Investigation into the death of a woman at Royal County Surrey hospital whilst in the custody of HMP Send in April 2009

Report by the Prisons and Probation Ombudsman for England and Wales

January 2010

The woman died in Royal County Surrey Hospital in April 2009 while in the custody of HMP Send. She had been suffering from cancer and was 40 years old. I offer my sincere sympathy and condolences to the woman's family and friends for their loss.

The investigation was carried out by one of my investigators. In addition, a clinical review of the woman's healthcare at HMP Send was undertaken by the clinical reviewer on behalf of NHS Surrey. I am grateful for her review. I would like to thank the Governor of Send and his staff for their co-operation and assistance.

The woman had spent a long time in prison by the time she went to Send in 2006. It appears that she valued her friends and the staff and did not want to move to another prison. She was diagnosed with cancer in 2006 and, although she underwent treatment, she was told that her illness had spread over the coming years. Although Send does not have 24 hour healthcare provision, staff were keen to accede to the woman's wishes and keep her in the environment she felt comfortable for as long as they could. I am pleased to record these efforts as it is clear that the woman was adamant that she did not want to leave Send.

I include one recommendation regarding recording family histories of cancer, and three areas of good practice regarding support from prisoners, multi-disciplinary meetings and restraints.

The version of my report, published on my website, has been amended to remove the names of the woman who died and those of staff and prisoners involved in my investigation

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2010**

CONTENTS

SUMMARY

The woman was born in October 1968. In 1997 she was sentenced to life imprisonment with a 15 year tariff for murder. She spent time in a number of prisons before transferring to HMP Send in 2006. Shortly after arriving there, she complained of a lump in her breast. Following a referral to hospital, she was diagnosed with advanced breast cancer.

The diagnosis shocked her, and she was angry that it was not investigated earlier as she had complained of a lump in her breast in a previous prison in 2004. The woman underwent treatment in the forthcoming months. However, she was diagnosed with further cancer in April 2007 and June 2008. This upset her and the prison's suicide monitoring process was used on a number of occasions to provide her with some extra support.

As the woman's health declined, staff began to consider whether she should move to a prison with 24 hour healthcare. The woman was very against this idea as she was settled at Send, and valued having friends and staff she knew around her. The prison was willing to look after her at Send until it became necessary for her to have constant healthcare.

The woman's health declined rapidly in early April 2009 and she was taken into hospital. Her nominated next of kin was contacted and was present at the hospital when she died. Prison staff told the other prisoners of her death, and showed her cell to her next of kin.

I believe that Send acted well to support a woman with a succession of serious illnesses by recognising her wishes to remain at Send as long as possible. The clinical reviewer comments that the woman's care was generally equitable to what she would have received in the community. I include one recommendation and three areas of good practice in this report. I hope that this report provides answers to any questions from the woman's friends and relatives.

THE INVESTIGATION PROCESS

1. One of my investigators led the investigation into the circumstances surrounding the woman's death. He contacted HMP Send and requested the relevant documentation. The paperwork took a long time to be sent to my investigator but, once it was received, my investigator reviewed it and planned the interviews.

2. My investigator wrote to NHS Surrey to request a review of the clinical care received by the woman while in custody. A clinical reviewer was appointed to carry out this review.

3. My investigator travelled to Send on 30 July with the clinical reviewer from NHS Surrey to undertake the interviews. The clinical reviewer was provided with the transcripts of the interviews.

4. One of the family liaison team contacted the person nominated as the woman's next of kin to inform her of the investigation. She declared that the woman was happy at Send and did not raise any specific concerns. My family liaison officer also contacted the woman's sister who asked why she had not been told about the woman's illness and death, and wanted to know if she had been on day release while in prison.

HMP SEND

5. Send was originally an isolation hospital, before becoming a junior detention centre in 1962. It was reclassified as a category C adult male training prison in 1987 but, having been re-rolled and rebuilt, opened as a female training prison in 1999. The capacity is 282. Send does have a healthcare unit in the main block but does not offer full 24-hour healthcare.

