinical manager noted that the woman did not display any overt mental health problems. However, she wrote to the woman's last known GP to clarify whether any medication for mental health problems had ever been prescribed. A reply was later received stating they no longer had the woman's medical notes.

The woman appeared at Birmingham County Court in October for sentencing. She was given two years imprisonment and returned to Brockhill until arrangements were made to move her to another establishment.

At 12:45am on 2 November, the woman asked to see a nurse. She was suffering with abdominal distension and discomfort, and wanted additional painkillers. Healthcare staff advised that the woman had received her medication at 10:30pm and could not have another dose at that time. However, wing staff were told to contact healthcare should her symptoms persist.

At 2:30am, the woman was still in discomfort and healthcare were again called. During her conversation with the nurse who attended, the woman stated she was under the care of Queen Elizabeth Hospital in Birmingham for the management of her Crohn's disease. She had been admitted to hospital in September 2005 and part of her colon had been removed. During this time she also suffered from a ruptured bowel. The nurse reassured the woman that she would be seen by the prison doctor in the morning. In the meantime, an out of hours GP was contacted for advice. The woman was then given some Paracetamol

On 3 November, the woman was seen by the prison doctor. It was noted that she had lost 5lbs in weight, was vomiting intermittently and that her pain was not being managed by her current prescribed dose of Tramadol. However, Ibuprofen taken during the night was helping. The woman was not able to tolerate her food supplements and had developed a central abdominal hernia. The doctor sent an urgent referral letter to the gastroenterology department at Queen Elizabeth Hospital. He noted that she had been admitted to the Queen Elizabeth Hospital on two occasions in the last couple of months, and that on both times she had been told she need an operation. In the meantime, the doctor prescribed Rabeprazole for gastric protection. He also wrote to the kitchen staff re-emphasising that the woman should be given sandwiches for meals and be provided with extra milk.

On 10 November, a nurse declared the woman fit for transfer to HMP Foston Hall. She was sent with five days of prescribed medication. On reception to HMP Foston Hall, the woman was seen by healthcare. It was assessed that due to her condition she should be in single cell. She was allocated a room on D wing set aside from the communal rooms. This guaranteed her some privacy.

The woman was referred to see a prison doctor the following day for a second health check. This further assessment has not been well documented although the doctor has noted that she was unfit for work.

On 17 November, Selly Oak Hosptal, which is part of the University Hospital Birmingham NHS Foundation Trust, wrote to confirm that an appointment had been made for the woman on 21 December. Attempts were made to try and secure an appointment more local to Foston Hall, but these were not successful.

During early December, the woman was seen on a couple of occasions by healthcare staff, including the prison doctor. Her prescribed pain relief was no longer proving sufficient. No action was taken to bring forward her hospital appointment. In the meantime, at her request, she was given a plastic bottle with ice in it to rest on her stomach. Healthcare staff encouraged her to try and eat a normal diet and instructed the kitchen to stop sending sandwiches for her meals.

On 15 December, risk assessment and escort paperwork was prepared for the woman's appointment at Selly Oak Hospital. A taxi was ordered to take her and escort staff to the hospital on the morning of 21 December. Prior to departure, the woman decided that she no longer wanted to attend the appointment. She was frightened of having further treatment, particularly surgery. The taxi was cancelled and the hospital contacted. On hearing that this had occurred a senior nurse telephoned the hospital. The senior nurse wanted to know whether, if they could persuade the woman to attend her appointment, the hospital would keep her appointment. Selly Oak agreed. The importance of the appointment was explained to the woman and she agreed to attend. Healthcare staff tried to

rearrange the taxi. Unfortunately, it was not possible to organise a taxi that could get her to hospital in time. The appointment was rescheduled for the 16 January 2006.

Whilst waiting for the hospital appointment, healthcare staff at Foston Hall continued to manage the woman's pain. She spent most of her time in her room, apart from going to collect her medication from healthcare. On the occasions when she was not fit enough to do this, healthcare staff would take her medication to the wing.

On 1 January, the woman refused to take one of her prescribed medications, Fosamax. She said that she had never taken it before and did not want to take it on this occasion. Healthcare staff stressed the importance taking specifically prescribed medication and her name was put on the doctor's list for a review following non-compliance. Her prescription chart indicates that she continued to refuse this medication.

