Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lawrence Nolan a prisoner at HMP Durham on 10 June 2017

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Lawrence Nolan died on10 June 2017 of oesophageal cancer while a prisoner at HMP Durham. He was 67 years old. We offer our condolences to Mr Nolan's family and friends.

We agree with the clinical reviewer that the standard of healthcare Mr Nolan received at Durham was equivalent to that which he could have expected to receive in the community. Prison healthcare staff made an urgent referral to a hospital specialist when Mr Nolan first presented with his cancer symptoms, facilitated subsequent hospital visits and provided compassionate end of life care to Mr Nolan.

However, we are concerned that, although Mr Nolan asked prison staff to contact his family when his condition deteriorated shortly before he died, no one did so until after his death.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **December 2017**

Contents

Summary 1
The Investigation Process 2
Background Information 3
Findings 4

Summary

Events

1. On 23 November 2015, Mr Lawrence Nolan was sentenced to three years and four months in prison for sexual offences. He was moved to HMP Durham on 21 April 2016.

2. On 28 June, he told a prison GP that he was vomiting frequently. The GP examined him and referred him urgently to a specialist under the NHS pathway that requires a person suspected of cancer to be seen within two weeks.

3. On 8 July, Mr Nolan collapsed and was taken to hospital, where he was diagnosed with oesophageal cancer. Mr Nolan was given a feeding tube that carried food and medicine to his stomach through his nose. Following his return to Durham in August, prison healthcare staff arranged a liquid diet and a care plan. During September, prison staff arranged for Mr Nolan to attend hospital appointments to receive radiotherapy treatment.

4. In April 2017, Mr Nolan coughed up a large blood clot. Prison staff arranged for him to go to hospital for a review. Hospital staff advised that no further treatment was possible and they discharged Mr Nolan back to the prison.

5. In May 2017, Mr Nolan spent 13 days in a hospice for pain control and had surgery (where a stent was fitted to help food and drinks to pass to his stomach). His family and friends visited him in the hospice. On his return to Durham, healthcare staff continued with his pain relief.

6. At the beginning of June, Mr Nolan told nurses he was in severe pain. In consultation with hospital cancer specialists, prison heathcare staff adjusted his pain relief. Mr Nolan's condition deteriorated and he died on 10 June.

Findings

7. Mr Nolan was appropriately referred to a hospital specialist when he first presented with his cancer symptoms. Healthcare staff produced detailed care plans and managed Mr Nolan's conditions in consultation with specialists. Towards the end of his life, staff provided constant medical and social care. The clinical reviewer concluded that the standard of care Mr Nolan received at the prison was equivalent to that which he could have expected to receive in the community. We are satisfied that Mr Nolan received a good standard of care at Durham.

8. However, when Mr Nolan asked staff to contact his family when his condition deteriorated shortly before he died, no one did so. We make the following recommendation:

Recommendation

- The Governor should ensure that when a seriously ill prisoner asks for his or her next of kin to be contacted, prison staff do this as soon as possible.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Durham informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. The investigator obtained copies of relevant extracts from Mr Nolan's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Nolan's clinical care at the prison.

12. We informed HM Coroner for County Durham and Darlington of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. The investigator wrote to Mr Nolan's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked about the pain relief available and why she was not informed of the deterioration in her brother's condition.

14. The investigation has assessed the main issues involved in Mr Nolan's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

15. Mr Nolan's family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

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

Background Information

HM Prison Durham

17. HMP Durham is a local prison, serving the courts of Tyneside, Durham and Cumbria. It holds approximately 1,000 men. G4S provides primary healthcare. The prison's inpatient unit has six beds with 24-hour healthcare, and provides a regional service for HMP Durham, HMP Northumberland and HMYOI Deerbolt.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Durham was in October 2016. Inspectors reported that the provision of healthcare was reasonable, with some excellent mental healthcare. Primary care service was assessed as reasonably good and secondary care as very good. Inspectors found that the inpatient healthcare unit provided compassionate care in a good environment. Interactions between healthcare staff and prisoners were very good. Nurse-led clinics for lifelong conditions, such as asthma, diabetes and heart disease, did not take place due to staff shortages, although a senior nurse ensured that physical checks and referrals were made where necessary. External health appointments were well managed.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to October 2016, the IMB reported that the recruitment of nurses to the healthcare unit continued to be a significant issue, with agency nurses and overtime used as cover. Despite the staff shortages, primary care services delivered a good standard of care. The IMB noted that the unit was usually fully occupied, which caused a shortage of inpatient beds.