Assessment, Care in Custody and Teamwork (ACCT)

6. The ACCT process is used by the Prison Service to monitor and support prisoners deemed at risk of suicide or self-harm. It replaced the system known as F2052SH.

7. Once ACCT procedures are begun, the prisoner is observed at predetermined intervals according to the perceived level of risk. Each prisoner is assessed within 24 hours and then reviewed at intervals decided on an individual basis. The ACCT guidance says that, to be effective, the review should involve the key people who know the person at risk or are involved in their care. The key questions for each review are listed as:

    - have the problems that caused the ACCT plan to be opened now been resolved?
    - if not, what needs to be done to resolve them?
    - have any further problems arisen that are now causing distress and more risk?
    - if so, what action can be taken to address these?
    - is the person at risk now in contact with friends, family or other support?
    - does the person at risk now have something in their lives that they feel good about?
    - if not, how can this be improved?

8. Over time, the reviews should also consider other factors such as:

    - distress – has anything changed to make the person at risk more or less desperate?
    - resources – has anything changed that makes the person at risk now feel more or less alone?
    - previous suicidal behaviour – has anything changed that makes suicide more familiar or more acceptable to the person at risk?
    - suicide intention or plan – has anything changed to show that the person at risk is more or less prepared to kill themselves?
    - pattern of self harm – is self harm becoming more or less frequent?

Use of restraints

9. When a prisoner is escorted outside of a prison a risk assessment has to be made on the methods used to maintain security. The assessment will consider the number of staff to escort the prisoner, and whether the use of

restraints is advisable. The issues taken into account include medical concerns, behaviour in the prison, specific areas of concern and criminal history.

Contacting a prisoner's next of kin

10. PSO 0500 (reception) makes clear that "Staff must ask prisoners for the name, address and telephone number of their next of kin and accurately record the information". PSO 2710 (follow-up to deaths in custody) instructs prisons to "Arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner … ". The prison will only contact the next of kin, and would often not have details or knowledge of anyone else.

Independent Monitoring Board

11. Each prison has an Independent Monitoring Board (IMB) made up of members of the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State. The most recent report from the Send IMB covers the period April 2008 to March 2009.

12. The IMB comment that the prisoners are treated fairly and humanely at Send. However, it accepted that the large amount of building redevelopment and staff shortages had made consistent care for prisoners difficult. The shortage of staff was particularly prevalent in the healthcare department. The report did say that the belated appointment of a new head of healthcare had improved matters.

HM Chief Inspector of Prisons

13. HM Chief Inspector of Prisons undertook a short unannounced inspection of Send from 18 to 22 August 2008. The previous inspection, conducted in early 2006, resulted in a report that described Send as "being very safe and respectful, with reasonable purposeful activity and resettlement provision". However, the follow-up inspection revealed problems stemming from a less settled population, and difficulties in staff recruitment and retention.

14. The prisoners' induction routine was reported to be haphazard, and self-harm had increased throughout the prison. Although relations between staff and prisoners were still described as positive, this was threatened by the turnover of staff. Prisoners were described as dissatisfied with healthcare, which also suffered from a difficulty in recruiting permanent nursing staff.

Previous deaths at Send

15. Send experienced two self-inflicted deaths in 2007, and one since the death of the woman. There was also another death due to cancer in May 2009 where Send were praised for their approach to the use of restraints in hospital.

KEY FINDINGS

16. The woman was arrested in 1996 and convicted of murder in 1997. She was sentenced to life imprisonment with a 15 year tariff and moved to HMP Durham, HMP Buckley Hall and HMP Foston Hall. While at Durham, in August 2004, the woman was assessed in healthcare with a lump in her breast. Nothing abnormal was found, and she was not referred to an outside hospital for treatment. She was transferred to HMP Send on 15 May 2006.

