Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nigel Nolan a prisoner at HMP Standford Hill on 1 July 2019

A report by the Prisons and Probation Ombudsman

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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*

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Summary

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

3. Mr Nigel Nolan, who was 56 years old, died of bowel cancer on 1 July 2019 at HMP Standford Hill. We offer our condolences to Mr Nolan's family and friends.

4. The clinical reviewer noted Mr Nolan arrived into custody with a number of pre-existing medical conditions, namely type 2 diabetes and asthma. He considered that despite being regularly reviewed by healthcare staff and having his medications appropriately reviewed and adjusted, his diabetic care did not meet NICE (National Institute for Health and Care Excellence) guidelines. He also noted that it was not until after his arrival at Standford Hill, was there any mention in his medical records of a formalised care plan being put in place to manage those pre-existing conditions.

5. The clinical reviewer was also concerned that in December 2017, when Mr Nolan first complained of unexplained weight loss and rectal bleeding, a routine referral was made to secondary care providers, rather than a two week wait referral. This was also contrary to NICE guidance which states that anyone over the age of 50 experiencing unexplained rectal bleeding should be subject to a two week wait referral. Likewise, NICE guidance also states that anyone over the age of 40 experiencing unexplained weight loss, should also be subject to a two-week referral.

6. Having noted his concerns in respect of the management of Mr Nolan's pre-existing medical conditions, and his initial referral to secondary care, the clinical reviewer considers the care Mr Nolan received, particularly in Ford and Lewes, was not of the required standard, and therefore not equivalent to that which would have been received in the wider community.

7. We did not find any non-clinical issues of concern.

Recommendations

- The Heads of Healthcare at HMP Ford, Lewes and Standford Hill should review the policies currently in place in respect of chronic disease management, to ensure they adhere to NICE guidance.

- The Head of Healthcare at HMP Ford should review the policy around referral of suspected cancer to secondary care, and consideration of 2 week wait referrals, with reference to recommendations from NICE.

Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Nolan's clinical care at HMP Standford Hill.

9. The PPO has investigated the non-clinical issues in Mr Nolan's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

10. Mr Nolan repeatedly told prison staff that he did not have any next of kin, nor was there anyone he wished to have informed of his condition.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at Standford Hill

12. Mr Nolan was the fourth prisoner to die at HMP Standford Hill in the last two years. Two of the deaths were from natural causes and one was not investigated.

13. There are no similarities between our findings in the investigation of Mr Nolan's death and the other deaths.

Key Events

14. In November 1999, Mr Nolan was charged with murder and sentenced to life in prison, with a minimum tariff to serve of 14 years. He was sent to HMP Whitemoor. He later transferred to Ford and Lewes prisons before finally moving to HMP Standford Hill on 23 March 2019.

15. After experiencing unexplained weight loss and rectal bleeding in December 2017 while at Ford, Mr Nolan was referred to secondary care providers for further review. Following a series of tests, he was diagnosed with bowel cancer in July 2018 and underwent courses of both chemotherapy, and radiotherapy, as part of his treatment plan.

16. However, on 12 February 2019, hospital staff told Mr Nolan his cancer was terminal and the only treatment option left open to him was palliative care.

17. On 21 June, when hospital staff confirmed he had a prognosis of less than three months to live, an application was made on Mr Nolan's behalf for him to be released on compassionate grounds.

18. Mr Nolan was moved to Wisdom Hospice, Rochester, on 27 June to receive end of life care. He was accompanied by a prison officer in civilian clothing.

19. Mr Nolan's condition continued to deteriorate, and at 6.11pm on 1 July 2019, he died. At 8.08 pm, a doctor at the hospice confirmed Mr Nolan's death.

20. A post-mortem examination gave the cause of death as disseminated bowel carcinoma (bowel cancer that has spread to other areas the body).

Lisa Burrell **March 2020**
Assistant Ombudsman