

**Investigation into the circumstances surrounding the
death of a man at HMP Whatton
in November 2009**

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

June 2010

This is the report of the investigation into the death of a man. The man had been receiving treatment for stomach cancer for some time. A post mortem examination confirmed that he died of natural causes.

I would like to extend my condolences to the man's wife, family and friends. I apologise for the slight delay in the production of this report.

This investigation was conducted by an Assistant Ombudsman. We would like to thank the Governor of Whatton and her staff for their assistance during the investigation. In particular, I am grateful to two members of staff for making various arrangements at Whatton during the investigation. A clinical review into the man's medical care at Whatton was commissioned from Nottingham County Teaching Primary Care Trust. They appointed a clinical reviewer to conduct the review, and I am grateful to him for his timely report.

As the prison population has aged over the last few years, prisons have increasingly had to deal with those who are terminally ill. In this case, Whatton have, in the judgement of the clinical reviewer, provided the man with a standard of care greater than that which would be expected in the community. I am particularly pleased to note that staff actively sought ways to make it as easy as possible for him to cope with his illness. For example training was arranged so that prison staff could administer blood transfusions, saving him frequent journeys to hospital. Staff also ensured that his wife was informed about his progress and was able to contribute to decisions about his future care. I see this as worthy of praise.

I make no recommendations as a result of this investigation.

Jane Webb
Acting Prisons and Probation Ombudsman
June 2010

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SUMMARY

The man was convicted of various offences on 21 December 2004 at a local Crown Court, and was sentenced to ten years in custody. After over three years at HMP Leicester, he transferred to HMP Whatton in 2008 to continue his sentence.

The man reported various illnesses through his first months at Whatton. They included claustrophobia, angina, dizziness and constipation. At this time, however, no underlying illnesses were found.

On 22 January 2009, the man was sent to a local treatment centre for an endoscopy. The endoscopy (a procedure in which a camera is inserted into the oesophagus) showed that the man had a possible malignancy in his pyloric canal, which is part of the digestive system which connects the stomach and the duodenum. Shortly afterwards, he was diagnosed with gastric adenocarcinoma, a form of stomach cancer.

Although he was offered an operation to remove the cancer, he decided that he did not want surgery. Staff at Whatton continued to discuss his options with him and his wife. They adjusted his pain relief when necessary, arranged for blood transfusions to take place in the prison (the first time this had been done) to save stressful journeys to hospital and ensured that effective palliative care was in place.

Staff also began examining whether early release might be possible. After further discussions with the man and his family, it was decided that he would be better cared for at Whatton than he could be at home, and so release was not pursued. The man died at Whatton on 9 November 2009.

The clinical review into the circumstances of the man's death has found that he received a standard of care greater than he would have received in the community, and the Governor and staff at Whatton should be thanked for this. I make no recommendations as a result of this investigation.

THE INVESTIGATION PROCESS

1. The investigation was opened after this office was notified of the man's death on 9 November. Initially, an investigator was appointed but because of pressure of work, the case was reallocated to an Assistant Ombudsman. He visited HMP Whatton shortly after the man's death, and spoke to the Governor, as well as other staff involved in the care of terminally ill prisoners.
2. A clinical review was commissioned from Nottinghamshire County Teaching Primary Care Trust (PCT) into the care provided for the man during his time in custody. The clinical reviewer was appointed to lead the clinical review, and I am grateful for his timely report.
3. One of the Ombudsman's Family Liaison Officers contacted the man's family. This was to explain the purpose of the investigation and to ask them if they had any concerns about the man's care. The man's wife told the Family Liaison Officer that she had nothing but praise for the way her husband had been treated at Whatton. Nonetheless, I hope that this report helps to address any issues the family may have had.
4. The Assistant Ombudsman has spoken to HM Coroner for Nottinghamshire to update him with the progress of this investigation. An inquest into the man's death took place on 11 March 2010. The jury concluded that his death was due to natural causes.
5. Following a review of the papers, the Assistant Ombudsman decided that he did not need to interview any members of staff at Whatton. On 8 February, he sent a letter to the Governor explaining this, and giving feedback on the standard of clinical care from the clinical review. As a result of this letter, the Governor gave further information about a recommendation in the clinical review, the content of which had already been considered.