On 5 January, the woman was seen by the doctor as she was suffering with pain. She requested a month's supply of Ibuprofen to have in possession rather than collecting it on a daily basis. The doctor suggested she try different painkillers. She was reluctant and insisted on taking ibuprofen. The doctor prescribed paracetamol to take in conjunction with Ibuprofen to manage her pain. It was noted in her medical records that the woman should cease taking the ibuprofen and that she needed her surgical referral.

Eleven days later, on 16 January, the woman was taken by prison escort to Queen Elizabeth Hospital for her appointment. A security risk assessment was completed prior to departure. This recommended that she remain in standard cuffs and on a closeting chain whilst outside the establishment. The woman was unhappy with having to wear restraints. However, as she had made attempts to escape on previous sentences, removing them for any reasons other than medical procedures was not an option.

Two prison officers were required to stay with her on bedwatch duty whilst she remained in hospital. The officers would change shifts every twelve hours. The same pair of officers would continue alternating shifts until relieved of duty by new staff. Due to the distance from Foston Hall, HMP Birmingham agreed to share the responsibility of daily management checks at the hospital and provide any immediate response if required. Foston Hall retained the responsibility for any security decisions.

The woman arrived at the hospital at 9:30am. She was admitted to a single room opposite the nurses' station on West Ward 4. It was noted during interviews with staff on bedwatch duty that, although the room gave her privacy, it was situated in a noisy part of the ward. This became a problem for the woman during her stay in the hospital as she was unhappy with the level of noise.

The woman was first seen by the doctor at 12:30pm. The doctor advised that a clinical team meeting would take place at 2:00pm to discuss what treatment would be required. At 2:45pm the doctor returned. It had been assessed that she had a 'mass' in her stomach and would need a chest x-ray and a scan before diagnosis. She was taken to the x-ray department at 4:45pm.

During the early evening, the woman complained of being in continuous pain and asked for some morphine. Nurses were not able to administer morphine at this stage as the woman had not had a formal diagnosis. However, it was administered later that evening by the doctor's instruction and then given at intervals of two hours as and when required.

The following morning, the woman continued to receive morphine to manage her pain. She was seen by a nurse at 10:45am who informed her that she would be given a blood transfusion and that a CT scan had been booked.

At 4pm, the woman was taken for a scan of her stomach, chest and lower back. After the scan, a nurse told bedwatch staff that the woman required surgery and she would need to stay in hospital for at least a week. At this stage the prison attempted to notify her next of kin. Unfortunately, information supplied in the woman's prison and probation records proved to be inaccurate.

On 19 January, the scan results arrived. Bedwatch staff were informed that the woman was very ill and a clinical meeting would take place to discuss whether surgery was possible.

The woman continued to question the need to wear restraints. She was unhappy with the security policy and asked the hospital to write to Governor of Foston Hall about having them removed. A bedwatch officer telephoned Foston Hall to inform them of the woman's intentions. Later that evening, the next shift of escort staff were advised to keep a close eye on her as she was making attempts to slip out of the cuffs.

The woman also began to question the frequency of administration of her medication. One of the nurses spoke with the woman about her keeping notes of when she was receiving her medication. The woman said that she was doing so under the instruction of her doctor and that she was to make note of when she did not receive medication when she had asked for it. The nurse explained that she could not have her medication more frequently than at two hourly intervals. The woman was unhappy with this response and refused to have her blood transfusion. However, 30 minutes later she did agree to have the transfusion. She had a very unsettled night and spent much of the time in the bathroom.

Her condition began to worsen. She was making more frequent and longer visits to the bathroom. Bedwatch staff were concerned by this and asked nursing staff

to check on the woman when she was in the bathroom. This constant checking agitated her. It would appear that prison escort staff were not fully aware of the symptoms of Crohn's disease and this led to a lack of appreciation for the woman's need for privacy. There was also little communication between medical staff and prison staff regarding the woman's condition. Issues of confidentiality prevented nursing staff sharing information with the prison escort staff who had to rely on what information the woman was willing to share.

The woman's difficult behaviour continued. She told the day escort staff that the night staff were negligent and slept, and told night staff that day staff went for frequent cigarette breaks. In addition, she continued to complain about wearing restraints and again asked the doctors to write to the Governor to have them removed. This behaviour concerned the escort staff and phonecalls were made to Foston Hall to seek advice. Staff were advised to keep the restraints on.

