Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Douglas Slade, a prisoner at HMP Isle of Wight, on 31 October 2024

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

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. In July 2016, Mr Douglas Slade was sentenced to 24 years in prison for sexual offences. He died in hospital of heart failure on 31 October 2024, while a prisoner at HMP Isle of Wight. He was 83 years old. We offer our condolences to Mr Slade's family and friends.

4. The Ombudsman's office wrote to Mr Slade's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They raised no issues but asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer to review Mr Slade's clinical care at HMP Isle of Wight.

6. The clinical reviewer concluded that the clinical care Mr Slade received at Isle of Wight was equivalent to that which he could have expected to receive in the community. She made no recommendations.

7. The PPO investigator investigated the non-clinical issues relating to Mr Slade's care.

8. We did not find any non-clinical issues of concern. We make no recommendations.

9. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies.

10. We sent a copy of our initial report to Mr Slade's next of kin. They did not notify us of any factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman **July 2025**

Inquest

At the inquest, held on 22 January 2026, the Coroner concluded that Mr Slade died from natural causes.

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