Previous deaths at HMP Durham

20. Mr Nolan was the seventh prisoner to die of natural causes at Durham since January 2016. There are no significant similarities between his death and the previous deaths.

Findings

The diagnosis of Mr Nolan's terminal illness and informing him of his condition

21. Mr Nolan was in poor health when he arrived at Durham. He had type 2 diabetes, lung cancer, heart disease and he smoked.

22. On 28 June 2016, he told a prison GP that he was frequently vomiting. The GP noted Mr Nolan had lost weight, weighing 67kg compared to having weighed 77kg on 12 March. He made an urgent referral to the hospital under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks.

23. On 8 July, Mr Nolan collapsed. A nurse attended. She noted that initially Mr Nolan was unresponsive and his iris appeared partially black. She arranged for paramedics to attend and they took Mr Nolan to hospital. While in hospital, Mr Nolan was diagnosed with oesophageal cancer.

24. The clinical reviewer was satisfied that Mr Nolan's initial care was of a good standard and the doctor appropriately made a referral for suspected cancer. We agree that the prison GP appropriately referred Mr Nolan to investigate his symptoms.

Mr Nolan's clinical care

2016

25. On 12 August, the hospital discharged Mr Nolan back to the prison. His medical records noted that hospital staff had diagnosed oesophageal cancer. Mr Nolan had been given a feeding tube in hospital and healthcare staff arranged for him to have a liquid diet and created a care plan to help him keep his feeding tube clear. The hospital prescribed pain relief, and high energy and protein drinks, which the healthcare staff gave to him.

26. The Northern Centre for Cancer Treatment at the hospital scheduled an outpatient appointment for 15 August. Mr Nolan attended his appointment and discussed his treatment options. The hospital consultant decided that Mr Nolan should start daily radiotherapy treatment in three to four weeks time.

27. A radiologist at the Northern Centre for Cancer Care at the hospital arranged for Mr Nolan to have radiotherapy every weekday for 22 days from 9 September. Prison staff arranged for him to attend his appointments. On 23 September, the prison appointed a Macmillan palliative care specialist to offer supportive care.

28. Healthcare staff contacted hospital dieticians and nutrionists for advice about suitable soft foods for Mr Nolan to have through his feeding tube. They made sure that when eating Mr Nolan did not cough, vomit or become unwell when feeding.

2017

29. On 11 April 2017, Mr Nolan coughed up a large amount of blood. A prison GP arranged for Mr Nolan's urgent admission to the Northern Centre for Cancer Care, as he suspected Mr Nolan had reached the final stages of his cancer.

30. In hospital, a gastroenterologist reviewed Mr Nolan and concluded that he was not suitable for further radiotherapy and he should have a follow up with the prison palliative care team. Mr Nolan said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect on 13 April.

31. Following his return to prison, prison GPs and healthcare staff checked Mr Nolan for discomfort, pain or coughing up blood and provided pain relief when required.

32. On 18 May, Mr Nolan told nurses he was in significant pain, which was not eased by paracetamol. A prison GP prescribed morphine and, as this did not help, prescribed oramorph, which eased his pain.

33. On 19 May, healthcare staff arranged for a palliative care consultant at a hospice to review Mr Nolan for assessment of symptoms and a management plan. Mr Nolan was in the hospice until 1 June. He received some medication through a syringe driver until surgeons inserted a stent (a flexible mesh tube inserted in the oesophagus to allow food and drink to pass from the mouth to the stomach).

34. At Durham, healthcare staff continued with the pain relief that Mr Nolan had received in the hospice. Mr Nolan asked for a heat pad for pain relief, which he had found useful when he was in the hospice and nurses were able to provide one for him.

35. A healthcare support worker noted on 7 June that Mr Nolan was in visible pain and coughing up green sputum. The Macmillan nurse assessed his pain score as 5 out of 10. Mr Nolan told her he felt distressed and was in constant pain. She prescribed a long acting morphine tablet and a saline nebuliser.

