Investigation into the circumstances surrounding the death of a woman at a hospice In October 2009 whilst in the custody of HMP Peterborough

Report by the Prisons and Probation Ombudsman for England and Wales

November 2010

This is the report of an investigation into the death of a woman, whilst she was in the custody of HMP Peterborough. She died in October 2009 in a hospice, having gone there from hospital. She had been suffering from cancer. She was 47 years old.

One of my family liaison officers contacted the woman's sister to explain our role. I would like offer my condolences to the family and friends of the woman. A delay receiving the clinical review means that this report is being issued later than usual. I must apologise for any additional distress this has caused to her family.

The investigation was undertaken by one of my senior investigators. Both he and I would like to thank the Director of Peterborough and his staff for their participation in the investigation. A clinical reviewer was asked by the local Primary Care Trust (PCT) to undertake a review of the woman's clinical care. I appreciate his report.

In my view, the woman received prompt, thoughtful and compassionate care from discipline and healthcare staff. The clinical reviewer found that she received a level of care at least as high as she could have expected in the community. He commends the team in the prison for their care of the woman. I fully endorse his judgement.

I make three recommendations: one to the Director, concerning talking to staff after a prisoner dies, and two to the Head of Healthcare regarding record keeping and communication with local hospitals. I am pleased to see that the Prison Service have accepted two of my recommendations and partially accepted the third. Their comments are included after the recommendations.

This 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.

Jane Webb
Acting Prisons and Probation Ombudsman **November 2010**

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SUMMARY

The woman was a 47 year old woman who had been in prison since 2006. She had a number of longstanding problems with her health, both mental and physical, before she arrived in HMP Peterborough in March 2007. They included cancer, which had resulted in a mastectomy (the removal of a breast) in 2005.

She had a history of harming herself, as well as not complying with her medical care. Staff encouraged her to accept medical care, with varied success. She was almost permanently subject to the prison's special support measures for those considered to be at risk of harming themselves. Her stay in prison was punctuated with frequent instances of her harming herself. She also had a high number of adjudications against her (findings that she had offended against prison rules), many for disobeying orders or for assaulting staff.

Due to her history of breast cancer, the woman was scheduled to have regular checks on her health. In 2007 she found a further lump in her breast, which was not cancerous. In June of that year she was due to attend her annual check up at the hospital, but refused to do so.

In March 2008, staff were concerned that the woman had been losing weight. They contacted the breast clinic, and arranged an appointment for her. The results were received in April and were clear. The consultant did not need to see her for a further year. The following year, in April 2009, she again refused to attend her annual check up. Following problems fitting her prosthetic breast, she did have contact with the hospital later that month.

The woman was taken to hospital a month later in late May 2009, following breathing difficulties. X-rays identified a mass in her chest, which was confirmed as cancer.

I have found that staff at the prison worked closely with all agencies to ensure the woman received the best possible care. Her condition continued to deteriorate and consideration was given to compassionate release. She was asked for her views and it was decided that she would miss the support she received in prison if she was to be released. She remained in prison until October when her deteriorating health meant that she needed to go to hospital. She moved from the hospital to a hospice on 22 October, where she died four days later.

I am satisfied that the woman received a good level of care. I make two recommendations to the Head of Healthcare about the maintenance of records and communication with the local hospital. I also make one recommendation to the Director about debriefing sessions after a death in custody.

THE INVESTIGATION PROCESS

1. My investigator was given full access to all relevant records relating to the woman, including her prison and medical files. During the investigation he visited Peterborough and spoke to staff who had cared for her. He interviewed eight members of staff and one prisoner, and these interviews were recorded. Transcripts are annexed to this report.

2. He issued notices inviting staff and prisoners to contact him if they thought that they had any information they thought might be relevant to the investigation. None was received.

3. The local Primary Care Trust asked a clinical reviewer to carry out a review of the woman's clinical care. I am grateful to him for undertaking this review. My investigator discussed aspects of her treatment both with healthcare staff at Peterborough and with the reviewer. The clinical review was due in January, but delays meant that it was not received in my office until the end of April.

