Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jason Thaxter, a prisoner at HMP Whitemoor, on 15 August 2023

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

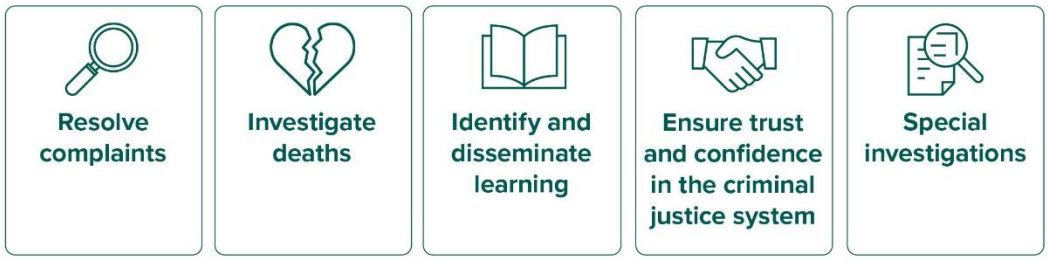
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 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

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.

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.

Mr Jason Thaxter died after being found hanged in his cell at HMP Whitemoor on 15 August 2023. He was 46 years old. I offer my condolences to his family and friends.

I have concluded that Mr Thaxter gave no obvious indication to staff that he was at risk of suicide. However, in the months leading up to his death, Mr Thaxter spent frequent periods of the day confined to his cell due to the restricted regime in place at Whitemoor. We found no evidence that staff attempted to engage in meaningful conversation with him during these periods and, as a result, opportunities to properly assess the risk he posed to himself were missed. Regrettably, as with other prisons, staff shortages and restricted regimes remain an issue at Whitemoor. I am satisfied that the prison is taking reasonable steps to tackle this issue.

Both illicit drugs and medication which had not been prescribed to him were found in Mr Thaxter's system after he died. Whitemoor is taking active steps to tackle drug supply and I make no further recommendation.

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

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

Contents

Summary

Events

1. In August 2015, Mr Jason Thaxter was remanded into custody, charged with murder. In December 2016, he was convicted and sentenced to life imprisonment, with a tariff (minimum time he would spend in prison) of 28 years.

2. Between 2015 and 2018, Mr Thaxter was monitored under Prison Service suicide and self-harm support procedures, known as ACCT, on two occasions.

3. On 17 September 2020, Mr Thaxter transferred to HMP Whitemoor. He told a nurse about his history of substance misuse but said that he did not want any substance misuse support.

4. From July 2021, Mr Thaxter complained of foot pain and was seen by healthcare staff. He refused to attend hospital for further investigation. In March 2023, Mr Thaxter tested positive for synthetic cannabinoids, but again said that he did not want any help from the substance misuse service.

5. In April, Mr Thaxter told a GP that he had used PS as pain relief for his foot. He continued to refuse hospital or see a specialist.

6. On 10 July, the prison received information that Mr Thaxter was frustrated with the cleanliness of the wing and the current restricted regime (which meant many prisoners were locked in their cells for most of the day without access to work, education, or purposeful activity).

7. On 15 August at 12.03pm, officers arrived at Mr Thaxter's cell to give him his lunch. They found Mr Thaxter suspended by a ligature from his window. A code blue medical emergency (used when a prisoner is unconscious or having breathing difficulties) was called immediately, and the control room alerted the emergency services. Prison staff removed the ligature and started CPR which healthcare staff continued. Mr Thaxter had signs of rigor mortis. When the paramedics arrived, they assessed Mr Thaxter, and continued resuscitation attempts.

8. At 12.51pm, an air ambulance crew arrived and confirmed that there were clear signs of rigor mortis present. They immediately ceased CPR and, at 12.54, pronounced that Mr Thaxter had died.

