

**Circumstances surrounding the death in January 2007 of
a man who was a prisoner at HMP Whitemoor**

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

October 2007

This is the report of an investigation into the death of a man who was a prisoner at HMP Whitemoor. The man died from apparent natural causes on 1 January 2007 in a local hospice. He was 46 years old.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by one of my Family Liaison Officers.

This investigation was undertaken by one of my investigators. He and I would like to thank the Governor of HMP Whitemoor and his staff for their assistance. A doctor was asked by Cambridgeshire Primary Care Trust to undertake a review of the man's clinical care and I also much appreciate her help.

There are a number of recommendations that emerge from the clinical review, but in other respects I was impressed by the attention paid to the man's terminal care. However, this report also shows that there was an unfortunate breakdown in communication between Whitemoor and the man's family following his death.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

The man was born in 1960. He was 46 years old when he died on 1 January 2007 in a local hospice.

The man had been received into custody on 29 December 2001 after he had been placed on remand. He was sentenced to five years imprisonment in June 2002 at Leeds Crown Court. The man was initially held at HMP Leeds before being transferred to HMP Whitemoor on 4 July 2002.

On 17 January 2006, after being unwell for ten days with vomiting, not being able to hold his food down and difficulty in opening his bowels for a week, the man was admitted to hospital. The man had surgery and was found to have advanced cancer of the colon. His prognosis was poor and he was told that he had two years left to live.

On 20 December 2006, the man was transferred to a local hospice and it was here that he passed away.

The clinical review concludes that the man's clinical care was appropriate and equivalent to that available in the community. I have endorsed the five recommendations in the clinical review.

I have also identified a number of aspects of good practice, while adding a recommendation concerning the prompt return of belongings after a prisoner's death.

THE INVESTIGATION PROCESS

1. My investigator studied all relevant prison records relating to the man. These included his main prison record, medical records and statements made by staff.
2. The Cambridgeshire Primary Care Trust asked a doctor to carry out a review of the man's clinical care. I am grateful to her for undertaking the review and for doing so in a timely manner.
3. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.
4. One of my Family Liaison Officers contacted the man's family. This gave them the opportunity to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed. The family had a number of concerns relating both to the man's healthcare while in custody and to the family's treatment following his death. In particular:
 - The family felt frustrated by the slow and generally poor communication from the prison and the prison's apparent failure to act on their concerns.
 - They were especially concerned about delay in returning the man's personal belongings.
 - The family said that Whitemoor had not offered to contribute to funeral/repatriation costs and they were told that financial assistance was flatly refused by the Governor. No explanation was offered for this decision.
 - The family also described the difficulties they had encountered with Whitemoor following the onset of the man's illness. When he was first diagnosed with terminal cancer, the family said they were told he could be moved to a lower category prison but this did not happen. The family also explained how the man had not been transferred to a hospice until 11 days before his death.
 - Having visited her brother, the man's sister said the healthcare facilities at Whitemoor were squalid and had upset her greatly. She also felt the prison failed to keep her and her family updated about the man's condition. When asked about any ongoing contact with the prison's family liaison officer, the man's sister said she had actually felt too angry to speak to her.

The clinical reviewer and my investigator have explored these points and I hope that this report provides the family with answers to their questions.

5. My investigator discussed aspects of the man's treatment with staff at Whitemoor and with the clinical reviewer.

6. A Senior Officer acted as liaison for this investigation. I am grateful for the energy and efficiency she showed when the ongoing problems of funeral expenses and the return of the man's belongings were brought to her personal attention.

