
A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the circumstances surrounding the
death of a woman at outside hospital while in the
custody of HMP and YOI Bronzefield in July 2012**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a woman, a prisoner at HMP Bronzefield. She died in July 2012 of disseminated malignant melanoma (skin cancer). She was 32 years old. I offer my condolences to her family and friends.

The investigation was carried out by one of my investigators. A GP specialising in Primary Care in Secure Environments was commissioned to carry out an independent clinical review of the care the woman received. Bronzefield cooperated fully with the investigation.

The woman had a history of misusing drugs and alcohol. She also suffered from osteomyelitis, an infection of the bone. She arrived at Bronzefield in November 2011. In May 2012, the woman saw a prison doctor and complained of back pain. The doctor considered the pain was caused by osteomyelitis and was also a symptom of drug withdrawal. He did not fully examine her. After two further consultations, an officer who was very concerned about the woman, took her back to healthcare. This time the doctor referred her to hospital, where she went the next day, 21 June. At hospital, she was diagnosed with a malignant melanoma which had metastasised to other parts of her body. She remained in hospital until she died, less than two weeks later.

The clinical reviewer is critical of the prison doctor's failure to examine the woman fully and believes that, had he done so, the extent of the skin cancer would have been obvious. This was clearly a serious omission. However, the woman's melanoma had been advanced for some time and she had not mentioned it earlier, apparently owing to embarrassment. As a result, it seems unlikely that her diagnosis when she first reported back pain to the doctor would have changed the outcome, although it might have allowed her more time to help come to terms with her situation.

The woman's parents were understandably unhappy about the healthcare their daughter received at Bronzefield. However, they were very positive about the support they and their daughter received from prison staff, with the exception of certain officers who displayed insensitivity when supervising her in hospital. Release on temporary licence to the hospital would have avoided the need for officers to be present in hospital at all, but this does not seem to have been considered by the prison and neither was any application for release on compassionate licence made on the woman's behalf.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

February 2013

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SUMMARY

1. The woman arrived at HMP Bronzefield on 24 November 2011, after being sentenced to two years imprisonment. At her reception health screen, the woman said that she was a heroin and crack cocaine user, and was also dependent on benzodiazepine. She suffered from asthma and osteomyelitis (an infection of the bone). She mentioned no other physical health concerns.
2. On 30 April 2012, the woman saw a triage nurse as she said she had been suffering from backache for a week. She was seen by a prison GP on 10 May, but he did not examine her back as he considered the pain was caused by osteomyelitis and symptoms of drug withdrawal. He saw the woman again on 10 and 25 May, when she complained of back pain but he did not examine her back or question her sufficiently about her pain to help find out what was causing it.
3. On 21 June, after becoming increasingly concerned about the woman's health, her personal officer took her to see the doctor. The doctor found the woman was sweating and her face ashen grey. He said she was too ill for a full examination but after she complained of discomfort in her abdomen he was concerned about an abnormal mass and referred her to hospital.
4. The next day, the woman was admitted to outside hospital. After she had two scans, doctors suspected that she had metastatic cancer in the lungs, liver and adrenal glands. The suspected primary cancer site was a black growth (believed to be melanoma) on her back. A referral was made for her to be seen by the palliative care team and for a skin biopsy to be taken from her back.
5. On 25 June, the woman told the hospital dermatologist that she had had the growth on her back for a number of years. Hospital records show that this was "almost definitely a melanoma and that her prognosis was likely to be months".
6. Bronzefield tried to arrange a suitable address for the woman so that she could be released on Home Detention Curfew. However, the woman's condition deteriorated quickly and she died on a day in July before arrangements could be finalised and before her early release eligibility date of 11 July. No appropriate consideration was given to release on temporary licence or compassionate release.
7. Although the woman appears to have had melanoma for some time before her arrival at Bronzefield, the clinical reviewer has identified some concerns about the lack of examination and clear medical record keeping. We make five recommendations about healthcare treatment, the need for sensitivity when prison officers are supervising terminally ill prisoners, and about possible release on licence for those at the end of their lives.