17. The woman approached healthcare staff on 26 May complaining of pain and a lump in her breast. The doctor referred her to the Royal Surrey County Hospital under the two week referral system (where the patient is seen by a specialist within two weeks), and in June she was diagnosed with breast cancer. She was reported as being upset and tearful in the days following her diagnosis. She was understandably resentful that her illness had not been diagnosed at other prisons earlier in her sentence. In her documentation, staff referenced the support they offered her, including helping her write a list of questions to ask the hospital doctors.

18. A F2052SH form was opened on 29 June. (This was the document the prison service used to monitor those at risk of self-harm or suicide. It has since been replaced by the ACCT process). The form was opened because the woman said she had thought of ending her life. The documentation included references to her being supported by other prisoners. Her mood was again reported as being very low on 3 July as she had been told by the hospital that the cancer had spread. She underwent chemotherapy at the Royal Surrey County Hospital from July to October.

19. A meeting was held on 7 November with attendees from healthcare and prison staff to discuss her care. The prison provided her with new pyjamas and a DVD player in order to make her more comfortable. During her time at Send, she was also moved to a larger cell with a hospital bed. She underwent a mastectomy with simple reconstruction in December. She had a course of radiotherapy from March to April 2007.

20. In April, she was diagnosed with a brain tumour. She underwent surgery at St George's Hospital in early May to treat the tumour. This was followed by a further course of radiotherapy at the Royal Surrey County Hospital.

21. She appears to have been in dispute with the healthcare department in September who began to reduce her morphine dosages. This was done in response to a request from her hospital consultant to prevent her having too much which could mask the symptoms of her illness, but it still upset her.

22. On18 February 2008, she collapsed on the wing and had a seizure. During this attack she also bit her tongue. She was told in April 2008 that her cancer was no longer curable. This upset her and staff arranged for two of her friends to stay and support her. Support from her friends continued throughout her time at Send.

23. A senior officer (SO) wrote in the woman's records that she was authorised two additional telephone calls each week. She was again recorded as feeling low in May 2008. Staff noted that the woman fainted again in May although she told them that she was alright.

24. The woman had an escorted absence in Woking on 25 June 2008. (The purpose of escorted absences include enabling prisoners to familiarise themselves with community life, making resettlement arrangements and showing their ability to behave responsibly. Prisoners are escorted by prison staff who monitor their adherence to the expectations set out for them.)

25. In July 2008, the woman received further bad news about her health from the hospital. They confirmed that she was also suffering from bone metastases (cancer that has spread from the original site to the bones) and was to undergo a course of radiotherapy. She complained about being in pain and collapsed again on 23 July which necessitated a visit to an outside hospital. The woman was visited by a specialist palliative care nurse on 28 July and these visits continued throughout the rest of her life at Send. Another meeting was held in late July to discuss her care and it was decided to schedule a follow-up meeting as her treatment continued.

26. A further meeting was held on 18 August when staff discussed the safety implications of the woman staying at Send. A letter was received from a palliative care consultant, on 11 September which indicated that the woman's health needs were becoming increasingly difficult to manage in a prison setting. Another meeting was held on 7 October to discuss the prospect of the woman going to HMP Holloway where 24 hour healthcare could be provided.

27. Another meeting was held on 1 December and staff agreed that ultimately the woman would need to transfer to Holloway. However, it was decided to postpone this move until a specific need arose as the woman was not keen to leave Send. She agreed to this course of action.

28. The ACCT process was begun on 17 December as the woman's mood was very low following the decision of the healthcare department to reduce her pain relief medication. This was done due to security information suggesting that the woman was trading her medication. It was deemed necessary to remove her liquid Oramorph at nights and reduce her pain relief medication in the day. Staff were concerned that if she had traded some of her medication, she might no longer have been used to the amounts that she was prescribed. The prison GP was consulted, and it was noted in the medical record that the hospital consultant would be contacted to explain the situation. The woman said to an officer that, when she was told about the reduction, she threatened to cut herself. When told the ACCT process would be started the woman was initially against the idea, but eventually agreed to the extra support.