HMP WHATTON

6. HMP Whatton first opened as a detention centre for juveniles, but its role changed in the early 1990s to that of a prison for vulnerable adult offenders. During this time, the prison developed as a specialist establishment for adult male sex offenders to enable them to participate in the Sex Offender Treatment Programme. Whatton has recently undergone large expansions in 2006 and 2008, increasing capacity by 500 places. On 6 August 2009, there were 839 prisoners in custody. The average age of prisoners at Whatton is far higher than elsewhere in the Prison Service
7. The regime at Whatton includes education, vocational training, industrial workshops and manufacturing, farms and gardening. There is a large range of offending behaviour programmes, including both Living Skills and Sex Offender Treatment Programmes.
8. The Nottinghamshire County Teaching Primary Care Trust (PCT) is responsible for healthcare provision within the prison. The healthcare centre is open daily, with healthcare staff on duty between 7.30am and 7.30pm. Outside of these hours, Nottinghamshire emergency medical services are used when required. Despite the average age of the prisoners, the PCT has not provided any inpatient healthcare facilities.
9. The healthcare department at Whatton runs a walk-in centre and a nurse-led GP practice. It runs nurse-led triage clinics, blood clinics, specialist clinics and follow up clinics. After the initial consultation, the nurse refers patients to the doctors or arranges appropriate prescriptions to be made up. Nurses take the lead in different diseases, and so they have various internal clinical specialists, including in palliative care. Occasionally, external specialist nurses come in. These include diabetic, COPD (chronic obstructive pulmonary disease) and TB (tuberculosis) nurses.
10. There is a portable automated defibrillator located on each wing. These machines can analyse the heart rhythm, diagnosing the shockable rhythms and then charging to treat. Defibrillation consists of delivering a dose of electrical energy to the affected heart. This halts abnormal electrical activity in the heart and can allow normal beating to be re-established.

Previous deaths at Whatton

11. There have been 15 deaths at Whatton in the past three years. Several of these deaths have occurred in similar circumstances to those of this man. I have previously noted that Whatton generally provides a high standard of care for prisoners who develop cancer. I have also noted that liaising with these prisoners' families is often carried out to a very high standard.

Her Majesty's Chief Inspector of Prisons' Report

12. HM Chief Inspector of Prisons made a full announced inspection of Whatton in January 2007. (There has been another, unannounced, inspection at Whatton since the man's death, but the report of that inspection has not yet been made available.)

13. In the report of the 2007 inspection, the Chief Inspector noted that there was good practice in the health services provided. She wrote:

“There had been a comprehensive health needs assessment that had sought the views of patients, carers and staff as well as reviewing clinical records, and the results were being used to plan services.”

Independent Monitoring Board (IMB) Report

14. Each prison is monitored by an Independent Monitoring Board, members of which are drawn from the local community. They have full access to prisoners and every aspect of the establishment.

15. In its latest annual report, covering the period 1 June 2007 to 31 May 2008, Whatton's IMB said: “Defibrillators are readily accessible for every prisoner with trained staff available.” The report also said:

“The IMB wish to place on record the proactive work of the Healthcare Manager and the dedicated staff who are now providing the best level of care the prison has ever experienced.”

Performance ratings

16. The National Offender Management Service produces assessments of performance for prison using an agreed framework. The Prison Rating System (PRS) which assesses 131 prisons (including 11 private prisons) by looking at performance in 34 indicators.

17. Prisons are given a rating from one (which indicates that there are serious concerns) to four (exceptional performance). Whatton has been given a rating of three or four for the last four performance reports.