On 20 January, a Governor from HMP Birmingham visited the woman. She asked to speak with the governor in private to discuss her issues with escort staff. The Governor explained to the woman that staff were only doing their job and that she should not be concerned. The woman settled down after the visit and remained quiet for the rest of the day.

On 21 January, the woman's condition worsened. She was experiencing more pain, vomiting and spending increasing time in the bathroom. This continued throughout the following day.

The woman's abusive behaviour towards staff worsened during the night bedwatch on 22 January. When the escort staff changed over for night duty, an officer noticed that she had a bandage on her left arm. The woman said a needle had been inserted underneath by the nurse. The officer spoke with the nurse who stated that there was no needle and that the woman had requested a bandage. The officer checked the cuff on her arm and it was loose. The padding given by the bandage made the cuff appear tighter than it was. The cuff was adjusted. The woman was very unhappy at this and became abusive towards the officer. The officer offered to loosen the cuff, but she refused to respond.

The woman became increasingly vocal and aggressive during the night. Both escort officers removed themselves from the room and sat outside. One officer remained on the closeting chain. The woman removed the bandage from her arm and her hospital identification tag. She calmed down at 11pm. The officers asked her again if she would like the cuff loosened, but she said that she was fine. She calmed down and apologised to the staff for her behaviour in the morning.

At 2:15pm on 23 January, a doctor informed the woman that more tests were required before her surgery could take place. It was noted in the bedwatch log that the woman was very unhappy with this and that she did not want to be given

anaesthetic. The next day she was told that they needed to drain some fluid from her stomach in preparation for keyhole surgery later in the week.

During night bedwatch on 24 January, the woman spent over two hours in the bathroom. This was longer than usual. A nurse checked on her. The nurse told one of the officers that the woman was sitting on the floor doing nothing. The woman had told the nurse that she preferred to stay in the bathroom, as she did not like the officers. She spent most of the night in the bathroom.

An officer who came on duty at 7:55am was told by the woman that she was not sleeping as she was worried about having surgery and what would happen to her next. Nursing staff asked the woman to limit her time in the bathroom as it was affecting other patients' access to the facilities. She did not comply and a commode was provided. At this stage the woman was also refusing to comply with her prescribed medications and had to be spoken to by the doctors.

During the evening bedwatch shift it was noted that the woman continued to be non-compliant. She was unhappy about having to use a commode. Her behaviour worsened and a nurse reported that the woman was disposing of her cups of coffee into a bowl to pretend that she had vomited. A doctor came to speak with the woman at 8:25pm. It was noted in the bedwatch log that he believed that her behaviour was strange, but he could not pinpoint why. The woman continued to have another restless night.

On 25 January, a doctor informed the woman that she had been put on the list for surgery. She refused surgery and asked to speak with her other doctor. It was decided that she would not have any more procedures for the rest of the week, as she needed additional time to get used to the idea of surgery. It was noted by an officer in the bedwatch log that the officer felt that the woman might be being forced into having the surgery. During an interview with the officer, my investigator asked about this comment. The officer elaborated and said that she felt that the woman was only being encouraged to have the surgery as it was for her own benefit. Without it, the woman had been told that she would die.

The woman continued with her pattern of sleeping more in the daytime and being more active during the night. She was relatively quiet in her behaviour. She spent less time occupying the bathroom. Instead, she created a screen between herself and the officers in her room using the bed curtain to maintain some privacy.

At 10:20am on 27 January, the woman was seen by the surgical team regarding her surgery. She maintained that she was still not ready to make a decision about having surgery and asked them to return during the afternoon. The woman's behaviour became difficult after seeing the doctor; she was rude to the bedwatch officer and verbally aggressive when challenged about this. The officer commented in the bedwatch log that she believed this behaviour was due

to being pressurised about surgery. A nurse informed the officer that the womanwould have to decide whether to agree to surgery by lunchtime; if she did not, she would be discharged from hospital.

At 12:15pm, a routine management check of the bedwatch took place. During this visit it was confirmed that the woman had now been released on temporary licence (ROTL) until the completion of her treatment. As of 9pm that evening, the escort would be reduced to one officer. The officer would remain with the woman to offer her support and assist the nursing staff, who often became distressed at her behaviour.

At 3:45pm, the bedwatch officer rang Foston Hall to inform them that the woman's surgery had been rescheduled for Monday 30 January. At 9pm, her restraints were removed and the conditions of her temporary licence explained.