HMP WHITEMOOR

7. Whitemoor is a high security prison for category A and B male prisoners. It is one of eight high security prisons within the prison system. Whitemoor will not accept prisoners who have sentences of less than four years. The prison is located on the outskirts of March in Cambridgeshire. The maximum number of prisoners who can currently be held at Whitemoor is 425.
8. Provision of healthcare within Whitemoor is the responsibility of the Cambridgeshire Primary Care Trust. The healthcare centre has nine in-patient beds and includes a therapy room. It is envisaged that the therapy room will be used in the future to enhance the rehabilitative services provided by the prison. The healthcare centre employs a full-time doctor and provides 24 hour nursing care. Various out-patient clinics are run on a regular basis including: dental care, optical care, diagnostic x-ray, chiropody care and physiotherapy. Visiting Consultant Forensic Psychiatrists attend on a regular basis too. Orthopaedic, medical, surgical, dermatology, urology and audiology specialists may sometimes visit on request. Healthcare staff run nurse-led clinics such as: Diabetes, Asthma and Wellman. An out of hours service (OOH) is provided to the prison by Suffolk doctors on call (Sufdoc).
9. Medication is administered on a weekly and/or monthly basis to those prisoners who have been risk assessed as suitable for holding it in their own possession. It is administered on a daily basis to other prisoners, when either they are considered to be at risk or the medication is considered unsuitable to be held in their possession.

KEY EVENTS

10. The man arrived at Whitemoor on 4 July 2002, after being previously held at Leeds. His medical history comprised a skin complaint and occasional pain in his back and knees
11. On 16 January 2006, the man attended the healthcare wing complaining of constipation and nausea. The man told staff that he had been constipated for seven days and that this had been preceded by diarrhoea for three days. This was the first recorded consultation with these symptoms. The man was seen by the prison doctor and laxatives and pain relief were prescribed. Observation was continued for review by the doctor on the following day.
12. On 17 January, the man was urgently referred to the local hospital with a provisional diagnosis of bowel obstruction. Whilst in hospital the man had a laparotomy (opening of the abdomen) and a colectomy (removal of part of his large bowel) as he was found to have advanced cancer of the colon.
13. The man was discharged from hospital on 1 February and returned to Whitemoor. He was seen by a member of the nursing staff who assessed his condition. He then returned to B wing to his normal living quarters to be re-assessed by the doctor the next day. It was noted that the man was fully aware of his diagnosis.
14. In a letter dated 14 February 2006, an oncologist at the local hospital summarised a discussion he had with the man. The man had agreed to palliative chemotherapy as his prognosis was quite poor and he was only likely to live for two years. The oncologist stated that the man was devastated by the prognosis but had agreed to go ahead with chemotherapy. On 20 February, a risk assessment was carried out to allow the man to have pain killing medications daily for self-administration.
15. On 30 April, the man complained of severe pain. This triggered a discussion between the prison doctor and his colleagues about the best pain relief for the man. It was noted that the prison doctor would liaise with the hospital pharmacist and the prison pharmacy. On 23 May, the man met a Community Macmillan Nurse. The man had been referred to her by the oncologist.
16. On 1 June, the Macmillan Nurse visited the man and recorded his significant psychological concerns about the progress of his disease. The man was given the opportunity to express anxieties about his treatment, his disease and his future care. His need for privacy, dignity and a peaceful environment were also discussed. Following her meeting with the man, the Macmillan Nurse met with him, the Acting Deputy Head of Healthcare at Whitemoor, a Staff Nurse and an officer from B wing. The discussion centred on the aim of facilitating as normal a lifestyle as possible for the man, while his disease allowed it. Several suggestions to make this easier were made, including the provision of earplugs and further medication arrangements. In addition, B wing officers and the man's friends on the wing were encouraged to give him help with such things as fetching meals.