Findings

9. We have concluded that Mr Thaxter gave no obvious indication to staff that he was at risk of suicide and that staff could not have foreseen his actions. However, in the months before he died, staff interactions with Mr Thaxter were minimal, and as a result, there were few opportunities to properly assess the risk he posed to himself. More meaningful interactions, including when there was evidence that Mr Thaxter was unhappy about aspects of life at Whitemoor, and regular keywork sessions may have identified possible risk factors to suicide and self-harm and built a more accurate picture of the risk Mr Thaxter posed to himself.

10. We found that Whitemoor was unable to deliver a consistent regime due to staff shortages. Prisoners had limited access to purposeful activity and those we spoke to were increasingly frustrated with spending extended periods of time locked in their cells. We do, however, also recognise the challenges faced by prison leaders when staffing resources are constrained. In common with many prisons, staff retention is an ongoing issue that Whitemoor must continually navigate. We found that since Mr Thaxter's death, Whitemoor has taken reasonable and positive measures to recruit and retain staff. This has enabled the delivery of a more consistent regime and has improved access to purposeful activity, work, and education.

11. The clinical reviewer found that the clinical care Mr Thaxter received at Whitemoor was of a satisfactory standard and was partially equivalent to that which he could have expected to receive in the community. The clinical reviewer did not consider that the aspect of healthcare he received that was not equivalent was relevant to his death.

12. We make no recommendations.

The Investigation Process

13. The Prisons and Probation Ombudsman (PPO) was notified of Mr Thaxter's death on 15 August 2023.

14. The investigator issued notices to staff and prisoners at HMP Whitemoor informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners responded.

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

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

17. The investigator interviewed eight members staff at Whitemoor in September 2023, some jointly with the clinical reviewer. In April 2024, the investigation was reallocated to another investigator.

18. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. He provided us with a copy of the post-mortem and toxicology reports. We have sent the Coroner a copy of this report.

19. The Ombudsman's office contacted Mr Thaxter's next of kin, his daughter, to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but asked for a copy of this report.

20. Mr Thaxter's family received a copy of the draft report. They did not make any comments.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed some pronoun inaccuracies, and this report has been amended accordingly.

Background Information

HMP Whitemoor

22. HMP Whitemoor is a long-term high security prison which holds sentenced category A and category B prisoners. Physical and mental healthcare are provided by Northamptonshire Healthcare NHS Foundation Trust. Substance misuse services are provided by Phoenix Futures.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Whitemoor was in December 2022. Inspectors reported a decline in the overall rating of the prison since their last inspection in 2017. Staffing shortfalls were a factor in this decline, and shortages remained much higher than in most prisons. Inspectors raised concerns that wing staff made little effort to develop effective relationships with prisoners on the two main wings, and inspectors frequently observed staff congregating in offices rather than engaging with prisoners. Although inspectors assessed there to be adequate staff on these residential units, not all used their available time to interact and assist prisoners, most of whom remained locked up.

24. Inspectors found that leaders and managers had not established a predictable regime in which all prisoners consistently attended their allocated activity. Neither staff nor prisoners could explain the daily regime to inspectors, so there was no clarity on what was supposed to be happening. Limited interventions and a lack of purposeful activity made it difficult for prisoners to demonstrate a reduction in risk, and much-reduced time out of cell contributed to dirty conditions as well as limited access to healthcare, key work and offender management.

25. HM Chief Inspector reported that the wings at Whitemoor were the dirtiest he had seen since coming into post. He noted that there was excess rubbish lying around and bins were overflowing. The rigidity of the regime meant that cleaners were unlocked for as little as an hour a day, which did not give them enough time to do their job.

Independent Monitoring Board

26. 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 annual report for the year 2022 to 2023, the IMB reported continuing staff shortages, which made it hard to revert to pre-Covid normality. Long-term sickness, maternity leave, temporary promotions, training and secondments meant that there were around 110 vacancies on a daily basis. Time out of cell and purposeful activities were therefore restricted. Prisoners felt somewhat adrift, and some had lost confidence in making progress at Whitemoor.