4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and request a copy of the post mortem report. When completed, my report will be sent to the Coroner to assist his enquiries into the woman's death.

5. One of my family liaison officers contacted the woman's sister, who was named as her next of kin. My officer told her of my investigation and invited the woman's family to ask any questions or raise any issues for consideration. The woman's sister said that they had lost contact for a period of time but, as far as she was aware, her sister had received good care and had never complained about her treatment. She did not have any particular questions she wanted my report to address at that time. A copy of my report was available to the family when published and they had an opportunity to comment on the findings. I hope this report helps clarify any issues that might remain unclear and helps them better understand what happened in the time leading to the woman's death. The family received a copy of the draft report, and have not raised any further questions in relation to the findings of the investigation.

HMP PETERBOROUGH

6. HMP Peterborough is a privately-run prison, operated by Kalyx under a 25 year contract. Opened in March 2005, it is the country's only purpose-built prison for men and women, who are kept separate at all times. The prison has a 12 place Mother and Baby Unit. The operational capacity is 624 men and 372 women.

7. On the women's side, the prison accepts adult women from Nottinghamshire, Lincolnshire, Leicestershire, Cambridgeshire, Northamptonshire, Norfolk and Suffolk. The main accommodation is in two houseblocks, with five wings in each.

8. The majority of the accommodation is single occupancy and the wings hold on average 34 women. There is a separation and care unit and a 15-bed healthcare facility which incorporates a first night centre for women who are new to custody.

Suicide and self harm monitoring

9. In common with all prisons, Assessment, Care in Custody and Teamwork (ACCT) has been introduced at HMP Peterborough to monitor and support prisoners assessed as at risk of suicide or self harm. Once placed on ACCT, the prisoner is observed at pre-determined intervals according to the perceived level of risk.

Do Not Resuscitate Notices (DNRs)

10. A Do Not Resuscitate order (DNR) on a patient's file means that resuscitation should not be attempted and is designed to prevent any unnecessary suffering. The United Kingdom medical profession has guidelines for circumstances in which a DNR may be issued:

    - if a patient's condition is such that resuscitation is unlikely to succeed
    - if a mentally competent patient has consistently stated or recorded the fact that he or she does not want to be resuscitated
    - if there is advanced notice or a living will which says the patient does not want to be resuscitated
    - if successful resuscitation would not be in the patient's best interest because it would lead to a poor quality of life.

Her Majesty's Chief Inspectorate of Prisons

11. HM Chief Inspector of Prisons last conducted an unannounced inspection of Peterborough in July 2008. None of the issues raised in the subsequent report are relevant to the woman's care.

Independent Monitoring Board (IMB)

12. Each prison in England and Wales has an Independent Monitoring Board (made up of volunteers from the local community) responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are

maintained. The last report published by the IMB for Peterborough was the annual report for the year up to 31 March 2009. Nothing from the report is relevant to this investigation.

Previous deaths at HMP Peterborough

13. The woman's was the third death in the female side of the prison since my office took over responsibility for investigating such deaths. There was nothing in the other two investigations which needs to be noted here.

KEY FINDINGS

14. Whilst a patient in a psychiatric hospital, the woman set fire to her bed on three separate occasions. She was charged with arson with intent to endanger life, and remanded to HMP Eastwood Park.

15. The woman's physical and mental health problems were noted at her initial health screening, along with her medication. Her self-harm history was also noted. On 24 July 2006, whilst on remand at Eastwood Park, she saw a prison doctor in connection with a lump she had detected in her left breast. The medical records show that she would be checked again after one week, but the results of further examinations are not recorded. She further complained of pain in her breast on 2 October, but examination did not show any lumps or other causes for concern.

16. On 4 September, the woman was given an indeterminate sentence for public protection (IPP. IPP prisoners are given a minimum length of time they must serve, but once this is served they will not automatically be released until the authorities are satisfied that they do not pose any further threat to the community). She was given a minimum time to serve of 40 months.

