Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Ann Browning, a prisoner at HMP Send, on 30 November 2025

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

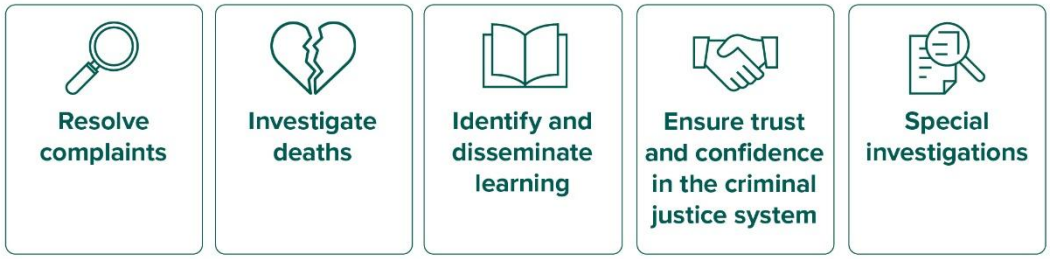
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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

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

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. In August 2011, Ms Ann Browning was sentenced to life imprisonment for murder. She died in hospital on 30 November 2025, while a prisoner at HMP Send. The Coroner gave the provisional cause of death as lung cancer. She was 68 years old. We offer our condolences to Ms Browning's family and friends.

4. The Ombudsman's office wrote to Ms Browning's son to explain the investigation and to ask if he had any matters he wanted us to consider. We mistakenly wrote that we were investigating Ms Browning's death as a post-release death. Mr Browning's son asked us to correct this as although Ms Browning had been temporarily released to hospital, she was still in the custody of HMP Send when she died. We apologised for this error by email.

5. NHS England commissioned an independent clinical reviewer to review Ms Browning's clinical care at HMP Send.

6. The PPO investigator investigated the non-clinical issues relating to Ms Browning's care. She spoke to two prisoners who knew Ms Browning, who said that Ms Browning's health deteriorated in the weeks leading up to her hospitalisation. They said they had to provide her with support with daily activities and that they raised concerns with healthcare staff and wing officers about her deteriorating condition. Although these concerns were escalated, they did not see any changes to Ms Browning's care prior to her admission to hospital. They were particularly concerned that Ms Browning was missing her GP appointments because she struggled both physically and mentally to attend them.

7. We did not find any non-clinical issues of concern.

8. The clinical reviewer concluded that the clinical care Ms Browning received at Send was of a good standard and equivalent to that which she could have expected to receive in the community. He found that Ms Browning had good mental health support and was appropriately referred to a GP when she developed physical symptoms. However, Ms Browning repeatedly did not attend medical appointments, and healthcare staff did not explore the reasons why. We recommend:

   The Head of Healthcare should ensure that a robust system is in place to monitor missed healthcare appointments and that staff routinely explore and record reasons for non-attendance, to identify and address any barriers to attendance.

9. The clinical reviewer made three other recommendations not related to Ms Browning's death that the Head of Healthcare will wish to address.

Good Practice

10. On 30 October, Ms Browning was granted Release on Temporary Licence (ROTL) using a Special Purpose Licence (SPL) under medical grounds and remained on ROTL until her death. This meant that she was temporarily released for medical treatment and was not restrained or guarded by officers. This provided Ms Browning and her family privacy in her final moments and ensured both dignity and respect in death.

11. We shared our initial report with HMPPS and the prison's healthcare provider, Central and North West London NHS Foundation Trust (CNWL). They found no factual inaccuracies. CNWL provided an action plan which is annexed to this report.

Adrian Usher **May 2026**
Prisons and Probation Ombudsman

Inquest

At the inquest, held on 18 June 2026, the Coroner concluded that Ms Browning died from natural causes.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100