

**Investigation into the circumstances surrounding the
death of a man in hospital, whilst in the custody of HMP
Whatton on 15 October 2009**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

March 2010

This is the report of an investigation into the death of a man, a prisoner at HMP Whatton, on 15 October 2009. The man had been diagnosed with lung cancer a month earlier. Following his diagnosis, the man stayed on a normal wing until he was transferred to hospital, two days before he died. He was 53 years old.

Her Majesty's Coroner for Nottinghamshire and Nottingham City was informed of the Ombudsman's investigation. A post mortem was undertaken and it was noted that the man died of natural causes resulting from cancer. I extend my sincere condolences to his partner and family.

The investigation was undertaken by one of my colleagues. A review of the man's healthcare whilst in custody was commissioned from Nottinghamshire County Teaching Primary Care Trust (PCT). Not for the first time, I am grateful to the clinical reviewer his report. I would also like to thank the Governor of Whatton and her staff for their help and assistance. I am especially grateful to liaison officer for her support.

I endorse what the clinical reviewer has to say about the good practice in facilitating in-cell visits for the man. I further note the good practice of linking the family liaison officer role with that of the personal officer, thereby offering support both to the man and to his family in a seamless way. I have also been pleased to note that he was not restrained when he was admitted to hospital.

All in all, this report reflects extremely well upon HMP Whatton and HM Prison Service as a whole. The approach to end-of-life care was admirable.

The prison service noted two minor inaccuracies which have been amended in this final report. The Governor has written to an officer thanking him for his work with the man and his family. His family have not raised any issues from the draft report.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

The man arrived at HMP Durham in May 2008 after being sentenced to five years imprisonment for conspiring to commit sexual offences. The following day an Assessment, Care in Custody and Teamwork (ACCT) plan was opened. (This documents interventions, care and observations of prisoners at risk of self harm.) The man had indicated to prison staff that he was thinking of self harm. Three weeks later, the ACCT was closed after the man was feeling positive and less anxious about being in prison. He moved to another wing to be apart from his co-accused.

On 1 July, the man was transferred to HMP Whatton. His medical notes record that he was in reasonably good health, although an asthma sufferer and smoker. An inhaler was prescribed and the man was offered access to health promotion facilities. He settled into the wing and worked in the recycling workshop.

In July, the man had a mental health review and was prescribed an anti-depressant, Fluoxetine. On 4 August, he was seen in healthcare with a pain on the right side of his chest and prescribed pain relief. At the end of September, the man had a medication review with a doctor and agreed to discontinue his Fluoxetine as he felt settled at Whatton.

Following a chest examination in October, the doctor examined the man and prescribed an antibiotic. In January 2009, The man was treated for haemorrhoids and later given Simvastatin, for high cholesterol, following a blood test.

The man saw healthcare staff with a sore throat in July. The symptoms persisted and on 12 August the doctor referred the man to an Ear Nose and Throat (ENT) physician at hospital under the two week rule. (This means an urgent referral for an appointment within two weeks when a cancer is suspected.) On 2 September, the doctor noted that results from the hospital indicated that cancer was suspected and arrangements were being made for further medical investigations.

On 17 September, the man was admitted to hospital as an emergency following deterioration in his health. On return to Whatton the following day, he told healthcare staff that he had been diagnosed with lung cancer and a deep vein thrombosis (DVT), a blood clot. He was moved to A8 wing on 29 September, where he could have a larger cell and additional personal care. He was visited daily by healthcare staff and allowed visits from his partner in his cell.

Following a further deterioration in his health, the man was admitted to hospital on 14 October. He was not restrained. His partner and relatives were informed and advised to make plans to visit him in hospital. The following day, he was transferred to the intensive care unit and his family was contacted. The man died at 8.00pm with his family at his bedside.

I note the very good practice demonstrated by healthcare and prison staff in their care of the man and his family.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened on 2 November 2009, when my investigator visited HMP Whatton. She was met by the liaison officer and reviewed the man's prison and medical files. Some copies of those documents were taken by my investigator. The Deputy Governor also met with my investigator.
2. Later, my investigator visited C3 wing and spoke to staff and a prisoner. The Ombudsman's terms of reference and notices of investigation had been sent to the prison in advance of her visit. There was no response to the notices of investigation from staff or prisoners.
3. Neither the prison's Independent Monitoring Board (IMB) nor the local branch of the Prison Officers' Association asked to see my investigator. I assume this reflects the fact that Whatton has significant previous experience of my investigations following deaths of prisoners from natural causes.
4. On 4 November, my investigator spoke to an officer by telephone. The officer had been the man's personal officer and the family liaison officer.
5. A review of the man's healthcare was commissioned with Nottinghamshire County Teaching PCT.
6. One of my family liaison officers made contact with the man's partner. His partner simply asked if the man had already contracted cancer before he was taken into custody. I will deal with his under the issues section of this report.

