Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ricardo Cotteral, a prisoner at HMP Sudbury, on 24 April 2022

A report by the Prisons and Probation Ombudsman

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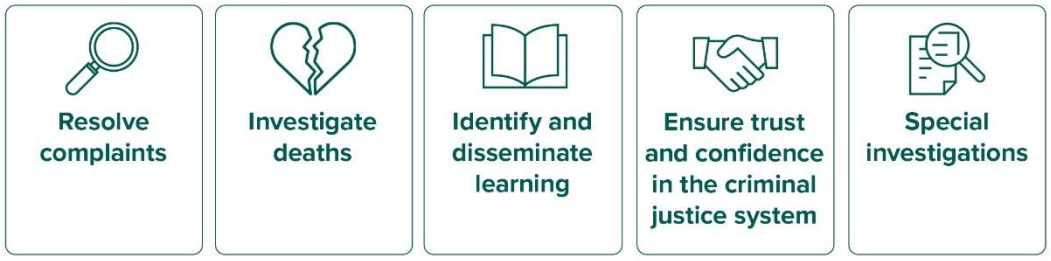
OUR VISION

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 HM Prison and Probation Service 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 Ricardo Cotteral was murdered by four men in Nottingham City Centre on 24 April 2022, while released on overnight temporary licence from HMP Sudbury. He died of a stab wound to the chest. He was 33 years old. I offer my condolences to Mr Cotteral's family and friends.

On 25 July 2023, the four men were found guilty of Mr Cotteral's murder and later sentenced to life in prison.

Prison managers assessed Mr Cotteral as suitable for release on temporary licence (ROTL) on 9 October 2021. He had been released on day and overnight ROTL many times before April 2022. However, the investigation found that Sudbury's process for granting ROTL were sub-optimal and did not allow for all relevant information to be considered.

Although the clinical reviewer considered that Mr Cotteral received a satisfactory standard of healthcare at HMP Sudbury, she was concerned that healthcare staff were not involved in the ROTL risk assessment process.

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 **January 2025**

Contents

Summary

Events

1. On 20 May 2020, Mr Ricardo Cotteral was remanded to HMP Nottingham, charged with possession with intent to supply a Class A drug. On 20 November, he was sentenced to three and a half years in prison.

2. On 18 August 2021, Mr Cotteral was transferred to HMP Sudbury.

3. On 15 October, the Head of the Offender Management Unit (OMU) authorised Mr Cotteral's application for release on temporary licence (ROTL, which allows prisoners periods in the community for work or to build family relationships). Mr Cotteral began periods of ROTL soon after.

4. On 18 January 2022, Mr Cotteral made a formal complaint that he could not start work in the community as his prison offender manager (POM) did not support his ROTL. The next day, the Head of OMU and a prison manager approved ROTL for paid work. Contrary to guidance, Mr Cotteral's POM responded to the complaint. Mr Cotteral appealed and was allocated a new POM.

5. Between 29 and 31 March, staff submitted intelligence reports that Mr Cotteral had access to a mobile phone and was suspected of being involved in the prison's illicit drug market. However, there is no evidence that staff took any action, and the details were not recorded in Mr Cotteral's prison record.

6. On 20 April, prison staff released Mr Cotteral on ROTL until 24 April.

7. At 1.57am on 24 April, a group of men approached Mr Cotteral outside a nightclub in Nottingham Town Centre and stabbed him. At 2.43am, paramedics at the scene pronounced that Mr Cotteral had died.

8. On 25 July 2023, four men were found guilty of Mr Cotteral's murder. They were sentenced to life in prison on 7 September.

Findings

9. Processes for granting ROTL at Sudbury were not as robust as they should have been, and information related to Mr Cotteral's suspected involvement in illicit activity in the prison was not considered. However, Mr Cotteral had been released on ROTL many times before 20 April, including almost every day in April, and there was no particular intelligence to suggest that his life was at risk in the community.

10. It is not possible for us to make a firm judgement on the appropriateness, or otherwise, of Mr Cotteral's release on ROTL on 20 April because the correct processes were not followed. It is not possible, in the context of his having been released over one hundred times previously, to draw direct causal link between the decision making (or lack thereof) and Mr Cotteral's death.

11. The clinical reviewer considered that the standard of healthcare that Mr Cotteral received at HMP Sudbury was equivalent to that which he could have expected to

receive in the community. However, the clinical reviewer was concerned that healthcare staff did not contribute to Mr Cotteral's ROTL risk assessment.

