

**Prisons &
Probation**
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stefan Slack, a prisoner at HMP Five Wells, on 20 November 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



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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.

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 Stefan Slack died in hospital on 20 November 2022, while a prisoner at HMP Five Wells. The cause of his death was a brain haemorrhage. Mr Slack was 28 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that Mr Slack's clinical care at Five Wells was equivalent to that which he could have expected to receive in the community.

Mr Slack became unconscious in the early hours of the morning, after complaining of a headache. I am concerned that there were delays in allowing paramedics to enter and leave the prison when he was clearly in a critical condition. I also consider that there is a need for greater clarity about the circumstances in which staff can discharge prisoners to hospital without a full risk assessment.

Given Mr Slack was comatose, he presented no risk of escape, so the use of handcuffs was highly inappropriate. While I acknowledge that this was the first death at Five Wells and many staff are new to the prison environment, Prison Service policies are very clear that restraints should not be applied in these circumstances. I urge the Director to prioritise training for operational and healthcare staff expected to complete security risk assessments.

I commend the prison's key workers and family liaison officers for the high standard of support to Mr Slack and his family, respectively.

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 2024

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Summary

Events

1. Mr Stefan Slack, aged 28, was convicted of sexual offences and sentenced to three and a half years imprisonment on 10 June 2021. He transferred to HMP Five Wells on 30 March 2022.
2. When he arrived at the prison, Mr Slack had no existing medical conditions and there was limited contact with healthcare staff over the following months.
3. At 12.40am on 19 November, Mr Slack told a wing officer that he had a headache and he appeared to be confused. Two nurses went to his cell. While examining Mr Slack, he became unconscious, and a medical emergency was called.
4. Paramedics attended and took Mr Slack to a local hospital. He was handcuffed and escorted by two prison officers. He was later transferred to a hospital that provides acute medical and trauma services, where he had surgery. Mr Slack did not recover and died on 20 November.

Findings

5. The clinical reviewer concluded that Mr Slack's clinical care at Five Wells was equivalent to that which he could have expected to receive in the community. However, she had concerns about some aspects of the emergency procedures.
6. We share the clinical reviewer's concern that paramedics experienced delays in entering and leaving the prison.
7. The investigation found several shortcomings in the handling of the security risk assessment for Mr Slack's journey to hospital. Healthcare staff at the prison had received no formal training on security risk assessments. The nurse who completed the healthcare information, retrospectively, had not been involved in the emergency and was unaware of Mr Slack's condition when she signed the risk assessment form.
8. We are concerned that Mr Slack was restrained while unconscious and sedated. This suggests that staff might not understand the risk assessment policy and processes, particularly the need to be proportionate and to consider a prisoner's condition and the need for decency when considering the use of restraints.
9. We consider that staff would benefit from more explicit instructions on the discretion to discharge a prisoner to hospital without a full risk assessment in a time-critical or life-threatening emergency.
10. The prison's family liaison officers kept in close contact with Mr Slack's family before and after his death and were highly supportive.
11. We were also impressed with the quality of the engagement between prison key workers and Mr Slack, evidenced in meticulous record keeping.

Recommendations

- The Director should ensure that there are no delays in ambulances entering and leaving the prison; and that in a medical emergency, access from the prison gate to the wing is coordinated, to allow paramedics to reach an incident quickly.
- The Director and Head of Healthcare should ensure that:
 - all staff undertaking security risk assessments for prisoners taken to hospital understand the legal position on the use of restraints;
 - healthcare information is accurate and sufficiently detailed to reflect the prisoner's clinical condition at the time, as well as the impact on their ability to escape unaided;
 - restraints are not used when a prisoner is unconscious, or during serious or invasive treatment; and
 - learning needs are formally identified and addressed.
- The Head of Healthcare should ensure that healthcare staff fully understand the context of documents they are asked to complete and sign and comply with the guidelines of their professional bodies.
- The Director should ensure staff are aware that, in a time-critical or life-threatening emergency, they have the discretion to discharge prisoners to hospital before completing a full risk assessment.
- The Director should share the Ombudsman's comments about the high standard of support and professionalism of the family liaison officers and prison key workers.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Five Wells, informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded but was discharged shortly afterwards, before he could provide further information.
13. The investigator obtained copies of relevant extracts from Mr Slack's prison and medical records. She had an informal discussion with the Head of Security.
14. NHS England commissioned an independent clinical reviewer to review Mr Slack's clinical care at the prison.
15. We informed HM Coroner for Northamptonshire of the investigation. She 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 Slack's mother, his next of kin, to explain the investigation. She had no specific matters for the investigation to consider.
17. We sent a copy of the initial report to Mr Slack's mother. She pointed out errors in the clinical review report, which have been rectified.
18. We shared the initial report with HMPPS. They found no factual inaccuracies.

