Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Nichols, a prisoner at HMP Whatton, on 23 January 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

T l 020 7633 4100

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 31 July 2007, Mr Brian Nichols received an indeterminate public protection sentence for making indecent photographs of children. He was recalled to prison on 17 February 2016 for breaching his licence. He died from pulmonary emboli (when blood clots block a blood vessel in the lungs) on 23 January 2024 while a prisoner at HMP Whatton. This was caused by deep vein thrombosis (when a blood clot forms in a deep vein in the body) and the pathologist noted that it was a sudden and unexpected death. Mr Nichols was 65 years old. We offer our condolences to his family and friends.

4. The PPO family liaison officer wrote to Mr Nichols' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer to review Mr Nichols' clinical care at HMP Whatton.

6. As part of our investigation, the PPO investigator and the clinical reviewer conducted interviews with two members of healthcare staff and the Head of Healthcare.

7. The clinical reviewer concluded that the clinical care Mr Nichols received at HMP Whatton was of a good standard overall and was equivalent to that which he could have expected to receive in the community. The clinical reviewer made two recommendations which are not related to Mr Nichols' death but which the Head of Healthcare will want to address.

8. The PPO investigator investigated the non-clinical issues relating to Mr Nichols' care.

9. We did not identify any significant non-clinical learning and we make no recommendations.

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

11. Mr Nichols' family received a copy of the draft report. They did not make any comments.

12. At the inquest held on 26 September 2024, the coroner concluded that Mr Nichols died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

October 2024

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