Previous deaths at HMP Whitemoor

27. Mr Thaxter was the fifth prisoner to die at Whitemoor since 1 August 2020. Three of the previous deaths were from natural causes and one was drug related. There

were no similarities between our findings in the investigation into Mr Thaxter's death and these previous deaths.

Assessment, Care in Custody and Teamwork

28. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

29. As part of the process, a care plan (plan of care, support and intervention) is put in place. The ACCT should not be closed until all the actions on the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison.

Key Events

Background

30. Mr Jason Thaxter had a history of offending related to his drug misuse. In August 2015, Mr Thaxter was charged with murder and remanded to HMP Doncaster. In December 2016, Mr Thaxter was convicted and sentenced to life imprisonment with a tariff (minimum time he would spend in prison) of 28 years. He returned to Doncaster.

31. Mr Thaxter was prescribed Naproxen (anti-inflammatory pain relief) from 2017 onwards as a result of pain from injuries sustained in a car accident in 2015. In May 2018, Mr Thaxter transferred to HMP Frankland. A few months later, he transferred to HMP Dovegate, where he remained until he transferred to HMP Whitemoor in September 2020.

32. Prison records show Mr Thaxter was monitored under Prison Service suicide and self-harm monitoring and support procedures, known as ACCT, on two occasions. The first occasion was in 2015 after he made cuts to his arm while at court. This ACCT was closed within one day. The second time was in 2018 when Mr Thaxter self-harmed in the prison transfer van as he said he did not want to be moved from Doncaster. Again, this ACCT was closed shortly afterwards.

33. Prior to being moved to Whitemoor, Mr Thaxter was found to be under the influence of illicit substances (psychoactive substances) on multiple occasions. He was supported by prison substance misuse services although his engagement was intermittent.

HMP Whitemoor

34. On 17 September 2020, Mr Thaxter transferred to HMP Whitemoor. He told a nurse about his history of substance misuse but said that he did not want any substance misuse support.

35. In July 2021, a podiatrist (a foot specialist) saw Mr Thaxter after he reported pain in his foot. She carried out treatment and gave Mr Thaxter some supporting insoles for his shoes. Over the next six months, Mr Thaxter attended regular appointments with the podiatrist but said that his pain was not improving. Healthcare staff referred him to see a physiotherapist.

36. In January 2022, a physiotherapist reviewed Mr Thaxter's ongoing pain. He told Mr Thaxter that he needed a specialist X-ray at hospital to diagnose the cause of the pain. A few days later, a nurse saw Mr Thaxter to complete an X-ray questionnaire prior to his appointment. Mr Thaxter refused to complete the questionnaire and said he did not want to attend hospital.

37. Over the next year, Mr Thaxter continued to be monitored by the podiatrist and was encouraged to attend hospital for further investigation into his foot pain. Mr Thaxter continued to say that he did not want to attend hospital and would manage his symptoms within the prison.

38. On 9 March 2023, an officer found Mr Thaxter unconscious on the floor of his cell surrounded by vomit. The officer radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Staff responded and suspected that Mr Thaxter was under the influence of an illicit substance. A nurse assessed him and told staff to complete 15-minute welfare checks. Officers removed a suspicious vape that appeared to have been tampered with, referred him to the substance misuse services (SMS) and arranged for Mr Thaxter to have a mandatory drugs test (MDT).

39. The next day, Mr Thaxter completed the MDT which was positive for synthetic cannabinoids. On 13 March, a substance misuse practitioner saw Mr Thaxter after receiving the SMS referral. They tried to engage him, but Mr Thaxter said that he did not want any help from the SMS and did not want any harm reduction advice. The same day, a GP assessed Mr Thaxter's ongoing pain in his foot. Mr Thaxter said he had used illicit drugs as pain relief and asked for stronger pain medication. The GP warned Mr Thaxter about the risks associated with taking PS, which Mr Thaxter said he understood. The GP prescribed him Nefopam (a strong pain medication).