12. Contrary to policy, Mr Cotteral's POM responded to a complaint that Mr Cotteral had made about him. It was not appropriate that the individual tasked with responding to the complaint was also the subject of the complaint.

Recommendations

- The Governor should ensure that:
  - all ROTL board reviews and decisions are made in or following a discussion or meeting between the board members and any other relevant individuals;
  - an urgent ROTL board review takes place when there is evidence to suggest an increased risk;
  - staff act on and share all information with OMU that indicates that ROTL may no longer be appropriate due to increased risk; and
  - staff put negative entries and security information on the prison's case management system so they can be identified in pre-ROTL checks and considered by the authorising manager.
- The Ministry of Justice's Release Policy Team should amend the ROTL Policy Framework to include that healthcare staff are consulted when there is information available to indicate concerns about a prisoners ability to comply with ROTL.

The Investigation Process

13. HMPPS notified us of Mr Cotteral's death on 24 April 2022.

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

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

16. The investigator interviewed seven members of staff at HMP Sudbury between 9 and 21 September 2023.

17. NHS England commissioned a clinical reviewer to review Mr Cotteral's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with healthcare staff.

18. We suspended our investigation between November 2022 and February 2023 while the police investigated the circumstances of Mr Cotteral's death, and his murder trial concluded. The investigator remained in regular contact with the police.

19. We suspended our investigation again between May and July 2023 while we waited for NHS England's clinical review.

20. We informed HM Coroner for Nottingham City of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

21. The Ombudsman's office contacted Mr Cotteral's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Cotteral's family wanted to know:

    - the conditions of his release of temporary licence; and
    - if someone checked that he was abiding by them.

    We have addressed these concerns in this report.

22. Mr Cotteral's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

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

Background Information

HMP Sudbury

24. HMP Sudbury is an open prison. Sudbury caters for prisoners in the latter stages of their sentence and specialises in rehabilitation and resettlement in preparation for release into the community. A number of prisoners are released each day on licence to help with their resettlement.

25. Practice Plus Group provides primary and mental health services. South Staffordshire and Shropshire Healthcare NHS Foundation Trust provides drug and substance misuse services.

HM Inspectorate of Prisons

26. The most recent full inspection of HMP Sudbury was in August 2023. Inspectors found that over 40% of the population had committed offences related to drug supply, with around a third connected to organised crime gangs. Despite having had a full-time police intelligence officer for several months, not enough had been done to reduce the supply of, and the demand for, illicit drugs.

27. Inspectors found that there was a wide range of creative opportunities available to prisoners to help build and maintain family ties, and good use of day and overnight ROTL.

Independent Monitoring Board

28. 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 2023, the IMB reported that preventing the supply illicit drugs into the prison was a continuous challenge. They also noted that a total of 229 prisoners had been transferred back to closed conditions.

Previous deaths at HMP Sudbury

29. Mr Cotteral was the fifth prisoner to die while a prisoner at Sudbury since April 2019. Two of the previous deaths were from natural causes and two were drug-related. There were no similarities between the findings of this investigation and those of the previous deaths we investigated.

Release on temporary licence (ROTL)

30. All prisoners, except those who fall within a defined group excluded from applying for ROTL or those subject to Restricted ROTL conditions, may apply for temporary release under a special purpose licence at any point during their sentence. ROTL facilitates the rehabilitation of offenders by helping to prepare them for resettlement in the community once they are released. This includes finding work and rebuilding family ties. ROTL is mostly used in open prisons, but closed prisons can release eligible prisoners if they have suitable resourcing and infrastructure in place. ROTL

can be granted for day-long periods (to attend work, for example) or for longer periods.

31. The decision to allow ROTL must always be considered by means of a rigorous risk assessment. A prison offender manager (POM) completes the assessment and a ROTL board should meet to discuss it and make decisions. The ROTL board is often chaired by a custodial manager (CM) and should include the POM and any other relevant member of staff. The board reviews the risk assessment and recommends whether they deem ROTL appropriate, as well as outlining any non-standard licence conditions and/or specific monitoring measures needed. A senior manager then reviews the risk assessment and if in agreement with the board, authorises the ROTL. A ROTL board risk assessment should be reviewed every six months, or earlier, if there is information or intelligence to indicate an increased risk.

