

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Nicholas Whitehead, a prisoner at HMP Sudbury, on 23 January 2020**

**A report by the Prisons and Probation Ombudsman**

## 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



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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.

Mr Nicholas Whitehead died from mixed drug toxicity on 20 January 2020 while a prisoner at HMP Sudbury. His death was caused by the combined effects of heroin, cocaine and psychoactive substances (PS). He was 38 years old. I offer my condolences to his family and friends.

I am concerned that Mr Whitehead was able to access illicit drugs at Sudbury and that the prison missed that he was taking drugs. Although I recognise the progress that Sudbury has made in reducing the level of illicit substances entering the prison, it needs to continue in its efforts to reduce the supply of and demand for illicit substances and staff need to remain vigilant for signs that prisoners are using drugs.

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**

**February 2024**

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# Summary

## Events

1. In March 2018, Mr Nicholas Whitehead was sentenced to five years in prison for burglary, theft and fraud and sent to HMP Dovegate.
2. He had a history of substance misuse. He completed a drug and alcohol assessment, started a detoxification programme and was prescribed detoxification medication at Dovegate. There is no evidence that he used drugs in prison.
3. In 2018, Mr Whitehead requested pain relief several times for headaches, toothache and migraine.
4. Having moved to HMP Oakwood, Mr Whitehead continued to have migraines. On 18 July 2019, a prison GP referred Mr Whitehead for an MRI scan (to scan his brain) and told him that if he was transferred to another prison before the appointment, he should tell the new prison that he had been referred.
5. On 4 October, Mr Whitehead was transferred from Oakwood to HMP Sudbury. There was no handover between the prisons about his outstanding MRI scan and Mr Whitehead did not tell Sudbury that he had an outstanding appointment for an MRI scan.
6. On 15 October, a prison nurse noted that Mr Whitehead had had an MRI referral before he was transferred to Sudbury and made a new referral.
7. On 18 November, Mr Whitehead had an MRI scan which indicated a 12mm lesion in one of the arteries to his brain.
8. On 23 December, Mr Whitehead had a second MRI scan which confirmed that he had an aneurysm.
9. On 4 January, Mr Whitehead had surgery to remove a burst gluteal abscess and returned to Sudbury the next day.
10. At approximately 8.20am on 23 January, Mr Whitehead's cellmate found him dead in his cell and alerted staff. Prison staff responded straightaway and called a medical emergency code blue (used when a prisoner is unconscious or has breathing difficulties). At 8.32am, healthcare staff responded with emergency equipment. Staff worked together to resuscitate Mr Whitehead but their attempts were unsuccessful. At 8.47am, paramedics arrived and pronounced him dead at 9.08am.
11. Mr Whitehead died from mixed drug toxicity having used cocaine, heroin and PS.

## Findings

### Substance misuse and drug strategy at Sudbury

12. There was no evidence before his death that Mr Whitehead was using illicit substances at Sudbury.
13. We are very concerned that Mr Whitehead was able to access cocaine, heroin and PS in prison, and that prison staff at Sudbury missed that he was using drugs. In a previous drug-related death at Sudbury, we raised a similar concern about a prisoner's access to drugs at the prison. However, we did not make a recommendation because we recognised that the prison was taking steps to address drug accessibility. Although we recognise that Sudbury has taken positive steps to address the availability of drugs at the prison, prison staff should continue to prioritise their work to reduce both the demand for and the supply of illicit substances.

### Clinical care

14. The clinical reviewer found that, on balance, the clinical care that Mr Whitehead received at Oakwood, his former prison, and Sudbury was partially equivalent to that which he could have expected to receive in the community. She found that Sudbury appropriately identified and actioned his outstanding MRI scan in the recommended timeframe. However, the clinical reviewer made several recommendations about continuity of care and communication which did not relate to Mr Whitehead's death (and we therefore do not repeat) but which the Heads of Healthcare for Sudbury and Oakwood will need to address.

## Recommendations

The Governor should ensure that:

- staff are vigilant for signs of substance misuse; and
- Sudbury's drug strategy is being effectively implemented to maximise the opportunities both to reduce the levels of illicit substances entering the prison and reduce the demand for them.

## The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Sudbury informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
16. The investigator did not visit HMP Sudbury due to the COVID-19 pandemic. Sudbury sent the investigator copies of relevant extracts from Mr Whitehead's prison and medical records.
17. The investigator interviewed two members of prison staff on 16 June 2021.
18. NHS England commissioned a clinical reviewer to review Mr Whitehead's clinical care at the prison.
19. We informed HM Coroner for Derby and Derbyshire of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.
20. The PPO family liaison officer contacted Mr Whitehead's mother to explain the investigation. She did not respond to our letter.
21. 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.

## Background Information

### HMP Sudbury

22. HMP Sudbury is an open prison which can hold up to 480 men. In April 2016, Care UK (now Practice Plus Group (PPG)) were awarded the healthcare contract. PPG provide healthcare services during the day on weekdays and in the mornings at weekends. There are specialist clinics to treat substance misuse.

