Investigation into the death of a man at HMP Whatton, in June 2011

Report by the Prisons and Probation Ombudsman for England and Wales

October 2012

This is the report of an investigation into the death of a man who died at HMP Whatton in June 2011. I offer my condolences to his family and friends for their loss. I apologise for the delay with this report. This was due to the ill health of the investigator.

The investigation was carried out by one of my investigators. I am grateful for the assistance and co-operation of the Governor of Whatton, and the staff involved in the investigation. A clinical review was completed.

The man attended Whatton's healthcare facility in September 2010, complaining of a chesty cough and coughing up blood. He was prescribed antibiotics and referred for a chest x ray. Unfortunately, the chest x ray results showed an abnormality. The man was immediately referred for further investigation and was subsequently diagnosed with cancer of the lungs, which was found to be terminal.

The man took some time to come to terms with his diagnosis and prognosis but eventually he accepted that he was terminally ill. He decided that he did not want chemotherapy treatment to extend his life and, although he was encouraged to continue with treatment, staff abided by his wishes. He told staff that he did not want Early Release on Compassionate Grounds to be considered and that he wanted to die at Whatton. His family were notified of his condition and were able to visit him before he died. Towards the end of his life, the man lived in the "Retreat", at Whatton - a purpose built unit for end of life care for prisoners with space for family and friends to visit.

The investigation found that staff at Whatton did all they could to ensure that the man's dignity and care towards the end of his life was appropriate. I make no recommendations in this report but commend the decision to appoint a Family Liaison Officer at an early stage, and SO A for carrying out his role to a high standard.

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.

Nigel Newcomen CBE
Prison and Probation Ombudsman **October 2012**

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SUMMARY

1. The man transferred to HMP Whatton from HMP & YOI Norwich in August 2010. When he arrived, he was given a healthscreen but did not report any chest problems. However, in September he attended healthcare complaining of a chesty cough which had kept him up in the night. He was also coughing up blood.

2. Staff prescribed him antibiotics and subsequently referred him for a chest x ray. The chest x ray took place in a timely way and showed that he man had a shadow on his lung. Prison Dr A explained that this might mean that he had cancer and he agreed to be referred for further, urgent tests. Unfortunately, the diagnosis was that the man had lung cancer and it was untreatable. He was duly informed of this and whilst at first he seemed to be in denial, he later accepted his condition.

3. When the man was diagnosed with hyponatraemia and syndrome of inappropriate secretion of antidiuretic hormone (SIADH - a condition found mostly in patients with cancer of the lung. It upsets the levels of fluid in the body and can cause swelling, water overload and other dangerous hormonal symptoms. It is treated by restricting fluid intake and testing blood regularly.). He was immediately transferred to City Hospital, Nottingham for urgent medical attention. Once this was controlled he was discharged and returned to Whatton with a comprehensive care plan.

4. The prison accommodated the man appropriately throughout his illness. At first he lived in a specially constructed cell on A wing. The cell was adapted for prisoners with disabilities, sympathetically decorated and with an integral wet room and toilet. As the man's illness progressed he moved to the Retreat, a specially designed unit for prisoners who need end of life care in prison.

5. Throughout the man's illness good communication took place between healthcare staff at Whatton and his consultant at City Hospital, Nottingham. His family was informed of his diagnosis and prognosis and were able to visit him in the Retreat before he died. Although Whatton does not have dedicated 24 hour healthcare, he was cared for by healthcare staff during the day and by agency healthcare assistants during the night.

6. The man decided that he did not want to be considered for Early Release on Compassionate Grounds, after this was suggested to him by staff. His next of kin was also suffering from poor health and the man did not want to be an added burden to them.

7. The man died in the early hours in June, in the Retreat at Whatton. His passing was described to the investigator as dignified and peaceful. We make no recommendations in this report but commend the way that staff caring for the man responded to his declining health and subsequent death.

8. **THE INVESTIGATION PROCESS**

9. The man died in June 2011. One of my senior investigators, opened the investigation on 16 June on behalf of another investigator. The senior investigator received copies of all the man's prison records and spoke to the Governor of HMP Whatton. He was also shown around the prison and the Retreat, where the man lived before he died.

10. Notices informing staff and prisoners of the investigation and inviting anyone who had any relevant information to contact the investigator were issued. No one replied in response to the notices. My other investigator returned to the prison on 8 August, when she carried out interviews with staff. She also met the Governor of Whatton and was shown around the prison, including the man's cell on A wing and the Retreat.