Key Events

32. On 20 May 2020, Mr Ricardo Cotteral was remanded to HMP Nottingham, charged with possession with intent to supply a Class A drug. On 20 November, he was sentenced to three and a half years in prison and returned to Nottingham.

33. On 30 November, Mr Cotteral was moved to HMP Ranby. Over the next eight months, he progressed through his sentence and achieved enhanced (trusted) prisoner status.

HMP Sudbury

2021

34. On 18 August 2021, Mr Cotteral was transferred to HMP Sudbury as part of his sentence progression.

35. On 25 August, a mental health nurse saw Mr Cotteral for a mental health assessment. He noted that Mr Cotteral reported a history of anxiety, attention deficit hyperactivity disorder (ADHD) and autism.

36. On 9 September, a community learning disability nurse reviewed Mr Cotteral and offered him ongoing support.

37. On 9 October 2021, a Custodial Manager (CM) recorded that he had chaired Mr Cotteral's initial Release on Temporary Licence (ROTL) risk assessment board. The ROTL board document indicates that several members of staff, including Mr Cotteral's prison offender manager (POM), attended. However, during staff interviews, it became apparent that the ROTL process at the time consisted of the POM completing the form and sending it to the chair for review, rather than a meeting of staff to discuss the application. The POM recorded that Mr Cotteral had enhanced prisoner status and had received positive feedback for his work in the prison's recycling department. The CM noted that the board recommended that Mr Cotteral should start with resettlement day release at his grandmother's address. They did not agree to resettlement overnight release as his family were concerned about him staying with his grandmother. There was no intelligence to suggest that Mr Cotteral's life was at imminent risk in the community.

38. On 15 October, the Head of the prison's Offender Management Unit (OMU) reviewed Mr Cotteral's ROTL board risk assessment and authorised resettlement day release.

39. On 8 November, a CM reviewed the revised ROTL board document the POM had sent her. Mr Cotteral's family had changed their minds about overnight resettlement. The POM noted that security staff suspected Mr Cotteral had access to a mobile phone and was involved in the prison's illicit drug trade. He concluded that he did not support ROTL as he felt that Mr Cotteral's risk could not be managed in the community. The CM noted that she had spoken to the prison's Head of Security and Mr Cotteral's community probation officer who supported resettlement overnight release at his grandmother's address. Overnight ROTL was subsequently approved.

40. Between 16 and 19 December, staff made several negative entries about Mr Cotteral's behaviour in his prison file. As a result, on 22 December, the POM suspended Mr Cotteral's ROTL for the Christmas period.

41. At 9.58am on 23 December, a nurse visited Mr Cotteral for an urgent review because he presented as anxious and agitated. She noted that he had lost his ROTL over Christmas and that she would tell the Head of OMU about his autism diagnosis. Later that day, the Head chaired a multidisciplinary team meeting and went through the negative entries with Mr Cotteral. He noted that Mr Cotteral attributed his behaviour to his autism and agreed to reinstate his ROTL.

42. On 31 December, Mr Cotteral received a job offer from Boots. He subsequently submitted a ROTL application form.

2022

43. Between 2 and 16 January 2022, Mr Cotteral left the prison six times on day release.

44. On 12 January, a business, community and engagement manager wrote to Mr Cotteral telling him that she was going to withdraw his job offer as his POM did not support his ROTL. Mr Cotteral made a formal complaint about his POM.

45. Senior prison managers concluded that Mr Cotteral was suitable for ROTL for paid work. (Mr Cotteral left the prison on ROTL 118 times before his death. Most of his ROTLs were on day release to attend work in the community but he also had several overnight releases to help maintain family ties.)

46. Staff continued to record negative entries about Mr Cotteral's behaviour. Including that they suspected he was involved in trading illicit drugs at Sudbury.

47. On 25 January, and contrary to the Prisoner Complaints Policy Framework, the POM replied in writing to Mr Cotteral's complaint about him. At interview, he told us that he did not want to respond because the complaint was about him, but a Senior Probation Officer (SPO), who was his manager, did not want to respond to it. (The SPO no longer works at Sudbury and was not interviewed as part of the investigation.)

48. On 9 February, a mental health nurse recorded that he saw Mr Cotteral for a mental health inreach review. He noted that Mr Cotteral was very distressed and not happy with his POM, whom he said had rejected his ROTL.