THE INVESTIGATION PROCESS

8. The investigator visited Bronzefield on 10 July 2012, and collected copies of the woman's prison files and medical records. She met several members of staff including the prison family liaison officer and the disability liaison officer. She saw where the woman had lived in the prison and spoke to staff on the wing. The investigator issued notices about the investigation to staff and prisoners, and asked anyone with relevant information to contact her. Seven prisoners came forward.
9. The investigator returned to Bronzefield on 10 September, to see the security manager, the prison GP, a Prison Custody Officer (PCO) and six prisoners. She saw another prisoner on 17 September, at HMP Send, and contacted the woman's offender supervisor.
10. A review of the woman's clinical care in prison was carried out by a clinical reviewer. A copy of our report will be sent to the coroner. The post-mortem recorded the cause of death to be disseminated malignant melanoma.
11. The investigator and one of the Ombudsman's family liaison officers visited the woman's parents on 7 August. The family liaison officer explained the investigation process and asked them if there were any issues they wished to be considered as part of the investigation. Her parents were very positive about support they had received from the prison's family liaison officer and the prison chaplain, but were very concerned about the standard of medical care their daughter had received at Bronzefield. They believed that if their daughter's condition had been identified earlier she could have received treatment and possibly her life might have been prolonged. They considered there had been miscommunication about their daughter's prognosis which had led them to believe she had months rather than weeks to live. They thought that some of the officers who supervised their daughter in hospital had behaved insensitively.
12. The investigation has assessed the main issues involved in the woman's care including her diagnosis and treatment, liaison with her family, her location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.
13. The woman's family received a copy of the draft report and were given the opportunity to comment on the contents.
14. The woman's death was a great loss to her family, and they believe that medical staff had been negligent. They commented that the six week delay in their daughter's diagnosis was critical. Her parents think that if she had been diagnosed earlier, it was possible that her life would have been prolonged by different treatments, which would have allowed her family to see her more often before she died. She might also have been able to move closer to her family.
15. After receiving the family's comments, the investigator spoke to the clinical reviewer to ask him about the use of a specific treatment (BRAF treatment, a biological treatment often used to treat cancer) cited by the woman's parents.

The clinical reviewer advised that he did not have the specialist knowledge to answer this question.

16. The investigator discussed the possible referral of the prison GP to the General Medical Council (GMC) with the clinical reviewer during the investigation. The clinical reviewer explained that he did not have any evidence that there was a recurrent failing and was satisfied after discussion with the prison GP that he was unlikely to take the same course of action in future. After reading the family's concerns, the clinical reviewer contacted the GMC for their advice and has now referred the GP to the Fitness to Practise Team at the GMC.

HMP BRONZEFIELD

17. HMP Bronzefield is a modern privately run prison for women run by Sodexo Justice Services holding up to 527 women prisoners. It is a local prison, accepting prisoners directly from the courts. Most women are on remand or serving short sentences although it also holds longer-term women prisoners including those serving life sentences. Primary Healthcare services are provided by Sodexo Justice Services. The GP contracted services are provided by Cimarron UK with Mental Health Services provided by Central & North West London NHS Foundation Trust. The prison has a 24 hour inpatient healthcare unit which accommodates up to 18 women.

Her Majesty's Inspectorate of Prisons (HMIP)

18. HMIP conducted a full unannounced inspection of Bronzefield in 2010. The Inspectorate found that the culture of the prison was positive and the physical environment clean and well maintained. However, inspectors reported that healthcare was an exception, the standard of service was described as "shockingly poor" and:

"... delivery was marred by poor organisation and inadequate staffing, both nursing and administrative; to meet the health needs of women prisoners who were almost unanimous in their dissatisfaction with the quality of health services. A lack of liaison between GPs and with other health care staff meant there was little continuity of care and inconsistency of practice."

19. HMIP reported that the disability liaison officer had worked well to meet the needs of women with disabilities. Adapted cells were available for women with mobility difficulties and there was good access to all parts of the prison.

Independent Monitoring Board (IMB)

20. The IMB is made up of unpaid volunteers from the local community who monitor the day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. In their 2010 report, they described healthcare provision as being well below standard. However, in 2011, they noted that an action plan for improvement had been drawn up and the management structure of healthcare had changed considerably.

Previous deaths in custody

21. There have been five deaths at Bronzefield since 2004. Three of these were from natural causes. There are no similarities in the circumstances.