17. Early in 2007 the woman found a lump in her left breast. The lump was removed on 9 January, and a biopsy found that it was an abscess which was not cancerous. In view of her family history of breast cancer, the importance of follow-up checks was stressed to her.

18. She had frequent contact with the medical team in Eastwood Park for both physical and psychological issues before she transferred to HMP Peterborough on 20 March 2007. She said that this was her first prison sentence.

19. The day after arriving in Peterborough, the woman was seen in the doctor's surgery, complaining that her neck and legs were painful from the journey. Two days later, 23 March, she was assessed by the mental health in-reach team (MHIT, who provide mental health services in the prison). She had not been receiving some of her prescribed medication, which was remedied.

20. On 23 March, the woman was taken to the healthcare centre, needing treatment for cuts she had made to her throat using a plastic knife. She said that she did it because she missed her son. The Assessment, Care in Custody and Teamwork (ACCT) support arrangements were put in place.

21. She had frequent contact with the medical team. They included:

    - 1 April, when she complained of stomach pains
    - 3 April a nurse was called to treat superficial scratches to her wrist and throat
    - 4 April she complained of stomach pains, which required a hospital appointment.

22. A note on the woman's medical record on 12 April shows that she complained of pain under her left arm, similar to what she felt prior to her breast operation. She saw one of the prison doctors the following day, and was referred to the breast clinic.

23. The next day, 14 April, her ACCT was reviewed. She reported that she was hearing voices (which she had complained of in the past), and was concerned about the pain in her breast. It was agreed that she should continue to be supported by the ACCT process.

24. A follow-up appointment was scheduled at hospital for 8 June. The woman, however, refused to attend. The importance of the appointment was explained, but she refused to attend or to sign a disclaimer. In view of her refusal, she was discharged from follow-up.

25. Over the following months she continued to need a high level of support. She displayed levels of paranoia and, on more than one occasion, assaulted staff. There were numerous occasions where she refused to take her medication or attend scheduled medical appointments. She also continued to harm herself, sometimes superficially and on other occasions more seriously. She frequently complained of physical ailments, which sometimes included chest and abdominal pains.

26. The woman's medical record shows that on 11 March 2008 there were concerns about her weight loss. She had had no follow-up from the breast clinic since she had refused to attend her last appointment. In the circumstances, a Nursing Sister contacted the clinic to arrange an early appointment for her.

27. The following day a nurse was called to attend the wing after the woman complained of chest pains radiating down her left arm. She was taken to the healthcare centre and given tests including an electrocardiogram (ECG – an electrical recording of the heart used in the investigation of heart disease). The results did not indicate a health problem.

28. On 24 March, the woman became emotional during a meeting with medical staff having developed a lump under her right arm. An x-ray was requested to assess whether this was a muscoloskeletal problem or the return of her cancer.

29. She did not attend a doctor's appointment on 25 March. On 28 March, she refused to take all her medication. She did not go to an appointment with the MHIT on 4 April and, on 17 April she refused Well Woman monitoring tests. Three days afterwards, on 21 April, she did not attend an appointment at the nurse clinic either.

30. The Nursing Sister contacted the Breast Care Unit at the hospital on 25 April to check the results of the woman's recent appointment. Her consultant confirmed that they did not need to see her again for a year.

31. The woman continued to have frequent contact with medical staff for both physical and psychological problems. She continued to be supported by the

ACCT procedures, and her mood and mental health fluctuated. There were further instances when she harmed herself, and she regularly refused to take her medication as well as not going to planned medical appointments. She spent periods in the healthcare centre.

32. After further review it was felt that the woman no longer needed to be supported under the ACCT process and, on 21 November, it was closed. However, four days later on 25 November, she cut her arms superficially. The ACCT was reopened and she was admitted to the healthcare centre. There were a number of self-harm incidents, refusal of medication and appointments. Following advice from the MHIT, she was taken back to the healthcare centre where she could have extra support.

