Investigation into the circumstances surrounding the death of a man in March 2011 at HMP Winchester

Report by the Prisons and Probation Ombudsman for England and Wales

July 2011

This is the report into the circumstances surrounding the death of a man in March 2011 at HMP Winchester. The man transferred from HMP Kingston to Winchester on 21 February 2011, for palliative care following a diagnosis of bladder cancer. He was admitted to the healthcare unit where the nurses looked after him until he died. He was 49 years old. I extend my sincere condolences to his family and friends.

Her Majesty's Coroner for Central Hampshire did not undertake a post mortem examination. He recorded that the man died of natural causes due to bladder cancer.

A review of his clinical care was commissioned with Hampshire Primary Care Trust (PCT). I am grateful to a doctor who undertook that review on behalf of the PCT.

I would like to thank the Governor of Winchester and his staff for their assistance with this investigation. I am appreciative of the support of the liaison officer.

I do not make any recommendations in this report. I am pleased to recognise the professionalism of the healthcare staff at Kingston and Winchester and note the clinical reviewer's commendation for the healthcare staff at both Kingston and Winchester in their liaison with hospital staff.

In this final report, I apologise for the misspelling of a name and this has been amended. No other inaccuracies were raised by the prison. The man's family have read the report and have no further issues for consideration. A copy of the final report will be sent to them.

Thea Walton
Acting Deputy Ombudsman **July 2011**

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SUMMARY

1. The man was sentenced to life imprisonment in September 2006, with a tariff (minimum time to serve in prison) of 14 years. He moved between five prisons and was prescribed medication for epilepsy. At Kingston in October 2009, he complained of pain on urination and was prescribed an antibiotic. A year later, he complained of similar symptoms and, following medical tests, was referred to a hospital for urgent investigations.

2. In November 2010, the man was diagnosed with bladder cancer after a surgical procedure. He returned to Kingston, a nursing care plan was developed and pain relief medication was prescribed. In January 2011, the man was admitted to hospital due to deterioration in his condition. Tubes were surgically inserted into his kidneys, and the cancer had spread to his liver and pelvis.

3. Kingston does not have 24 hour healthcare cover, or an inpatient unit. Consequently, arrangements were made for the man to be taken from hospital to HMP Winchester's inpatient unit. A multi disciplinary team including healthcare staff, palliative care nurses and the local hospice ensured that his pain relief medication was appropriately prescribed and a suitable care plan was in place. (Palliative care is a method of nursing and caring for those with a terminally illness.)

4. The man was discharged to Winchester on 21 February. A nurse stayed with him constantly so that he was not alone and palliative care specialists visited regularly to assist with his pain control and comfort. His family telephoned the healthcare unit for regular updates on their brother's condition and spoke to the healthcare staff. They visited the man once in the healthcare unit.

5. The man' health deteriorated on 4 March and his family were advised to travel to Winchester to see him. However, they were unable to arrange a until 10.00pm that evening when, for security reasons, it was not possible for them to be in the prison. It was agreed with the prison staff that they would visit the following morning.

6. The man died at 10.17am on 5 March, when his family were already en route to Winchester. The duty governor decided not to telephone his family to pass on the news, but to wait until they arrived. The man's family were met at the prison on their arrival at midday and taken to the Governor's office, where the duty governor broke the news of their brother's death.

7. I make no recommendations in this report but acknowledge the professionalism of Kingston and Winchester's healthcare staff for the care they afforded to the man. The liaison of healthcare staff with the hospital has been commended by the clinical reviewer.

THE INVESTIGATION PROCESS

8. The investigation into the man's death was opened on 10 March 2011, when my investigator visited Winchester. She was met by the liaison officer and the Governor. My investigator reviewed the man's prison file and asked for selected documents from those files to be forwarded to her.

9. The Ombudsman's notices of investigation and terms of reference were sent to the prison in advance of my investigator's visit. Up to the circulation of this report there have not been any responses to the notices. The Independent Monitoring Board (IMB) and the Prison Officer's Association (POA) did not ask to speak to my investigator. (The IMB are volunteers drawn from the community who monitor the day to day life of the prison, staff and prisoners. The POA is the prison officer's trade union.) My investigator's details were made available to the IMB and POA should they wish to speak to her at a later date.