17. On 18 August, the man attended an out-patients appointment for a second course of chemotherapy. His blood sugar had been found to be high and Diabetes Mellitus Type II was diagnosed. He was discharged from hospital four days later and returned to his cell on B wing. The man's diabetes was monitored regularly and his care was facilitated and led by the Community Diabetic Specialist Nurse who visited him every six weeks. The man had his own blood glucose testing equipment and kept his results in a book which was reviewed by the nursing staff who visited him several times a day.
18. On 25 August, the man expressed some difficulties with personal hygiene to the Macmillan Nurse. A Multidisciplinary Review Meeting was held at which the anxieties of the prison officers and prisoners on B wing were discussed. The man's difficulties were also addressed. The aim of the man's care plan was to allow him to live as normal a life as possible for as long as possible. The plan was under constant review and would be changed according to changing circumstances and the man's continuing needs. Arrangements were also made for the man to visit the healthcare wing several times a week for personal hygiene needs.
19. On 20 October, the Macmillan Nurse informed the healthcare team that the man had been told at the oncology clinic that his prognosis was two months. As the last course of chemotherapy had not reduced his tumour progression, no further chemotherapy would be offered. She recommended regular monitoring of the man's blood count, as he was anaemic, and his pain relief medication should be increased. It was felt that he might need admission to a local hospice in approximately six weeks time.
20. The Macmillan Nurse visited the man on 2 November. They discussed the pros and cons of continuing his care on B wing or in the healthcare wing. It was noted that the man said his pain was well controlled. Respite care was discussed and the man was keen to maintain personal choice. He said he valued the support of other prisoners. The man expressed a wish to transfer to the healthcare wing and this was approved.
21. On 5 December, a discussion took place between the man, the Macmillan Nurse, another nurse and the Acting Deputy Head of Healthcare about advance care planning, including resuscitation arrangements. The man said he would not wish for any attempt to be made to resuscitate him. It was noted that he gave his opinions freely and clearly. At this meeting, the man raised issues regarding contact with his sons and he was offered practical help to write a letter to each of them, which he accepted. The man was also asked at this meeting whether he still wanted to pursue a transfer to HMP Garth, a lower category prison, to be nearer to his family. He said that he no longer wished to be transferred there but wanted to go to the local hospice which he thought would be the best place for him. Following the discussion, the prison doctor wrote a DNAR (do not attempt resuscitation) instruction.

22. On 14 December, the Macmillan Nurse visited the man and observed that he was now very weak and having difficulty co-ordinating movements. His gait was unsteady and he was taking only a minimal diet. She discussed with him his imminent transfer to the local hospice, answering his questions. She wrote that the man seemed at ease with his prognosis and at peace with himself.
23. On 20 December 2006, as his condition deteriorated, the man was transferred to the local hospice where he was accompanied by staff from the prison. The Macmillan Nurse met him at the hospice. The man was not restrained while he was at the hospice as a result of a risk assessment and his deteriorating health. The prison staff who were on bedwatch duty had been instructed to dress in civilian clothes. The man was accommodated in a double room to allow space for the attending officers. When interviewed, Officer A confirmed that the man was at this stage unable to communicate with either prison or nursing staff. The officer added that prison staff had been given permission to withdraw from the man's bedside if his family wanted to spend time alone with him.
24. Healthcare staff contacted the hospice on a daily basis to monitor the man's progress. The Acting Deputy Head of Healthcare noted that at the start of his stay the man was alert and aware of his surroundings. When she visited him on 28 December, she noted that his condition had deteriorated considerably.
25. On 1 January 2007 at 7:45am, Officer A arrived at the hostel. He wrote in the bedwatch log that the man's niece was still in attendance as she had spent the night at his bedside. Around 9:10am, the local General Practitioner (GP) saw the man and said that he was very weak. There were two further entries in the bedwatch log, at 10:00am and 10:40am, noting that the man was drifting in and out of sleep. Around 11:15am, his niece asked nurses to come and attend to the man. The nurses attended and said that the man had passed away. The local GP pronounced death at 11:30am.
26. When the family attended the hospice after the man's death, they were met by a Principal Officer who offered condolences and support. The Principal Officer was appointed as the prison's family liaison officer. She maintained contact with the family and assisted with the arrangements for the funeral. Special arrangements had also been made that the man's particular friends on B wing would learn of his death personally from the chaplain, rather than from a note pushed under their cell doors.
27. The post mortem report records the man's death as being due to natural causes, as a consequence of carcinomatosis (cancer), caused by adenocarcinoma of the sigmoid colon.