The woman's condition was visibly deteriorating. She was spending more time asleep either in her chair or sitting on the commode. She continued to vomit frequently and require constant pain relief. Her legs were starting to swell and she was encouraged by the doctor to spend more time in her bed. The woman did not want to do this and admitted that she was stubborn.

On 29 January, the woman was put on a 'nil by mouth' diet and only allowed clear fluids in preparation for her surgery. She was largely compliant, but did eat the occasional piece of food. When the bedwatch officer informed nursing staff of this, the woman became angry and said that the officer was interfering. At 5:30pm, the anaesthetist saw the woman.

During the evening, the woman suffered with constant pain and vomiting. She was seen by a doctor at 7:10pm. Her behaviour became more demanding as the evening progressed. She was unhappy at only being allowed fluids. The woman was given a sleeping tablet to help her sleep.

On the morning of 30 January, the woman was abusive to staff on being found with a milky drink. She continued to be difficult and insistent on trying to drink during the course of the morning. This became progressively worse until the ward sister spoke with the woman and told her that her behaviour was unacceptable.

At 2:20pm the woman was taken to theatre for exploratory keyhole surgery. After the surgery it was explained to her that she needed further surgery urgently. It was emphasised that if she did not undergo the operation then she would die. The operation was scheduled for the weekend.

The bedwatch officers changed shift at 7:40pm. The woman was in a pain that evening and asked that her room be left in darkness as she was embarrassed about her condition. The bedwatch officer sat outside the woman's room until

10pm to give her some privacy. It was noted in the bedwatch log at this stage that the woman was very ill and frail.

At 10:40pm, the officer rang Foston Hall for advice on what to do about being asked by the woman to remain outside the room for privacy. The advice given was that the officer should remain in the room. The woman was not happy with this decision and became verbally aggressive and abusive towards the officer. She remained difficult with both prison and nursing staff.

The woman continued to display difficult behaviour with all staff during the following day. She wanted to be left alone and resented the presence of escort staff, making it difficult for them to carry out their duties by requesting they leave the room and switch the lights off.

At the beginning of February, the Head of Healthcare at Foston Hall rang West Ward 4 to receive a clinical update on the woman's condition. She was told that woman was very ill and needed surgery within 48 hours. For this to occur, the woman needed to have a drip and catheter in place, however she refused to keep them in. The Head of Healthcare was told that she could not have a more in-depth briefing of the woman's condition over the phone, and would need to visit the hospital.

The woman's pain was worsening and she was still having difficulty sleeping through the night. She was then granted compassionate release on temporary licence and the bedwatch was removed. This meant she was temporarily released for the duration of her ill health. However, on discussion with medical staff an agreement was reached, that should the woman become disruptive and nursing staff felt they needed additional support, then an escort officer would be reinstated. It was also agree that should her condition considerably deteriorate then an officer would return to provide the woman company. Arrangements were made with Birmingham prison to supply officers if they were required until staff from Foston Hall could attend.

As Foston Hall was still unable to trace her next of kin and did not want the woman to be left on her own, a member of staff remained with her to keep her company and provide support.

The Head of Healthcare visited the Queen Elizabeth Hospital and spoke with the woman's doctor The surgical team were still hoping to operate, but were conscious of the obvious risks in doing so given her fragile health. They were still experiencing difficulty in getting the woman's consent to operate. She was unsure of whether she wanted the treatment. The doctor explained that the ward sister was responsible for informing Foston Hall should her condition change and a decision be taken to discharge her. This would give Foston Hall the opportunity to consider next steps and make appropriate arrangements for the woman's needs.

Over the next few days, the healthcare unit at Foston Hall continued to maintain contact with the Queen Elizabeth Hospital regarding the question of surgery. The information given over the telephone by nursing staff was limited, however it was clear that the woman was still undecided over her treatment. Her condition continued to be unsettled and her levels of pain increased.

During the first week of February, the Governor, Head of Healthcare, the Resettlment Manager and a Probation Officer met at Foston Hall to discuss the woman's deteriorating condition and their next steps. Despite enlisting the aid of the police, the woman's family could not be traced.

