Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Delphon Nicholas, a prisoner at HMP Whitemoor, on 21 March 2021

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

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.

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

Mr Delphon Nicholas died in hospital on 21 March 2021, after being found unresponsive in his cell at HMP Whitemoor three days before. The post-mortem examination found that he died from cocaine toxicity. He was 41 years old. I offer my condolences to Mr Nicholas's family and friends.

Mr Nicholas had a history of taking illicit drugs in prison and was also suspected of being involved in drug supply. I am satisfied that the prison took appropriate action when they found Mr Nicholas under the influence of drugs or in possession of illicit items and that he was offered support. I am also satisfied that the prison is doing what it can to tackle the supply of drugs generally.

Mr Nicholas asked to see a nurse during the early hours of 18 March. When the nurse arrived, Mr Nicholas asked to be taken to the healthcare unit but did not say why. The nurse assessed that Mr Nicholas was not acutely unwell or under the influence of drugs, but he did not go into Mr Nicholas's cell to assess him. I am concerned that the nurse did not properly assess Mr Nicholas before making the decision that he did not need medical attention.

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

Sue McAllister CB
Prisons and Probation Ombudsman **February 2022**

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Summary

Events

1. Mr Delphon Nicholas was sentenced to life imprisonment for murder in October 2008. On 17 April 2017, he was moved to HMP Whitemoor.

2. Mr Nicholas had a history of drug use in prison. Records show that Mr Nicholas was seen under the influence of illicit drugs on numerous occasions and was suspected of supplying and dealing drugs at Whitemoor.

3. On 14 March 2021, Mr Nicholas returned to A Wing after a period in the Segregation Unit. Prison intelligence suggests he sought drugs from other prisoners on his return to the wing.

4. At around 4.30am on 18 March, Mr Nicholas rang his cell bell and slipped a note under his door asking to see a nurse. When staff responded, he told them that he wanted to move to the healthcare unit but would not say why. Staff called for a nurse. The nurse assessed Mr Nicholas through the cell door. He said Mr Nicholas appeared agitated, but did not look unwell, and, as he refused to say why he wanted to move to the healthcare unit, the nurse advised that managers should leave him in his cell until he could apply for a move later that morning.

5. Mr Nicholas continued to press his cell bell asking to see a nurse, but between 6.02am (when he last pressed his cell bell) and 7.30am, he was quiet. When an officer responded to his cell bell at 7.39am, he was lying on his bed and appeared to be asleep. The officer knocked on the door and called to Mr Nicholas but got no response. She asked another officer to check on him. The officer looked through the cell observation panel. He said he saw the rise and fall of Mr Nicholas's chest and heard him snoring.

6. At around 8.30am, when the day nurses arrived on A Wing, they checked on Mr Nicholas. He was sitting on the floor, leaning on his bed, with his head down. They were unable to get a response from him, so staff went into his cell. Mr Nicholas appeared to be asleep as he was snoring, but he was unresponsive. Staff called a medical emergency code at 8.28am and gave Mr Nicholas oxygen. Paramedics arrived at 8.44am. By 9.52am, Mr Nicholas was unable to breathe on his own. He was taken to hospital by air ambulance, but died three days later, on 21 March.

7. Mr Nicholas's post-mortem report concluded he had died from cocaine toxicity.

Findings

8. We are satisfied that the prison acted appropriately in response to Mr Nicholas's drug use and that it is taking steps to tackle drug supply.

9. We consider that the nurse should have gone into Mr Nicholas's cell and assessed him properly when he asked to be taken to the healthcare unit during the early hours of 18 March. The clinical reviewer was concerned that the nurse took no physical observations to support his decision that Mr Nicholas did not need medical attention.

10. The nurse also failed to update Mr Nicholas's medical record until he returned to work that evening, by which time Mr Nicholas was in hospital.