33. The prison chaplaincy had been making efforts to find the woman's family. On 13 February 2009, staff told her that they had traced her sister. They passed the contact details on to her, and she subsequently made contact.

34. On 10 March, the woman began a smoking-cessation course, but only managed a week of trying to stop smoking before she had trouble coping and asked to be taken off the course. Around this time, the MHIT told her that she would be assessed as to whether she should be in a psychiatric hospital rather than in prison.

35. The woman was due to have her annual check-up at the breast clinic on 7 April but, when the date came, she refused to attend. However, after more problems fitting her prosthetic breast, she requested an appointment which took place on 11 April.

36. As part of her mental health care, a visiting psychiatrist saw her on 30 April to assess whether she should be admitted to hospital for psychiatric care. The files do not show the outcome of this assessment. On 2 May, after becoming upset, staff arranged for her to speak on the telephone to her sister. She remained upset the following day, and made cuts to her arms. She occasionally refused to take her medication and her mood and behaviour fluctuated.

37. Following further occasions when she harmed herself, the woman also set fire to the waste paper bin in her cell on 10 May. Her mental health appeared to be deteriorating, and prison staff enquired about the availability of a bed in a secure mental health unit for her. However, before a decision was reached, her physical health took a turn for the worse. Following problems breathing, staff arranged for her to go out to hospital as an out-patient on 22 May. She was diagnosed with a chest infection, and given antibiotics to take back to prison with her.

38. Over the following days the woman continued to have difficulty breathing, partly due to asthma. A taxi was booked on 24 May to take her back to hospital, but her asthma attack grew more severe and an ambulance was called instead. She was admitted to hospital, and required morphine during the night for pain relief. A chest x-ray showed signs of disease on her lung and she was referred for further tests.

39. The Parole Board were due to consider the woman's case in October. Her parole dossier, containing all the reports and papers which the Board would consider, was assembled. It was submitted to the Board on 29 May.

40. The same day, 29 May, the Nursing Sister spoke to the hospital, and was told that the woman would be going to a different hospital for further tests. X-rays had shown enlarged lymph nodes, and hospital staff were concerned that this could indicate a new primary cancer site. She was referred for further tests and, on 5 June, a biopsy was taken. It confirmed the presence of cancer in her breast, with secondary cancer in her lung and ribs.

41. On being told of the return of her cancer, she initially had some difficulty grasping that it was terminal. Staff had long discussions with her, explaining palliative care and pain relief and, over time, she seemed to accept her circumstances.

42. When the woman returned to the prison, she was allocated a cell in the healthcare centre. The prison arranged for her friends from the houseblock to be allowed to visit her. She had spent a long time out of contact with her family, and had only recently re-established contact, and so it was felt to be important that she could have contact with prison friends despite being in healthcare. Her friends were allowed to visit and bring small presents of chocolate and coffee. A number of prisoners also sent cards, letters, poems and flowers.

43. The cancer had spread to the woman's liver, and she began courses of radiotherapy and chemotherapy. A bed in a mental health secure unit became available on 3 June but, as she had begun her cancer treatment, it was judged important that this was not interrupted.

44. Suffering from breathlessness and chest pain, the woman was taken back to hospital on 8 June. Medical records show that she cut her arms the same day. She returned to prison on 16 June, but became unwell again and had to go back into hospital two days later on 18 June when she developed pneumonia. Records show that she tried hard to remain positive throughout. She returned to prison on 3 July, and a family visit on 4 July boosted her spirits.

45. After being found to have very high blood sugar levels, the woman was taken to hospital on 8 July. The records are not clear about when she returned to prison, but she was back in hospital on 12 to 14 July.