40. On 19 April, a nurse told Mr Thaxter that Nefopam was no longer prescribed to him. This was due to the drug being discontinued within prisons for its potential to interfere with the results of MDTs. The nurse suggested that Mr Thaxter should attend a hospital appointment, where a specialist would be able to help establish the cause of his pain. Mr Thaxter again said he did not want to go. The nurse said that he should discuss his pain management needs with the GP and take standard pain relief in the meantime. Mr Thaxter declined both options.

41. On 20 April, staff submitted an intelligence report to say that Mr Thaxter felt his health issues were not being treated appropriately and that he may seek out illicit drugs to cope with his pain. There is no evidence that this information was shared with the healthcare team. We do not know where the information came from and there is no evidence in Mr Thaxter's prison file that staff discussed his concerns with him.

42. In May 2023, Mr Thaxter's prescription of Naproxen (which he had been allowed to keep in his cell) was stopped. It is not clear why, nor does there appear to have been a discussion with him about it.

43. From 28 April to 28 June, Mr Thaxter submitted several applications to the healthcare team for various unrelated health concerns. Staff made him several appointments to see a GP and a podiatrist, but he did not attend any of these.

44. On 15 June, staff submitted an intelligence report to say that a number of prisoners on B wing, including Mr Thaxter, were under the influence of an illicit substance. Staff noted that there was insufficient evidence to suggest which substance was being misused. There is no evidence of any action being taken as a result of this intelligence report.

45. On 10 July, staff submitted an intelligence report that Mr Thaxter was frustrated with the cleanliness of the wing and the current regime. The information noted that Mr Thaxter wanted to protest by climbing on the netting (between wing landings) or damaging his cell. The report does not indicate where this information came from

and there is no evidence that staff spoke directly to Mr Thaxter about his frustrations.

46. On 7 August, staff believed Mr Thaxter was under the influence and therefore did not permit him to attend work in the kitchens. He was given a warning and a MDT was arranged.

47. On 10 August, Mr Thaxter refused to complete the mandatory drugs test. He was charged with disobeying a lawful order and an adjudication was scheduled.

48. On the evening of 14 August, an officer completed routine check of prisoners on B-wing. At approximately 7.20pm, she noted that Mr Thaxter was sat on his chair, in his single cell, watching television. Mr Thaxter was not subject to any checks overnight and he did not press his emergency cell bell. He had not had any social visits while at Whitemoor and his last telephone call had been on 28 July.

Events of 15 August 2023

49. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to prison radio transmissions from 15 August. She also obtained information from the East of England Ambulance Service. The following account has been taken from all sources.

50. On 15 August at approximately 7.00am, an officer completed a routine check on B-wing. At interview, he said that Mr Thaxter was asleep in his bed and that he saw nothing that caused him concern. He was not required to be checked again until lunchtime.

51. At 12.03pm, officers arrived at Mr Thaxter's cell to give him his lunch. Officer A opened the observation panel but could not immediately see Mr Thaxter, so he asked Officer B to stay with him whilst he entered Mr Thaxter's cell. At 12.05pm, he went into the cell and saw what he believed to be Mr Thaxter standing at his window, with the curtain drawn across him. As Officer A was getting no verbal response from Mr Thaxter, he pulled back the curtain and saw that Mr Thaxter was suspended by a ligature made from a shoelace from his window bars. He said that Mr Thaxter felt cold and stiff, so he immediately shouted, "code blue" while simultaneously cutting through the ligature and lowering Mr Thaxter to the floor. At 12.06pm, Officer B radioed a code blue to alert the control room to call an ambulance.

