Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nigel Farrant, a prisoner at HMP Isle of Wight, on 7 October 2023

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. On 18 November 2010, Mr Nigel Farrant was convicted of sexual offences and received an Indeterminate Sentence for Public Protection (IPP) with a minimum term of five years. He was sent to HMP Elmley. Mr Farrant spent time in several prisons and had spent time at HMP Isle of Wight on two occasions. His last transfer to HMP Isle of Wight was on 22 November 2018.

4. Mr Farrant died in hospital of acute sigmoid volvulus (a twisted intestine) on 7 October 2023, while a prisoner at HMP Isle of Wight. He was 64 years old. We offer our condolences to those who knew him.

5. NHS England commissioned an independent clinical reviewer to review Mr Farrant's clinical care at HMP Isle of Wight.

6. The clinical reviewer concluded that the clinical care Mr Farrant received at HMP Isle of Wight was partially equivalent to what he could have expected to receive in the community. The clinical reviewer made three recommendations which are not directly linked to Mr Farrant's cause of death, but which the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Farrant's care. We did not find any non-clinical issues of concern. We make no recommendations.

8. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman **April 2024**

Inquest

At the inquest, held on 12 November 2025, the Coroner concluded that Mr Farrant died from natural causes.

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