ISSUES

The diagnosis of the woman's terminal illness

22. The woman arrived at HMP Bronzefield on 24 November 2011, after being sentenced to two years imprisonment. She was seen for a reception health screen by a nurse the same day. The woman said that she was a heroin and crack cocaine user, and was dependent on benzodiazepine. She suffered from asthma. Five years earlier, she had shattered her right heel and left knee and contracted osteomyelitis, an infection of the bone which required long term antibiotics. She did not mention any other physical health problems.
23. The woman had limited mobility because of her osteomyelitis. She could stand unaided but spent most of her time in a wheelchair. The nurse assessed the woman as not fit for normal location, work or cell occupation. Due to mobility problems and previous drug use she spent her first night in the healthcare unit and moved to house block one (the induction and detoxification wing) the next morning, where she started a drug and alcohol detoxification programme.
24. The disability liaison officer assessed the woman as part of the reception process. The woman said that she did not need a personal carer and could attend to her own personal needs.
25. A nurse carried out a routine secondary health screen on 30 November, when the woman said that she had no concerns about her physical health. She asked to be assessed as 'fit for work' so she could get a prison job. She subsequently worked as a teaching assistant during Information Technology classes. She had three further appointments about her osteomyelitis before a court appearance on 4 January 2012. When she returned from court she told a nurse in reception that she was okay and had no issues.
26. A nurse saw the woman on 30 April, when she said she had been suffering from backache for about a week. She said that ibuprofen eased the pain during the day but she suffered with breakthrough pain at night. The nurse referred her to the prison GP who saw her on 10 May, and wrote in the woman's medical notes
- "Rt [right] foot osteomyelitis weeping again. Told by hospital either long term abx [antibiotics] or amputation also back pains. Examination – rt [right] lateral foot discharging sinus with redness".
27. The woman was prescribed diclofenac and nefopam (both for pain relief) for her back pain. The prison GP explained to the investigator that he did not take a history of the woman's back pain or examine her back as he thought the pain was from her foot, and her back pain was caused by osteomyelitis. He also commented that people on methadone programmes often suffered from aches and pains. The clinical reviewer commented that:
- "He [the prison GP] prescribed diclofenac along with nefopam [pain relief]. In the absence of an examination or any history about the back pain to exclude potentially serious causes, this is not good practice. It

would also be important for the prescriber to document that there had been no past history of seizures before initiating nefopam, because seizures are a contraindication to this drug”.

28. The prison GP saw the woman again on 25 May. She complained of continuing back pain and that diclofenac was causing nausea and indigestion. He noted in her medical records, “Pain is mid back (shoulder blade area) and radiates down”. He prescribed ibuprofen and nefopam for back pain. He explained to the investigator that from his recollection this consultation was to review the woman’s pain relief medication, and it was “difficult to say” if he examined her back at this time. He told the clinical reviewer that it was possible that he might have examined her spine, but could not recall. There is no record of such an examination and it is apparent from what was discovered when she later went to hospital that one did not take place.
29. On 20 June, the woman’s personal officer said she went to see her as she had become increasingly concerned about her health and had noticed that she had been spending more time lying on her bed to try and alleviate the pain. She said the woman looked very grey. The other prisoners the investigator spoke to said they had been concerned about her condition for several weeks but, apart from the woman’s personal officer, no one seemed to notice. The officer advised her to see a doctor if she did not improve. The next day she found her sweating and in pain. The officer phoned healthcare to say that the woman’s health had deteriorated and she wanted her to see a doctor that day. She was told that the woman had already had a doctor’s appointment and her medication had been reviewed.
30. The woman’s personal officer spoke to her manager who went to see the woman. When he saw how unwell she looked, he told the officer to take her to healthcare where she was seen by the prison GP. The woman said she had lower back pain, loss of appetite and that her abdomen felt full. The GP examined her in her wheelchair, and found her abdomen to be hard with a possible mass. He wrote a referral letter for the woman to be taken to hospital within 24 hours for a review. The GP again did not examine her back and told the investigator that she was too ill for a full examination. He said that in making the 24 hour referral he had expected the woman to go to hospital that day but he did not believe that an emergency admission was necessary.
31. The woman was taken to outside hospital the next morning, 22 June, accompanied by her personal officer and a further PCO. At the hospital, when she was being examined her personal officer noticed what she described as a rash on her back, with “warts that went all around her side”. She told the investigator that the woman told her later that she had been aware of the growth on her back, but was embarrassed to mention it as she thought it was ugly. She had an ultrasound scan (which uses sound waves to create images of internal organs) and was told that a growth had been detected. She later had a CT scan (a three dimensional x-ray) of the chest, abdomen and pelvis.