### HM Inspectorate of Prisons

23. Inspectors completed a scrutiny visit of HMP Sudbury in April to May 2021. They reported that health services were good and well-led. They found that there was appropriate action to manage the risk of illicit substances entering the prison, including the use of intelligence-led drug testing, with a high number of positive results which suggest effective intelligence.

### 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 May 2021, the IMB noted that it understood the Sudbury's open nature and that both intelligence-led and routine searches led to detecting and recovering both large and small quantities of illicit items, including drugs. However, they had concerns about the apparent frequency with which illicit items continued to enter the prison.

### Previous deaths at HMP Sudbury

25. Mr Whitehead was the second prisoner to die at Sudbury since April 2019. The previous death was from natural causes. There are no similarities between Mr Whitehead's death and the previous death in 2019. Since Mr Whitehead's death, there have been two more deaths at Sudbury, one which was from natural causes and the other which was also drug-related. In the drug-related death, the prisoner died from mixed drug toxicity at HMP Sudbury 18 months after Mr Whitehead. In our investigation in that death, we raised a similar concern about a prisoner's access to drugs at the prison. However, we did not make a recommendation because we recognised that the prison was taking steps to address drug accessibility, and we acknowledged the steps taken.

### Psychoactive substances

26. PS, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical

health, there is potential for PS to precipitate or exacerbate the deterioration of mental health, with links to suicide and self-harm.

## Key Events

27. In March 2018, Mr Nicholas Whitehead was sentenced to five years in prison for burglary, theft and fraud and sent to HMP Dovegate. He had a history of substance misuse, including alcohol and PS.
28. Mr Whitehead was referred to the substance misuse service team and completed a detoxification programme. A prison GP also prescribed detoxification medication. Staff from the substance misuse team assessed Mr Whitehead and completed a stabilisation care plan for him.

### HMP Oakwood

29. On 8 April 2019, Mr Whitehead was transferred to HMP Oakwood.
30. On 17 July, a prison optician gave Mr Whitehead a full eye examination because he had headaches. The next day, a prison GP told Mr Whitehead that he needed reading glasses and referred him for a brain scan because of the duration of his headaches. He also prescribed medication.

### HMP Sudbury

31. On 4 October, Mr Whitehead was transferred from Oakwood to HMP Sudbury.
32. At Mr Whitehead's initial health screen at Sudbury, it was noted that he was prescribed sumatriptan (for migraines) which he administered himself and that he had no outstanding appointments. He said that he did not have any problems with alcohol or drugs, and did not tell healthcare staff that he had been referred for an MRI scan. No issues were raised in his second health screen on 10 October.
33. On 15 October, a nurse noted that Mr Whitehead had ongoing migraines and had had an MRI referral before he was transferred to Sudbury. The nurse arranged for Mr Whitehead to see a prison GP who referred him for an MRI scan.
34. On 18 November, Mr Whitehead had an MRI scan which indicated a lesion on one of the arteries in his brain. A further MRI scan was recommended to confirm if it was an aneurysm. Mr Whitehead's medical records do not make clear when Sudbury received the scan results.
35. On 26 November, the nurse reviewed Mr Whitehead. She noted that he had migraines three to four times a month and that he appeared tired. She noted that he had had an MRI scan and was waiting for the results.
36. On 4 December, a hospital doctor telephoned Mr Whitehead to explain to him that he had a possible aneurysm. He was referred urgently for another MRI scan.
37. On 13 December, a prison GP increased Mr Whitehead's sumatriptan and advised that he should see an optician.
38. On 14 December, an intelligence report recorded that Mr Whitehead's cell door observation panel was covered. An officer removed the covering, went into the cell

and noted that Mr Whitehead's cellmate appeared to be under the influence of drugs.

39. On 23 December, Mr Whitehead had his second MRI scan which confirmed that he had an aneurysm. He returned to Sudbury without a discharge note, explaining the results of the MRI scan. An urgent referral was made to the hospital neurosurgery team. The prison received a posted copy of the MRI scan results on 31 December.
40. On 31 December, Mr Whitehead asked for pain relief throughout the night.
41. On 2 January 2020, the prison's regional healthcare team arranged for Mr Whitehead to see a prison GP to talk to him about his results on 9 January.
42. On 3 January, Mr Whitehead went to hospital because he had a gluteal abscess which had burst. On 4 January, he had surgery to incise and drain his abscess, and he returned to Sudbury the next day.
43. On 6 January, a prison GP prescribed Mr Whitehead codeine for post-surgical pain relief. There was no indication in the health records that he was taking or suspected of taking any illicit substances.
44. On 9 January, a prison GP saw Mr Whitehead, told him about his aneurysm and referred him urgently to a neurosurgeon. However, an appointment was not received before Mr Whitehead died.
45. Mr Whitehead's cellmate said in his prison statement that on 22 January, Mr Whitehead had had a haircut as he was going to be released on temporary licence the following day. He said that in the evening, they talked about Mr Whitehead's release and went to bed at around 11.00pm that night. Two officers completed roll checks that night but noted nothing unusual or untoward about Mr Whitehead or his cellmate. An officer said that if she noticed anything unusual, she would have noted it in the wing observation book which she did not. There was no CCTV footage available. Mr Whitehead's cellmate said in his statement that at about midnight during the roll check, Mr Whitehead was asleep on his back, snoring.
46. At around 8.20am on 23 January, Mr Whitehead's cellmate tried to wake him as he was due for release on temporary licence. In his statement, he said that Mr Whitehead was slumped over on his side. He said that his arm was cold and blood had pooled around his mouth. He ran to the wing office to alert prison staff who attended straightaway and called a medical emergency code blue (used when a prisoner is unconscious or has breathing difficulties). At 8.32am, healthcare staff responded with emergency equipment and a defibrillator. Officers and healthcare staff tried to resuscitate Mr Whitehead. Three crews of paramedics arrived between 8.47am and 9.05am. At 9.08am, paramedics pronounced that Mr Whitehead had died.