HMP WHATTON

7. HMP Whatton is a category C training prison for prisoners convicted of a sexual offence, or who have a sexual element in their offending history. (A training prison is one which has offending behaviour courses and opportunities for work in preparation for release.)
8. In response to overcrowding across the prison estate, Whatton underwent a rapid expansion in 2006, increasing the operational capacity from around 400 prisoners to 841 by 2008. Before the expansion the prison only accepted prisoners who were assessed as suitable for sex offender treatment programmes and who were in denial of their offence. With the new accommodation the admission criteria were changed. Whatton now accepts offenders who are in denial of their offence and are assessed as being unsuitable for undertaking specialist offending behaviour courses.
9. Healthcare is provided by Nottinghamshire County Teaching PCT. There is no 24-hour in-patient facility at the prison and an out of hours emergency doctor service is used during the evenings and weekends. Visiting doctors hold daily surgeries during the week and there are qualified nurses on duty with healthcare assistants from 8.00am to 8.00pm. A range of clinics are held in the healthcare unit which include smoking cessation, well being, and specialist clinics for chronic diseases and older prisoners.
10. Following an announced inspection of Whatton in 2007, HM Chief Inspector of Prisons said many aspects of the regime at Whatton that had been applauded in a previous inspection were still in place. HM Chief Inspector further commented on healthcare services:

“Health services were commissioned by Nottinghamshire County Teaching Primary Care Trust. Funding for health services, in particular mental health services, had not kept pace with the rapid growth in size of the establishment. The health services department was a clean and clinical environment but its location was difficult for older prisoners to access. There had been a health needs assessment that was used to plan services, but prisoner delays in getting to basic services, such as GP appointments or to see the dentist, were unacceptably long. Health promotion activities were being developed, and there were check ups for prisoners with lifelong conditions. The primary mental health service and the in-reach mental health team were both under-resourced.”

11. The Independent Monitoring Board's most recent annual report noted:

“HMP Whatton is one of the few prisons if not the only prison in the country with an average age in the mid forties. The general adult male prison population has about 80% under the age of 40 whilst Whatton will regularly house some 60% to 70% of its 845 prisoners over the age of 40 years. Naturally, this brings a completely different dimension to the healthcare needs of those in Whatton to almost any other prison

establishment. It is therefore inevitable that more prisoners will die of natural causes in Whatton with the resultant effect that the healthcare has been required to respond to major incidents from time to time, on the palliative care of individuals. It has done this and continues to do so with great staff dedication and in an extremely sensitive manner. Whilst there is a number of healthcare professionals that visit the prison on a regular basis providing care through a doctor, dentist, chiropodist, optician, phlebotomy and triage nurses and a psychiatrist, there are also a number of regularly held nurse led clinics in operation, mainly relating to the management of chronic conditions and primary prevention in 'at risk' prisoner. The IMB continually monitors the provision of healthcare provided for the prisoners as it is regarded as an essential indicator on the wellbeing of these above average aged prisoners in the prison system."

12. There have been 16 natural cause deaths at Whatton since my office began investigating all deaths in prison custody in 2004. A number of these deaths were terminally ill prisoners who received nursing and palliative care.
13. Whatton has received funding to provide a special room for terminally ill prisoners to be cared for in an appropriate setting, with relevant healthcare support.