32. The scan results showed a suspected metastatic cancer (the spread of a disease from one organ or part to another) in the lungs, liver and adrenal glands. The suspected primary cancer site was the black growth (believed to be a melanoma) on her back. A doctor referred her to the palliative care team and for a skin biopsy. On 25 June, the woman told the dermatologist who reviewed the biopsy results that she had had the growth on her back for a number of years. The dermatologist told her that it was almost definitely a melanoma [the most dangerous type of skin cancer] and that her life expectancy was likely to be months.
33. It is apparent that the prison GP appropriately referred the woman to hospital after he noted a mass in her stomach and, once there, her condition was quickly diagnosed. We note that the woman said she had had the growth for some years. However, the doctor's failure to examine her more thoroughly at previous appointments led to a delay in this diagnosis being made. The clinical reviewer noted that "had even a rudimentary [basic] examination of her back been undertaken, it seems inconceivable that the extensive skin cancer would have been missed." The clinical reviewer commented that patients with osteomyelitis who complain of back pain should be examined in line with General Medical Council (GMC) guidelines. Paragraph 2a of "Good Medical Practice" states that:

"Good clinical care must include adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient's views, and where necessary examining the patient."

34. The clinical reviewer said,

"it is my opinion that the diagnosis of melanoma was delayed by a maximum of six weeks due to [the GP's] failure to properly examine [the woman]. However, it seems that the melanoma had been present for some considerable time prior to the back pain presentation on 30 April 2012,"

While it appears unlikely that the six week delay in diagnosis would have made a difference in the outcome, it is evident that the lack of examination when the woman presented with back pain in May 2012, led to a delay in her eventual diagnosis. This was a significant omission by the doctor, but the clinical reviewer did not have any evidence it was a recurrent failing and was satisfied after discussion with the doctor that this was unlikely to be one that the doctor would repeat. We make the following recommendation:

The Head of Healthcare should ensure that doctors adequately assess a patient's condition and examine them as necessary, in line with GMC guidelines.

Informing the woman about her condition and treatment

35. The woman was told on 22 June, the day she arrived at the hospital, that a growth had been detected. The next day she was told that scan results indicated metastatic cancer in the lungs, liver and adrenal glands. On 25 June, a dermatologist informed her that the growth on her back was thought to be a

melanoma and the primary cancer site. She was told that her life expectancy was likely to be months. The consultant discussed the findings with the woman's family on 27 June. Hospital records regularly refer to discussions with the woman, her family and prison healthcare.

36. The woman saw the palliative care team on 29 June, as no other treatment was possible. On 4 July, she agreed to sign a do not resuscitate order.
37. We are satisfied that once she arrived at hospital, the woman was fully informed of her condition.
38. The woman's parents were concerned that there had been some confusion about how long their daughter was expected to live. They believed the prison had given the impression she had months to live but, after she died, they were told by the hospital that her life expectancy was only ever termed in weeks. The prison records are unclear. On 4 July, the escort record notes that a hospital doctor spoke to the woman and told her that she could have a matter of weeks left to live. The next day, the inpatient services team leader at Bronzefield noted that the hospital told her that the woman had "a few months to live, [with] no specific timeframe".
39. The records indicated that the prison's family liaison officer made good efforts to ensure that the woman's family was kept well-informed at the hospital. It is not clear how there came to be mixed messages about her life expectancy. Staff from Bronzefield recorded different accounts on consecutive days, which suggests that there was some uncertainty at the hospital. We believe that prison staff made appropriate attempts to ensure that the woman's family were provided with accurate and timely information about her condition and prognosis.