46. Staff at the prison were concerned that the healthcare centre might not be equipped to deal with the woman's needs after discharge from hospital. They convened a meeting of the agencies who would be involved in her care. They included the Macmillan nurses (specialist nurses dealing specifically with cancer patients) from outside the prison. The first meeting was held on 22 July, and they were held approximately every two weeks. She was already being supported by the ACCT procedures, but the multi-disciplinary meetings were held separately from her ACCT reviews. A member of the MHIT was always present at the multi-disciplinary meetings to ensure that her mental health was considered.

47. The meetings helped to ensure that any necessary equipment was obtained, and that any care needs were considered. The woman was given the healthcare centre's double cell, but as a single occupant. This gave space for a hospital bed to replace the ordinary bed, which improved her comfort. Because of her breathing difficulties, an oxygen condenser was brought in. The security department was represented at these meetings, and staff arranged, as a departure from the usual policy, for her cell door to remain unlocked during nights when she was particularly unwell, so that the nurses could care for her more easily.

48. Another benefit of having the Macmillan nurses at the meetings was to improve liaison with the hospital. Peterborough is a privately-run prison, and the healthcare in the prison is not provided by the local Primary Care Trust (PCT). There were some problems with communication between the prison and the hospital, and the woman would sometimes return from appointments without a proper discharge summary. The Macmillan nurses were able to help improve the flow of information.

49. Risk assessments were made of the security required for the woman's frequent trips to hospital. When first diagnosed with cancer, she was subject to the standard security measures of two members of staff to escort her, one of whom was handcuffed to her. But when she required longer stays in hospital, the cuffs were changed to what is known as an escort chain. She was still cuffed to an officer, but via a six foot chain, which allowed more personal space.

50. The woman returned to hospital on 31 July, remaining there until 6 August. She went back to hospital on 9 August and returned to prison on 14 August, where she was visited the following day by her family.

51. Another issue discussed at the multi-disciplinary meetings was the possibility of compassionate release for the woman. The relevant forms were completed, and preparations were made in case an application might be required. But following discussions which included her, the team concluded that if released she would not have access to the levels of 24 hour care and the support available to her in prison. Even though she had recently resumed contact with her family, for which she was thankful, she said that she felt that the prison was her home, where she felt comfortable and where she knew people. She said that she did not want to die in prison, but did not want the prison to apply for compassionate release. Instead contact was made with the local hospice and the hospice manager was invited to one of the meetings to outline their requirements. Risk assessments were carried out in advance of her requiring hospice care.

52. After suffering from chest pains, the woman was taken to hospital on 23 August. She remained there until 1 September.

53. The ACCT procedures stopped briefly but, on 7 September, the woman cut her arms using a plastic knife she had concealed from staff. Another ACCT was opened. Late on 9 September she became more ill and had to be taken to hospital, where she remained until the following day.

54. A symptom of her treatment was nausea and, on 13 September, the woman had to go to hospital for that reason. She returned to prison the following day. She also continued to attend for chemotherapy sessions.

55. The Macmillan nurses were able to give advice about the woman's condition and, on 21 September, advised that she was reaching the end of her life. An end-of-life care plan was to be put together which would follow the Liverpool Care Pathway, a recognised care programme to improve the quality of life for dying patients.

56. After concerns about smoking in her room where there was oxygen equipment, the woman was told on 27 September that she could only smoke when staff could take her out to the exercise yard. She accepted this. Her weakening state meant that she was readmitted to hospital on 28 September, but she discharged herself back to prison on 2 October. However, she had to return to hospital later that same day.

57. The woman returned to the prison on 6 October, where the severity of her condition was explained to her three days later on 9 October. She became a little distressed, and staff helped to support her. They also contacted her sister and arranged for her to visit.

58. After earlier enquiries by healthcare staff, a fax was received by the prison doctor from the woman's consultant at the hospital on 9 October on the subject of a Do Not Resuscitate (DNR) notice. The consultant said that, in view of her terminal illness, resuscitation would not be appropriate. He also said that, taking into consideration her high anxiety levels, this arrangement should not be discussed with her. A note was made on her medical record that she was not to be resuscitated if the situation arose.