11. Managers did not hold a debrief after the medical emergency on 18 March.

Recommendations

- The Head of Healthcare should ensure that nurses carry out an appropriate assessment of a prisoner who appears unwell or agitated, including going into their cell to allow a more thorough assessment.
- The Head of Healthcare should ensure that all staff are aware of the requirement to maintain full and contemporaneous healthcare records.
- The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with him.
- The Governor and Head of Healthcare should ensure that all staff know that heavy snoring may be a sign of a drug overdose.
- The Governor should ensure that the managers consider holding a debrief after all traumatic incidents, including serious medical emergencies.

The Investigation Process

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

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

14. NHS England commissioned a clinical reviewer to review Mr Nicholas's clinical care at the prison. The investigator interviewed nine members of staff. Some interviews were conducted jointly with the clinical reviewer. The interviews were completed by video and telephone due to the restrictions imposed by the COVID-19 pandemic.

15. We informed HM Coroner for Cambridgeshire and Peterborough District of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Nicholas's family to explain the investigation and ask if they wanted to raise any issues. They asked the following questions:

    - What caused Mr Nicholas's death?
    - What time was he last seen or checked?
    - What time did Mr Nicholas press his cell bell and what was the response?
    - Was any drug paraphernalia found in his cell?
    - How are drugs getting in to Whitemoor and what is being done about it?
    - What help is there for prisoners found under the influence of illicit drugs?

17. The family's solicitor asked whether the PPO were aware of a police investigation into illicit drugs at Whitemoor. These questions are addressed in this report and the clinical review.

18. We shared our initial report with HM Prison and Probation Service (HMPPS). They raised two factual inaccuracies, one of which has been corrected in this report.

19. We provided Mr Nicholas' next of kin with a copy of our initial report. Their solicitor raised a number of issues that have been addressed separately.

Background Information

HMP Whitemoor

20. HMP Whitemoor is a high security prison, which holds around 450 men serving long sentences. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services and Phoenix Futures provides substance misuse services.

HM Inspectorate of Prisons (HMIP)

21. The most recent full inspection of Whitemoor was in March 2017. Inspectors found prisoners could obtain illicit drugs and alcohol easily. Staff carried out a low number of mandatory drug tests and there was an emerging problem of psychoactive substances (PS) in the prison. However, the prison was aware of its challenges and was managing it appropriately.

22. HMIP found support for prisoners with substance misuse issues was adequate, but not as good as it had been.

23. In July/August 2020, HMIP carried out a Scrutiny Visit (a shortened inspection to report on treatment and conditions during the COVID-19 pandemic). Inspectors reported that managers and staff had worked hard to deliver a limited regime during the pandemic, which was better than that currently offered at most other establishments they had visited. Good partnership work meant that key health services, including access to nurses, the GP and mental health support, continued. However, the range of substance misuse psychosocial services provided by Phoenix Futures had been diminished as a result of the pandemic. All groups had been suspended, and a reduced team had come into the prison, with others shielding and working offsite. At the time of the visit the prison had not yet been able to reintroduce suspicion drug testing, which could have helped with disrupting drug supply, and the amount of drug-impregnated mail entering the prison had increased in July.

Independent Monitoring Board

24. 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 31 May 2020, the IMB reported that the number of intelligence-led drug tests had increased, and the prison was now achieving its monthly drug test target. The IMB was concerned about the prevalence of psychoactive substances (PS) and cannabis at Whitemoor.

Previous deaths at HMP Whitemoor

25. Mr Nicholas was the fifth prisoner at Whitemoor to die since March 2019. Three of the previous deaths were due to natural causes and one was self-inflicted. We have previously made a recommendation about healthcare record keeping.

Key Events

26. In October 2008, Mr Delphon Nicholas was sentenced to life imprisonment for murder, with a 30-year tariff. He was moved to HMP Whitemoor on 17 April 2017.

27. Mr Nicholas had a history of taking illicit drugs in custody and in the community.

28. On 6 October, Mr Nicholas tested positive for psychoactive substances (PS). Staff advised him how to reduce the risk of harm of taking illicit drugs and alcohol. Mr Nicholas said he had previously taken cocaine, PS and ecstasy. He agreed to work with healthcare staff to address cannabis use, but later chose not to do so.