The woman's medical appointments and treatment of the prisoner

40. The woman reported having back pain on 30 April, when she saw the triage nurse. She was not given an appointment to see a doctor until ten days later. The clinical reviewer notes that this is acceptable after nurse triage for a *routine* problem. We believe that this is too long in the prison context, especially when a prisoner is experiencing pain and the alternatives in the community are not available. The women prisoners we spoke to complained about delays in getting healthcare appointments including nurse triage. We also note that the Inspectorate report of 2010 found that waits of up to a week to see a GP after nurse triage were too long.
41. When the woman saw the prison GP on 21 June, he wrote a referral letter for her to be seen at hospital within 24 hours and she was taken to hospital the next morning in line with that request. The doctor later explained that he had expected this to happen the same day. While there was no significant delay to the woman's treatment as a result, it is important that doctor's instructions about the need for hospital referral are clear.
42. We make the following recommendations:

The Head of Healthcare should ensure that, except in exceptional circumstances, women prisoners are able to see a GP within a week.

The Head of Healthcare should ensure that doctors give clear instructions on the urgency of a case when they make a referral to hospital.

The woman's pain relief and medication

43. On 10 May, the woman was seen by the prison GP when she complained of back pain. She was prescribed diclofenac (pain relief). This was prescribed in addition to the methadone she received as part of her drug detoxification program. The clinical reviewer noted that this was appropriate.
44. Subsequently, the woman was admitted to outside hospital and her pain relief and medication was the responsibility of the hospital, which is outside the remit of the Prisons and Probation Ombudsman. The clinical reviewer has commented in his clinical review about the woman's pain relief in hospital.

Liaison with the woman's family

45. After the woman was informed of her diagnosis on 23 June, the hospital suggested that her next of kin should be contacted. The prison chaplain spoke to her the same day, but she did not want her family to be contacted immediately and her wishes were respected. The next day, 24 June, the woman spoke to her family by telephone and the chaplain spoke to her father.
46. On 25 June, the prison family liaison officer (FLO), and the prison chaplain visited the woman and the FLO arranged to meet the woman's parents at the hospital two days later. The prison's FLO explained her role and arranged for a doctor to explain the woman's condition to her parents (which she also did on subsequent occasions). The FLO and chaplain kept in regular contact with her family while the woman was in hospital.
47. The woman died at the hospital at 4.40am on a day in July. The Director of Bronzefield, the FLO, the prison chaplain and a further family liaison officer went to the woman's parents' home to break the news that morning and arrived there at 9.20am. The prisoner telephones were switched off that morning to help ensure that the woman's family were notified by prison staff in person.
48. The woman's funeral was held on 24 July. Bronzefield contributed to the funeral costs in line with Prison Service policy. A memorial service was held in the prison on 13 August, which was attended by prisoners and staff, as well as her family. The memorial service was delayed to enable the woman's step-sister, who was out of the country when she died, to attend.
49. The woman's parents were very positive about the support the prison's family liaison officer and the prison chaplain had given them and their daughter. On 19 August, her parents wrote to the prison to thank them.

The woman's location

50. On 21 February 2012, the woman transferred to house block two at Bronzefield where a double cell had been converted for her sole use allowing her enough room to move around in her wheelchair.
51. After the woman received her diagnosis, it was initially thought that she might return to Bronzefield. The Head of Healthcare told the investigator that a three bed ward in the healthcare unit had been reserved for the woman's sole use. The prison had also contacted the local hospice and arranged for a Macmillan nurse to come to help. At first, the woman said she did not want to be transferred to a hospice as she hoped to be able to return to her parents' home. When it became apparent this would not be possible because of her care needs, she said she would prefer to go to a hospice near her family. Sadly, the woman's condition deteriorated very rapidly and she died in hospital on a day in July, less than two weeks after her admission.