Later that afternoon, the Head of Healthcare spoke with a nurse at the Queen Elizabeth Hopital, who gave an update on the woman's condition. Her health was deteriorating by the day. It was decided that a psychiatric assessment should be undertaken to ensure that the woman was capable of make a decision regarding surgery. It was also agreed to arrange for the hospital's social worker to speak to her. In addition, a case conference would take place before the end of the week between the Head of Healthcare and the Resettlement Manager and Probation Officer from Foston Hall. This would determine the options available, and also look at the possibility of a discharge from hospital on Early Compassionate Release. Both the woman and her consultant's permission would be required for the case conference to go ahead. This was sought and agreed.

The psychiatric review was scheduled for the next morning. This was postponed until the afternoon as the woman refused to meet at the arranged time. After the meeting, it was agreed that she was capable of making her own decision about surgery.

At 5pm, the Head of Healthcare contacted West Ward 4 on information that the woman was to be moved to an intensive care unit (ICU). The ward sister told the Head of Healthcare that the woman was being moved as she was very dehydrated. She had agreed to have the operation and she would go into surgery the following day. The Governor of Foston Hall was asked to ring the hospital during lunchtime to find out what time the surgery would take place.

On the morning that the woman went into surgery, a message was left for Foston Hall to let them know. She would be transferred to the ICU after surgery. The Head of Healthcare made several phone calls to the ICU during the day to check up on the woman. However, it was not until 8:50am on the next day that she succeeded in getting any news. The woman was on a ventilator and under mild sedation. She had been fitted with a colostomy bag. It was not clear at this stage whether this would be a permanent or reversible.

At midday the woman was assessed by the doctor, she had been taken off the ventilator. It was decided that it was not necessary to reinstate prison officer escorts. Nursing staff were advised to contact HMP Birmingham or Foston Hall should they feel this decision needed revisiting. A governor from Birmingham was due to visit the woman the next day.

The search for the woman's family continued. Back probation records were traced and efforts were made to find reference to any family members. Reception at Foston Hall checked the woman's property card and stored property to see if there was anything that could assist in the search. An adoption certificate, medical card and post office card were among her belongings. The Deputy Governor asked staff to try and trace the woman's father using the adoption certificate as it stated that he used to be a Lance Corporal in the Army. Contact was made with the Army's Casualty and Compassionate Centre who made enquires with the Disclosures Branch of the Army Pension Centre. They were unable to make a trace without a date of birth. Enquires were made with Hampshire Country Adoption Team, but they had no record of the woman's adoption.

Two days before she died, the woman's condition was reported as being stable. Unfortunately, she deteriorated rapidly the next day when fluid began to collect on her lungs. She was taken for a chest x-ray where it was discovered that she had a pneumothorax on the top left-hand side of her lung. Her lung had collapsed and a chest drain was inserted.

At 8:50pm, a nurse called Foston Hall to report that the woman was fully conscious and that she had become hostile and agitated. Two members of nursing staff had to sit with her. The nurse was concerned that this was unduly occupying valuable ICU nursing resources. She was equally concerned for her staff's safety. Two prison officers from Birmingham were sent on bedwatch duty for the night. The officers were in uniform but no restraints were used.

The following day, the Head of Healthcare visited the woman. An update on her condition was provided. The surgery had resulted in the woman requiring a colostomy due to a blockage caused by adhesions within the bowel. Her health was generally very poor, and this was impairing her recovery. Whilst the woman had been taken off the ventilator, she still required 80% oxygen which was not an encouraging sign.

It was decided that prison officers were not required to stay with the woman. They added little or no benefit to her care as she was receiving one to one nursing. A nurse asked whether the prison had succeeded in finding the woman's next of kin. They had not at this stage.

During her visit, the Head of Healthcare noted that the woman recognised her. She was unable to communicate verbally, but had written a note asking that the

Head of Healthcare take her back to Foston Hall. She reassured the woman that they would when she was in better health. The woman was frail and very thin in appearance.

On morning that the woman died, the Head of Healthcare telephoned the ICU. The woman had a settled night and slept well. There was no change in to her condition. At 4:05pm, the Head of Healthcare was informed that the woman had passed away at 4pm.

Events following her death

The Head of Healthcare contacted the ICU and thanked the nursing staff for all the care and support given to the woman. Her medical records were collected and sealed. The ICU nurse advised that the woman would be referred to the coroner due to her recent surgery at the hospital. The coroner would be informed the following day.