2018-2020

29. Prison records show that between 2018 and 2020, Mr Nicholas's behaviour was disruptive, and intelligence suggested he was arranging for drugs to be brought or sent into Whitemoor, taking illicit drugs himself and supplying drugs to other prisoners. Staff found that Mr Nicholas had mobile telephones, chargers and SIM cards in his possession. Staff dealt with this through the disciplinary process (where Mr Nicholas either forfeited his privileges or earnings or was given cellular confinement) or through the Incentive and Earned Privileges (IEP) scheme when Mr Nicholas moved from a standard regime to basic.

2021

30. On 22 February 2021, Mr Nicholas was placed on a disciplinary charge for having unauthorised items in his cell. This was proven at a disciplinary hearing, and he spent 21 days in the Segregation Unit as a punishment. Mr Nicholas moved back to his cell on A Wing during the morning of 14 March. Intelligence reports suggest that Mr Nicholas was drug-seeking from other prisoners on his return to the wing.

31. Mr Nicholas's last telephone call was to a friend on 17 March, at 3.30pm. The call lasted 14 minutes and they seemed to be talking in code.

18 March

32. At approximately 4.30am on 18 March, Mr Nicholas pressed his cell bell. An operational support grade (OSG) was working on A Wing overnight. She went to Mr Nicholas's cell and found he had put a note under his door which read "need nurse now". She asked Mr Nicholas why and whether he was okay. Mr Nicholas did not respond verbally but waved his hands gesturing no. He seemed to be struggling to speak. She asked Mr Nicholas whether he had taken drugs. He shook his head again.

33. The OSG immediately telephoned the healthcare unit and explained to Nurse A what had happened. The nurse said he would see Mr Nicholas. The OSG then telephoned the Custodial Manager (CM), who was responsible for the prison overnight (known as Oscar 1), to let him know a member of healthcare staff needed to be escorted to the wing to check Mr Nicholas.

34. The OSG returned to Mr Nicholas and told him a member of healthcare staff would be on the wing shortly. Mr Nicholas was sitting on his bed and nodded in response.

She asked whether he wanted to talk to her, but he shook his head and gestured that he would not say anything in case he was overheard.

35. The CM and a Supervising Officer (SO), who was Oscar 2 (Oscar 1's deputy), collected Nurse A and arrived on A Wing at approximately 4.45am. The managers stayed in the office and checked Mr Nicholas's prison records for any recorded concerns, while the nurse went to Mr Nicholas's cell.

36. Nurse A said he spoke to Mr Nicholas through the observation panel in the cell door. He did not ask staff to open the door. He said Mr Nicholas appeared normal and was sitting on his bed drinking water. He said that when he asked Mr Nicholas why he needed to move to the healthcare unit, Mr Nicholas turned his back and stopped engaging with him.

37. Nurse A returned to the wing office and said that Mr Nicholas had asked to move to the healthcare unit but would not say why. He said Mr Nicholas appeared a little distressed but seemed 'okay' and not unwell. He said he did not think Mr Nicholas had taken drugs and that there was no reason to move him. Following the nurse's advice, the CM decided Mr Nicholas should remain in his cell, but he asked the OSG to check him frequently. The CM, SO and nurse left the wing at approximately 4.50am.

38. The OSG returned to Mr Nicholas's cell once they had left. He was standing by his bed. She said she asked whether he was alright or whether he wanted to talk, but Mr Nicholas shook his head. She suggested he might write something and pass it under the door, but he shook his head again. She noted that Mr Nicholas seemed calmer, but he asked to see someone from healthcare. She said he had just seen a nurse and if he needed to move to the healthcare unit, he should apply later that morning. Mr Nicholas seemed unhappy about this and started to press his cell bell. She told him she would speak to the nurse again. Mr Nicholas thanked her.

39. The OSG telephoned the healthcare unit again and Nurse A said Mr Nicholas would be seen again later that morning. The nurse told us he did not recall this conversation.

40. The CM and SO saw the OSG again just before her shift finished at 6.00am. The OSG said Mr Nicholas had been pressing his cell bell still wanting to move to the healthcare unit, but he had been quiet for the past 20 minutes.