10. Later, my investigator visited the healthcare unit and saw the cell occupied by the man until his death.

11. One of my family liaison officers contacted the man's brother to explain the Ombudsman's role in this investigation. The man raised three questions for the report. Firstly, they were concerned that they had not been told that the man was so critically ill on the morning he died, they were upset that they could not visit him in Winchester after 10.00pm, and thirdly, why was he allowed to smoke in the healthcare unit. I trust that I have dealt with these matters to the family's satisfaction in the investigation report.

12. A doctor carried out a review of the man's healthcare whilst he was in both Kingston and Winchester. The review is attached as an annex to this report.

13. My investigation assesses the following aspects of the man' care and treatment:

    - Whether his diagnosis was made in a timely fashion?
    - Whether the man was told about his condition and the treatment which followed?
    - Whether he was treated properly and attended hospital appointments as necessary?
    - Whether the liaison with the man's family was appropriate?
    - Whether the man was accommodated in the most appropriate part of the prison?
    - Whether consideration was given to compassionate release from prison?
    - Whether appropriate palliative care was provided?

HMP WINCHESTER

14. HMP Winchester was built in 1846, for a maximum population of 554 male prisoners. As a local prison, the majority of prisoners arrive directly from court appearances and the population changes frequently. Many of the prisoners are either held on remand or are serving short custodial sentences.

15. From October 2008, primary healthcare services at Winchester were commissioned by NHS Hampshire and provided by Portsmouth Community and Mental Health Services. In April 2010, provision transferred to Solent Healthcare. The healthcare department is located separately from the main prison building. It has a 22 bed inpatient facility (mostly for patients with mental health needs plus a few with primary care needs) and provides 24 hour cover. The majority of nurses work between 7.30am and 5.30pm. Three nurses work between 5.30pm and 8.30pm, and two work overnight. Doctors attend the prison from a local practice to hold surgeries in the mornings from Monday to Saturday, as well as offering an all day surgery on Tuesdays.

16. Her Majesty's Chief Inspector of Prisons carried out an unannounced inspection of Winchester in September 2010. He said of healthcare services:

> "Health services had improved. Waiting times for GP services had been reduced by bringing the clinic into the main prison but there were still long waiting lists for other services. Failure to attend rates were high and there were problems with staff availability for escorting prisoners to the health centre. There was a range of primary care clinics and support for those with life-long conditions. Secondary care was good, with few cancelled hospital appointments at the general hospital."

17. The Independent Monitoring Board (IMB) report for 2009-2010, found that there had been some improvements in healthcare. There were still some ongoing problems including a severe shortage of nursing staff and irregular association for prisoners in healthcare. (Association is the period of time when prisoners are unlocked from their cells and are able to mix with their fellow prisoners.)

18. The man' death was the third to occur at Winchester in the last year, and all three deaths were due to natural causes. Recommendations from those previous reports do not relate to any issues raised in this investigation.

ISSUES

The diagnosis of the man's terminal illness

19. The man saw a nurse on 4 September 2010 and complained of pain whilst passing urine. The nurse prescribed antibiotics and asked him to return to the healthcare unit to check on his progress. Five days later, the man saw a doctor who noted that his symptoms were improving. On 29 September, the man told the doctor that the pain had returned. The doctor noted that the man had not lost weight but ordered a fasting blood test. (For a fasting blood test, the patient must not eat or drink for a number of hours before the sample is taken.)

20. On 13 October 2010, a doctor examined the man. There were no abnormalities present in his blood test. He told the doctor he had now lost some weight, that blood was present in his urine and had abdominal pain. The doctor referred the man to a hospital for an abdominal scan.

21. The man was taken to a hospital as an emergency, following a seizure (fit) on 17 October. He returned to the prison later that day having been reminded to take his epilepsy medication. A week later, he attended the hospital for his abdominal scan.

22. The clinical reviewer commented in his review of the man' healthcare:

> "The man's initial symptoms of a simple episode of cystitis [urinary tract infection] improved with antibiotics. He was investigated quickly and effectively following the development of blood in his urine a month later, and his bladder tumour was identified within a further two weeks. This is a typical presentation of early bladder cancer and was dealt with appropriately."

23. A doctor wrote in the man's medical record on 1 November that a bladder tissue mass (tumour) had been found on his abdominal scan, although it was yet to be confirmed as a cancerous tumour. On 6 November, the man was an in patient at a hospital undergoing a cystoscopy (procedure where a camera is placed into the bladder) and a biopsy (a biopsy is a procedure where body tissues is analysed to determine any abnormalities). He returned to Kingston on 14 November.