11. A clinical review of the healthcare provided to the man was commissioned. We are grateful to the clinical reviewer for his review, which is attached to the report at annex 1.

12. A Family Liaison Officer, spoke to the man's family to ask them if they had any concerns that they wanted to be addressed in the report. They said they had no complaints but would like a copy of the draft report.

13. The investigation assesses the following aspects of the man's 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.

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The man

14. The man was serving an indefinite sentence for public protection. He was sentenced at Maidstone Crown Court. He was transferred to Whatton where he lived until his death.

HMP WHATTON

15. Whatton was built in 1966 as a detention centre for boys. It became a young offender institution in 1989. It was re-roled in 1990 to an adult male category C training prison. (Prisoners whose escape would be highly dangerous to the public are held in category A conditions. Those who do not require the highest security conditions but for whom escape must be made very difficult are held in category B conditions. Those who are the least likely to be

dangerous if they escape are held in category C conditions.) During the 1990s the prison developed its role as a prison for male sex offenders. Its population more than doubled in early 2006. The population of 841 is made up predominantly with those who have committed offences against children but with a significant minority who have committed offences against adults.

The Retreat

16. In 2009 in conjunction with Nottinghamshire Healthcare NHS Trust, Whatton made a bid to the King's Fund (a charitable foundation) to improve the facilities at the prison for end of life care. This was in response to the clear need to provide a suitable facility for prisoners to spend their final days and to enable family members to visit more easily. (Previously, facilities had been provided on one of the residential wings.) The bid was successful and a multi disciplinary team was established to develop an end of life suite adjacent to the existing healthcare building. The facility was completed at the end of 2010 and formally opened in March 2011. The facility was called the Retreat after a staff and prisoner competition for a name.

Independent Monitoring Board (IMB)

17. The most recent IMB annual report covers the period from June 2009 to May 2010. As this does not take in the more recent changes described in this report, specifically the Retreat, the investigator asked if the IMB would provide a more up to date response. She was given the following information from the current draft annual report, which covers the period June 2010 to May 2011, for the purposes of this report.

    "During the reporting year, the new Coroner for Nottinghamshire opened the new Palliative Care Suite, named as The Retreat, at the prison. This was funded by a King's Fund Grant and provides a specialist room within the healthcare unit in which terminally ill prisoners can reside until death.

    "The Board is pleased that the current healthcare provider (Nottinghamshire Healthcare Trust) won the contract to provide healthcare to the prison following a tendering process. Two external audits (security and safer custody) have been carried out during the reporting year, for which the prison received a very high return.

    "The IMB wishes to record its thanks to the Project Team without whose hard work and dedication over a long period of time this would never have materialised. Hence the care for those who are near to their end of life has been made as comfortable and dignified as possible and also provides day facilities for their family and close friends during visits."

Her Majesty's Chief Inspectorate of Prisons' report (HMCIP)

18. The most recent inspection at Whatton was an unannounced short-term follow up inspection. In the report of this inspection, published in July 2010, inspectors found that "much emphasis had been given to the care of older prisoners and those with life-long conditions." Overall, inspectors found the progress made at the prison to be "impressive"

ISSUES

Diagnosing the man's terminal illness

19. The man had a medical history of asthma. When he arrived at Whatton in August 2010, it was noted on his initial healthscreen that he had been a smoker for 50 years. He was described as physically fit and well.

20. In September, the man attended healthcare, complaining of a chesty cough. He told staff that he had been coughing up blood over the previous night. He also said that he felt short of breath and staff noted that he looked pale. The man subsequently told Nurse A that he had had the cough for about a month but it had recently got worse. He also said that he had chest infections in the past and that his current symptoms felt the same. His observations were normal except for a raised respiratory rate (faster breathing than normal.)

21. Nurse A contacted Nottingham Emergency Medical Service (NEMS) and the man was subsequently prescribed amoxicillin, an anti biotic medication. A follow up appointment was made. Unfortunately, the man did not attend this appointment. When the investigator asked why he did not attend, staff said that the man often did not attend appointments throughout his illness. Prison Dr A said that this was because either he has started to feel better or because he spent some time in denial about his illness.

22. Prison Dr A examined the man on 1 October because he said he was hearing voices and there were worries about his mental health. He presented as very stressed at this meeting apparently because he was having problems with his cell mate. Dr A was unable to carry out a mini mental state examination (MMSE) because of the man's stress level. However, she talked to him and subsequently asked the wing staff to change his cell mate, which they subsequently did. The doctor arranged the MMSE for the week afterwards.