Staff and prisoners at Foston Hall were informed of the woman's death. Those close to her were told first and in person.

Further attempts were made to try and trace the woman's next of kin. A Principal Officer found a telephone number for the woman's Prison Project Worker in her records. The Project Worker had known the woman for a number of years, but said that she had no information about her adoptive parents. The day after she died, the Principal Officer and Resettlement Manager phoned all the numbers stored in a mobile phone found in the woman's property. Unfortunately, they did not speak to anyone who could help. The Police Liaison Officer at Foston Hall searched through the woman's belongings again to try and find a link to her next on kin. The next day, he contacted Birmingham Police and the Army for assistance. Eight days later, he successfully traced the woman's adoptive parents and they were informed of her death.

An external post mortem examination was carried out at Derby Royal Infirmary. A full internal examination did not take place, as the pathologist was unwilling to do so given his belief that the woman was HIV positive. HM Coroner for Derby and South was dissatisfied with not having a full post mortem and instructed one to be carried out at a later day. This took place on 6 March.

The Governor of Foston Hall wrote to the woman's adoptive parents on 2 March, offering her condolences and explaining that staff from both prison and the Queen Elizabeth Hospital provided care and support to their adopted daughter. A letter was also sent to the Coroner formally advising him of the woman's death and providing background information on her circumstances.

A memorial service was held in the prison's chapel on Friday 10 March. Both staff and prisoners were invited to attend.

The woman's family wrote to the Governor on 11 March, thanking her for her letter. They were grateful for the information given about their adopted daughter's condition and circumstances, as they had not heard from her in the last nine years. They said they would like to attend the funeral and were grateful for the prison's offer to make and pay for the arrangements.

Findings and conclusions

Clinical

The clinical review was written in two stages. The initial report submitted by the clinical review team was based on a review of the woman's medical records, interviews with staff at Foston Hall and the two post mortem reports. My investigator asked the team to elaborate on the issues highlighted in the first draft, and a more in-depth follow-up paper was produced to support their findings and recommendations. The review has been summarised below. Both papers can be found in full at annexes 4 and 5.

History of Events

The woman had a long history of Crohn's disease and had had previous abdominal surgery for this. There was mention of previous positive results for HIV although her HIV status in this last stay at Foston Hall was unclear.

From the drug chart provided, the woman was on the following medication:

- Paracetamol as required
- Alendronate 70mg once a week (for prevention of osteoporosis which is common in diseases such as Crohn's that cause malnourishment)
- Tramadol 100mg 4 times a day as required (a strong analgesic)
- Mebeverine 135 mg three times a day (an antispasmodic commonly used in bowel disorders)
- Prednisolone 15 mg every day (a steroid to treat Crohn's disease)
- Rabeprazole 20mg every day (a drug to reduce stomach acid)
- Codeine phosphate 60mg 4 times a day (to reduce diarrhoea)
- Ibuprofen 400mg 3 times a day (an anti-inflammatory painkiller) which appears to have been stopped on 9 January 2006.

On 3 November 2005, whilst at HMP Brockhill, the prison's Medical Officer wrote to the woman's specialist at Queen Elizabeth Hospital, Birmingham requesting an urgent review because of her deteriorating Crohn's disease. An outpatient appointment was scheduled for 21 December 2005, by which time the woman was at Foston Hall. Apparently, she refused to go.

The appointment was rescheduled and the woman was eventually seen at Queen Elizabeth Hospital on 16 January 2006. Blood tests taken on that day showed her to be very anaemic (Hb 5.5, normally > 11). Because of this, and her generally poor state, the woman was admitted to hospital.

Whilst in hospital, the woman refused the treatments suggested. She became increasingly unwell and died following a laparotomy for small bowel obstruction. Subsequent post mortem examinations showed the woman died of

bronchopneumonia secondary to a collapsed lung and small bowel obstruction, in turn caused by her Crohn's disease. She was very malnourished and this was stated to have contributed to her death.

Discussion of the woman's Care at Foston Hall

Main points:

- The woman was clearly very unwell at the time of transfer to Foston Hall, which appears not to have been fully appreciated.
- She had a history of refusing treatments, this continued until her death.
- Any earlier medical interventions made whilst at Foston Hall were unlikely to have altered the subsequent events.

In the opinion of the clinical review team, the medical assessment that the woman received during her stay at Foston Hall, given her apparent ill health, could have been more thorough than that described in her notes.