Background Information

HMP Five Wells

19. HMP Five Wells, in Wellingborough, is the UK's first purpose-built resettlement prison. It opened in 2022 and is operated by G4S. The prison holds around 1,680 men. Practice Plus Group provides healthcare services 24 hours a day.

HM Inspectorate of Prisons

20. There has yet to be an inspection of HMP Five Wells.

Independent Monitoring Board

21. No IMB reports have been published for HMP Five Wells.

Previous deaths at HMP Five Wells

22. Mr Slack's death was the first at Five Wells. There has since been another recent death from natural causes.

Key Events

23. Mr Stefan Slack was convicted of sexual offences and breach of a sexual harm prevention order. On 10 June 2021, he was sentenced to three and a half years imprisonment and sent to HMP Hull. On 30 March 2022, Mr Slack transferred from HMP Stafford to HMP Five Wells.
24. Healthcare staff conducted initial and secondary health screens on 30 and 31 March, respectively. Mr Slack had no pre-existing medical conditions and there were no concerns about his physical or mental health.
25. Over the following months, Mr Slack had limited contact with healthcare staff. His appointments were mostly for a stomach condition, minor ailments and dental care.

Events of 19 November 2022

26. Accounts of events after Mr Slack became unwell vary slightly in detail.
27. At 12.40am on 19 November, Mr Slack rang his cell bell and told a prison custody officer (PCO) that he had a headache. The officer was concerned that Mr Slack appeared to be confused and telephoned the healthcare centre.
28. Two nurses went to the cell. Mr Slack told them that he had stood up and briefly lost consciousness. He thought he had hit his head on a table when he collapsed (but there were no signs of injury). The nurses found it difficult to take Mr Slack's blood pressure, but his other clinical observations were within normal range. While they were examining Mr Slack, he became agitated, confused and, at 1.07am, lost consciousness. They called a code blue medical emergency (which indicates that a prisoner is unconscious or has breathing difficulties) and the control room immediately called an ambulance. The nurses placed Mr Slack in the recovery position and gave him oxygen while waiting.
29. Paramedics arrived at the prison sometime between 1.51am and 1.53am and entered the prison gate at 1.57am. They began to examine Mr Slack at 2.03am and noted he was unresponsive but breathing.
30. The operational manager in charge of the prison that night noted that due to the urgency, there was insufficient time to complete the security risk assessment before the ambulance left the prison, so he briefed the escort officers verbally. The night duty security manager and the operational manager later completed the risk assessment.
31. At 2.42am, the paramedics took Mr Slack to Northampton General Hospital. He was escorted by two prison officers and handcuffed. A CT scan revealed that Mr Slack had a severe bleed on the brain.
32. At 6.33am, Mr Slack was transferred to John Radcliffe Hospital, which provides services for acute conditions. One of the escort officers noted that the handcuffs were removed as there were only three seats available in the back of the ambulance and two doctors had to accompany Mr Slack. He added that Mr Slack had already been sedated ready for surgery.

33. After surgery, Mr Slack was admitted to the intensive care unit. On 20 November, the hospital withdrew treatment and Mr Slack's mother was with him when he died at 1.38pm.

Contact with Mr Slack's family

34. At around 8.30am on 19 November, a prison manager informed Mr Slack's mother that he was seriously ill. The manager and the prison's family liaison officer (FLO) remained in close contact throughout Mr Slack's time in hospital. They promptly passed on important messages and questions from hospital clinicians, ensured all contact details were exchanged and arranged for Mr Slack's family to visit him before he died.
35. After Mr Slack's death, the FLO spoke to Mr Slack's mother regularly and arranged for his family to visit the prison. Mr Slack's funeral was held on 17 January 2023 and a video link was provided for prisoners to attend. In line with national policy, the prison contributed to the funeral expenses.

Support for prisoners and staff

36. A prison manger debriefed the escort officers and offered support.
37. The Head of Healthcare held a team debrief for healthcare staff. The prison later posted notices informing other staff and prisoners of Mr Slack's death and signposting to the options for support.

Post-mortem report

38. The report of the post-mortem examination concluded that the cause of Mr Slack's death was a spontaneous intracerebral haemorrhage (bleeding within the brain which had not been caused by injury or surgery).

Findings

Clinical care

39. The clinical reviewer concluded that Mr Slack's clinical care was equivalent to that which he could have expected to receive in the community. However, she was concerned about delays escorting the emergency ambulance when Mr Slack fell ill, and anomalies in the clinical input to the security risk assessment. We share the clinical reviewer's concerns, which are reflected below.