36. On 8 June at approximately 3.30am, Mr Nolan complained to a nurse that he was in terrible pain. She administered oramorph. At 4.32am, Mr Nolan told the healthcare support worker that he was still in unbearable pain and that in the morning he wanted someone to telephone his solicitor, as he wanted to be in hospital to receive care for his pain. At 6.05am, Mr Nolan was begging for pain relief. At 6.45am, a nurse issued him with more oramorph. At 12.00pm, the Macmillan nurse reviewed Mr Nolan and spoke to the oncall palliative care consultant, who advised that Mr Nolan could receive increased pain relief and also medication for anxiety.

37. Mr Nolan's condition deteriorated. Nurses administered pain relief. During the early hours of 10 June, the healthcare assistant noted that Mr Nolan was breathless, dizzy, with rolling eyes, a greyish complexion and he appeared confused. A nurse reviewed him and administered medication for pain relief and to ease his anxiety. Healthcare staff reassured him and gave him further pain relief. Later that morning at 9.20am Mr Nolan died.

38. The post-mortem report showed the cause of death as disseminated and locally advanced oesophageal squamous cell carcinoma (widely spread cancer, which

originated in his gullet). An indirect contributing factor was ischaemic heart disease.

39. We agree with the clinical reviewer that Mr Nolan received a good standard of end of life care. The prison's healthcare team gave Mr Nolan commendably well-coordinated and compassionate care, which was at least equivalent to that which he could have expected to receive in the community.

40. Prison doctors made appropriate referrals for further tests and assessments in line with national guidelines. Care plans were in place to manage Mr Nolan's medical conditions and he was able to attend his outpatient appointments. We are satisfied that healthcare staff offered appropriate support and advice to Mr Nolan throughout his treatment.

Mr Nolan's location

41. On 10 August 2016, the healthcare manager visited Mr Nolan in hospital. Mr Nolan told him he would like to return to his wing. However, as Mr Nolan had to use tube feeding he told him it would be better to be in healthcare.

42. Hospital staff discharged Mr Nolan to prison on 12 August and he was admitted to healthcare. Mr Nolan was able to return to his wing for brief periods but on 11 April 2017, to manage his pain and for frequent nurse observations, healthcare staff decided Mr Nolan should remain in healthcare. We are satisfied that Mr Nolan's location was appropriate throughout his illness.

Restraints, security and escorts

43. When prisoners have to travel outside the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public, but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

44. Mr Nolan had many hospital visits for radiotherapy and hospital consultant reviews. Prison managers completed escort risk assessments for his journeys and appropriately decided that he should not be handcuffed.

Liaison with Mr Nolan's family

45. The prison appointed a member of the chaplaincy team as the family liaison officer (FLO). Prison staff arranged for Mr Nolan's family and friends to visit him in the hospice in May 2017.

46. In the early hours of 10 June, healthcare staff noted Mr Nolan was restless. Mr Nolan asked healthcare staff to contact his family on his behalf so they could be present and his solicitor contacted. No one did this.

47. After his death, the prison appointed a prison officer as the Family Liaison Officer (FLO) and another officer as her assistant. She telephoned Mr Nolan's next of kin to tell her of his death.

48. Mr Nolan's sister rang healthcare staff and complained that other family members had been notified that Mr Nolan had died. The investigator asked the prison to check who was notified of his death. Their records showed that they had only contacted Mr Nolan's sister.

49. Mr Nolan's funeral was held on 29 June. The prison contributed to the costs, in line with national policy.

50. Prison Service Instruction (PSI) 64/2011, Safer Custody, requires that prisons should have arrangements to engage with the next of kin, or other nominated person, of prisoners who are either seriously or terminally ill. Prison Rule 22 also requires the governor to inform the prisoner's spouse or next of kin and "any person who the prisoner may reasonably have asked should be informed" when a prisoner is seriously ill.

51. We are concerned that when Mr Nolan specifically asked in the early hours of 10 June for someone to inform his family, no one did so. This meant that they did not have the opportunity to visit and spend time with Mr Nolan before his death. The clinical reviewer said that when Mr Nolan's end of life was imminent a visit may have offered comfort to both. We agree and make the following recommendation:

The Governor should ensure that when a seriously ill prisoner asks for his or her next of kin to be contacted, prison staff do this as soon as possible.

Compassionate release

52. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

53. There was no specific documentation stating that Mr Nolan was near end of life. However, prison staff were liaising with social services for a place in a nursing home as Mr Nolan was scheduled for release from prison two weeks after he died.

Prisons & Probation

Ombudsman

Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141