The initial medical assessment form states that she was very underweight, lists her medications (as above) and that she had Crohn's disease. A full medical history would have been sent from Brockhill. The prison doctor was asked to see the woman the day after her arrival at Foston Hall, but the record provided is brief and only says she was unfit for work.

Foston Hall should review its standardised assessment by nursing staff for the first screen health check. Issues identified during this assessment (e.g. current, active disease, physical measurements outside the normal range) should be thoroughly reviewed and documented by the prison medical officer.

Staff who had known the woman previously recorded that she was less "bubbly" than she had been, had a poor colour and her abdomen was distended.

Staff reported that the woman did not wish to stay in the Healthcare Centre and remained on the wing. She initially walked over to the Centre to receive her medication. However, during her stay the decision was made to take the woman her medication "because she looked so weak".

She was seen repeatedly during her stay because of her ill health, but no further investigations, i.e. blood tests were requested. The feeling seemed to be that she would be seen soon in outpatients. Despite her ongoing bowel problems, the health records do not contain any records of her weight. It would seem likely that the woman's severe anaemia would have developed slowly and therefore easily missed unless blood tests were requested.

The woman's medications had been used appropriately for her condition and at the correct doses. There was a concern raised by a visiting doctor on 5 January 2006 that the ibuprofen may have been aggravating her abdominal pain and that she should not take it. This drug can cause indigestion as well as relieving pain. However, the same record states that the woman wanted to continue it. Use of the ibuprofen does not appear to have been a significant factor in the woman's death.

Should staff at Foston Hall have acted differently?

The clinical review team believe that the staff at Foston Hall could have acted differently in their approach to the woman's care. As stated in their review, health care staff at Foston Hall were fully aware that the woman was more unwell than in previous admissions and that she was awaiting a review of her Crohn's disease at Queen Elizabeth Hospital. This review was prompted by her worsening health.

Despite her short stay at Foston Hall, the clinical review team were surprised that a more thorough medical assessment is not present in her healthcare notes. As there is little in her notes concerning any such assessment or care management plan, it is not possible to be definite about what could, or should, have been done. In addition, he states it is not entirely appropriate to apply the level of care expected in the community with that in the prison environment. Prisoners as a group are more likely to have serious illnesses, and there is a custodial element to their care, therefore a more rigorous approach to healthcare must be used. As the woman obviously had worsening Crohn's disease, the clinical review team would have expected to find:

1. A plan that the woman should have been weighed, at least monthly.
2. A dietary assessment, with consideration given to involvement of a dietician.
3. Blood tests requested whilst awaiting the outpatient appointment.

The results of the above may have prompted staff to try and expedite the woman's delayed outpatient appointment.

The clinical review team comment that it is surprising that management plans for the ongoing care of prisoners is not in place. The team states that the responsibility for the creation and implementation of such care plans lie at a national level, although the Primary Care Trust would be happy to work with local prison healthcare staff to achieve these recommendations.

Healthcare should produce clear care management plans for prisoners with ongoing health needs. The medical officer should decide when this plan should be revisited, and by whom. The management plan should be a working document and take into account any new and emerging issues

during the course of care. This should be maintained by nursing staff, but reassessed at intervals by the prison medical officer.

From reviewing the medical notes, the clinical review team's opinion is that that staff never really got to grips with the woman's illness, which was clearly worse than they appreciated - her severe anaemia was missed. This is perhaps because it was generally thought any assessment could be left to the team that she was due to see at Queen Elizabeth Hospital, or that she would only be staying for a short time at Foston Hall.

The fact the woman preferred to stay on the residential wing did not materially alter events. On speaking with healthcare staff at Foston Hall, the clinical review team were told that the knowledge healthcare staff had of prisoners would not be compromised by their choice of accommodation.

The woman's refusal of treatment

Unfortunately, as the woman had a tendency not to comply with or refuse suggested medical interventions, it is unlikely her death could have been avoided. Despite her implied mental health problems, the clinical review team found nothing to suggest she was not capable of making decisions surrounding her health. Her poor compliance is, in any case, not relevant to the events between November 2005 and January 2006, but was certainly relevant to her last hospital admission and, the team assumes, to her illness in the months and years prior to November 2005.

The woman's HIV status

The notes and post mortem reports are conflicting and unclear as to whether the woman was HIV positive or not. This is unlikely to have impacted on her care as there is no suggestion she had an AIDS related illness.