Emergency response

40. Prison Service Instruction (PSI) 3/2013, Medical Emergency Response Codes, sets out the actions staff should take in a medical emergency. This includes a mandatory requirement that prisons must, "...prevent any unnecessary delay in escorting ambulances and paramedics to the patient and discharging them from the prison (with or without the patient) ..."
41. The paramedics recorded that there had been a delay entering and leaving the prison while waiting for the gates to be opened, applying handcuffs and observing other security protocols. Their records show that after arriving at the prison, they waited between 2-4 minutes before the main gate was opened and it took 10-12 minutes, overall, to get to Mr Slack's cell. (Prison healthcare records indicate that the paramedics arrived at the cell at 2.15am, but this was incorrect as the paramedics' assessment began at 2.03am.)
42. The Head of Security told the investigator that it is a large site and emergency ambulances are not searched. We acknowledge that there is limited staffing at night. Nevertheless, staff were expecting the ambulance, so a wait of several minutes before getting through the main prison gate seems excessive, without good cause. It is essential that there are no avoidable delays in enabling paramedics to gain access to the prison. We recommend:

The Director should ensure that there are no delays in ambulances entering and leaving the prison; and that in a medical emergency, access from the prison gate to the wing is coordinated, to allow paramedics to reach an incident quickly.

Security risk assessments and the use of restraints

43. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.
44. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical

condition. The judgment indicated that a medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

45. These requirements are reflected in the HMPPS policy framework, Prevention of Escapes – External Escorts, on the use of restraints. The policy encourages sensitive handling to ensure that the needs of security are balanced against the clinical needs of a seriously ill prisoner. It also makes clear that the handcuffing of a prisoner receiving lifesaving treatment must be justified by documented security considerations which are specific to the prisoner.

Healthcare information included on the risk assessment form

46. Five Wells' Hospital Escort Risk Assessment form specifies that healthcare information *must* be completed before the prisoner leaves the prison unless there are no healthcare staff on duty. Understandably and justifiably, the duty security manager exercised his discretion to allow Mr Slack to leave without a full risk assessment, so the form was completed later.
47. The responses in the healthcare section of the form indicated that there were no objections to the use of restraints; and that Mr Slack's current state of health and mobility did not affect his ability to escape. A nurse had been asked to complete and sign the healthcare assessment when she arrived for duty at around 7.00am. (She also signed an updated bedwatch risk assessment that day.)
48. The nurse was fairly new to working in prisons. She had not been on duty during the emergency and did not know about Mr Slack's condition. She said she had been guided by a security officer. It is unclear why the nurses involved in the emergency were not asked to complete the form.
49. The Head of Healthcare said that although there had been discussions about completing the risk assessments, healthcare staff had received no formal training. She has since identified training needs and intends to deliver appropriate training.

Decision to use restraints

50. Mr Slack was an enhanced prisoner on the prison's incentives scheme. His case notes were positive, and he had no recent negative behaviour or disciplinary charges. The night duty security manager concluded that the risk of escape was 'normal' (the standard rating if no information is available) and recommended the use of handcuffs and an escort chain. The operational manager authorised this.
51. The Head of Security told the investigator that many of the operational staff at Five Wells are new to the prison environment, but they have all received training in escort duties and the use of restraints. He was constructive and committed to learning any lessons arising from the investigation.
52. We are content with the decision to allow Mr Slack to leave the prison without a full risk assessment, as he needed urgent specialist treatment. However, a concern is that although the national policy framework provides for prisoners in a life-threatening condition to leave the prison without an escort risk assessment, this is not explicitly stated on Five Wells' risk assessment guidance. The impression given

on the form is that the absence of healthcare staff is the only exception. Without broader and more specific instructions on this issue, some staff might be unaware that they have the authority to exercise discretion in exceptional circumstances.

53. We are also concerned about the judgements and decision-making when the risk assessment was later completed. The nurse should not have completed and signed the medical entry without knowing the condition of the prisoner concerned. It is unacceptable that Mr Slack was restrained while unconscious and sedated. We recommend:

The Director and Head of Healthcare should ensure that:

- **all staff undertaking security risk assessments for prisoners taken to hospital understand the legal position on the use of restraints;**
- **healthcare information is accurate and sufficiently detailed to reflect the prisoner's clinical condition at the time, as well as the impact on their ability to escape unaided;**
- **restraints are not used when a prisoner is unconscious, or during serious or invasive treatment; and**
- **learning needs are formally identified and addressed.**

The Head of Healthcare should ensure that healthcare staff fully understand the context of documents they are asked to complete and sign and comply with the guidelines of their professional bodies.

The Director should ensure staff are aware that, in a time-critical or life-threatening emergency, they have the discretion to discharge prisoners to hospital before completing a full risk assessment.

Good practice

Family liaison

54. The prison's family liaison officers provided an exceptional standard of support. Their advice, help and interactions were evidenced by detailed record keeping. We commend their professionalism, responsiveness and compassion.

Key work and record keeping

55. The investigation also found that there was a high level of support and engagement with Mr Slack's key workers. Interactions were comprehensively documented and gave a clear picture of the positive relationships between staff and Mr Slack.

The Director should share the Ombudsman's comments about the high standard of support and professionalism of the family liaison officers and prison key workers.

Inquest

56. At the inquest, held from 30 September to 7 October 2026, the jury concluded that Mr Slack died from natural causes.

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