59. By 14 October, the woman was extremely unwell. She was having trouble breathing, which caused her to panic, exacerbating the problem. Staff contacted the hospice to see if there would be a bed available for her. Unfortunately, they could not accommodate her. The following day she experienced increasing shortness of breath, a high temperature, and chest pain. She was admitted to hospital, and her cancer was found to have spread through her lung and liver. Staff also feared that she had developed a clot around her heart.

60. The woman was initially more comfortable in hospital and, on 16 October, following a security risk assessment, the arrangements were relaxed and the security cuffs were removed. She received a family visit from her brother and two sisters on 17 October. The next day, 18 October, the bedwatch was reduced from two officers to one officer. Following further deterioration in her condition, prison staff, the Macmillan team, and the woman herself, discussed her care. She complained of chest pain, shortness of breath, pain across her stomach, and feeling nauseous. They all agreed that she should go into the hospice where she would be more comfortable as she became more ill. She was admitted to a hospice on 22 October.

61. As an application for compassionate release had not been made, the woman remained in the custody of the prison. She was accompanied by a member of the prison staff but was not subject to any physical restraints such as handcuffs. She seemed to appreciate the continued company of prison staff, and nurses from the healthcare centre also visited her in the hospice. Her laundry was taken back to the prison and clean clothing taken to her in the hospice. On 23 October, it was decided that the escorting prison officer would not wear uniform.

62. The woman continued to suffer from increased agitation, shallow breathing, and panic attacks. She also continued to refuse some of her medication. Her heart rate was raised. Her condition continued to deteriorate and, at 7.35am on 26 October, she died. Although the prison chaplaincy team had been liaising with her family on behalf of the prison, it was staff from the hospice who informed them of her death.

63. Members of the chaplaincy attended the hospice. They and the nurses remained with the woman, and read messages and cards passing on the good wishes of her friends, something the friends later said they appreciated.

64. Medical staff at the prison were involved in a debrief meeting after the woman had died but discipline staff were not involved. Support was available to staff who required it and senior managers spoke to staff, though not all the staff told the investigator that they recalled further support being offered.

65. All the prisoners on ACCT documents were assessed in case the woman's death had a detrimental effect on them. Staff reminded prisoners of support that was available, including Listeners (prisoners trained by the Samaritans).

66. A memorial service was held for the woman in the prison. In line with the relevant Prison Service Order, the prison also arranged and paid for her funeral. The prison chaplain performed the ceremony, and other prison staff attended. The woman's sister said that the funeral was well attended, and that the family were treated well by the prison after her sister died.

Post mortem

67. A post mortem examination was carried out. The cause of death was given as:

    - Carcinomatosis due to
    - Carcinoma of the right breast.

68. This means that the cancer had spread from her breast. Her other organs became affected, which eventually caused her death.

ISSUES

Assessment, Care in Custody and Teamwork (ACCT)

69. Due to the woman's mental problems and her history of harming herself, she was supported by the ACCT procedures almost continually whilst at Peterborough. She was judged well enough to be taken off it in November 2008 but cut her arms four days later. The clinical reviewer also considered her self-harm history, and concludes that this was managed appropriately.

70. Once her cancer had been confirmed, ACCT reviews were held separately from the multi-disciplinary meetings about her medical care. But a member of the mental health team was involved in these meetings. I judge that her safety was properly managed through the ACCT process during her time in Peterborough.

Clinical care

71. The clinical reviewer also found that the woman received appropriate care for her mental health problems and the follow-up to her breast cancer. As well, the return of her cancer was diagnosed promptly. She frequently refused to cooperate with her own treatment, but she was made aware of the importance of continuing to communicate with medical staff.

72. Once prison staff were aware that the woman's condition was terminal, they set up a multidisciplinary team to consider her care. The meetings not only considered her medical needs, but also made arrangements for security and her wellbeing. Individualised plans were put in place, which were varied as her condition deteriorated. The clinical reviewer notes that medical management and pain management were particularly well handled within the prison setting.