KEY FINDINGS

14. The man was born in South Shields. He was separated from his wife and lived with his partner in Carlisle. He was unemployed. During 2006-2007, the man underwent medical examinations at hospitals in the North East for a deep vein thrombosis, re-current respiratory problems, and skin rashes. His medical notes further recorded he had suffered from irritable bowel syndrome.
15. Whilst living in the community, the man has a chest x-ray in June 2007 and was subsequently referred to a chest physician. Medical investigations, including a computerised tomography (CT) scan and a bronchoscopy indicated some chronic inflammatory changes in his lung base. (A CT scan takes internal images of the body and a bronchoscopy is an examination of the chest area by passing a camera down the throat). However, a CT scan in early January 2008 showed an improvement and he was discharged from seeing the chest physician.
16. In January 2008, the man was convicted of conspiring to commit sexual offences. Four months later, he was sentenced to five years imprisonment and taken to HMP Durham. This was the man's first time in prison since 1982.
17. The following day, an ACCT was opened. The man had handed a letter to an officer the previous evening saying he was considering taking his life. The ACCT remained open until 17 June, when the man felt much better and had a more positive attitude. It was further noted that the man might have been subject of harassment from his co-accused and he was moved to another wing. On 1 July he was transferred to HMP Whatton.
18. On the man's reception into Whatton it was recorded in his medical notes that he was in reasonably good health, was a smoker, and had a history of asthma for which medication was prescribed. The man was allocated a job in the recycling workshop.
19. The Healthcare Manager saw the man on 21 July for a mental health review. He told the manager that he was not sleeping well, and was anxious at being in prison. The manager prescribed Fluoxetine, an antidepressant, and advised the man to seek help from healthcare staff if he felt he needed it. Otherwise, they would review him in two weeks time.
20. The man was seen in the healthcare unit on 4 August, complaining of muscular pain in his right side. He was prescribed pain relief of ibuprofen and advised to rest for two days. The man returned to healthcare on 18 September with an infected rash on his chest. Antihistamine medication was prescribed to relieve the itching.
21. Two weeks later, the man saw a doctor in the healthcare unit for a review of his asthma and medication. They discussed the man's previous low mood and he told the doctor that he had now settled at Whatton and agreed that he

no longer needed to take Fluoxetine. The man was advised that, should his mood change, he should make an appointment to see the doctor.

22. The man saw a nurse on 15 October. He told the nurse that his asthma had worsened despite using his inhaler. The nurse advised the man that he was not using his inhaler correctly and demonstrated techniques on how to use a different inhaler that might help control his symptoms. The nurse also gave the man an influenza injection. The following day, he had an appointment with a doctor. The doctor examined his chest and prescribed an antibiotic. She advised him to return to healthcare if his condition did not improve.
23. On 2 December, the man was seen in the healthcare unit by a nurse as he was experiencing pain in his shoulder. The nurse examined him and prescribed paracetamol for pain relief. The man was told to return to healthcare the following day if he was still in pain. Nine days later, he saw a doctor and she examined his shoulder which was still causing him pain. The doctor prescribed an ibuprofen based medication and a cream to rub into the shoulder area.
24. The man attended a smoking cessation session on 23 December, but decided to leave the session and said he would rejoin after Christmas. A week later, he was seen by a nurse complaining of rectal bleeding. The nurse arranged an appointment for him to see the doctor.
25. A doctor examined the man on 7 January 2009, and noted that his rectal bleeding might have been haemorrhoids. A blood test was taken to check for any other illness and a cream was prescribed to soothe the condition. A month later, the man was prescribed Simvastatin, as his blood test results had noted a high cholesterol reading.
26. A nurse examined the man's knee on 16 February, after he complained of pain and his knee 'giving out'. The nurse also noted that the man had a red rash on his lower leg. He therefore asked a nurse prescriber (a nurse qualified to prescribe medication) for a cream to help with the rash. A week later, a doctor examined the man's knee. There was good movement to the knee with minimal pain. The man was told by the doctor to return to healthcare if there was increased pain or stiffness in the joint.
27. On 24 March, a nurse wrote that the man had not taken his Simvastatin and advised him to ensure that he ordered his medication on a regular basis. Three weeks later, the man was prescribed Niquitin patches to help him stop smoking. However, it was later noted that he had not attended smoking cessation sessions.
28. Following a routine blood test, a doctor increased the man's Simvastatin medication on 27 May. A nurse saw him in the healthcare unit on 2 July, as he was complaining of a sore throat. On examination the nurse noted that his throat was red but there was no sign of an infection. She advised the man to take paracetamol and return to healthcare if the symptoms persisted.