CONCERNS RAISED BY THE FAMILY

28. The man's family had a number of concerns relating both to his treatment while in custody and the family's subsequent treatment following his death. They raised their concerns in correspondence with Whitemoor both before and after the man's death. However, they felt frustrated by the delay in response from Whitemoor and the initial apparent failure on the part of the prison to act on their concerns.
29. The family said that at no time had Whitemoor offered to contribute to funeral/repatriation costs. When the family had asked via the prison's family liaison officer whether this was possible, they were told that financial assistance was flatly refused by the Governor with no further explanation offered. The family said the prison's response felt incredibly dismissive and the general expectation was that the family would cover all costs.
30. Support for funeral costs is addressed in Prison Service Order (PSO) 2710. The PSO says that the prison should "offer to pay reasonable funeral expenses or, if the family want particularly expensive arrangements, offer a contribution. £3,000 is the sort of figure considered reasonable in 2005-06 but do not quibble over small sums. This offer should be made irrespective of whether the family is entitled to claim a grant from the Social Fund."
31. My investigator brought this to Whitemoor's attention in May 2007 and asked for the decision to be re-considered. The Senior Officer who acted as liaison for my investigation was able to make arrangements for a cheque of £3,000 to be paid to the family. This payment was received by the family in July 2007. I believe that the delay in dealing with this matter has contributed to the family's discontent with the prison. I make the following recommendation:

The Governor should ensure that decisions about funeral costs are clearly explained to the next of kin. Any financial assistance should be given within two weeks of the funeral date.

32. The family was particularly concerned about the delay in returning the man's personal belongings. Initially, several small items were returned to the family, including his house keys, donor and bank cards. These were returned to the family by the prison chaplain after the man's memorial service. They were handed over in a Marks and Spencer carrier bag. The family has since questioned the appropriateness and sensitivity of this. Following the death, the prison's family liaison officer agreed to provide the family with an itemised list of all the man's belongings. However, this did not materialise. These issues were raised by my investigator with Whitemoor. The prison's family liaison officer confirmed that some of the man's belonging were returned in a Marks and Spencer carrier bag. The prison's family liaison officer was not on duty when this happened and agreed that it was insensitive.

33. The issue of the delay in returning the man's belongings was raised with Whitemoor on a number of occasions. The man's belongings were returned to the family on 11 May 2007, five months after his death. This delay caused the man's family considerable and unnecessary distress and I make the following recommendation:

The Governor should put in place measures to ensure that any belongings are returned to the bereaved family promptly, with a review a month after the death to ensure that this has been done.

34. The family also felt disappointed with the ongoing lack of communication from Whitemoor. Having experienced difficulties getting through to the right person when contacting the prison by phone, the family opted to communicate in writing. However, the family has found Whitemoor to be slow in responding and felt frustrated by the prison's inability to follow through on their promised actions within a reasonable timescale. As noted earlier in this report, when asked about ongoing contact with the prison's family liaison officer the man's sister said she felt too angry to speak with her. She later wrote to Whitemoor to ask that another member of staff act as liaison with the family.
35. My investigator was unable to ascertain why there were communication problems between Whitemoor and the family. The family felt that they were not being kept up to date with what was happening, while Whitemoor said they experienced difficulty reaching the family by phone as calls were not answered or returned.
36. The family also described difficulties they said they had encountered with Whitemoor following the onset of the man's illness. When he was diagnosed with terminal cancer, the family was told he could be moved to a lower category prison. However, despite months of correspondence and the involvement of solicitors and their local MP, this never transpired. The family said that they did not receive a written response until their MP became involved. As noted earlier, the family was also concerned that the man had not been moved to a hospice until 11 days before his death.
37. As noted on page 4 above, the man's sister said the healthcare facilities at Whitemoor were squalid and this had upset her greatly. She also felt the prison failed to keep her and her family updated about the man's condition. She felt they were not told about his deterioration until it was too late.