73. From late August until early October, requests were made to the hospital for clarification over the issue of a Do Not Resuscitate (DNR) notice and whether resuscitating the woman in the event of her health failing seriously would be in her best interests. It is not clear from the records whether the issue was raised with her herself, because of fears of the effect it could have on her mental wellbeing. It is unusual for a patient and the next of kin to be excluded from decisions about resuscitation. However, the clinical reviewer notes that in view of her mental state and anxiety this medical decision was probably justified, and I accept his judgement.

74. Aside from the delay getting advice about resuscitation, communications between the prison and the hospital were managed although there were some difficulties. The prison's medical facilities were well equipped and maintained to deal with the woman's illness, and there were no apparent gaps in staff training. The multi-disciplinary meetings helped to ensure that all care and equipment were provided as necessary. She had visits from her friends and family which helped to maintain her morale.

75. One issue identified is some of the record-keeping. Whilst the induction procedures were good, and the record-keeping relating to the woman's

psychological care and her cancer are full, some handwritten notes and forms do not include either her name or that of the member of staff making the entry. Some entries even appear to refer to someone else. The clinical reviewer recommends that the medical and drug records are reviewed regularly.

The Head of Healthcare should consider regular reviews to ensure the proper maintenance of records.

76. The policies in place in the prison were followed properly. The clinical reviewer concludes that the woman's treatment was of an acceptable standard, and healthcare staff made considerable efforts to ensure the best management. He notes that the medical staff in the prison "should be congratulated for the level of commitment" shown in her care. Having considered the evidence, I agree.

Communication with the hospital

77. Medical staff at the prison spoke of problems with communication between prison and hospital. The investigator was told that the woman would go to hospital appointments with copies of her care plans, notes, prescription charts and any other necessary information. But, on return, she would often have no more than a small discharge summary containing basic information. This meant that the prison medical team needed to work harder to ensure continuity in her care.

78. I note that, as a private prison, the medical services are not provided by the local Primary Care Trust (PCT), and I wonder if that may have been a factor in these problems. It would be of benefit if a protocol were in place between the prison and local hospitals to facilitate good communication between the two.

The Head of Healthcare should consider a formal protocol with local hospitals to ensure effective communications.

Compassionate release

79. The clinical reviewer notes that while the prison made efforts to facilitate visits by members of the woman's family, it was clear that her family would not be able to provide the extensive care she would need. The issue of compassionate release was considered in multi-disciplinary meetings, which included her. She viewed the prison as her home, and had relationships and levels of support she would not have enjoyed if she had been released to the community whilst seriously ill. The manager of the local hospice was involved to ensure that procedures were in place so that she would not die in prison.

80. Whilst in other reports I have recommended that terminally ill prisoners should be released from custody, I believe that the decision made in this case was the correct and indeed the most compassionate option. It meant that the woman was looked after in the place where she was most comfortable until she needed more specialist care and was taken to the hospice. As well, the security arrangements were considered carefully and bedwatch officers stayed and provided additional company for her.

Caring for the woman

81. I am impressed by the caring attitude that staff displayed to the woman. This extends throughout her medical, managerial and personal care. Multi-disciplinary teams ensured that she had all the medical care and equipment she needed, even though she had a history of not complying with her medical care.

82. Managers put a number of measures in place to help the woman's wellbeing. Her friends were allowed to visit her from the wing, and bring small gifts such as toiletries, sweets and bottles of orange juice to help her cope. On a personal level staff seemed to be very sensitive, for example providing her with colouring and word search books, which she particularly enjoyed. One of her friends told my investigator that the woman thought that she did not have the usual prisoner and prison officer relationship with a number of staff in the healthcare centre, but felt much closer than that. She felt very well supported through her illness.

83. One female prison officer volunteered to be the escort officer for the woman's hospital appointments as she herself had gone through breast cancer and understood what she was experiencing. I think that this was a very brave and very compassionate example of care, and whilst I do not want to name her for reasons of privacy, I hope that the Director ensures that all staff involved in the woman's care see my report so that the officer concerned will note my commendation.