23. On 8 October, prison Dr A reviewed the man and completed the MMSE. She asked him about his chest infection and he said that he had only one episode of the chesty cough and was okay now and had not had it since. The doctor suggested that he should have an urgent chest x ray because he was a long term smoker and had a history of coughing up blood. Initially the man refused, saying it was: "too far to go." However, he later changed his mind and agreed to the referral. The doctor subsequently made arrangements for him to have a chest x ray. The man failed to attend an appointment with the doctor on 12 October, but asked for paracetamol on 13 October because he was suffering from cold symptoms.

24. The man attended healthcare again on 19 October, complaining of another chesty cough. The nurse advised him and gave him an Atrovent inhaler (Atrovent is an inhaler used to help with breathing.) She asked if he would try a different inhaler but he refused. He said he would wait for the x ray results before taking any other medication.

25. The man had his chest x ray on 21 October and prison Dr A received the results by fax on 22 October. In an urgent appointment the same day, she explained to the man that the results were abnormal. There was a shadow on

his lung and an unexplained mass also showed up on the x ray. She explained what this might mean and said there was a possibility that he might have lung cancer. The man was understandably anxious, especially as he had recently been told that his brother was also suffering from lung cancer. He agreed to be referred for further tests and was referred under the two week rule (designed to make sure someone suspected of having cancer is seen by a consultant within two weeks of referral). He was prescribed more antibiotics and was signed off work pending the investigations.

26. On 25 October, the man again attended healthcare as he had noticed a small amount of blood in his sputum after coughing. Staff advised him of his upcoming scans and outpatient appointments and made an appointment for him to see prison Dr A. On 28 October, the man again failed to attend a healthcare appointment.

27. The respiratory consultant examined the man on 5 November and arranged for him to have further investigations and a computed tomography (CT) scan. (A CT scan is a special type of x ray which shows a 3D image of the area scanned.) He noted further complications with the man's condition because it seemed that the mass in his lungs was pressing onto his heart. The respiratory consultant subsequently arranged for the man to have a bronchoscopy on 9 November. (A bronchoscopy is a technique where a tube is inserted through a patient's nose or mouth to examine the lungs with a flexible telescope.) The prison Dr A met with the man on 8 November to explain the purpose of the tests he was having.

28. The man failed to attend a triage appointment on 10 November, but was examined later that day by Dr B, another prison doctor. The man told the doctor that he was not eating and had been retching since he had the bronchoscopy. He also complained of pain in the right side of his chest and upper abdomen. The doctor arranged for some blood tests because the man was very pale and prescribed him with medication to stop him being sick and some stronger painkillers.

29. Healthcare staff received a telephone call from the oncology (cancer) consultant at hospital, on 12 November. The man's blood tests had indicated a drop in his salt levels and the oncology consultant required him to be admitted to hospital urgently. Arrangements were subsequently made and the man was admitted later that day. He was diagnosed and treated for SIADH (Syndrome of Inappropriate Secretion of Antidiuretic Hormone (ADH), in which the ADH is often secreted from a cancerous cell) and hyponatraemia (low sodium concentration in the blood serum). Prison Dr A explained in interview that these were indicators that the man had cancer.

30. Whilst he was in hospital, Nurse B telephoned for updates on his condition on a daily basis. The oncology consultant arranged for a bronchoscopy and a bronchial biopsy whilst the man was in hospital. This confirmed that the man had cancer. In addition, his scan results indicated that the cancer had spread to his stomach and thorax. This meant that there was no curative option and the man was consequently to be cared for by the palliative care team. The man discharged himself from hospital against advice, and returned to Whatton.

31. Prison Dr A was proactive in arranging a chest x ray for the man at the onset of his chest problems. Investigative procedures were carried out in a timely way and the man was encouraged to attend hospital and healthcare appointments so that a timely diagnosis could be achieved. There was a gap of approximately two months when the man was undergoing appropriate investigative procedures, before he was diagnosed substantively with incurable cancer. Neither we, nor the clinical reviewer, can find anything inappropriate regarding the diagnosis that the man was suffering from incurable cancer.

Informing the man about his condition and treatment.

32. Prison Dr A received the results of the abnormal chest x ray on 22 October and made an urgent appointment the same day to discuss the results and potential diagnosis with the man. She again discussed his illness with him before his bronchoscopy on 8 November.