29. The man returned to healthcare on 20 July and saw a nurse. His throat was still sore and his voice hoarse. The nurse noted that whilst his throat was not too red there was thrush (a fungal infection) in his mouth. The nurse asked a doctor to prescribe a mouthwash. Ten days later, a nurse saw the man in the healthcare unit. He still had a sore throat and loss of taste. The man's symptoms were discussed with the doctor and it was agreed to prescribe Lansoprazole (a drug used to restrict the flow of gastric fluid into the mouth).
30. A doctor examined the man on 12 August, he still had a sore throat and a hoarse voice. Following examination, the doctor referred the man to an Ear Nose and Throat (ENT) specialist at hospital under the two week rule (i.e. an urgent referral when cancer is suspected). Twelve days later, the man was seen in the healthcare unit with chest pain and shortness of breath. On examination, a nurse noted that there was no obvious cause of the pain or any injury. The man was advised to continue with paracetamol and ibuprofen, and would be seen the following day.
31. A nurse saw the man on 25 August. His pain had eased by taking maximum doses of pain relief. The nurse wrote a letter to the hospital outlining the man's symptoms with reference to his referral to an ENT specialist. The following day the man was escorted to hospital to see the ENT specialist.
32. On 2 September, a doctor noted in the man's medical notes that following his visit to hospital he had a suspected malignant tumour of the lung (cancer) and a DVT of the lower limb. The following day, a nurse saw the man in the healthcare unit and recorded that he had constipation and a laxative had been prescribed.
33. The man was seen by a nurse as an emergency on 8 September. He was short of breath and struggling to speak. The man told the nurse that, following his hospital appointment, he had been told his windpipe was partly blocked and there was a shadow on his lung. The nurse referred the man to a doctor. The doctor examined the man and noted that he was waiting for a biopsy appointment at the hospital. He prescribed medication and an antibiotic for a suspected chest infection.
34. A nurse reviewed the man on 9 September and wrote that his breathing was easier but he had little voice left. The nurse further noted that the man would have a CT scan on 21 September. When the prison was notified of the results of the scan, staff should be aware that it might confirm cancer.
35. A nurse saw the man on 14 September as he was feeling unwell, cold, and wanted to go to bed and sleep. His observations were taken and recorded as blood pressure 93/98 (a normal reading is 130/80), pulse rate 96 beats per minutes (a normal reading is between 60-100), and a blood oxygen saturation rate of 98%. The man was advised to rest in his cell and to drink plenty of fluids.
36. Three days later, a nurse saw the man in the healthcare unit. He was still feeling very unwell and complained of pain in the left side of his calf. The

nurse spoke to a senior nurse and an urgent blood test was taken. Following the result of the blood test, the nurse spoke to an out of hours doctor service and it was agreed that the man should be taken to hospital. An escort was arranged and the man was transferred to hospital with two officers and on an escort chain. (An escort chain is a 1.8 metre length of chain with one cuff attached to the prisoner and the other to an officer.)

37. The following day, the man returned to Whatton and was seen by a nurse. He told the nurse that hospital staff had told him he had lung cancer and a DVT. On his return to the wing, the man spoke to his personal officer and received support following this diagnosis. The hospital had prescribed Clexane for the man to self administer. (Clexane is an injected medication to stop the formation of blood clots.) The nurse watched whilst the man used his injection of Clexane.
38. On 19 September, the man was seen in the healthcare unit by a nurse. He was tearful but did not wish to discuss his diagnosis. The nurse assured him that staff were there to support him and he could talk to any member of staff when he wished to. Later, the nurse made a telephone call to the out of hours doctor's service as the man was experiencing pain in his leg. The doctor advised that these symptoms were consistent with a DVT and the man should rest as much as possible.
39. Three days later, the man had an appointment with A doctor. The doctor wrote that he was short of breath and had lost weight. She prescribed a food supplement and morphine tablets to help with pain control. A nurse spoke to the man and told him her role was to support him following his diagnosis. The nurse noted that the man was tearful.
40. A nurse saw the man on 23 September and he told her that he had been to the hospital the previous day. The specialist was making arrangements for a lung biopsy and a bronchoscopy. The nurse wrote that the man was less tearful and they were able to talk about his illness. The man was also noted now to be retired from his job in the recycling workshop.
41. The man was visited in his cell the following day by a nurse who noted that he was breathless. The nurse wrote that wing staff were concerned over his mental health and that he seemed to have given up. The nurse advised wing staff that the man was obviously very unwell and his diagnosis of lung cancer had been a shock to him. The nurse recorded that the man would need a larger cell and his social visits might need to be arranged in his cell rather than in the visits hall. She noted that special aids of a bed, mattress, commode and pillows were to be ordered to offer some comfort for the man.
42. On 28 September, a nurse visited the man on the wing. He told the nurse that he did not wish to have the bronchoscopy, saying that he felt too unwell to attend hospital. The man signed a disclaimer form with an option to change his mind. It was decided that the man should move to Alpha eight (A8) wing where he could be cared for in a more suitable environment and have a bigger cell. The following day, he decided to undergo the

bronchoscopy and was escorted to hospital for the procedure. On his return to Whatton, the man was taken to A8 wing, where his personal possessions had been transferred in readiness.