52. Moments later, additional officers arrived at Mr Thaxter's cell and a Custodial Manager (CM) began giving chest compressions. In his statement, the CM told us that he did not believe Mr Thaxter was alive, as he was showing signs of rigor mortis (his arms were rigid and dark black from the elbows down, and his legs were bent at the knee).

53. At 12.07pm, several nurses arrived at Mr Thaxter's cell and told staff to move Mr Thaxter onto the wing landing. The nurses applied a defibrillator (a device that gives shocks to the heart to restore a normal heartbeat) and continued resuscitation attempts. At interview, a nurse told us that Mr Thaxter was showing clear signs of death which included the pooling of the blood and the presence of mottled skin.

54. At 12.20pm, a GP arrived at Mr Thaxter's cell. At 12.26pm, two paramedics arrived, shortly followed by four members of staff from Cambridgeshire Fire and Rescue Service. The paramedics continued resuscitation attempts, assisted by the Fire Service.

55. At 12.31pm, a doctor and critical care paramedic from the air ambulance service arrived. At 12.51pm, they got to Mr Thaxter. Their notes confirm that there were clear signs of rigor mortis present and resuscitation attempts were futile. They immediately ceased CPR and at 12.54pm, pronounced that Mr Thaxter had died. (The prison was unable to explain why it had taken 20 minutes for the advanced medical team to reach Mr Thaxter's cell.)

Contact with Mr Thaxter's family

56. At 4.30pm, Family Liaison Officers (FLO) travelled to Mr Thaxter's next of kin's address (his daughter). When the FLOs arrived at the address, neighbours told them that Mr Thaxter's daughter no longer lived there. South Yorkshire Police provided an updated address, but when the FLOs arrived they found that Mr Thaxter's daughter had also moved on from there. At 8.32pm, the FLOs located Mr Thaxter's daughter as she had rung the prison after neighbours told her staff were looking for her. They met her at her home address and offered their condolences.

57. The prison contributed to the cost of Mr Thaxter's funeral in line with national guidance.

Support for prisoners and staff

58. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

59. After Mr Thaxter's death, a senior prison manager held a debrief and those involved in the emergency response were given the opportunity to discuss any issues arising. They were also offered support by the staff care team and signposted to support services available to them.

60. The prison posted notices informing other prisoners of Mr Thaxter's death and offering support. They ensured that Listeners were available on the wing to support prisoners.

Post-mortem report

61. The post-mortem concluded that Mr Thaxter died from suspension by ligature (hanging).

62. Toxicological analysis of post-mortem blood showed evidence of recent use of the psychoactive substance ‘Spice’ (a synthetic cannabinoid). The pathologist noted that smoking PS can cause adverse health effects including agitation, delirium, hallucinations, and shortness of breath. These effects can start within minutes and intoxication can last up to five hours.

63. The pathologist also noted the presence of Naproxen in Mr Thaxter’s system. Mr Thaxter had been prescribed this on a long-term basis in his possession previously, most recently in May 2023. Naproxen is not a drug that can easily be misused or is regularly diverted or traded within prisons. The pathologist found that the quantity of Naproxen found in Mr Thaxter’s system was not likely to have directly contributed to his death.

Findings

Management of Mr Thaxter's risk of suicide and self-harm

64. Prison Service Instruction (PSI) 64/2011, Safer Custody, lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under Assessment, Care in Custody and Teamwork (ACCT) procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making.

65. Mr Thaxter had some recognised risk factors for suicide, including a history of substance misuse, some history of self-harm and he was serving a long sentence. On the face of it, Mr Thaxter gave no obvious indication to staff that he was at risk of suicide. However, on two occasions in the months before his death, staff submitted intelligence reports suggesting that Mr Thaxter might be finding it harder to cope at Whitemoor. We were surprised that this information was dealt with by way of intelligence reports and that there was no evidence that anyone sought to speak to Mr Thaxter directly to understand his concerns or provide support.