### **Contact with Mr Whitehead's family**

47. On 23 January, a Supervising Officer was appointed as the prison's family liaison officer (FLO). That day, Mr Whitehead was due out on day release. At approximately 9.55am, the FLO and an officer left the prison to visit Mr Whitehead's mother. On their way, they met Mr Whitehead's brother who had come to the

prison to meet him for his day release. The officers took him into a private room and broke the news of Mr Whitehead's death. He was concerned about how his mother would take the news, and how it would affect her health. They visited her together and broke the news to her. They offered their condolences and support.

### **Support for prisoners and staff**

48. After Mr Whitehead's death, the Governor debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
49. The prison posted notices informing other prisoners of Mr Whitehead's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Whitehead's death.

### **Post-mortem report**

50. The post-mortem report established that Mr Whitehead died from mixed drug toxicity caused by the combined effects of cocaine, heroin and PS.

# Findings

## Substance misuse and drug strategy at Sudbury

51. Mr Whitehead died from mixed drug toxicity. He had a history of substance misuse. When he arrived in prison, he was referred to the substance misuse service team to start detoxification and was prescribed detoxification medication. A drug and alcohol assessment was completed and he started a stabilisation care plan. We are satisfied that Sudbury offered him appropriate support.
52. We are concerned that Mr Whitehead was able to access cocaine, heroin and PS at Sudbury, and that the prison missed that he was using drugs. There was no intelligence or reported instances that he misused drugs at Sudbury before 23 January and there was no indication in his medical records that he was taking or was suspected of taking any illicit substances. A cell search was conducted shortly after he died and no illicit substances were found. In the absence of evidence, we cannot say whether or not he misused drugs regularly in prison.
53. In their most recent reports about Sudbury, both the IMB and HMIP noted the action that the prison had taken to reduce the levels of illicit substances entering the prison, although the IMB had concerns about the apparent frequency with which illicit items continued to enter Sudbury.
54. Sudbury has in place a strategy to address both the supply of, and demand for, drugs. It includes numerous actions intended to reduce the supply of drugs into the prison and movement of drugs around the prison. There are also measures to educate and support those known to use drugs and disciplinary measures to deter drug use, as well as partnership working with local police to secure prosecution for those involved. In October 2020, Sudbury implemented a revised drug strategy which included roll-out of increased and repositioned CCTV cameras in and around the prison. .
55. Although we recognise that Sudbury has a sound drugs strategy in place, and improvements have been made, Mr Whitehead apparently had no difficulty in obtaining and using drugs without staff becoming aware. While we consider that Sudbury has taken positive steps to address the drugs problem and we decided not to make a recommendation in our previous investigation into a drug-related death at the prison because of this, we are concerned that this is now the second death we have seen within an 18-month period, where we have raised concerns about prisoners having access to illicit substances. It is therefore important that tackling this issue remains a priority and we recommend that:

### **The Governor should ensure that:**

- **staff are vigilant for signs of substance misuse; and**
- **Sudbury's drug strategy is being effectively implemented to maximise the opportunities both to reduce the levels of illicit substances entering the prison and reduce the demand for them.**

## **Clinical care**

56. The clinical reviewer considered, on balance, that Mr Whitehead's care was only partially equivalent to that which he could be expected to receive in the community. She found that Sudbury appropriately identified and arranged for Mr Whitehead to have his outstanding MRI scan within waiting time standards.

## **Continuity of care**

57. However, the clinical reviewer found that Oakwood failed to process Mr Whitehead's MRI referral and that there was no handover about the MRI when he transferred from Oakwood to Sudbury. This led to a delay in Sudbury identifying his brain aneurysm. Although these findings did not relate to Mr Whitehead's death, they have implications for good continuity of care and might be critical in another case. The Head of Healthcare at Oakwood has since implemented a new process which ensures that hospital referrals are followed up.
58. The clinical reviewer also found that Sudbury did not inform the hospital about his suspected aneurysm before his surgery, and that this was not equivalent to the care which he could have expected to receive in the community.

## **Inquest**

59. The inquest, held on 20 December 2023, concluded that Mr Whitehead died from mixed drug toxicity.

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