IEPS

18. The Incentive and Earned Privileges Scheme (IEPS) was introduced to prisons in 1995. It is designed to encourage prisoners to progress through their sentence plan, to undertake hard work or other purposeful activity and create a better and safer environment for prisoners and staff. There are three levels under IEPS – basic, standard and enhanced – with all new prisoners initially being on standard level. Changes to that level will then depend on their conduct and progress through their sentence plan.

Early release on medical grounds

19. Guidance on applications for early release on medical grounds is contained in Prison Service Order 6000. This states, in paragraph 12.4.1, that:

“Early release may be considered where a prisoner is suffering from terminal illness and death is likely to occur soon. There are no set time limits, but three months may be considered to be an appropriate period. It is therefore essential to try and obtain a clear medical opinion on the likely life expectancy. The Secretary of State will also need to be satisfied that the risk of re-offending is in the past and that there are adequate arrangements for the prisoner’s care and treatment outside prison.”

In the following paragraph, the PSO continues:

“Early release may also be considered where the prisoner is bedridden or severely incapacitated. This might include those confined to wheelchairs, paralysed or severe stroke victims”.

Liverpool Care Pathway

20. The Liverpool Care Pathway has been developed in order to establish a method to bring the hospice model of care for dying patients to other environments. It is implemented when clinicians agree that a patient is dying, and includes sections dealing with the support of the family of the patient.

KEY FINDINGS

21. The man was convicted of various sexual offences on 21 December 2004 at a local Crown Court. On 8 February, he was sentenced to ten years in custody and taken to HMP Leicester. Although he appealed against the length of the sentence for various reasons including his poor health, it was upheld.
22. On arrival at Leicester, he was seen by a healthcare worker. She noted that the man had diabetes and heart problems, as well as Paget's disease (a disease affecting the bones which can lead to difficulty moving). He was also seen by a doctor, who noted that he had outpatients' appointments for urology and integrated medicine. These appointments were rescheduled.
23. Four days later, he asked for medical assistance as he had chest pain. Various observations were completed, and blood tests taken but nothing untoward was found. Later that day, the man confirmed that he felt better. He was given co-codamol to ease the pain. However, the next morning, he told the nurse that he had fallen in his cell and again felt pain in his chest and right arm. He asked for medication to ease trapped wind, which was given. The next day, he was seen by a doctor who referred him to Leicester Royal Infirmary (LRI) for inpatient tests.
24. The man remained at LRI for seven days, and returned to Leicester with a letter from the hospital confirming that they had diagnosed gallstones, inflamed gallbladder and malfunction of the kidney. They had decided not to operate, however, because of his heart condition. The man continued to be monitored by medical staff during the rest of his time at Leicester.
25. In June 2005, the man moved to Whatton. On 12 August, he reported further pain in his ribs. He was given pain relief and a doctor advised that, should the pain get worse, he should be admitted to hospital. Three days later, he again reported pain and nausea, and was sent to a local hospital for further investigation. A scan confirmed that he had gallstones, and a cholecystectomy (surgical removal of the gallbladder) was to follow in the future.
26. An appointment for the operation was made for 20 February 2006, but was cancelled as the prison could not get the man to the hospital in time as there had been a misunderstanding about the time he needed to be there. The operation eventually took place on 4 April.
27. On 12 July, the man reported having vertigo and dizziness. He was prescribed Stemetil (an anti-psychotic medication used to treat vertigo and nausea), but returned on 21 July saying that it had not helped. The symptoms continued for the next couple of months, but medical staff were unable to establish the cause.
28. An annual diabetic check was completed on 26 October. His blood sugar levels were found to be high and he was monitored until they returned to normal in December.