33. The man returned to Whatton after discharging himself from hospital. Nurse B, the lead palliative care nurse at Whatton, had a long chat with him. The Nurse asked the man what he knew about his illness. He responded that he was not aware of anything except that he had a shadow on his lungs. The nurse had received a letter from the oncology consultant which said that he had explained the situation to the man and told him that he had lung cancer which was not treatable.

34. The man told Nurse B that he felt great and was “as fit as a fiddle” but she noted in the record that he looked unwell and grey in colour. She asked him if he wanted any further information but he declined, saying he “did not want to know yet.”

35. On 22 November, Prison Dr A had another long chat with the man about his diagnosis. She explained to the investigator that there were frequent discussions because the man seemed to be in denial and took some time to come to terms with his diagnosis. On this occasion, the man started to accept his prognosis.

36. The clinical reviewer writes in his review, “the man’s’ own wishes were always maintained. When he took time to come to terms with his illness, the staff were sensitive and accommodating.” Furthermore the clinical reviewer notes that “the man was happy to have his palliative care managed at HMP Whatton and confirmed on more than one occasion to healthcare staff.”

37. We are satisfied that healthcare staff at Whatton dealt with the man in a sensitive, supportive way throughout his illness. Staff spent time with the man to explain his diagnosis and treatment and this is evidenced on numerous occasions in his clinical records.

Medical appointments and treatment of the man

Appointments

38. The investigator asked staff about the procedure for ensuring that the man was able to attend outside hospital appointments. Prison Dr A explained that any prisoners with urgent or life threatening illnesses were prioritised and were able to attend outside appointments.

39. The man attended a number of appointments with prison healthcare and the oncology and respiratory departments at outside hospital. However, Prison Dr A explained that the man chose not to attend some appointments. He failed to attend an outpatient appointment on 28 October, although healthcare staff tried to persuade him to attend. He also failed to attend the lung clinic on 5 November. On 15 November, and against medical advice, the man discharged himself from hospital and returned to Whatton.

Liaison with hospital

40. During interview, Prison A and Nurse B explained to the investigator that on both occasions when the man was in hospital, communication with the hospital was very good. When the man's blood tests showed that he had hyponatraemia, the oncology consultant telephoned the prison to arrange for him to be admitted to hospital urgently. Prison healthcare and discipline staff responded to this in a timely way. Whilst the man was in hospital, staff spoke on the telephone daily and arranged follow up appointments and medication.

41. After the man had his first chemotherapy session, he was discharged back to Whatton without follow up appointments. The practice nurse at Whatton, noted that the man's discharge letter did not have details of emergency telephone numbers or when his next appointment was due. She immediately contacted the hospital to ascertain the information and duly noted it in the man's clinical records.

42. When the man refused to attend for chemotherapy treatment, healthcare staff contacted the hospital to inform them. They also ensured that the opportunity for further appointments remained available should he change his mind about the treatment

Treatment

43. When the man first complained of chest problems, he was treated with antibiotics and an urgent x ray was arranged. Once the result of the x ray was received and it was found that it was abnormal, he was referred for further investigative tests as outlined above. During this time, he was treated with various inhalers, pain killing medication and tablets to stop him feeling sick.

44. When he was admitted to hospital with hyponatraemia, his fluid was restricted and his temperature was taken on a daily basis. When he discharged himself from hospital a care plan was put in place to ensure that he was treated according to the consultant's suggestion.

45. After the man had attended one appointment for chemotherapy, he decided that he did not want to attend any more. Officer A and Senior Officer (SO) B both tried to persuade the man that chemotherapy would be beneficial to him, as did healthcare staff. However, in January and February, he maintained that he did not want any further treatment or hospital intervention. His wishes were complied with.

46. When the man was told that his cancer was incurable, he was treated palliatively. On a number of occasions, he refused to take his prescribed medication but asked for Lucozade, cough syrup and antibiotics. Healthcare provided this for him. In his clinical review, the clinical reviewer states

> “His wish to stop medication was respected, as was his preferred treatment, which for a long time was with hyoscine patches [used to treat nausea], small doses of morphine, and bottles of lucozade and cough syrup.”

47. As the man neared the end of his life, staff made preparations and subsequently used a syringe driver to provide pain relief to the man. (A syringe driver is a small pump which administers medication gradually over a period of time. It is generally used when a patient can no longer take medication orally.) The clinical reviewer summarised that

> “The man required a substantial amount of medical and nursing care whilst he was a prisoner at HMP Whatton. The level of care maintained his quality of life until the end.”