Compassionate release

52. Prisoners who are diagnosed with a terminal illness can be considered for early release on compassionate grounds. The decision to release a prisoner on compassionate grounds is made by the Secretary of State taking into account information provided by Prison Service staff and medical opinions. There are no set time limits in considering whether the prisoner is likely to die "soon", but a life expectancy of three months is considered an appropriate period and a clear medical opinion on life expectancy is required. The Secretary of State will also need to be satisfied that the risk of re-offending is past and that there are adequate arrangements for the prisoner's care and treatment outside prison. There is also a requirement that the early release of a prisoner will bring some significant benefit to the prisoner or his family.
53. Although the woman was very quickly diagnosed with a terminal illness shortly after she was admitted to hospital, the prison do not appear to have considered the possibility of release on compassionate grounds. Instead the prison seems to have focussed on the possibility that she might be released under home detention curfew (HDC) arrangements. She was sentenced to two years imprisonment on 16 January 2012 and her 'home detention curfew' (HDC) eligibility date was 11 July 2012. HDC allows prisoners serving between three months and under four years early release from prison. Prisoners subject to HDC are required to wear an electronic tag, and are subject to a curfew.
54. The woman's application for HDC was started on 24 January 2012 and forms were sent to Surrey and Sussex Probation Trust on 10 May. These had to be re-sent on 20 June as they never received them. An offender supervisor was appointed to the woman the week before she died and visited her in hospital on 28 June, to speak about the HDC application. The woman hoped that she would be able to return to her parents' home and did not want to go to a hospice. The next day, the offender supervisor recommended HDC if a suitable address and appropriate care and support were available. Later that day she was informed that the woman would not be able to return to her parents' home due to her healthcare needs.

55. The woman's offender supervisor said she was unable to find suitable accommodation for her and that it was difficult to assess what the options were until there was a firm diagnosis from the outside hospital. In the event, the woman's condition deteriorated very quickly and she was unable to find a suitable release address before she died.
56. The member of staff who had been asked to progress the woman's release on temporary licence (ROTL) application) said that an application for ROTL was not progressed because there was no release address. We are surprised that there appears to have been no consideration given to releasing her on temporary licence to the hospital. This would have allowed her to remain in hospital without the need for officers to supervise. It is also a concern that no apparent thought was given to making an application for release on compassionate grounds. We make the following recommendation

The Director should ensure that the possibility of release on temporary licence and release on compassionate grounds is considered for all terminally ill prisoners who meet the criteria.

Palliative care plans

57. After the woman received her cancer diagnosis at outside hospital, she was referred to the palliative care team. Hospital records show several entries by a consultant and nurse specialist in Palliative Care. The clinical reviewer has commented in his report on the care the woman received while she was at hospital.

Restraints, security and bed watch

58. When the woman was taken to outside hospital on 22 June 2012, she was assessed as a low risk of escape and escorted by two officers. She was not restrained at any time. The escorting officers (sometimes known as the "bedwatch") were told they could wait outside her room during any medical discussions unless they had concerns about her behaviour or security.
59. The woman's parents were concerned about the behaviour and attitude of some of the prison staff. During a visit, one of the woman's brothers wanted to show her some photographs and videos of his daughter on his mobile phone. He tried to give his phone to his sister to hold so she could see the images clearly, but she was told by an officer that this was not allowed. The woman's parents said it would have been helpful if the officers had been more sympathetic and sensitive to their needs at this difficult time.
60. The security manager at Bronzefield said that he understood the woman's family's concerns. However, he explained that all prison staff are instructed to deal with all women prisoners in the same way. He said that while most are fully compliant, others behave very differently. He said that if a prisoner hid a mobile phone on them while in hospital; it would then be inappropriate for an officer to forcibly remove it.
61. As mobile telephones are prohibited in prison, it is perhaps understandable why the officers might have been concerned. However, the woman was

terminally ill and we believe appropriate consideration should have been given to her circumstances and previous compliance while in hospital.

62. The woman was a smoker. Her parents explained that one of her main concerns while in hospital was that she wanted to go outside to have a cigarette, but the escorting officers had been told that she was not allowed to leave the building. While we have sympathy we understand that the outside hospital is a smoke-free site. The hospital website states “The [NHS Foundation Trust] actively discourages smoking and takes the view that smoking is not permitted in any of its grounds or premises.”
63. The woman’s parents explained that during one of their visits to the hospital officers spoke quite loudly, in front of them, about planning their holidays. They found this insensitive and inappropriate in the circumstances. They also described how some bedwatch officers ate pizzas and other food in front of their daughter when she was finding it extremely difficult to eat.
64. The security manager at Bronzefield agreed that the behaviour observed by the woman’s parents was inappropriate. We consider that there is a need for officers to be reminded of how their conduct on bedwatches can affect prisoners, relatives and the reputation of the establishment and that there is a need for special sensitivity when the prisoner is terminally ill. We make the following recommendation:

The Director should ensure that all officers who conduct bedwatches are aware of the standards of behaviour expected of them and are sensitive to the needs of terminally ill women.