43. The man was seen by a nurse in his cell on 2 October. The nurse administered morphine to help with pain control and noted that the man was very lethargic, lying in bed. Later, a doctor visited the man and they discussed his prognosis. The doctor wrote that he was very distressed and tearful. However, after a long chat, the doctor re-assured the man that his pain could be controlled with medication and staff were on hand to offer support. The doctor told the man that he could have visits in his cell, which she arranged with wing staff. She would see him next week, whilst his partner was visiting, so they could talk through any issues. Furthermore, healthcare staff would visit him daily to ensure he was comfortable.
44. A nurse noted on 4 October that the man's pain was controlled with an increased dose of morphine and he had visited a friend on A7 wing in a wheelchair. Five days later, a doctor visited the man and his partner on A8 wing. They spent time discussing his present medical condition and ways in which he could be cared for following his diagnosis of lung cancer. Because of the man's loss of voice, the doctor made arrangements for his partner to have email communications with the man through wing officers.
45. On 10 October, the man's personal officer on A8 wing introduced himself to the man. (This officer is also a trained family liaison officer.) The officer wrote that they had a chat about his current illness and he had offered any support the man might need. Later, the man's partner visited him on A8 wing. The officer spoke to her and gave her his contact details in both his role as a family liaison officer and as a personal officer.
46. A nurse wrote that on 11 October the man was in a more positive mood, moving around the wing, and that his pain was well controlled. However, the following day it was noted that the man was very sleepy and spending the day in bed. The nurse wrote that on 13 October the man was experiencing pain. The nurse asked that staff use the assessment tool (a plan that monitors the efficiency of pain relief medication) to ensure that he was pain-free. Observations were to be carried out to look for any increase in pain, which in turn should be reported to the doctor.
47. The following morning a nurse saw the man on A8 wing. He was complaining of dizziness when standing. The man now had a hospital type bed with a pressure mattress to aid his comfort. He was spending more time in bed. The nurse noted she would discuss the implementation of a care plan with healthcare staff to ensure all interventions were documented.
48. At 5.00pm, the nurse attended the man's cell to offer personal care and observed that he was very short of breath and had diarrhoea. After several attempts to get a reading, the man blood pressure was noted to be low at 80/40. A temperature reading was recorded at 38.6 degrees, higher than a

normal reading of 36.5. He self-scored his pain at 10/10 and the man was unable to swallow his medication. The nurse contacted a senior nurse.

49. Following a further examination, the senior nurse contacted a doctor at his community surgery and explained the man's symptoms. The doctor was concerned but unable to offer advice as he was not involved in the man's care. Clinical matron decided that the man should be admitted to hospital as a matter of urgency. An escort was arranged and the man was transferred to hospital. A risk assessment was carried out and restraints were not applied. (A risk assessment is an appraisal of the prisoner's threat to the public whilst being escorted away from the prison.) The man's personal officer made contact with the man's partner to tell her of the transfer to hospital, and suggested that she should start to make arrangements to visit him.
50. On arrival at hospital, the man was taken to a side room on a ward. It is recorded in the bed watch notes that at 2.05am on 15 October a doctor told the man he had pneumonia and his kidney function was poor. The doctor said he was seriously ill and his condition was terminal. The man was distressed by this news and asked the escort officers if his partner could be contacted. The escort officer made contact with the duty governor who in turn asked prison staff to telephone the man's partner to tell her the latest poor prognosis and to advise her to travel to the hospital as soon as possible.
51. At 3.00am, the man was transferred to the high dependency unit. His personal officer made contact with the escort officers at 11.20am to tell them that the man's partner, and his ex-wife and children, were on their way to the hospital. They arrived at 1.10pm. The man's family remained by his bedside, taking it in turns to comfort him.
52. The man's personal officer and another officer took over bed watch duties at 7.00pm. An hour later, it was noted that the man had died. His partner was by his bedside. The man's death was confirmed at 8.45pm by a doctor.
53. The man's personal officer supported the man's partner and family following his death, and later a memorial service was held in the prison chapel. Friends of the man arranged for a floral tribute to be sent to his funeral service on 5 November. The funeral was attended by his personal officer and the Deputy Governor. The prison offered to meet the funeral expenses.