29. On 6 January 2007, the man saw a nurse and a doctor after complaining of further chest pain. He took his GTN spray (glycerol trinitrate, which is used to alleviate the effects of angina), and the pain rapidly went. An ECG (electrocardiograph, a test which shows the electrical activity in the heart) was conducted, which suggested an irregular rhythm, but the doctor was satisfied that the GTN spray had worked.
30. Over the next few months, the man was assessed for wheelchair use because of pain in the knee, brought on by Paget's disease. He also continued to experience problems with dizzy spells. At the end of 2007, on New Year's Eve, he complained of stomach pain. He was monitored over several days, with both blood and stool tests completed. Nothing adverse was found. On 17 January 2008, he had two episodes of angina which were treated with his GTN spray.
31. The man was found collapsed in his cell on B wing on 20 May. Nurse A attended, took his pulse and checked his breathing. The man told her that he had suffered an episode of claustrophobia. Nurse A suggested that a change of cell may help. At an appointment with Nurse B on 27 May, the man confirmed that he wanted the light kept on at night. Nurse B telephoned the wing and it was agreed that he would move to C wing.
32. On 10 June, the man was seen by, a prison doctor(Doctor A) He had again complained of being claustrophobic, after he had been moved back to B wing from C wing after an Incentive and Earned Privileges Scheme (IEPS) assessment. He said this had once brought on an attack of angina, which was relieved by taking his GTN spray. Doctor A was concerned that these symptoms were a result of the man's location, and referred this to the residential staff.
33. Despite a note in the man's medical record from a prison manager, which said that she would refer the possibility of a move of cells to the Head of Residence, by 25 June the man still had not moved. He was seen by Nurse A again that day, and complained of ongoing symptoms of claustrophobia, including headaches, spinning head, and sleep and appetite problems. Nurse A believed that all of these symptoms were because of claustrophobia and made it a priority to arrange a cell move. No further problems were noted in relation to claustrophobia.
34. On 24 October, the man again saw Nurse A. He reported that he had fallen twice in his cell in the previous few days, on both occasions shortly after he had stood up. He also reported having felt off colour for the previous week. Nurse A carried out an ECG, which was normal with the exception of one reading (there are 12 leads which measure electrical activity, and it was the measurement from lead II that was irregular). Nurse A referred the man to a doctor. He saw Doctor B on 28 October and was found to be well.

35. The man saw Nurse A again on 7 November. He complained of having been constipated for a few days and, although this was no longer a problem, he had started to pass blood. He also reported having a lot of wind, some gastric pain and having lost weight. Urine and blood samples were taken, and an appointment made for the man to be reviewed the following week.
36. By 14 November, he was again reporting being constipated. He saw Doctor C who prescribed a course of senna (a natural laxative) in the first instance. In the following month, the man complained of back pain after eating, and, on 30 December, told Doctor A that his appetite was reduced. Doctor A referred him for an endoscopy (a procedure in which a camera is inserted through a tube to enable doctors to see inside the body). After receiving the results of blood tests on 13 January 2009, Doctor A noted that the man's iron levels were low.
37. On 22 January, the man attended the Nottingham Treatment Centre for the endoscopy. It showed that there was ulceration in the pyloric canal (which connects the stomach to the duodenum) which suggested that there may be a malignancy. A biopsy was taken which was sent for urgent analysis.
38. Doctor A saw the man four days later. He said that he was feeling "rough" and was short of breath and dizzy. Doctor A noted that he was pale and arranged for him to be admitted to a local hospital, as he needed a blood transfusion.
39. While in hospital, the man was diagnosed with gastric adenocarcinoma (a form of stomach cancer). Staff from Whatton telephoned the hospital every day to check the man's progress, and also informed his wife of his admission to hospital. He left hospital on 13 February, with a distal gastrectomy operation (removal of part of the stomach) planned for the near future.
40. On his return to Whatton, he was seen by Doctor A. They discussed his diagnosis, and the man confirmed that he understood. A week later, Doctor B reviewed the man's iron levels and found that they were low. He arranged for him to be readmitted to City Hospital for a blood transfusion that day. The man stayed in hospital for one night before returning to Whatton.
41. On 2 March, Nurse C visited the man in his cell to explain the role she would take in his care. The man was tearful, but Nurse C described the meeting as "positive" in his medical record. He also explained that he was still suffering from gastric pain.
42. The next day, the man saw Doctor A again. They discussed his diagnosis, and the proposed surgery. The man said that he had decided not to have surgery (he had been told that he only had a one in four chance of survival) and was aware of the implications. As he was still experiencing pain, Doctor A prescribed Oramorph (an oral solution containing morphine). The man also asked for some night sedation, but Doctor A decided to wait to see if the pain control also helped him sleep. The man agreed to further blood tests in case he needed further blood transfusions.