24. On 17 December, the man was diagnosed with a serious malignant tumour in the bladder. In early January 2011, it was noted that the man was also suffering from renal failure.

25. The clinical reviewer noted that the diagnosis of the man's illness was, "thoroughly investigated in a timely fashion". The doctor recorded that when the man first complained of pain whilst urinating, he was prescribed antibiotics and his symptoms improved. Later, when blood was noted in his urine, further medical investigations were ordered which lead to his urgent referral to hospital.

26. The man was diagnosed as having widespread bladder cancer. Following the results of the biopsy the cancer was deemed to be unsuitable for chemotherapy. (Chemotherapy is a treatment for cancer related illnesses.) The clinical reviewer added that the man had an aggressive form of bladder cancer which spread to his pelvis and liver. Furthermore there was damage to the kidneys.

27. The man's medical notes clearly show that healthcare staff at Kingston were extremely proactive in supporting the man during this difficult time, particularly whilst an in patient. They ensured that he was made aware of his medical care and his prognosis.

28. I agree with the clinical reviewer that the man's diagnosis was timely and appropriate.

Informing the man about his condition and treatment

29. Following the man's first scan appointment he was told by a doctor that a bladder mass was identified. Hospital doctors told the man that he had a terminal illness after his cystoscopy and biopsy.

30. A nurse saw the man in his cell on 17 December, the day of his diagnosis. The nurse sat with him and offered her support during this difficult time. She explained to the man that she would arrange for him to have help cleaning his cell and with his personal hygiene. The nurse explained that he might have to be transferred to Winchester if he needed full nursing care. The man told the nurse he would prefer to stay at Kingston. A care plan was started which included Tramadol, for medium to severe pain. According to his medical record, nursing staff attended to him several times a day.

31. A consultant urology surgeon wrote to Winchester on 14 February 2011, giving a full chronology of the man inpatient care and treatment. In the same month, a planned operation to remove the tumour was cancelled. The man's condition had deteriorated and a decision was made that only palliative care management would be appropriate.

The man's medical appointments and treatment of the prisoner

32. The man attended all his medical appointments with the healthcare unit and at the hospital. He was admitted to hospital as an emergency on 19 December, following deterioration in his condition. The man stayed there until 30 December, when he returned to Kingston for nursing care, with a catheter. (A catheter is a tube which is place into the bladder to urine into an external bag.)

33. He was readmitted to hospital on 14 January 2011, with a high temperature and poor oxygen levels. The hospital made a decision not to treat the man with chemotherapy as the cancer was too advanced.

34. The modern matron at Kingston visited the man in hospital on 19 January. She wrote in his medical record, that he was sleepy but able to speak to her in short sentences. He was receiving dialysis (a procedure to clean the blood when

kidney function is impaired). Furthermore, the matron was told by hospital staff that, should the man go into cardiac arrest, he would not be resuscitated. She asked the hospital staff to keep in close contact with her and she would look at alternative nursing care for the man when he was ready to be discharged.

35. It is clear from the man's medical notes that a full consultation process took place between Kingston's modern matron and the modern matron at Winchester. To care appropriately for his medical needs at Winchester, various nursing aids, a bed and a pressure mattress would need to be in place before they could accommodate him. Despite the hospital wanting to discharge the man in early February, Kingston's matron and her staff told the hospital staff that his physical and medical care could not be appropriately managed within their limited healthcare setting. Arrangements for a discharge from hospital could only be considered when Winchester was in a position to care for all of the man's needs.

36. Two tubes were surgically inserted to drain urine directly from the man's kidneys. He had tried to dislodge one of these tubes himself and it had been surgically replaced. However, when the tube again became dislodged, the hospital staff made the decision not to replace it. The other tube remained in place. The man was physically very weak and not independently mobile.

37. On 10 February, the man was visited in hospital by a member of staff from Kingston healthcare unit. The medical notes show that he was extremely unwell. The staff member spoke to the palliative care team, to ensure continuity of care for the man on discharge from hospital.

38. The man remained in hospital until 21 February and then transferred to the healthcare unit at Winchester. A cell had been prepared in readiness for his arrival with all the medical aids he would need for appropriate palliative nursing care. At Winchester, the man was supported by nurses experienced in providing palliative care. The healthcare staff also received assistance and advice from a hospice.