29. A second officer filled out the Immediate Action Plan part of the ACCT form which set out what actions should be carried out with regard to the woman's location, staff support, phone and Listener access. (A Listener is a prisoner

trained by the Samaritans to provide confidential emotional support to other prisoners.) With regard to her location in the prison, the second officer wrote that the woman wanted to stay in her own cell. The second officer stated that the woman should be observed every hour, and staff must have at least one conversation with her each shift. She should have access to the telephone and a Listener should she wish to.

30. Although she felt low, the woman told staff that she did not have any specific thoughts of suicide. She was reviewed on a regular basis and the first ACCT review meeting was held on 19 December. The offender supervisor was unable to attend and submitted written notes in advance. She commented that, although the woman was stable, she would soon need 24 hour healthcare. The offender supervisor noted that the woman would prefer to remain at Send or be released on compassionate grounds. However, the offender supervisor wrote that she was unlikely to be released. The woman was reported as being tearful and in pain at the review. She was angry about the reduction in her pain relief medication but was persuaded to go to healthcare for a further assessment.

31. Another ACCT review was held on 24 December and the woman was described as much happier as her morphine had been increased. She asked for the ACCT to be closed, but a second SO explained that this was not possible as he was not the case manager. However, the number of observations was reduced and the caremap was updated. The ACCT was closed at the next review meeting which was held on 30 December.

32. On 6 January 2009, the woman reported that she had fallen in the shower and had bruised her buttocks but had no other injuries. She told staff that she had discharge from her left breast and lumps in her breast on 12 January. She was seen in the Royal Surrey County Hospital as part of her routine follow-ups and for her Herceptin infusions. (Herceptin is a drug used to treat breast cancer.)

33. During January 2009, the woman told healthcare staff she was experiencing a cough with thick yellow sputum. Her appetite was poor and two different anti-nausea drugs were prescribed. She also complained of chest and head pain, and was still having chemotherapy.

34. The woman learned she had been refused parole on 13 January and this upset her. She was late for her Herceptin treatment on 23 January because prison staff were unaware that she was going out of the prison on that day. Her blood sample had not been taken the previous day which meant that she could not receive all of her treatment. She was told at the hospital that she needed to have further radiotherapy and chemotherapy as there was a mass in her chest. Blood samples were taken the following day and she returned to hospital on 26 January to have her Herceptin treatment.

35. On 2 February, the woman reported pain in her hip and knee following a fall during a seizure but there were no further injuries. She underwent radiotherapy and Herceptin treatments throughout February at the Royal

Surrey County Hospital. When she was seen at the hospital at the end of March it was noted that she was beginning to look unwell and quite frail.

36. A third officer wrote in the woman's file on 25 February that her health was the main concern and she was "living day to day". A case conference was held on 2 March where staff discussed that other prisoners may have been having access to the woman's morphine as other prisoners had tested positive for the drug. It was decided to fix a box in the woman's room that could only be opened by the woman in the presence of an officer.

37. The woman was visited by a Macmillan nurse every week as her illness progressed. Staff told the investigator that she greatly valued these visits. She suffered another seizure on 28 March, but this did not present any additional complications.

38. It was documented on 2 April that the woman's tumour markers had risen markedly and new lumps were noted in her chest and neck. (Tumour markers are substances in the body that can become elevated during cancer.) In addition, she was not well enough to go to hospital for the Herceptin to be administered. She remained in bed coughing and vomiting, and became increasingly sleepy.

39. Healthcare staff told prison staff on 3 April that the woman had deteriorated and requested that they check her throughout the night. In the morning healthcare confirmed that her health had worsened and that she needed to go to hospital. The woman left the prison at 2.00pm escorted by two officers and went to the Royal Surrey County Hospital in Guildford. A third SO described her on 4 April as very weak, unable to walk properly or digest food and fluids.