49. On 10 February, the POM emailed the Head of OMU, outlining concerns that Mr Cotteral's ROTL had been reinstated, despite them agreeing that Mr Cotteral needed to demonstrate improved behaviour first. The Head told the investigator that he was on annual leave at the time and was not sure who decided to allow Mr Cotteral to continue with his ROTL to work outside of the prison.

50. On 18 February, Mr Cotteral submitted another complaint, stating that he was not happy with his POM's response. He said that he was expecting the SPO to respond and asked, "where is independent scrutiny?" The following week, the OMU hub manager wrote to Mr Cotteral that the Head of OMU and the SPO would respond as soon as possible.

51. On 15 March, the Head of OMU wrote to Mr Cotteral, saying that they had discussed his complaint and he hoped he was happy with the outcome. He also confirmed that he had appointed him a new POM. At interview, the Head said that he could not recollect the exact events, but remembered attending a meeting with Mr Cotteral, the SPO, and the new POM to discuss his concerns.

52. Between 29 and 31 March, staff submitted intelligence reports indicating that Mr Cotteral had access to a mobile phone and was mixing with another prisoner suspected of involvement in the illicit drug trade. There is, however, no evidence that staff took any action.

53. Mr Cotteral was released on ROTL to attend work almost every day in April.

54. On 19 April, a case administrator checked NOMIS for any negative entries or intelligence to suggest an increase in risk before the duty manager signed off Mr Cotteral's licence. She did not identify information to cause concern (the intelligence reports were not reflected on NOMIS and there is no evidence that the process included her separately checking security intelligence.)

55. On 20 April, prison staff released Mr Cotteral on resettlement overnight release until 24 April. He stayed at his grandmother's home and was subject to standard licence conditions (including a requirement not to offend, to be of good behaviour, keep in touch with his supervising probation officer and reside at an approved address).

Events of 24 April

56. At around 1.57am on 24 April, a group of men stabbed Mr Cotteral outside a nightclub in Nottingham Town Centre. Mr Cotteral ran off down the street, but the men chased after him and stabbed him multiple times.

57. At 2.43am, paramedics at the scene pronounced that Mr Cotteral had died. At 12.15pm, the police notified the prison.

Contact with Mr Cotteral's family

58. The police had broken the news of Mr Cotteral's death to his family and had appointed a police family liaison officer. Mr Cotteral's family had visited the place where Mr Cotteral died.

59. At 2.30pm, the prison appointed an officer as family liaison officer (FLO)and an Operational Support Grade (OSG) as his deputy. The FLO was not at work on 24 April and, because Mr Cotteral's family had a police family liaison officer, a CM agreed that he could start family liaison duties when he returned to work on 25 April.

60. At 12.15pm on 25 April, the FLO and a prison chaplain visited Mr Cotteral's ex-partner, who was Mr Cotteral's named next of kin. They offered support and explained the next steps.

61. On 27 April, the FLO, his deputy and a prison governor visited Mr Cotteral's ex-partner. Later that day, the governor and the deputy visited Mr Cotteral's sister and mother. At both visits, they offered their condolences and support.

62. The FLO remained in contact with Mr Cotteral's ex-partner. Mr Cotteral's funeral took place on 4 October and the prison contributed towards the cost, in line with national policy.

Support for prisoners and staff

63. The prison posted notices informing other prisoners of Mr Cotteral's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Cotteral's death.

Post-mortem report

64. The post-mortem report concluded that Mr Cotteral died of a stab wound to the chest.

Events after Mr Cotteral's death

65. On 25 July 2023, four men were found guilty of Mr Cotteral's murder. On 7 September, they were sentenced to life in prison, with minimum terms to serve ranging from 25 to 30 years. In court, the murder was described as a revenge attack linked to a previous violent incident involving Mr Cotteral and the defendants.

Findings

66. Mr Cotteral was murdered while on overnight ROTL from Sudbury. There was no intelligence to suggest that his life was at risk in the community.

Release on Temporary Licence processes

67. Mr Cotteral had been released on day and overnight ROTL over 100 times since arriving at Sudbury. Our investigation identified some short comings in the ROTL process.