39. The clinical reviewer noted that the man's treatment was good and said,

> "When it became clear that no active treatment options remained, he [the man] was given full palliative care, and when transferred to HMP Winchester to die in as comfortable an environment as was possible within the prison system."

The man's pain relief and medication

40. Before the man was diagnosed with bladder cancer, he was already prescribed pain relief of paracetamol and ibuprofen, an antibiotic and a laxative. Following his fit, he was prescribed Phenytoin Sodium and Carbamazepine to treat epilepsy. On diagnosis of bladder cancer, the man was prescribed Tramadol, with a gradual increase in dosage. (Tramadol is an opiate medication to relieve moderate to severe pain.)

41. On his transfer to Winchester, the man was given a complex medication therapy as directed by the palliative care specialists. This included Alfentanil and Morphine for pain control through the syringe driver. He was also given medication to reduce nausea and laxatives to relieve constipation.

42. It is noted in the man's medical record that healthcare staff at Winchester kept in regular contact with the hospice consultant for medication advice. The palliative care nurses were available to offer support and guidance on pain relief medication.

43. The man's treatment and medication was prescribed and reviewed by hospital doctors. During his in patient admissions to hospital and, whilst at Kingston and Winchester, his medical notes show that he was fully supported by both healthcare and wing staff.

44. Towards the end stages of his life and on his transfer to Winchester, the man had a syringe driver inserted into his body to administer the opiate medication of Oromorph. This enabled him to control his pain relief. (A syringe driver releases continuous controlled pain relief medication.)

45. The clinical reviewer comments,

> "When it became clear that his disease was rapidly progressing he was involved in the decision to withdraw treatment. "

The man's location

46. After being told of his diagnosis of bladder cancer and the intensive nursing care he would need, the man told healthcare staff that he would like to stay at Kingston. Whilst healthcare staff endeavoured to try and meet his wish, as his illness progressed they were unable to provided appropriate care for him.

47. Following his discharge from hospital in February 2011, the man was transferred to the healthcare unit at Winchester. Kingston does not have 24 hour healthcare and was therefore unable to offer the continuous level of nursing which he would need for his terminal illness. Location on a normal wing, following his discharge from hospital would also have been inappropriate given the sterile environment he would need to reduce the risk of infection.

48. Winchester liaised with the hospital, a hospice, and specialist nurses. Those organisations were able to offer practical care with specialist support.

49. I agree with the clinical reviewer who confirms that the man's transfer to Winchester was appropriate and agreed that his needs were best met there.

Compassionate release

50. Kingston's matron approached the deputy governor at Kingston on 20 December 2010, to discuss a compassionate release for the man, following his poor

prognosis. On 4 February, she wrote in his medical notes that a compassionate release would not be appropriate.

51. The Governor acknowledged the man's condition but said that his prognosis was still uncertain. The advice from hospital staff was that he might have more than three months to live. Balanced against the length of time to serve of his sentence of a minimum of nine years, the Governor decided that the man did not meet the criteria for a compassionate release at this time. In my view, this was a reasonable decision to make. The Governor has a duty to protect the public and I agree that compassionate release was not appropriate at the time.

52. A staff nurse noted in the medical record that another application for compassionate release would be made on 4 March. She would liaise with the probation officer at Winchester, for the medical information that would be needed to progress this release.

53. Unfortunately, the second compassionate release application had not been completed before the man's death. The clinical reviewer commented that there was an opportunity to apply for compassionate release when the surgically inserted tubes became dislodged. This reduced the man's life expectancy by a few weeks and a timely application might have been successfully considered. Nevertheless, I acknowledge the good practice of both the healthcare and prison staff in considering compassionate release.

Palliative care plans

54. From 17 December 2010, a care plan was opened by healthcare staff for the man's nursing and medical care. It was plain from his medical records that staff went to great lengths to care for him. The records include concise and regular entries which the clinical reviewer describes as "a high standard".

55. Before the man's arrival at Winchester, an updated care plan was developed and clear instructions entered for healthcare staff to follow when caring for the man. Medical aids and a specialist bed were prepared for his arrival into the unit. The clinical review is clear that healthcare staff sought advice and were supported by palliative care specialists

56. The man's medication was readily prescribed and reviewed by healthcare staff, palliative care nurses and palliative care specialists, to ensure his pain relief was controlled. It is evident from the man's medical notes that there was excellent communication from all agencies involved in his palliative care.