41. Mr Nicholas rang his cell bell at 6.02am and it was answered one minute later. At 6.30am, the CM handed over to a CM. He asked that staff continue to check Mr Nicholas and said that Mr Nicholas needed to see healthcare as soon as the prison was unlocked later that morning. The CM said he would arrange this.

42. Mr Nicholas pressed his cell bell at 7.39am. CCTV shows Officer A responding at 7.41am. She said she saw him lying on his bed and he appeared to be asleep. She knocked on the cell door and called Mr Nicholas, but he did not respond.

43. Officer A was concerned, so asked her colleague, Officer B, to check Mr Nicholas. Officer B went to the cell at 7.50am and CCTV shows that he stayed for 30 seconds looking thorough the observation panel. Mr Nicholas seemed to be asleep on top of his bed. Officer B said he saw his chest rise and fall and heard him snore. He

knew that healthcare staff were due to see Mr Nicholas that morning, so he telephoned the healthcare unit to ask whether they could come to A Wing earlier. He was told they were finishing the medication round on F Wing and would then go to A Wing.

44. Officer C was assisting two nurses to give prisoners their medication on A Wing that morning. They had had a handover from Nurse A and agreed they needed to see Mr Nicholas before they started the A Wing medication round. Around 8.30am, they knocked on his door and opened the observation panel. Mr Nicholas was sitting on the floor, leaning on his bed, his back to the door and his legs stretched out in front of him. Officer C called his name, but Mr Nicholas did not respond. He was snoring loudly.

45. Officer C called Officer D to assist unlocking the cell, as two officers needed to be present when unlocking prisoners. Officer D looked through the observation panel and saw Mr Nicholas sitting on the floor, leaning on his bed, with his head down. He opened the door and called Mr Nicholas, but he was unresponsive. He appeared to be asleep as he was snoring.

46. Nurse B and Officer C laid Mr Nicholas on the floor, and Nurse C said he needed urgent medical care as she ran to get an emergency bag. Officer D immediately radioed an emergency code blue call (indicating a life-threatening medical emergency) at 8.28am. The control room called for an ambulance.

47. The nurses put Mr Nicholas in the recovery position, while Officer C and Officer D moved some furniture out of the cell to give them more room. Nurse B gave Mr Nicholas oxygen. As more staff responded to the emergency call, they moved Mr Nicholas from his cell on to the landing.

48. The prison's control log shows that an ambulance arrived at Whitemoor at 8.44am, and paramedics arrived on A Wing ten minutes later. They assessed Mr Nicholas and noted his NEWS (National Early Warning Score), which assessed his respiration, blood pressure, oxygen and level of consciousness was 12, indicating that Mr Nicholas's condition was life-threatening, and he needed immediate hospital treatment. By 9.52am, Mr Nicholas was no longer breathing independently.

49. At 10.48am, Mr Nicholas was taken to hospital by ambulance.

50. Staff recovered the note Mr Nicholas had pushed under his door, which had been thrown in a bin on the wing. There was no sign of illicit drugs in his cell.

Contact with Mr Nicholas's family

51. Two officers were appointed as the prison's family liaison officers (FLOs). One FLO telephoned Mr Nicholas's father at approximately 11.00am, on 18 March, to tell him what had happened, and that Mr Nicholas was in hospital. Mr Nicholas's father was not initially allowed to visit his son due to COVID-19 restrictions at the hospital but was with him when he was pronounced dead at 3.47pm on 21 March.

After Mr Nicholas's death

52. The prison gathered intelligence from prisoners after Mr Nicholas's death. Some said Mr Nicholas had died after taking illicit substances.

53. A prisoner wrote to the investigator on 26 March, saying that the prison should not be blamed for Mr Nicholas's death as he had taken drugs.

54. The investigator spoke to police involved in an investigation into illicit drugs at Whitemoor. They said there was no connection between their investigation and Mr Nicholas's death.

Support for prisoners and staff

55. Mr Nicholas died in hospital on 21 March. There is no record of managers holding a debrief either after the emergency incident on 18 March, or once they had been told Mr Nicholas had died. Most staff involved in the emergency response told us they had been offered support from colleagues, managers and the Care Team.