40. The escort procedures stated that the chain restraining the woman was only to be used when there was only one officer present or if she was being moved. The hospital doctor asked for the woman's next of kin details at 9.30pm. The prison had one person nominated in the woman's records as her next of kin, and did not have details for anyone else, including any relatives. The investigator did not discover any evidence that the prison asked her if there was anyone else she wished to be contacted. The governor called the escort staff at 10.25pm to say that the restraints could remain off and should not be reapplied. The woman was moved into the Intensive Care Unit at 11.30pm.

41. The woman's nominated next of kin was telephoned and updated about her condition at 1.00am on 5 April. (The woman's sister has asked if there was a written directive that the woman had expressly said that she did not want her family informed of her illness or death. The investigator has found no record of such a wish and the prison had no record of the woman having a sister.) The woman was intubated (a tube inserted into the throat) at 6.40am to help her breathe. The woman's next of kin was again updated, and arrived with her partner at the hospital at 12.15pm. The chaplain arrived at 2.15pm and spent some time with her and her next of kin. The chaplain and the woman's next of kin left the hospital at approximately 3.45pm.

42. The escort staff spoke to the woman several times throughout the night to reassure her of their presence. The hospital doctor told the escort staff at 5.45am that the woman had deteriorated since midnight and was unlikely to live beyond the morning. The doctor informed the woman's next of kin of the prognosis.

43. Another prison chaplain spent time with the woman at approximately 10.45am. The prison chaplain told the escort staff that the woman had been given communion and the last rites and had taken confession earlier that week. At approximately 12.30pm, a second governor met some of the other lifer prisoners at Send to update them about the woman's condition.

44. The woman's next of kin returned to the hospital at 1.40pm and the woman died at 2.00pm. The first governor and the prison family liaison officer arrived shortly afterwards to meet the woman's next of kin and her partner. The governor took them back to Send at 3.00pm and showed the woman's cell. They were also introduced to the woman's friends who wished to meet her.

45. The second governor had another meeting at 4.10pm for those prisoners who had not yet heard that the woman had died. A third officer told the investigator that the prison organised a group meeting following her death for those staff involved in the woman's care. The officer only received the letter regarding the meeting on the day of the event, but explained that the intention was that all who wished to attend could. She also said that the care team was available to all staff who wished to have further support.

ISSUES

Clinical care

46. The clinical reviewer wrote that:

> "In the main the health care provided for the woman followed an expected pathway for any woman of that age with a similar grade of disease and prognosis. … Overall the care provided for the woman by all the staff and some of the other prisoners appears to have been appropriate at the different stages of her disease progression and similar to that which could be expected by any woman with the same disease. Apart from the natural history of metastatic breast cancer I have been unable to identify any adverse incident which contributed to the death of the woman."

47. The clinical reviewer did note that the woman varied from the expected treatment pathway for people with cancer in some respects due to her being in prison. These were:

- "reduced access to other women with breast cancer
- the inevitable constraints on the availability of some types of pain and other symptom relief
- a lack of access to 24 hour nursing care, which might have resulted in her being admitted to hospital more frequently than would normally be expected had she been living in another environment.
- The subsequent support for the staff and other prisoners may have been less than that available to health care staff, family and friends of patients in other environments who had the same outcome from their disease process."

48. These divergences from the expected pathway were largely unavoidable given that the woman was in custody. The lack of access to 24 hour healthcare could have been achieved but the woman was keen to remain at Send as long as she could. The clinical reviewer's opinion was:

> "Overall the care provided for the woman by all the staff and some of the other inmates appears to have been appropriate at the different stages of her disease progression and similar to that which could be expected by any woman with the same disease."

49. The woman was unhappy that her cancer had not been diagnosed despite her raising it with healthcare in her previous prisons. The lack of early diagnosis is disappointing and the clinical reviewer considers that it was a contributory factor to her death:

> "[The] Possibility of disease being detected earlier if significance of family history had been recognised, though this may have been due to the poor and inconsistent family history provided by the woman."