48. Whilst the man lived in the Retreat, he was provided with 24 hour care. During the night, a health care assistant was present and the investigator was shown care plans and instructions to inform the agency healthcare staff about the man’s needs.

The man’s pain relief and medication

49. As discussed above, the man was provided with various appropriate medication for pain and until December his preferred treatment was antibiotics. He asked staff if he could have his lung cancer surgically removed on 8 December but was told that was not possible. Staff believed that he was still in denial of the extent of his illness, although they encouraged him to take the medication he had been prescribed.

50. On 14 December, the man deteriorated and staff arranged for delivery of oxygen and a syringe driver to the prison. However, the man denied being in any pain. Nevertheless, staff told the investigator that, in obtaining the syringe driver and oxygen, they were planning for the man to receive the most appropriate end of life care over the Christmas period, when they might not be able to obtain the equipment at short notice.

51. The man continued to refuse chemotherapy but prison Dr A continued to check with him whether he had changed his mind. During the rest of December, the man took his morning antibiotic. On occasions, he took some morphine, but did not take his evening dose of morphine.

52. In February 2011, the man was noted to have a rash and facial swelling. Prison Dr A discussed this with the oncology specialist. It was felt that the man should be admitted to hospital, but he refused. He was therefore prescribed different antibiotics (dexamethasone) and steroids.

53. The man started to take Oromorph (a painkilling drug) from 5 March but continued to refuse to take other medication. He preferred instead to use hyoscine patches and drink Lucozade, which were provided for him.

54. On 3 June, staff noted that the man was struggling to swallow his medication. A syringe driver was used on 5 June when he was conscious but was not communicating. Staff said he did not appear to be in pain. He continued to have his medication provided through the syringe driver until his death.

55. We agree with the clinical reviewer that the man's medication was appropriate throughout his illness and staff took care to maintain his wishes when he refused treatment and medication.

Liaison with the man's family

56. The man' sister telephoned the prison on 15 December to ask how her brother was. She was given information by healthcare staff. It is not clear when the prison appointed a family liaison officer (FLO), but SO B, a trained family liaison officer, was involved in review meetings about the man's care from 20 December 2010.

57. It is worth noting that prisons are only required to appoint a FLO after a death in custody. Appointing a FLO when a prisoner is diagnosed with a terminal illness is an example of good practice, which is by no means universal across the prison estate.

58. SO B's role involved him liaising with the man's family and managing their visits. He spoke to the man's brother and arranged for him to visit the man both on 16 April and, with another brother, on 21 April. Unfortunately, the man's brother was also suffering from ill health at this time and was unable to visit regularly because of the distance from home to the prison.

59. SO B spoke to the man's family and asked whether it would help the family to visit more often if the man was transferred to Maidstone prison, nearer to the family home. He also suggested that the prison could take the man to Maidstone for an overnight stay so that the family could visit, if a permanent transfer was not a possibility. However, the man refused to move to Maidstone and he became too ill to visit overnight. When the family were unable to visit, SO B arranged a facility for weekly telephone calls.

60. The man's brother was asked how he would like to be informed of the man's death when it occurred. He informed SO B that he would prefer a telephone call rather than a home visit. On the man's death, SO B contacted the family by telephone and at their request made arrangements for the funeral to take place in Whatton. The prison met the funeral expenses.

61. SO B made early contact with the man's family and also tried to make visits easier towards the end of the man's life. As visiting was difficult for the family, SO B tried to help by arranging a transfer to Maidstone. However, the man's wishes were considered and this move did not take place.

62. We are satisfied that the level of family liaison with the man's family was appropriate and commend the Governor for appointing a FLO at an early stage and commend SO B for trying to help the family visit more often.

The man's location within the prison

63. When the man suffered with hyponatraemia, he was admitted to hospital. He later discharged himself and told staff that he did not want further hospital treatment. He then lived on A wing in a single cell until his condition deteriorated and, on 24 December, he moved into a specially constructed palliative care cell on the wing. The man was clearly happy to remain on the wing. He was the first person to use the specially constructed and it is noted on the minutes of a review meeting between the man, healthcare and the family liaison officer, SO B that he said: "that cell is being made for me."

64. When wing staff said that they were becoming concerned about the level of care that the man needed on the wing, plans were put in place to move him to the Retreat. A specialist company was used to move him to the Retreat on 15 April in a private ambulance.