38. In a statement, the Acting Deputy Head of Healthcare at Whitemoor said that facilities at the healthcare centre are certainly not squalid and that staff take great pride in their department, as well as in the service they provide. I note that HM Chief Inspector of Prisons, Ms Anne Owers, carried out an inspection of Whitemoor in February 2006. Ms Owers found that the healthcare services were basic and limited to what could be provided within the staffing levels. However, she wrote that prisoners appeared content with the quality of healthcare and were complimentary about the way they were treated. When my own investigator visited Whitemoor, he found that the healthcare centre was clean and that patients seemed content.
39. The Acting Deputy Head of Healthcare said that the man was cared for professionally and appropriately at all times. With the support of nursing staff, he was able to remain on his parent wing, in the company of his friends, for as long as was practicable. This was so that he could live as normal a life as possible within the limitations of his condition. At all stages of his illness, the man indicated what he wanted to happen. When it became necessary for the man to be cared for as an in-patient within the healthcare centre, he was provided with professional nursing care, designed to meet his needs holistically. He was able to maintain contact with his friends from the wing by way of visits which staff arranged to take place in the healthcare centre.
40. The Acting Deputy Head of Healthcare confirmed that the man did, at one point, express an interest in transferring to HMP Garth. This option was being explored on his behalf, but the man then changed his mind. He told the Macmillan Nurse that he would prefer to be at the local hospice at the appropriate time, with familiar healthcare professionals, including the Macmillan Nurse, remaining in contact.
41. In her statement, the Macmillan Nurse said that, throughout her contact with the man, they discussed in detail his expectations of the future, and the care he wished to receive, including possible transfer into the hospice. The Macmillan Nurse explained to the man on several occasions that he might need to be admitted to the hospice if his condition deteriorated rapidly.
42. Throughout the Macmillan Nurse's involvement with the man, there were many conversations about his day-to-day care, the emphasis being that the man should be continuing to 'live' his life, rather than waiting to die. The man was encouraged, as any other patient would be, to maintain his independence for as long as possible, acknowledging that there would be periods of time where he might need the additional support of friends and fellow prisoners. As the man's condition deteriorated, he was encouraged to remain in the healthcare unit, where his needs could be attended to immediately, adaptations to dietary requirements and visits from friends being facilitated by healthcare staff.

43. As the man's health declined, the Macmillan Nurse was in frequent contact with the medical staff at the hospice and the Palliative Care Consultant. She discussed the appropriateness of his transfer and its timing. The Macmillan Nurse wished to avoid a scenario where, having had some respite in the hospice, the man reached a plateau and was discharged back to his 'home' environment, as is normal hospice practice. The Macmillan Nurse felt this would have been psychologically detrimental to the man as he had, by that time, reached an acceptance of his disease and was acknowledging his imminent death. The man's subsequent transfer to the local hospice was guided by the Macmillan Nurse's professional experience and knowledge and was dictated by the availability of beds.
44. The Macmillan Nurse also confirmed that on several occasions throughout her involvement with the man, the subject of his family's understanding of his illness arose. The Macmillan Nurse offered to contact them and speak to them on his behalf, if he wished. She also suggested that if the man chose to do so, he could ask his family to contact her. Throughout the Macmillan Nurse's contact with the man, he chose not to pursue this option. However, he was keen, following discussion with the Macmillan Nurse, to write letters to his sons about his illness and she was aware that a member of healthcare staff helped him do so.

CLINICAL REVIEW

45. A review of the man's medical care was undertaken by a doctor on behalf of Cambridgeshire Primary Care Trust. The review found that, prior to January 2006, the man had not complained of any symptoms which might have indicated that he had any bowel problems or cancer of any kind.
46. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services. The clinical review concludes that there are no circumstances indicating that death could have been anticipated or prevented, but makes recommendations for improvements to clinical practice.
47. The clinical reviewer judged that the prison should develop a protocol for pain management for prisoners who are terminally ill. The review notes that special attention should be given to arrangements for flexibility and availability when the patient is living in his usual cell outside the healthcare wing.

Consideration should be given to the preparation of a protocol for pain management in the terminally ill, with special attention given to arrangements for flexibility and availability when the patient is living in his usual cell outside the healthcare wing.

48. The reviewer drew attention to the fact that a palliative care pathway for the prison, which is already planned, should be completed and consideration should be given to sharing it with other prisons.

The production of a palliative care pathway for the prison should be completed. Consideration should be given to sharing it with other prisons.

49. The reviewer also judged that there should be prompt acknowledgement and consideration of prisoners' anxieties arising from a diagnosis or prognosis.

There should be early acknowledgement and discussion of potential anxieties and fears arising from a patient's diagnosis or prognosis, in the community in which the patient is living – i.e. prisoners and officers in that wing.

50. The reviewer recommended that there should be a clear system for the management and recording of clinical investigations. The reviewer also recommended that all contacts between doctor and patients should be recorded fully in the medical record. This should be audited. However, the reviewer noted that there had been an improvement in record keeping towards the later part of 2006.