50. The clinical reviewer commented that a lesson to be learned from this is:

> "Where appropriate the relevant screening programme should be available to a prisoner where there is a strong family history of cancer."

51. She also made a recommendation regarding this:

> **Records of the health of close family members should be kept up to date especially where there is a history of cancer in the family.**

52. I will be writing to HMP Durham to make them aware of this recommendation.

Security concerns over the medication

53. As the woman's illness spread and the pain grew, she required pain relief medication. Staff were adamant that control of the woman's pain was a key security concern. The nurse said:

> " … it was always made clear that the woman was to have her medication. There was some medication that she'd have in possession overnight on and off, and even though that's not in the policy of the prison, it was always made security tight and made sure that the woman had access to those medications when she needed them."

54. The clinical reviewer stated:

> "Attempts were made to control her pain even during the times when she appeared to be trading her morphine which made assessment of her symptoms and pain very difficult."

55. The woman was allowed to hold her own medication in order to manage her pain through the night. A second nurse explained the reason behind this:

> " … in order to maintain her pain relief over a 24 hour period while we weren't here, it meant that she had to have some Morphine in possession, small Morphine in possession, which obviously goes against the grain in a prison setting to have medications like that in possession. And so we worked out, with the team of us and obviously the Pharmacist and the Pharmacy Lead, a safe way for her to have access to painkillers over a 24 hour period when we weren't here."

56. There was suspicion amongst staff that the woman was trading some of this medication. The issue was discussed in the multi-disciplinary meetings and the prison provided a locked box in her cell. The second nurse explained the system:

> " … when she had her supervised Morphine tablets with the Nurses before we went home in the evening, she would then pick up two vials, plastic vials with Oramorph which would be counted out and put in her box which was, the outer box was locked by an officer and she had the key for the inner box, so that when she required pain overnight, she would ask the officer who would come to her room, open and supervise her taking the Oramorph. She would then bring back the empty vials in the morning, if she hadn't used it we'd count it back in, if she had used it we'd mark off and at what time."

57. The box appears to have minimised the risk of the woman trading her medication. I consider this to be a proportionate response to the problem posed by the security concerns.

Whether the woman should have remained at Send

58. Send does not have 24 hour healthcare provision and prisoners requiring such care are moved to other prisons. The woman's prognosis meant that a transfer to a prison with 24 hour healthcare was a way of ensuring she received the appropriate care.

59. However, the woman was adamant that she did not want to leave Send. The third officer told the investigator that " … she would get very upset at the thought of being sent to another prison". She had friends at Send that she did not want to be away from. She had also built up a rapport with some of the staff. Staff were willing to keep the woman at Send until her illness meant that she required 24 hour healthcare support. The second nurse told the investigator " … if she did suddenly deteriorate, we wouldn't be able to look after her here, she would need to move to a 24 hour unit". The woman declined rapidly after she was taken to hospital for the last time. I am satisfied that there is no indication that she should have been moved earlier. The nurse said that prior to her last removal to hospital " … there was no reason to move her at that stage, and we kind of took her thoughts into that, into consideration for that reason".

60. During her illness the prison made several changes to her living arrangements to provide her with more comfort. She was given new pyjamas and a DVD player and moved into a cell that had been modified for prisoners with disabilities. The first nurse described the differences a cell of this type offers as it being bigger with a larger bathroom door. It also has rails and room for a hospital bed.

61. The woman also had access to a Macmillan Nurse who visited regularly. The first nurse did not remember the woman ever asking for anything else that might add to her quality of life. The clinical reviewer said that:

> "The woman appears to have been supported by the health care staff, prison chaplin and selected prisoner buddies. She had ongoing support from the neurological team for her epilepsy and specialist palliative care team for her metastatic cancer. Overall the evidence provided shows that the woman chose to stay at HMP Send with the staff and prisoners who were able to provide her with support during her illness, this allowed her to be cared for in the place of her choice, recognising her limited choices, this is in line with the pathway of care available for any woman living outside of prison."