Conclusion

The clinical review team was encouraged to hear that Foston Hall now has a regular doctor to act as medical officer; this was not the case during the woman's stay. This will provide better continuity of care and an opportunity to develop new protocols. In addition, the use of information technology is set to increase at Foston Hall, and should improve record keeping.

In conclusion, staff at Foston Hall gave the clinical review team no reason to suggest they are anything but very caring. However, the organisation of healthcare needs to be brought up to modern standards in line with the Primary Care Trust.

General

Medication at Foston Hall is dispensed from a small hatch area at the main entrance to the healthcare unit. This is located at a central part of the establishment and is easily accessible from all wings. There is a ramp up to the entrance, and there are no stairs as it is all on one level. The woman had a short walk from her wing to healthcare to collect her medicines and was happy to do this as it meant she moved from her room. There were occasions when she was too frail to make the journey and healthcare staff were asked to bring her medications to the wing. Although this is not usual practice, I commend the flexibility of healthcare staff and their willingness to accommodate the varying needs of prisoners.

The inpatient facility at Foston Hall is small and largely used for patients with mental health needs. Although the woman chose to reside on the wing, being permanently based on healthcare would not have been a practical option. When my investigator discussed with discipline staff the subject of having chronically ill patients on the wings, it was noted that they are not briefed by healthcare about prisoners' conditions. Whilst I understand the issue of patient confidentiality, I do think that it would be better practice to ensure that discipline staff have a general overview of what to expect when housing a chronically ill prisoner. My investigator was told that staff are not aware of any prisoner's condition on the wing, and that they would not know if a prisoner was diabetic or asthmatic. Given that discipline staff are usually the first on scene during a medical emergency, knowing these basic facts about a prisoner could result in a quicker and more effective response.

The Head of Healthcare should consider providing basic medical information regarding chronically ill prisoners to discipline staff who have a duty of care to prisoners based on their wing, in accordance with the Department of Health guidelines on sharing information.

I concur with the prison's risk assessment regarding the use of restraints and cuffs whilst the woman was still in full custody. She had made attempts to escape on previous sentences and showed clear intentions of removing her restraints under the bedwatch. The woman was fully mobile in the early stages of her admission to hospital and was disruptive and uncooperative with both prison and nursing staff. Equally, I agree with the prison's later decision to grant the woman release on temporary licence (ROTL), and then compassionate release on temporary licence once it was clear that she was too frail and sick to pose a threat to the public. However, I do have concerns about officers being uniformed in an intensive care unit. I doubt this is appropriate except in the most exceptional circumstances.

The woman's behaviour towards staff during her stay at hospital was frequently unacceptable and aggressive. This has been well documented within the

bedwatch logs. I appreciate that this must have been particularly stressful for the escort staff who were required to remain with her at all times. My investigator spoke with three members of staff who confirmed that it was, at times, extremely frustrating. However, despite understanding the difficulties posed, I do not condone some of the language used within the bedwatch logs. Some staff comments are inappropriate and rude in describing the woman's behaviour. I have chosen not to use extracts within the body of the report as they did not directly affect her care, however the logs are attached as an annex. The Governor has reminded staff that the logs are for noting observations and not for venting personal opinions.

Staff at Foston Hall went to great lengths to find the woman's adoptive parents and I commend them for their actions taken.

The Governor should commend staff for their time and effort in finding the woman's adoptive family.

Recommendations

Clinical

- **Foston Hall should review its standardised assessment by nursing staff for the first screen health check. Issues identified during this assessment (e.g. current, active disease, physical measurements outside the normal range) should be thoroughly reviewed and documented by the prison medical officer.**

- **Healthcare should produce clear care management plans for prisoners with ongoing health needs. The medical officer should decide when this plan should be revisited, and by whom. The management plan should be a working document and take into account any new and emerging issues during the course of care. This should be maintained by nursing staff, but reassessed at intervals by the prison medical officer.**

- **The Head of Healthcare should consider providing basic medical information regarding chronically ill prisoners to discipline staff who have a duty of care to prisoners based on their wing, in accordance with the Department of Health Guidelines.**

General

- **The Governor should commend staff for their time and effort in finding the woman's adoptive family.**

The Governor states in her response that she has thanked the staff concerned for their efforts.