Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Foulkes, a prisoner at HMP Preston, on 5 March 2022

A report by the Prisons and Probation Ombudsman

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Our vision

To carry out independent investigations to make custody and community supervision safer and fairer

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Alan Foulkes, who was 81 years old, died in hospital from cancer on 5 March 2022, while a prisoner at HMP Preston. We offer our condolences to Mr Foulkes' family and friends.

4. The clinical reviewer concluded that the clinical care Mr Foulkes received at Preston was of a good standard and was equivalent to that which he could have expected to receive in the community.

5. We found that there was insufficient communication between the prison's family liaison officer (FLO) and Mr Foulkes' wife and an incomplete record of contact with her.

Recommendations

- The Governor should ensure, in line with PSI 64/2011, that the next of kin of terminally ill prisoners are kept informed of the prisoner's condition and all contacts with the next of kin are recorded in the family liaison log.

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The Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Foulkes' clinical care at HMP Preston.

7. The PPO investigator has investigated the non-clinical issues in Mr Foulkes' care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. The PPO's family liaison officer wrote to Mr Foulkes' next of kin, his wife, to explain the investigation. She did not respond.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS identified a name inaccuracy in the clinical review, which has been corrected in the version accompanying the final report. Their action plan is annexed to the final report.

Previous deaths at HMP Preston

10. Mr Foulkes was the second prisoner to die at Preston since March 2020. The other death was self-inflicted. There are no similarities between our findings from our investigation into Mr Foulkes' death and our investigation findings from the previous death.

Key Events

11. On 21 April 2021, Mr Alan Foulkes was sentenced to three years and two months imprisonment for sexual offences and was sent to HMP Preston.

12. Mr Foulkes had many health conditions when he arrived at Preston, including hypertension (high blood pressure), polycythaemia (overproduction of red blood cells), chronic obstructive pulmonary disease (COPD - the term for a group of serious lung diseases), arthritis, spinal problems, and heart disease. He was also clinically obese. Mr Foulkes was a wheelchair user and needed help to get into and out of bed, and to wash and dress himself. He was located in the healthcare centre where staff were able to provide him with the support he required.

13. On 30 July, a prison GP reviewed Mr Foulkes' blood test results and noted he was developing anaemia (a fall in the level of haemoglobin, the oxygen carrying component of red blood cells). She checked his clinical history and found that similar tests the previous year had led to some detailed investigations that showed nothing of concern.

14. The GP asked for Mr Foulkes' blood to be monitored and by the beginning of October, Mr Foulkes was becoming more anaemic, and the GP made an urgent referral to the hospital to check for cancer.

15. Following appointments with the hospital in October and November, Mr Foulkes had a gastroscopy (a camera is inserted down the throat to check for abnormalities in the throat, oesophagus and stomach). On 3 December, a doctor diagnosed cancer of the oesophagus.

16. Mr Foulkes had several follow up trips to hospital in December and January 2022. On 28 January, a consultant said that they could not operate on Mr Foulkes' cancer, and that treatment would not be beneficial and likely to make him unwell. At the beginning of February, prison and hospital staff started palliative care planning (where treatment is focused on making the patient as comfortable as possible in the end stages of their life).

17. On 4 February, the cancer specialist treating Mr Foulkes estimated that he had six months to a year to live. However, Mr Foulkes deteriorated rapidly in February. On 28 February, he was experiencing a lot of pain and was admitted to hospital.

18. Mr Foulkes' condition continued to worsen in hospital, and he died there on 5 March.

Cause of death

19. There was no post-mortem examination as the coroner accepted the cause of death provided by a hospital doctor. The doctor gave the cause of death as 1a aspiration pneumonia (pneumonia caused by breathing something into the lung which leads to an infection); 1b bowel obstruction; 1c metastatic cancer of the oesophagus (cancer of the oesophagus which has spread to other parts of the body). COPD was given as an underlying condition which contributed to, but did not cause the death.

Non-Clinical Findings

Liaison with Mr Foulkes' family

20. Prison Service Instruction (PSI) 64/2011 on Safer Custody says that prisons must have arrangements in place for an appropriate member of staff to engage with the next of kin of prisoners who are either terminally or seriously ill and that it is good practice for a log of the contact with the family to be maintained. It says that following a death, a log book must be opened and that every contact with the next of kin should be recorded.

21. A prison chaplain was appointed as Mr Foulkes' family liaison officer after Mr Foulkes was told that his cancer was terminal. Initially, he provided good support to Mr Foulkes and his wife. On 9 February, the prison chaplain facilitated a video call, on a portable tablet, between Mr Foulkes and his wife. However, despite him saying that there would be future video calls between Mr Foulkes and his wife every two weeks, there is no record of any more taking place. On 28 February, another member of the chaplaincy team phoned Mr Foulkes' wife to update her on his health. Mr Foulkes' prison records show that a standard video call was booked for 2 March, but by that time he was in hospital.

22. On 3 March, the prison chaplain went on planned leave, and his deputy, another prison chaplain took over. By this time, Mr Foulkes was very ill in hospital. The bedwatch log (a record of events kept by officers accompanying Mr Foulkes while he was in hospital), does not mention any involvement or visits by the FLOs.

23. The FLO log was started on 5 March, after Mr Foulkes died. It does not appear to be a complete record of interactions with Mr Foulkes' wife. For example, there is no mention of a discussion about funeral arrangements but in answer to questions by the investigator, we know that the prison contributed to the costs of the funeral in line with national policy.

24. The sparseness of recorded contact with Mr Foulkes' wife both before and after his death, suggest that insufficient contact and support was given to her. There is no record of when the prison contacted her to let her know that her husband had been taken to hospital and was dangerously ill. In the week before Mr Foulkes died, his wife complained that she had tried to contact the prison on several occasions but had not been able to get through to speak to anyone. We are concerned that a FLO was not in regular contact with her during this time. We recommend:

    The Governor should ensure, in line with PSI 64/2011, that the next of kin of terminally ill prisoners are kept informed of the prisoner's condition and all contacts with the next of kin are recorded in the family liaison log.

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