ISSUES

Clinical care

54. A review of the man's medical care whilst in custody was undertaken by a general practitioner (GP), on behalf of Nottinghamshire County Teaching PCT. The GP reviewed the man's medical notes and made a chronology of the medical interventions and consultations.
55. The clinical reviewer records that the man had been seen by a chest physician in 2007, before he was taken into custody, when a chest x-ray had shown suspected abnormalities. Further medical investigations were concluded in 2008 when a CT scan showed an improvement and he was discharged from seeing the specialist.

Reception into Whatton

56. The clinical reviewer notes that the man's reception health screen was completed appropriately. It was recorded that he was not suffering from a mental disorder despite being anxious at being in prison. A vaccination history was documented and he was prescribed medication of an inhaler for asthma. The man was also informed of health promotion facilities that he could access.

Summary of healthcare treatment

57. The man had contact with the healthcare services when he felt the need to see a member of staff. Over the last 12 months of his life he had 83 contacts with healthcare staff and was offered relevant health screening and promotion facilities. The clinical reviewer writes:

"Towards the end of his life, when his mobility had become a problem, the man was visited on the wing every day. At the most significant time in the course of his illness, the man and his partner were seen together in his cell. In my opinion, the healthcare department and discipline staff should be commended for facilitating this. I cannot find any significant shortcomings in how the man was managed whilst at HMP Whatton and can confirm that, in my opinion, his standard of care was more than comparable to that of an NHS patient treated in the community."

58. I share the clinical reviewer's commendation of healthcare and prison staff in facilitating the man's visits in his cell, and ensuring his partner was fully informed of medical interventions.

Family Issues

59. One of my family liaison officers made contact with the man's partner. She did not raise any specific issues to be included in the investigation but did ask if her partner had cancer before he was sent to prison. As noted

in the report by the clinical reviewer, medical investigations had been completed in 2007-2008 for a shadow on his lung. However, doctors noted that there was an improvement in his condition in early 2008 and the man was discharged. I cannot say categorically that he had not contracted cancer while in the community, but the evidence would suggest not. As my investigation has shown, the man was referred by the doctor at Whatton, under the two week rule, as soon as his symptoms became a concern.

Restraints

60. It is noteworthy that the man was escorted to hospital without restraints being applied. This was good practice.

Family Liaison

61. An officer, a trained family liaison officer, became the man's personal officer on his transfer to A8 wing. The practice of using trained family liaison officers to become a prisoner's personal officer when they are seriously or terminally ill is commendable, and a further example of good practice.
62. The officer was able to build a relationship with the man, and his partner, before his death. As time progressed, the officer updated the man partner on his condition before he was taken into hospital. Following his transfer to hospital, the officer ensured the man's partner was notified and arrangements made for her to visit him.
63. Following the man's death, the officer maintained contact with the partner and offered her support. It was also advantageous that on this occasion the officer was on bed watch duty when the man died.
64. As well as commending the practice of using trained family liaison officers to become personal officers for terminally ill prisoners, I further note the professional manner in which the officer carried out both those roles. The Governor may wish to consider if the officer's actions should be formally recognised. I would certainly be grateful if my own comments could be passed on to him.

CONCLUSION

65. The man was referred for further medical investigation at an appropriate time. When his diagnosis of cancer was confirmed he was cared for by healthcare and prison staff in a highly supportive and dignified manner. the clinical reviewer comments that the care the man received was more than comparable with that he would have received in the community. He has commended both healthcare and prison staff for allowing the man's partner to be actively involved in discussion around he partner's illness and allowing in cell visits, and I share his views.
66. The support given to the man by his personal officer during the last few days of his life, and that given to his partner, was very good practice. A kind and appropriate decision was taken that the man should not be restrained when he was admitted to hospital for the final time.
67. All in all, this report reflects hugely well upon Whatton and upon HM Prison Service as a whole.

GOOD PRACTICE

1. Facilitating the man's visits in his cell and allowing his partner to be kept fully informed of his medical interventions was good practice.
2. Using trained family liaison officers to become personal officers for terminally ill prisoners is good practice from which other jails might learn. I further note the professional manner in which his personal officer carried out both those roles.
3. I note the good practice that the man was not restrained when he was admitted to hospital.