68. The ROTL Policy Framework states that a ROTL board must convene to make an appropriate recommendation based on the information contained in the ROTL risk assessment. This did not happen in Mr Cotteral's case. The ROTL board did not meet on 9 October and 8 November 2022. The POM told the investigator that, at the time, the local procedure was for the POM to collate all the relevant information, complete a risk assessment and send it to the chair of the ROTL board for review and to make a decision about whether a prisoner should be released on temporary licence. Staff should have met to discuss the potential risks and to minimise their impact. This would have been particularly important on 8 November when he did not support ROTL and his relationship with Mr Cotteral began to break down.

69. The ROTL policy states that it is essential that the ROTL board process is supplemented by systems that ensure that significant changes in risk or offender behaviour can lead to an urgent review of ROTL and to suspension where necessary. While we appreciate that the POM held a meeting with Mr Cotteral and several members of staff to discuss his complaint in March 2023, staff should have held a ROTL board. The POM had raised valid concerns about Mr Cotteral's ability to comply with ROTL, and his concerns should have been discussed. It is also possible that by changing his POM and not fully addressing the concerns that the first POM raised, the prison effectively enabled Mr Cotteral to manipulate the system to his advantage. Holding a board review with all the relevant stakeholders, including the first POM, would have allowed for a systematic and fair assessment of his risk.

70. We found weaknesses in the process for identifying relevant intelligence ahead during the ROTL process. OMU staff responsible for running pre-ROTL checks did not have sight of the intelligence reports staff had submitted about Mr Cotteral in the early part of 2022.

71. There was no direct information that Mr Cotteral's life was at risk in the community and, indeed, he left the prison on ROTL almost every day in April to work and for at least one other overnight stay that month. However, we do not think that the ROTL approval processes at Sudbury are sufficiently robust. We make the following recommendation:

The Governor should ensure that:

- **all ROTL board reviews and decisions are made in or following a discussion or meeting between the board members and any other relevant individuals;**

- **an urgent ROTL board review takes place when there is evidence to suggest an increased risk;**
- **staff act on and share all information with OMU that indicates that ROTL may no longer be appropriate due to increased risk; and**
- **staff put negative entries and security information on the prison's case management system so they can be identified in pre-ROTL checks and considered by the authorising manager.**

Healthcare involvement in ROTL risk assessments

72. Mr Cotteral had autism and was supported by the mental health team at HMP Sudbury. The clinical reviewer was therefore concerned that healthcare staff were not involved in Mr Cotteral's ROTL risk assessment.

73. The ROTL Policy Framework states that it is good practice that healthcare checks are made before overnight releases to ensure that a prisoner's needs are identified and that they have access to any treatment they need during release. This did not happen in Mr Cotteral's case.

74. We contacted the Ministry of Justice's Release Policy Team by email as part of our investigation, to establish whether healthcare staff should be invited to contribute to ROTL risk assessments. They said that the Policy Framework does not mandate the involvement of healthcare staff in ROTL risk assessments but that they expected consultation with healthcare staff where relevant.

75. We agree with the clinical reviewer that for a risk assessment to be holistic, healthcare staff should contribute to the process. We make the following recommendation:

    The Ministry of Justice's Release Policy Team should amend the ROTL Policy Framework to include that healthcare staff are consulted when there is information available to indicate concerns about a prisoners ability to comply with ROTL.

Clinical care

76. The clinical reviewer considered that the standard of healthcare that Mr Cotteral received at HMP Sudbury was equivalent to that which he could have expected in the community.

Governor to note

77. The POM responded to a complaint that Mr Cotteral had made about his decision-making. The Prisoner Complaints Policy Framework states that complaints must be answered by someone who can provide an adequate and meaningful reply and is not the focus of the complaint.

78. The Head of OMU told us that when a prisoner submitted a complaint about a member of staff, their manager would normally respond, which was why it was sent

to a SPO to address. He added that it was likely that she allocated the complaint to the POM as staff try to address complaints at the lowest level. However, the POM told us that he felt the SPO did not want to respond to the complaint. Regardless of the reason, it was not appropriate for the POM to respond.

79. By asking the POM to respond to Mr Cotteral's complaint and by authorising Mr Cotteral's ROTL without a full discussion of his concerns, we consider that senior prison and probation staff undermined his authority and expertise. The Governor will want to ensure that staff address complaints from prisoners in line with the Prisoner Complaints Policy Framework.

Inquest

80. At the inquest, which took place on 17 July 2024, the Coroner concluded that Mr Cotteral died of unlawful killing.

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