43. One week later, the man saw Doctor A again, and this time she agreed to prescribe medication to help him sleep. The man had taken the Oramorph twice and found that it helped.
44. During the next few weeks, the man was seen regularly by the practice nurses and Doctor A. Doctor A saw him on 1 April, when they again discussed his options. He remained adamant that he would not have surgery. At this meeting, the man reported that he wanted to try an additional painkiller to Oramorph. Doctor A prescribed MST, a tablet containing morphine sulphate. His pain relief medication was reviewed by Doctor B on 14 April, and the dose of MST increased.
45. On 16 April, the man was admitted to hospital for a further blood transfusion. He was seen on his return by Nurse C, and reported feeling much better. He saw Doctor A again on 21 April, and told her that the hospital had recommended weekly transfusions. Doctor A thought it might help if the transfusions were administered at Whatton, and agreed to see if this was possible. In the meantime, the man continued to be taken to hospital as an outpatient for further transfusions.
46. Doctor A met the man on 7 May, and told him that his next transfusion was likely to take place at Whatton, as staff had been trained to administer them. On 21 May, Doctor A inserted a cannula (a small tube) in preparation for the transfusion, which was then administered by Nurse D. The man commented that he thought the procedure had gone well and that he preferred having it done in healthcare than going to hospital. Further transfusions were arranged to take place at Whatton.
47. The man continued to receive regular care from healthcare staff. On 29 June, Nurse C met the man and his wife. The nurse introduced herself and explained her role as the palliative care nurse. They discussed the possibility of chemotherapy (the nurse had sent the man some information by post), and his wife said that she was grateful that she had a point of contact in healthcare at Whatton. At the same time, Nurse C ordered a hospital bed for the man.
48. On 6 July, Nurse A visited the man on the wing as he complained of constipation. The nurse gave him glycerol suppositories, as well as co-danthramer (a laxative) and Sevredol (a morphine-based pain killer). The next day, the man saw Doctor A. They discussed the constipation, and the man said that he felt better. Doctor A also asked if he was aware of the prognosis for his cancer. She advised him that the likely prognosis was eight to 12 months. The man said he was aware of this, and had told his wife. Doctor A said that Whatton could provide care for him if he was not released. Nurse C followed this meeting by telephoning the man's wife to offer her support, and both Doctor A and Nurse C spoke to the man again over the next few days.

