Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lindsay Phair a prisoner at HMP Whatton, on 18 November 2024

A report by the Prisons and Probation Ombudsman

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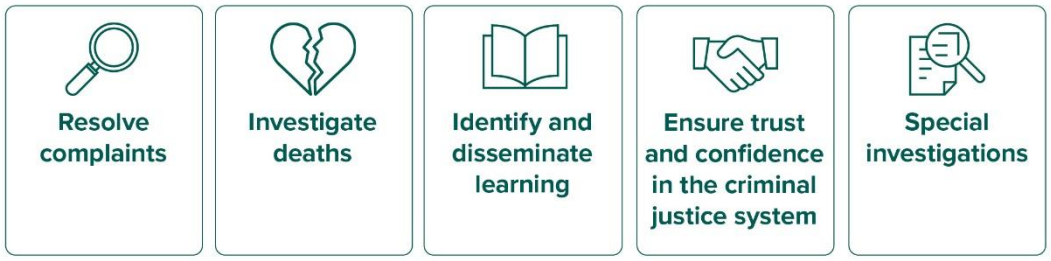
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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

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

3. On 26 May 2021, Mr Lindsay Phair was sentenced to 15 years in prison for rape. He died from disseminated oesophageal poorly differentiated adenocarcinoma, which was contributed by ischaemic heart disease on 18 November 2024, while a prisoner at HMP Whatton. He was 64 years old. We offer our condolences to Mr Phair's family and friends.

4. The Ombudsman's office wrote to Mr Phair's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer, to review Mr Phair's clinical care at HMP Whatton.

6. The clinical reviewer concluded that the clinical care Mr Phair received at Whatton was of a high standard and at least equivalent to that which he could have expected to receive in the community. He found that Mr Phair's symptoms were well managed, however found that healthcare missed opportunities to implement care plans to manage Mr Phair's falls. The clinical reviewer made four recommendations not related to Mr Phair's death that the Head of Healthcare will want to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Phair's care.

8. We did not find any non-clinical issues of concern. We make no recommendations.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). Practice Plus Group pointed out some factual inaccuracies in the clinical review, which has been amended accordingly.

10. In an inquest held on 23 January 2025, the Coroner concluded that Mr Phair died of natural causes.

Adrian Usher **December 2025**
Prisons and Probation Ombudsman

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