66. We found that, in the months prior to his death, staff interactions with Mr Thaxter were minimal and as a result, there were few opportunities to properly assess the risk he posed to himself. We found infrequent entries in his prison record with gaps of several months at a time. The quality of these entries was poor, with no evidence of any meaningful conversations. More regular and meaningful interactions may have identified possible risk factors to suicide and self-harm and alerted staff to when this risk was increased.

Keywork

67. The keywork model aims to improve safety in prisons by promoting better relationships between staff and prisoners. Officers are trained to develop constructive, motivational, and supportive relationships with prisoners through regular one-to-one keywork sessions. These sessions give the prisoner the opportunity to raise any concerns they may have and be signposted to appropriate support services.

68. In common with some other prisons, the key work scheme had not been operating as it should at Whitemoor due to staff shortages. Whitemoor told us that keywork was limited to those in 'priority keyworker groups' (including prisoners on ACCTs and those in segregation). Mr Thaxter was not in any of these groups and as such, had just a single key work session in over seven months. Regular key work sessions may have enabled staff to recognise signs of deterioration in his wellbeing, would have provided an opportunity to discuss the content of the intelligence reports with him and might have built a more accurate picture of the risk he posed to himself.

69. Since Mr Thaxter's death, the expectation is that every prisoner at Whitemoor should have access to one keywork session per month, with those in priority

keyworker groups receiving two sessions. However, we were told that, due to continued staff shortages, Whitemoor are not always able to fulfil this expectation. We accept that the Governor is trying to improve the key work provision at Whitemoor but that this remains a challenge until staffing levels are sufficiently stable. We make no recommendation, but the Governor will want to continue to monitor the provision.

Regime

70. Prior to Mr Thaxter's death, we found frequent use of the 'red regime', a type of regime used when staff resources have fallen below the locally agreed minimum and only basic activities and services can be delivered. These restrictions mean prisoners have less access to purposeful activity (such as education and work) and can be locked up for most of the core day. This can lead to increased boredom, frustration, and a sense of hopelessness amongst prisoners.

71. There was evidence that Mr Thaxter was becoming increasingly frustrated by the prison's restricted regime. One month before his death, the prison received information suggesting that Mr Thaxter planned to protest about the cleanliness of the wing and the restricted regime. After Mr Thaxter's death, a prisoner told us that Mr Thaxter had spoken to him about his frustrations about being locked in his cell, and how this was negatively affecting his wellbeing. The prisoner went on to say that he felt the red regime was having a profound effect on many prisoners' mental health, substance misuse and general wellbeing.

72. We spoke to the Governor about the limited regime and the impact this was having on prisoners and staff. She explained that staff shortages since the COVID-19 pandemic had a chronic impact on the prison's ability to provide a consistent regime. In July 2023, a more tightly controlled regime plan was put in place which consisted of three regime levels; red (basic delivery of services), amber (reduced delivery of services and green (full delivery of services), with the type of regime delivered being staff-level dependent. She said that since the death of Mr Thaxter, staff retention had improved, and the prison was recruiting more staff than they were losing to resignations.

73. Additionally, Whitemoor was being supported by staff on 'detached duty' (where officers are temporarily deployed to other prisons in need of support) which increased staffing levels and allowed for a more consistent regime delivery. The Governor told us that the detached staff were generally more experienced officers who had been able to give the less experienced Whitemoor officers additional confidence, support, and guidance. Although the prison still had red regime periods, these were less frequent, and the additional staffing had meant there had been improvements in getting prisoners engaged with work and purposeful activity.

74. We acknowledge the pressures faced by prison leaders in running a consistent, safe and decent prison regime when faced with staffing constraints, and we acknowledge that in these instances, staff resources are reserved for the most vulnerable and risky prisoners. We found that Whitemoor had made reasonable and positive steps to recruit and retain staff since Mr Thaxter's death and for this reason, we make no recommendation, although clearly this is an issue that both the Governor and the Executive Director for the long term and high security estate will want to keep a close eye on.