65. On 18 April, Prison Dr A stopped all the man's unnecessary medication and started a syringe driver. He was medicated with diamorphine, a strong painkiller, midazolam (a sedative)and levopromazine (another sedative). The care plans at that stage were updated to the Liverpool Care Pathways (the Liverpool Care Pathway is designed to improve the care given to the terminally ill in their final hours).

66. On 10 April, the Prison Dr A reviewed the man and, because he was now drinking and eating well, the syringe driver was stopped and he reverted to taking morphine orally.

67. It is clear that staff at the prison enabled the man to live where he felt most comfortable and in a location appropriate to his needs throughout his illness. The prison used a specialist company to move the man to the Retreat, which is situated at the opposite end of the prison from A wing where he lived previously.

Compassionate release

68. In a multi disciplinary meeting held on 20 December, SO B said that the man had told him that he did not want to die in Whatton prison. SO B discussed early release on compassionate grounds (ECRG) with the man and explained that, at that stage, issues around the level of risk of re-offending remained. As such, there was only a limited possibility of early release, until his health deteriorated to such an extent that his mobility was fully impaired. Nevertheless, SO B left an application form for early release with the man for

him to complete. The man did not complete the application form. He later told staff that he wanted to die at Whatton.

Palliative care plans

69. Palliative care is a specialised area of healthcare that focuses on relieving and preventing the suffering of patients, in particular those who are terminally ill and who are nearing the end of life. Palliative medicine utilises a multidisciplinary approach to patient care, relying on input from physicians, pharmacists, nurses, chaplains, social workers, psychologists, and other allied health professionals in formulating a plan of care to relieve suffering in all areas of a patient's life. This multidisciplinary approach allows the palliative care team to address physical, emotional, spiritual and social concerns that arise with advanced illness.

70. On 15 April, the man moved to the Retreat, the specially built end of life palliative care suite at Whatton, by private ambulance. Multi disciplinary meetings continued between healthcare staff and discipline staff to ensure that the man’s palliative care was planned and dignified. The doctor stopped all unnecessary medication and ensured that his pain was managed appropriately either by syringe driver or orally.

71. Healthcare staff ensured that the man had a selection of DVDs to watch and that his friends from the wing were able to visit him. He also had access to newspapers and television and radio. Staff said that he had a number of visitors including Listeners, the chaplain and the Governor. Staff also helped him to write letters and when he was unable to read letters himself, staff read them to him. SO B assisted the man to write down his wishes regarding funeral arrangements. The clinical reviewer said “the man was happy to have his palliative care managed at HMP Whatton and confirmed this on more than one occasion to healthcare staff.”

72. The clinical reviewer commented that he could not find any “shortcomings in how the man was managed whilst serving his sentence at HMP Whatton. I can confirm that, in my opinion, his standard of care was comparable to that of any NHS patient treated in the community.”

Restraints, security and bedwatch

73. The man remained within the prison for the last few months of his life and refused hospital treatment and appointments. Accordingly, there were no issues relating to restraints, security or bedwatch.

The man’s family’s concerns

74. The man’s family had no concerns in relation to his care and treatment whilst he was at Whatton. They have received a copy of the draft report and do not have any further concerns.

CONCLUSION

75. The man fell ill with a chest infection and was coughing up blood on 26 September. He was treated with antibiotics and, when he had a further appointment with prison Dr A on 8 October, he said that he only had one episode of coughing up blood and that he was well.

76. Prison Dr A encouraged him to have a chest x ray because of his long history of smoking and because he had coughed up blood. The man eventually agreed to this and he was found to be suffering from cancer of the lung.

77. The clinical reviewer makes no recommendations in his clinical review and writes:

> "The man died of incurable lung cancer and HMP Whatton Healthcare Department could not have anticipated this disease. Following diagnosis, treatment was palliative only and with the restrictions he placed on taking chemotherapy, his life could not have been extended any further."

78. We are satisfied that the man received good care from both the prison and the hospital and endorse the view of the clinical reviewer. Care for people dying in prison presents a particular challenge to healthcare staff, officers and Governors. In our experience, the facilities and good liaison with his family helped to make the man as comfortable as possible as he reached the end of his life.

GOOD PRACTICE

79. We make one commendation of good practice in this report. SO B acted diligently and sympathetically with the man and his family and went out of his way to enable his family to visit. The appointment of a FLO at the time of the man's diagnosis should also be commended.