56. The prison posted notices informing other prisoners of Mr Nicholas's death, and offering support. They also issued a notice to prisoners about the effects and harm of taking illicit drugs. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Nicholas's death.

Post-mortem report

57. Mr Nicholas's post-mortem concluded he had died from a hypoxic brain injury (lack of oxygen to the brain) and cardiac arrest due to cocaine toxicity.

Findings

Mr Nicholas's substance misuse

58. In April 2019, HM Prison and Probation Service (HMPPS) published the National Drug Strategy. It set out plans to reduce substance misuse in prisons by providing detailed guidance to help prisons identify issues and share best practice. Whitemoor produced an updated local drugs strategy in 2020, due for revision in September 2021. It sets strategies to restrict the supply, reduce demand and build recovery. HMIP and the IMB both expressed concern about the prevalence of illicit drugs at Whitemoor, but HMIP accepted the prison were managing this problem.

59. Mr Nicholas had a history of illicit drug use in the community and while in prison. He had been offered support and intermittently engaged with substance misuse services, but since June 2018, he had maintained he did not need support from the substance misuse team.

60. Prison intelligence records Mr Nicholas's suspected involvement in the supply of drugs into Whitemoor and of taking illicit substances. Over a 12-month period, staff found five mobile telephones in Mr Nicholas's cell. The possession of a mobile telephone is often an indication that a prisoner is involved in supplying drugs. Mr Nicholas was appropriately managed through the prison's adjudication process and IEP scheme. The prison was achieving its drug testing targets.

61. We are satisfied that Mr Nicholas was offered appropriate support for his drug use.

Clinical care

62. The clinical reviewer concluded that Mr Nicholas's care at Whitemoor was of a reasonable standard, and mostly equivalent to that which he could have expected to receive in the community.

63. However, we share the clinical reviewer's concern that Nurse A did not fully assess Mr Nicholas when he asked to be taken to the healthcare unit on the morning of 18 March. He only spoke to Mr Nicholas through his cell door. The clinical reviewer was concerned that he did not try to take any physical observations from Mr Nicholas to support his clinical opinion that Mr Nicholas did not require a move to the healthcare unit. At interview, the nurse accepted that staff would have allowed him access to Mr Nicholas's cell if he had asked to be let in, but said he saw no need.

64. The clinical reviewer also noted that while Nurse A gave a verbal handover to the day staff, he did not make an entry in Mr Nicholas's medical record until the evening of 18 March, by which time Mr Nicholas was in hospital. This was very poor practice.

65. We make the following recommendations:

    The Head of Healthcare should ensure that nurses carry out an appropriate assessment of a prisoner who appears unwell or agitated, including going into their cell to allow a more thorough assessment.

The Head of Healthcare should ensure that all staff are aware of the requirement to maintain full and contemporaneous healthcare records.

The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with him.

66. When Officer A and Officer B checked Mr Nicholas at 7.50am the following morning, he was snoring and seemed to be asleep. In fact, heavy snoring can be a sign of a drug overdose. We regularly see cases where staff and other prisoners assume that a prisoner is fine and is 'sleeping it off' because he is snoring, when in fact the snoring indicates respiratory distress. If the officers had known that, given the events overnight, they might have gone into the cell immediately to check on Mr Nicholas. We do not criticise them for not doing so and we cannot say whether it might have affected the outcome for Mr Nicholas. However, we make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff know that heavy snoring may be a sign of a drug overdose.

Debrief

67. Prison Service Instruction (PSI) 09/2014, *Incident Management*, says that Governors must consider offering a Critical Incident Debrief as part of their duty of care to staff following any incident that may have been traumatic for staff.

68. There is no evidence that the prison held a debrief either after the emergency on 18 March or after Mr Nicholas died three days later, although some staff said they felt supported.

69. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed. It also provides those directly involved with an opportunity to process events. We make the following recommendation:

The Governor should ensure that they consider holding a debrief after all traumatic incidents, including serious medical emergencies.

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