49. Nurse C reviewed the man's care on 15 July, creating care plans to prevent pressure sores or chronic pain and was able to remain mobile by using a walking stick. On 21 July, Doctor A met the man again and recorded that he was "clearly deteriorating". The man had a forthcoming appointment with his oncologist, and Doctor A reminded him that there would not be a cure for his cancer. The man confirmed that he understood this, and asked Doctor A to speak to his wife. Doctor A agreed, and the man's wife said that she understood how ill her husband was.
50. On meeting the man again on 28 July, Doctor A raised the issue of resuscitation in the event of him collapsing. The man confirmed that he understood that resuscitation would not be appropriate as there would be little chance of success. Over the next week, the man again complained of constipation and, when speaking to medical staff, said that he thought he was becoming forgetful. On 13 August, the man's wife telephoned Nurse C and also mentioned that she thought her husband was becoming forgetful. She wondered whether this was because of the medication he was taking. She also wondered if he was not telling her things in order to protect her.
51. Nurse C saw the man again on 16 August. They discussed the man's telephone conversation with Nurse C. The man said that he would discuss his end of life choices with her, and said that he would prefer to die in a hospital or hospice if possible. He also confirmed that he wanted resuscitation to be attempted if he died. Doctor A saw the man on 20 August before a blood transfusion. The man told her that he did not want to die in prison. Doctor A agreed to speak to staff at a local hospice about a possible admission.
52. Over the next few weeks, the man did not receive further blood transfusions as his haemoglobin levels remained satisfactory. However, by 17 September, he required a further transfusion and he told Doctor A that he felt better having weekly transfusions.
53. The following day, however, Nurse E was called to the man's cell at the request of Nurse F. The man said he had been unwell and had vomited blood throughout the night. Nurse E noted that he had a tender abdomen, and arranged for him to see Doctor C. Doctor C told the man that, while the situation might return to normal, the loss of blood may have been due to an internal bleed which, in turn, may be a sign of the start of a deterioration in his health. She implemented a plan to assist with his care, including calling his wife to let her know of his condition, and prescribing anti-nausea medication.
54. Two hours later, Doctor A returned to see the man with the Nurse Manager. The man had changed his mind again said that he wished to be cared for in prison and agreed that he should not be resuscitated (with the local emergency services made aware of this wish). Later that day, Nurse F spoke to the man's wife, and arrangements were made for her to visit the following day.

55. Before she arrived, Nurses D and E went to the man's cell as he had again been ill. Nurse D ensured that the man had everything he needed and helped him tidy up. She brought some flowers to the cell before the man's visit. The man confirmed to Nurse D later that day that he had had a good visit from his wife.
56. Doctor C saw the man on 21 September, when he told her that he still felt in pain and had vomited over the weekend. He was also having trouble with his eyes, which Doctor C thought might be because of the opiate based medication he was taking. The man reported feeling light headed when standing. Doctor A visited the man the next day, when he reported that he had pain "everywhere". The doctor confirmed that the man did not want to attend any oncology appointments or be resuscitated. The man also said that he was frightened of dying. Doctor A arranged with the Nurse Manager that a carer would be provided for the man overnight.
57. By 1 October, staff both on the wing and in healthcare were becoming worried about the man keeping his medication. He was becoming confused and also still had problems with his sight. Doctor C spoke with him about this at length the next day, and staff agreed to monitor his use of medication.
58. Over the next few days, staff noted that the man was confused and they often had trouble understanding him. Doctor A visited him on 7 October and found him confused and frail, but aware of who he was. He confirmed that he did not want any transfusions or hospital attendances. Doctor A noted in the man's medical record that she would speak to a member of staff from Public Protection Casework Section (the Prison Service unit dealing with the man's case) about the possibility of his release.
59. Staff continued to monitor the man, noting that he was becoming increasingly frail. On several occasions other prisoners helped him shave or made him drinks. On 15 October, Doctor A contacted a doctor at the hospice to seek advice about the man's pain relief as he was struggling to cope with tablets.
60. Doctor C spoke to the man's wife on 20 October. She confirmed that she understood that her husband was in the terminal phase of his illness. She said that she no longer wanted him to be released as she did not think that she would be able to cope with him as well as he was being cared for at Whatton. The next day, Nurse A saw the man after he was found on the floor. With the nurse manager, she ensured that he was not injured and noticed some pressure sores. She inflated an airbed to help.
61. Nurse E completed the documentation for the Liverpool Care Pathway on 21 October. The man later attended healthcare as he had pulled out a driver (which is used to administer drugs into the vein). Over the next few days, staff continued to attend to the man.