62. The clinical reviewer also commented on the help provided by other prisoners:

> "Although the woman, as a prisoner, was unable to access a breast cancer patient support group she was allowed to have a group of "buddies" who were other prisoners and they seem to have provided her with support throughout her treatment and during the palliative care phase of her disease. I feel that this is an example of notable practice which should be shared with other prisons."

Allowing other prisoners to act as a support group to the woman is an example of good practice.

Information sharing and multi-disciplinary working

63. The prison held regular meetings of both prison and healthcare staff to discuss the woman's care. This was a valuable means of ensuring that all relevant staff were kept informed of her progress, and able to voice any concerns. All too often in other cases the Ombudsman has commented on less satisfactory communication between prison and healthcare staff but this has not been the case here.

The use of multi-disciplinary meetings is an example of good practice.

Compassionate release

64. The Ombudsman has had cause to comment on the lack of consideration of compassionate release in other cases. The Secretary of State is able to release a prisoner early on compassionate grounds under certain circumstances. PSO 6000 (Parole, Release and Recall) explains the background to a compassionate release on medical grounds:

> "Early release may be considered where a prisoner is suffering from a terminal illness and death is likely to occur soon. There are no set time limits, but three months may be considered to be an appropriate period."

65. In the woman's case, it appears that her sudden decline in April was rapid. Prior to this, it is not clear that she had no more than three months to live. It is important to note that there is no guarantee that any application will be granted as several factors are taken into account when making the decision. Although it is the prisoner who applies for release, the application must be supported by the medical practitioner, probation officer and the Governor. The investigator saw no evidence that the woman began the application process for compassionate release towards the end of her life.

Use of restraints

66. The prison initially requested that the escort chain be applied to the woman in the hospital but the decision was later made for the chain to be removed. The Ombudsman has frequently been concerned about the excessive use of restraints and it was encouraging to hear of the approach taken by Send. It granted the woman more dignity in her last hours without compromising security.

The removal of restraints, once the risk had been assessed, is an example of good practice.

Support for staff and prisoners

67. Although, the clinical review commented favourably on the help provided by the other prisoners, the clinical reviewer was concerned that support should also be given to them. I am happy to reflect the work of the second governor undertook in informing the other lifer prisoners of the woman's condition. The prison also sought to provide support to staff affected by the woman's death although, as the testimony of the third officer revealed, not all staff were actually able to attend the meeting arranged for this purpose.

CONCLUSION

68. The woman had spent a long in time in prison before she was diagnosed with cancer. Despite treatment, the cancer spread and the woman was told that it was inoperable. I am satisfied that Send acted well to maintain the woman's quality of life, as far as was possible. The report contains one recommendation regarding the recording of family history of cancer, but I am also glad to record several instances of good practice. The regular meetings held at Send were an effective means of ensuring communication between different areas of the prison. Allowing other prisoners to support the woman provided some comfort during her time in prison. I was also reassured to see that Send removed the woman's restraints in hospital once it was clear that this would not create a security risk.

RECOMMENDATIONS

1. Records of the health of close family members should be kept up to date especially where there is a history of cancer in the family.

The National Offender Management Service accepted this recommendation:

"This has been fed back to the PCT."

Good practice

2. Allowing other prisoners to act as a support group to the woman is an example of good practice.

The National Offender Management Service commented:

"This was deemed appropriate for her and if it is seen to be appropriate in future case, we would allow it again."

3. The use of multi-disciplinary meetings is an example of good practice.

The National Offender Management Service commented:

"This is standard practice for any prisoners at risk of self harm (which she was) as well additional meetings as part of her palliative care team to address any other issues or concerns."

4. The removal of restraints, once the risk had been assessed, is an example of good practice.

The National Offender Management Service commented:

"This is standard practice and has been highlighted again as best practice in a subsequent death at HMP Send from terminal cancer."