57. The man's family asked if they could bring some music for their brother to listen to on 4 March. Healthcare staff were unable to grant this request for security reasons and because it might disturb other prisoners being cared for on the unit. I am surprised by this explanation. Prisoners generally have radios and televisions in their cells and prisons are not silent places. Although I make no recommendation on this matter, I suggest that the Governor and head of healthcare work together to avoid this happening again. I would have thought

that listening to quiet music would be a comfort to a dying man. The clinical reviewer commented and said:

> "This restriction would not have occurred had he died in a hospice. However, every effort was otherwise made to ensure he was as comfortable as possible."

58. I am pleased that, during the last week of his life a nurse sat by the man's bedside to support and care for him 24 hours a day. Those nurses also read to him, ensured that he was comfortable, and that his pain relief was consistent. His cell door was left open during patrol state when prisoners are generally locked in their cells and staffing levels are reduced. This is also commendable, taking into account that Winchester is a Category B prison (one which holds prisoners of medium to high risk to the public). I acknowledge this compassionate and sensitive approach to caring for the man during the last days of his life.

Restraints, security and bed watch

59. The man was a Category C prisoner, and deemed to be of medium risk to the public. Whilst an in patient in hospital he was restrained by an escort chain. An escort chain is a 1.8 metre length of chain with one cuff attached to an officer and the other to the prisoner. Medical records show that although he was very unwell, with the exception of a few days, he could walk around, although his mobility was limited. In these circumstances, I am satisfied that the level of restraints was appropriate.

60. Kingston's matron wrote in the medical notes that the officers on escort duty at the hospital in February, kept helpful observation records. This information was of great assistance to the healthcare staff when assessing the day to day physical health of the man. Seemingly, this was invaluable when hospital staff wanted to discharge the man back to Kingston, and helped determine that it was inappropriate for him to be cared for within their prison healthcare setting.

Liaison with the man's family

61. There are clear and informative notes about the liaison with his family in the man's medical record. On 20 December 2010, Kingston's matron wrote that whilst visiting him at the hospital a doctor had asked for the man's next of kin details so the hospital could discuss their brother's declining health with them. Kingston's matron rang the prison and passed on those details to hospital staff.

62. On 8 January 2011, Kingston's matron noted that the man's sister had telephoned her to ask after her brother's health. The matron passed on to the man that his sister had rung to enquire about his well being. A month later, on 5 February, healthcare staff recorded their concerns that while he was an in patient at the hospital, the man's next of kin should be kept in touch with his condition by a healthcare professional.

63. Following the man's transfer from hospital his brother telephoned Winchester healthcare unit on 25 February to ask for an update. Arrangements were made for him to speak directly by telephone to the man the following day. The man's brother also asked if he could speak to the matron, and this was arranged.

64. The following day, a staff nurse confirmed, with a senior prison manager, that regular next of kin liaison would be more appropriate through healthcare staff. Later, she spoke on the telephone to the man's sister. She assured her that her brother was being cared for and that his family could call at anytime to speak to a member of the healthcare staff. If there was a sudden deterioration in the man's condition, his sister told the nurse that the man's brother should be contacted. Furthermore, the man's sister asked that messages were not to left on her telephone answer machine. She also expressed her thanks to the healthcare staff for their kindness in caring for her brother.

65. The matron spoke to the man's brother on 27 February, and advised him that the family should "visit today" as he was very unwell. This was confirmed with the duty governor who made the necessary arrangements for the visit. At 8.00pm, the man's family arrived at Winchester and spent an hour with their brother in the healthcare unit. The family asked staff to ensure that their brother did not smoke anymore.

66. A family liaison officer met with the matron the following day. It was agreed that the family liaison officer would take over the role of family contact from healthcare staff. It was established that the family could visit their brother at anytime other than when the prison was in patrol state. The family were also told that they could telephone their brother as arranged.

67. The man's brother and the matron had a long telephone conversation the following day, when the matron made him fully aware of his brother's poor prognosis and treatments. They also discussed the decisions about the man's care which were made by both the hospital and healthcare staff.

68. A nurse spoke to the man's sister on 3 March. He explained that the man remained very poorly. His sister said that she had fed him some yoghurt during her visit and he had swallowed this, so he should be eating. The nurse explained that the man was unable to swallow and that palliative care specialists were aware of this. The nurse said that feeding the man food could have caused him to choke. Nevertheless, his sister remained concerned that he was not being fed.