Drug supply and support at Whitemoor

75. Mr Thaxter had a history of drug misuse. When he arrived at Whitemoor in 2020, he told a nurse that he did not have problems with substance misuse and did not want help from the substance misuse service. Despite being found under the influence numerous times, Mr Thaxter continued to refuse substance misuse intervention at Whitemoor. The post-mortem found that he had recently used synthetic cannabinoids and also had Naproxen in his system which he had been previously prescribed but which he should have stopped taking in June 2023.

76. In common with many prisons, drug supply and demand are constantly evolving at Whitemoor. The methods used to traffic drugs into prisons are becoming increasingly harder to detect and as a result, require an ever more proactive approach. We spoke to the Head of Security about the supply and demand of drugs at Whitemoor. As a high security prison, Whitemoor has enhanced security measures in place which help to reduce the supply of drugs into the prison. This includes the use of enhanced gate security measures, X-ray machines, body scanners, stringent monitoring of visits, and advanced drug testing equipment. Additionally, the Head explained that their drug strategy is a live document which is discussed and updated at a multi-disciplinary monthly meeting. This enables new threats to be identified, information to be shared, and for appropriate actions to be taken to disrupt the supply and demand of drugs at Whitemoor.

77. The Head of Security told us that PS is the most common drug entering the prison as it can easily be melted onto paper and sent in via the prisoners' mail. Due to this, the prison swabs every letter that enters the prison and those that show any traces of PS are confiscated, with the prisoner receiving a photocopied version. This is helping to reduce the amount of PS available in the prison. However, it does still enter via other means. Due to staff shortages, the prison is unable to complete as many drug tests and searches as they would like, although this is increasing as staff levels improve. We note that Mr Thaxter was considered to be under the influence of drugs on several occasions but underwent only one MDT (and refused another).

78. We are satisfied that the prison continues to make efforts to combat drug supply and demand. We therefore make no recommendation.

Clinical care

79. The clinical reviewer found that the care Mr Thaxter received at Whitemoor was of a satisfactory standard and was partially equivalent to that which he could have expected to receive in the community.

80. Mr Thaxter told a GP that he was using PS to cope with foot pain. However, the clinical reviewer found that Whitemoor was responsive to Mr Thaxter's pain management needs. He noted that Mr Thaxter frequently declined to attend hospital appointments and was unwilling to discuss any alternative pain management treatment options.

81. The areas of non-equivalence found by the clinical reviewer relate to the inappropriate use of CPR as well as other issues unrelated to Mr Thaxter's death, which the Head of Healthcare will wish to address.

Governor and Head of Healthcare to Note

Emergency response

82. Both prison staff and nurses performed CPR on Mr Thaxter when he was found unresponsive, despite them all noticing clear signs of death. Paramedics also continued CPR which was not stopped until air ambulance paramedics arrived and immediately pronounced Mr Thaxter dead, 45 minutes after CPR started.

83. The European Resuscitation Guidelines 2015 state that resuscitation is inappropriate when there is clear evidence that it will be futile. We bring this to the Head of Healthcare's attention.

84. We are satisfied that upon arrival at Whitemoor, the initial paramedic responders were escorted to the wing in a timely manner. However, there was a delay of approximately 20 minutes from the air ambulance paramedics arriving at the prison to arriving on the wing. The prison could not explain the reason for the delay. Although this did not affect the care Mr Thaxter received and did not change the outcome for him, we are concerned that a similar delay could affect the outcome for someone in a life-threatening condition, in need of urgent medical care. The Governor will want to review this delay and consider their security measures to ensure paramedics have timely access to a patient in a medical emergency.

Inquest

85. The inquest into Mr Thaxter's death finished on 5 November 2025. It concluded that Mr Thaxter died as a result of suicide.

Prisons & Probation Ombudsman
Independent Investigations

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

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

T I 020 7633 4100