    The Director should ensure that all the staff who looked after the woman have the opportunity to read my comments about her care

84. The staff who my investigator spoke to commented on the involvement of the chaplaincy. They supported the woman, and also traced and contacted her family, allowing her to regain contact before she died. After she passed away, the chaplaincy were available to provide support if necessary both to staff and prisoners. The prison chaplain performed the service at her funeral.

Support for staff

85. The staff all said that they were either offered support, or would have known where to obtain support should they need it. However, not all the staff who knew the woman were involved in the debriefing sessions held after she died. Debriefing sessions are important as they give staff the chance to share their feelings, as well as consider with hindsight if there were any ways that the circumstances could have been improved. She died in a hospice, some days after leaving the prison, and her death was expected. Nevertheless, the Director will wish to satisfy himself that there are adequate arrangements for staff to attend debriefing sessions following the death of a prisoner.

    The Director should review arrangements for debriefing sessions after a death in custody.

CONCLUSION

86. The woman was a woman with a history of mental and physical health problems. Her mother had died of breast cancer in her 40s, and she herself had previously had cancer, which had necessitated a mastectomy. She came into prison after a number of years in mental health facilities and, despite sometimes being difficult to manage, she settled well in Peterborough. She continued her previous pattern of harming herself and was almost permanently on special measures to support prisoners vulnerable to self-harm.

87. Despite her previous cancer and her fears over her family history, the woman did not always cooperate with medical services. She also continued to smoke. Nevertheless, I believe that the healthcare team in Peterborough worked patiently with her, and encouraged her to care for herself. When her cancer returned, staff set up regular multi-disciplinary meetings, including outside agencies, to ensure that she received the best care. Any additional equipment was obtained and she was given a double cell to herself to accommodate her needs.

88. Consideration was given to applying for compassionate release. After some years without any outside contact, the chaplaincy put the woman back in touch with her family. But she had a good network of support in prison that she could not have enjoyed outside, and it was agreed that release would have been counterproductive. Arrangements were made so that she could go to a hospice when necessary, so that she would not die in prison. When she was moved to hospital, and it was agreed that she was near the end of her life, she did indeed move to the hospice, where staff from the prison continued to visit her until her death.

89. I am told that the woman was a lively and popular woman, despite her many problems. Although often reluctant to engage with her own medical care, I have found that she received a good standard of support from Peterborough, both medical and personal. Once it was known that her cancer had returned, I believe that staff did their best to ensure that she received the best possible standards for the remainder of her life. I commend the excellent care that HMP Peterborough provided for her.

RECOMMENDATIONS

1. The Head of Healthcare should consider regular reviews to ensure the proper maintenance of records

The Prison Service has accepted this recommendation. They comment:

> "Responsibility for this work will fall to the Clinical Leads to maintain medical confidentiality. This role, along with other relevant management checks, will be incorporated into a Quality Assurance checklist that will be passed to the Head of Healthcare on completion on a monthly basis. This check will be at a minimum of 10% of records held."

This was scheduled to commence on 1 October 2010.

2. The Head of Healthcare should consider a formal protocol with local hospitals to ensure effective communications

The Prison Service has partially accepted this recommendation. The prison will discuss this at the next Health Partnership Board meeting at the end of November 2010, with the outcome dependent on the other parties required to enter into such a protocol.

3. The Director should review arrangements for debriefing sessions after a death in custody.

The Prison Service has accepted this recommendation. They comment

> "The Director will hold a meeting with the Head of Public Protection, who has responsibility for the management of all establishment contingency plans, to ensure that the DIC contingency plan identifies such a requirement. Further to this it will be raised at the next Operational Management meeting and further relayed to all managers via a Notice to Staff. This requirement will also be included in the Duty Manger's role brief."

This was scheduled to take place by the end of September 2010.