69. During the afternoon of 4 March, the man's condition had deteriorated further and a governor spoke to his brother. The governor advised him that the family should arrange to travel to Winchester to be at their brother's bedside. The prison could facilitate a visit up to 10.00pm when it would then go into patrol state. However, the family were unable to make the journey that evening and arranged to be at the prison at about 11.00am the following day. At 2.00am on 5 March, the man's sister telephoned the healthcare unit to ask for an update on her brother's condition. She was told that he remained unchanged but stable. The matron stayed at the man' bedside during the night.

70. The man died at 10.17am that morning. Regrettably his family had not arrived at the prison and were still on their way. The duty governor made the decision not to telephone the family whilst they were travelling. They arrived at the prison gate at around midday and were met by the duty governor, who took them to the Governor's office to inform them of their brother's death. Later, the duty governor arranged for the family to visit the hospital mortuary to see their brother.

71. Funeral expenses were offered to the man's family and two members of staff represented Winchester prison at the man's funeral.

Family issues

72. The man's family raised three issues with my family liaison officer. Firstly, they were concerned that their brother was allowed to smoke whilst he was so ill. Secondly, they asked why they could not visit him in Winchester after 10.00pm. Their final point was they were not updated about their brother's seriously deteriorating condition during the night of 4 March and the morning of 5 March.

73. The man's family were concerned that during a visit to see him he was allowed to smoke whilst he was so unwell. The family noted that their brother was too ill to roll his cigarettes or even hold them to smoke. My investigator made enquiries with healthcare staff and was told that it was a prisoner's right if they chose to smoke. Although the man was in the healthcare unit, he was still allowed to smoke in his cell. I fully appreciate his family's concerns that their brother was allowed to smoke while he was terminally ill with a cancer-related illness. However, it was his choice to continue smoking and the prison could not stop him, without breaching his rights.

74. The man's family had some way to travel to visit him in Winchester. Despite being advised of his critical condition in the afternoon of 4 March, they could not get to the prison before it was locked down for the night shift at 10.00pm. There are a minimum number of staff on duty during the night when the prison is in patrol state and entry into the prison is for emergencies only. I am satisfied that it would have been inappropriate for the man's family to be present in the prison during this time for security reasons.

75. It was noted that the man's sister telephoned the healthcare staff at 2.00am on 5 March and was told that he was in a stable condition. According to his medical record, there was no notable change to his condition before the man died the following morning. The duty governor was aware that the family would be travelling to Winchester on the morning of 5 March. She decided not to tell them by telephone of their brother's death until they arrived.

76. I appreciate that the man's family were distressed about not being with their brother when he died. I do not think that it would have been possible for anyone including healthcare staff to have predicted the time of the man's death, although he was near the end of his life. I understand the duty governor's decision not to telephone the family whilst they were on their way to the prison.

77. Prison Service Order (PSO) 2710 advises that families are informed of a death face to face and the duty governor followed this instruction. (A PSO is a set of national instructions and orders for the prison service.) Furthermore, it is noted that the duty governor arranged for the family to see the man at the mortuary later that day. Although I regret any upset to the man's family, I am satisfied that the duty governor acted with the best intentions and according to policy.

CONCLUSION

78. The man was referred to hospital for urgent medical investigations when it became apparent that he was unwell with bladder problems. Following his diagnosis of bladder cancer, he was cared for by Kingston's healthcare staff until he was admitted to hospital with deteriorating health. The clinical review shows that the man had an aggressive form of bladder cancer which spread to other organs and chemotherapy was inappropriate.

79. Careful planning for the man's discharge from hospital took place between Kingston and Winchester healthcare staff. This included a multi disciplinary team to ensure his palliative nursing was in place. The man's final stage of life was appropriately managed within a prison setting. I agree with the clinical reviewer that arrangements were made for the man to receive the best nursing care within a prison setting.

80. Liaison with the man's family was established and they were able to telephone healthcare staff for daily updates on their brother's health. However, I understand the family's distress at not being able to be with their brother when he died. Healthcare staff could not have predicted when the man would die although he was in a critical condition.

81. I do not make any recommendations. I acknowledge the good practice of facilitating a nurse to be by the man's bedside during the last week of his life. Furthermore, I note the professionalism of Kingston and Winchester healthcare staff for their care of the man and the clinical reviewer's commendation of healthcare staff in their liaison with hospital staff.

82. In conclusion, the clinical reviewer wrote in his review that the care the man received was equitable to that which would have been provided for him in the community,