There should be a clear system for the management and recording of clinical investigations which should be auditable, and audited.

All contacts, whether personal or on the telephone, by a doctor with or about a patient should be recorded fully in the medical record. This should be audited.

51. The clinical reviewer drew attention to good practice employed by Whitemoor:

- The man was fully and completely involved in all aspects of his care planning at all times. There is evidence that his wishes and opinions were taken into account when planning his future care and making any changes to that plan. The aim of his care plan was to be holistic, and to allow him as normal a life as possible for as long as possible, so mirroring what his care might have been like in the community.
- The early involvement of the Macmillan Nurse enhanced the care that the man received. Her experience was of great value to healthcare staff, and she is now collaborating with the Acting Deputy Head of Healthcare in writing a palliative care pathway for Whitemoor.
- The special arrangements which allowed the man to end his days in a local hospice with dignity, without restraint, with supervision by officers in civilian clothing and where members of his family were able to spend time with him.
- Special arrangements were also made so that the man's B wing friends could visit him in the healthcare wing. His friends were notified of his death in a sensitive manner by the prison chaplain.

CONCLUSION

52. The man arrived at Whitemoor in July 2002 and died from natural causes in January 2007. In January 2006, the man had been diagnosed with cancer and was told that his prognosis was poor.
53. For whatever reasons, there was clearly a breakdown in communication between Whitemoor and the man's family after this death. To say the least, this was unfortunate. Indeed, the five month delay in returning the man's belonging simply should not have occurred. I also think that the initial decision not to pay funeral costs should have been communicated much more effectively. I am glad that the family's concerns have now been addressed by Whitemoor. I trust that the Governor will draw the issues raised in my report to the attention of relevant members of his staff.
54. In light of the findings of the clinical review and my own investigation, I conclude that the man's medical care was correct and caring. I have endorsed the five recommendations from the clinical review. These need to be addressed by the Cambridgeshire Primary Care Trust in partnership with the Governor of Whitemoor.
55. I have made two additional recommendations of my own and, jointly with the clinical reviewer, drawn attention to four examples of good practice.

RECOMMENDATIONS

For the Governor

- 1. The Governor should ensure that decisions about funeral costs are clearly explained to the next of kin. Any financial assistance should be given within two weeks of the funeral date.**
- 2. The Governor should put in place measures to ensure that any belongings are returned to the bereaved family promptly, with a review a month after the death to ensure that this has been done.**

Accepted. The new Safer Prisons policy (local) will have a specific section on funeral arrangements for death in custody.

Medical

- 3. Consideration should be given to the preparation of a protocol for pain management in the terminally ill, with special attention given to arrangements for flexibility and availability when the patient is living in his usual cell outside the healthcare wing.**
- 4. The production of a palliative care pathway for the prison should be completed. Consideration should be given to sharing it with other prisons.**
- 5. There should be early acknowledgement and discussion of potential anxieties and fears arising from a patient's diagnosis or prognosis, in the community in which the patient is living – i.e. inmates and officers in that wing.**

Accepted. The learning in action that transpired from this particular case has now led to a new initiative between the Health Care Centre team at Whitemoor and the local community Macmillan Nurse specialist. A new Whitemoor palliative care pathway is under development. In June 2007, this won a highly commended award presented by Health Enterprises East.

- 6. There should be a clear system for the management and recording of clinical investigations which should be auditable, and audited.**

Accepted. A system is currently in place which will be reinforced in staff meetings and followed up in writing. This process will be audited on a quarterly basis.

- 7. All contacts, whether personal or on the telephone, by a doctor with or about a patient should be recorded fully in the medical record. This should be audited.**

Accepted. This process is already in place, but further follow up work will be carried out. A lunch-time learning session will also be delivered to clinical staff on record keeping and the law.

Good practice

- 1. I commend the co-operative working between the healthcare staff at Whitemoor and the Community Macmillan Nurse who between them provided terminal care for the man.**
- 2. The man appeared to be fully involved in all aspects of his care planning at all times. His wishes and opinions were taken into account when planning his future care. This allowed him a normal a life as possible for as long as possible, so mirroring what his care might have been like in the community.**
- 3. I also commend the special arrangements that allowed the man to end his days with dignity.**