62. Nurse C spoke to the man's wife on 30 October to update her on her husband's condition. She asked a member of healthcare staff to contact her should he die in his sleep. Nurse C then tried to arrange for a second overnight carer for the man to help change his position and give personal care. She also spoke to a Governor, who authorised an extra visit for her should she want to visit the next day.
63. Staff continued to look after the man. On her daily rounds on 9 November, however, Nurse A noticed that the man was very pale, had shallow, rapid breathing, did not respond to stimuli and was cyanosed (this means there was a pale blue tint to the skin consistent with a lack of oxygen in the blood). Nurse C also came to see the man and thought that, after checking his pulse, breathing and pupil dilation, he had died. Nurse A and the Nurse Manager arrived, and Doctor C confirmed that the man had died at 11.20am. The man's wife, who was at the prison visiting her husband, was with him at the time.
64. Nurse C remained with the man's wife until she left the prison. A notice was published by a Governor to both staff and prisoners, informing them of the man's death.
65. A post mortem established that the primary cause of death was Poorly Differentiated Adina-carcinoma of the Stomach. An inquest was held into the man's death on 16 March 2010 by a Coroner. The jury concluded that he died of natural causes.

ISSUES

Clinical care

66. In an investigation such as this, the issues largely concern the quality of care and medical treatment afforded to the prisoner. A clinical review into the man's care was conducted by the Clinical Reviewer, who was commissioned by the Nottinghamshire County Teaching PCT to undertake this review. He concluded his review by saying that "... in my opinion, [the man's] standard of care was more than comparable to that of a NHS patient treated in the community".
67. The clinical reviewer noted several examples of good practice in his review, and I believe that it is worth repeating them in this report. He notes that healthcare staff underwent training in order to deliver blood transfusions to the man at Whatton, rather than in hospital in Nottingham. He also pointed out that this made a significant difference to his quality of life. This initiative was led by Doctor A, and I commend her for making every effort to ensure that the man's wishes were carried out.
68. The man's family were fully involved in decisions about the progress of his illness, with consultations often held while his wife was visiting Whatton. The family were also contacted quickly whenever his condition changed. The man was fully aware of his prognosis, and was able to make informed decisions throughout.
69. In many investigations, it is noted that record keeping could be improved. In this case, the clinical reviewer noted that the records were well kept, especially those concerning the blood transfusions. Documentation surrounding the implementation of the Liverpool Care Pathway, and other nursing plans, were also "contemporaneous, detailed and sensitive to the needs of the man and his family". The clinical reviewer highlighted that, as a result of the Liverpool Care Plan, the man did not suffer any pain or agitation in his last 48 hours.
70. The Clinical Reviewer made one recommendation in his report, that, given the age profile at Whatton, consideration should be made to increase out of hours medical resources, with permanent or intermittent provision of a 24 hour healthcare department. The Assistant Ombudsman informed the Governor of this recommendation in a feedback letter on 8 February 2010. The Governor replied that this had been discussed but was not thought to be necessary at Whatton at this time. As the matter has already been raised at Whatton, I do not intend to repeat the recommendation in this report. However, I will monitor the situation in any future investigations.
71. Although I make no recommendations of my own, I would like to add a comment on the standard of care that was given to the man at Whatton. It is evident from the man's medical record that his family were closely involved in decisions about his care, including whether an application for compassionate release should be pursued. In the end, the man's wife decided that she would

not be able to care for him at home and that it would be in his best interests to remain in prison. Staff continued to provide an excellent level of care following this decision, not only to the man but also to his wife. While this report has focussed on healthcare staff, I was equally impressed with the care given by officers. I think that this is worthy of note, and I hope that the Governor and Head of Healthcare will share these sentiments with their staff.

CONCLUSION

72. The man was already an elderly man when he was sentenced. In 2008, he was diagnosed as having terminal stomach cancer.
73. Staff at Whatton made every effort to help both the man and his wife come to terms with his illness. This included undertaking training to reduce the number of hospital visits he needed to make, arranging for extra support and ensuring that all parties were kept informed and that the man was able to make clear decisions about his future care. The clinical reviewer has assessed that the standard of care he received before he died was greater than that which he would have received in the community, and I agree with his conclusion.