CONCLUSION

65. The woman arrived at Bronzefield in November 2011. There is no evidence that she ever complained to healthcare of any skin changes or moles on her back, although it seems that she was aware of them. It appears that she was embarrassed by the growths on her back and had therefore not reported them. The hospital dermatologist recorded that the woman had noticed an enlarging mole on her back over several years.
66. The woman's condition would have been noticed more quickly had the prison GP conducted a full examination when she complained of back pain. However, the clinical reviewer notes that the delay in diagnosis was, at most, six weeks. This was unlikely to have made a difference to the eventual outcome for the woman, although it would have provided more time for her to come to terms with her diagnosis.

RECOMMENDATIONS

To the Director

1. The Director should ensure that the possibility of release on temporary licence and release on compassionate grounds is considered for all terminally ill prisoners who meet the criteria.

The National Offender Management Service responded with,

Accepted - HMP Bronzefield accepts that the possibility of release on temporary licence and release on compassionate grounds is considered for all terminally ill prisoners who meet the criteria. However, on this occasion, they feel that early release on compassionate grounds had been considered although the woman's Offender Supervisor had concerns about her risk of self harm. Staff therefore wished to expedite the HDC (as this process was already underway) and find a suitable release address so that appropriate support and structure would be in place.

Release addresses considered were to be in Suffolk or Norwich, but these were assessed as not suitable due to the location and distance from family. Whilst waiting for the woman's health update, Bronzefield did utilise their housing team to source other options but all sources suggested a hospice. The woman was adamant that she would not go to a Hospice.

2. The Director should ensure that all officers who conduct bedwatches are aware of the standards of behaviour expected of them and are sensitive to the needs of terminally ill women.

The National Offender Management Service responded with,

Accepted - HMP Bronzefield accepts this recommendation and will remind staff of their duties. However, they would like to draw the investigators attention to the fact that an investigation was carried out to identify if the staff had behaved inappropriately whilst on the Bedwatch and it was not deemed necessary to reprimand anyone involved.

Whilst prisoners are located at an outside hospital, they remain under rules and regulations of custody. Whilst we accepted that this can appear insensitive in such circumstances, the fact remains that the woman was not allowed access to mobile phones for security reasons.

Staff identified that they naturally felt intrusive of the woman's recently re-established and limited contact with her family and would on occasion discuss unrelated subjects and try to act as normally as possible so as not to appear to be eavesdropping. However, staff will be reminded of the sensitivity of these situations and the need to have specific meal breaks.

To the Head of Healthcare

3. The Head of Healthcare should ensure that doctors adequately assess a patient's condition and examine them as necessary, in line with GMC guidelines.

The National Offender Management Service responded with,

Accepted - The Head of Healthcare to liaise with GP provider Cimarron and reiterate that GPs conducting medical assessments in HMP Bronzefield, are to ensure they conduct adequate assessments when assessing a patient's condition and examine them as necessary and in line with GMC guidelines.

The Director of Cimarron to provide assurance that GP's follow GMC guidelines and appropriate corrective action taken where guidelines are not followed.

4. The Head of Healthcare should ensure that, except in exceptional circumstances, women prisoners are able to see a GP within a week.

The National Offender Management Service responded with,

Accepted - Women prisoners are able to see a GP, except in exceptional circumstances within a week. Evidence at the time of the woman's death shows waiting time to see the GP was 3 days.

The fact this did not happen is therefore not due to the length of the waiting times but a failure to make an appointment. On this occasion the time line was breached, therefore a system review of the appointment process will be undertaken and findings communicated to all nursing staff.

5. The Head of Healthcare should ensure that doctors give clear instructions on the urgency of a case when they make a referral to hospital.

The National Offender Management Service responded with,

Accepted - The referral paperwork from the referring GP clearly stated within 24hrs which was achieved on this occasion. However, to further improve the referral process and ensure clarity on doctors' instructions regarding the urgency of a case, additional referral specifications will be provided on the referral form.