Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ricky Slade a prisoner at HMP Nottingham on 3 February 2017

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*
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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.

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

Mr Ricky Slade was found hanged in his cell at HMP Nottingham on 3 February 2017. He was 30 years old. I offer my condolences to Mr Slade's family and friends.

Mr Slade was identified as at risk of suicide when he arrived at Nottingham on 25 January, but an officer concluded he was no longer at risk of suicide or self-harm and stopped monitoring the next day. Mr Slade was found hanged eight days later.

We have raised concerns in the past with Nottingham about the quality of their assessments of prisoners' risk of suicide and self-harm. In particular, we have repeatedly flagged that staff place too much reliance on how someone appears at the time of a review and not on known risk factors, thus missing an opportunity to offer appropriate support and monitoring. We express similar concerns this case, as well as highlighting another significant missed opportunity to identify Mr Slade's risk of suicide.

There were also deficiencies in the emergency response, including a delay before anyone went into Mr Slade's cell and attempting resuscitation despite signs that he had died.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **October 2017**

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Summary

Events

1. On 25 January 2017, Mr Ricky Slade was remanded to HMP Nottingham, awaiting sentence for sexual offences. It was his first time in prison and he had no previous convictions. Mr Slade told reception staff that he had cut his wrists that morning. Reception staff assessed he was at risk of suicide or self-harm and started Prison Service suicide prevention measures, known as ACCT. The reception nurse referred him for a mental health assessment.

2. At his ACCT assessment the next day, Mr Slade said he had no reason to live if he could not contact his three children. He had thought about jumping off a multi-storey car park but he was not thinking about suicide at that time. He was upset to be in prison for the first time and was anxious about what would happen to him. A supervising officer held an ACCT case review later that day, with only Mr Slade in attendance. Mr Slade said he would not kill himself because of his children and said he would speak to staff if he felt like harming himself. The supervising officer considered he was no longer at risk of suicide or self-harm and stopped suicide prevention measures on 26 January.

3. On 2 February, Mr Slade's offender manager interviewed him via video link for his pre-sentence report. She had to stop the interview because he became so upset when he spoke about his offences. Mr Slade told the offender manager he had self-harmed the day before, but that prison staff were managing his risk. The offender manager recorded the conversation on his probation record, but did not speak to prison staff about it.

4. The same day, a trainee mental health nurse assessed Mr Slade's mental health and he told her he had no thoughts of suicide or self-harm. He said he was upset about not being able to see his children and planned to speak to his ex-partner to arrange this. The trainee mental health nurse concluded that he had settled in prison and no longer needed mental health support.

5. A night officer found Mr Slade hanging at 5.45am the next morning. He shouted and radioed for assistance, but did not call an emergency code. He waited for the night manager's permission and extra staff to arrive before he went into Mr Slade's cell. Despite clear signs of rigor mortis, staff attempted to resuscitate Mr Slade until paramedics pronounced his death at 6.02am.

Findings

6. Staff appropriately began ACCT suicide and self-harm prevention measures when Mr Slade arrived at HMP Nottingham, but relied heavily on his presentation over his known risk factors so stopped monitoring too quickly. There was a significant failing in the communication and management of his risk, which meant staff missed a key opportunity to support him.

7. Nottingham's emergency response needs improvement. Despite instructions to staff to the contrary, the night officer understood that he was not allowed to go into Mr Slade's cell when he found him hanging. The investigation also found that staff tried unnecessarily to resuscitate Mr Slade when it was clearly too late.

Recommendations

- The Governor should ensure that effective mechanisms are in place to identify risk factors, that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff, including medical staff, should:
  - Ensure case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including healthcare staff attending first case reviews.
  - Assess risk of suicide and self-harm based on available information and all known risk factors and not just on the prisoner's presentation.
- The Governor and the probation divisional office for the Midlands should ensure that effective arrangements are in place so that offender managers can share all urgent risk information and such information is acted on with sufficient urgency.
- The Governor should ensure that all staff are aware of and understand PSI 24/2011 and Nottingham's local instructions for entering a cell alone. In particular, staff, including operational support grades should understand that, subject to a personal risk assessment, they should always enter a cell at when there is potentially a risk to life.

The Investigation Process

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

9. The investigator visited Nottingham on 10 February. She obtained copies of relevant extracts from Mr Slade's prison and medical records.

10. The investigator interviewed five members of staff at Nottingham prison on 15 March, telephone interviewed another member of staff and spoke to Mr Slade's solicitors by telephone. She interviewed Mr Slade's offender manager on 2 May.

11. NHS England commissioned a clinical reviewer to review Mr Slade's clinical care at the prison. The investigator and clinical reviewer jointly interviewed two members of the healthcare staff.

12. We informed HM Coroner for Nottinghamshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Slade's parents to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked for details of his self-harm and wanted to understand when and why the prison stopped suicide and self-harm prevention measures. They also asked why Mr Slade was in a single cell.

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

15. Mr Slade'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.

Background Information

HMP Nottingham

16. HMP Nottingham is a local prison holding over 1,000 men. Nottinghamshire Healthcare NHS Foundation Trust provides health services at the prison.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Nottingham was in February 2016. Inspectors reported that some aspects of support for those arriving new into the prison had improved but delays in reception were still significant.

18. The Inspectorate was concerned that vulnerable prisoners on the induction wing (like Mr Slade) experienced an extremely poor regime with very limited time out of cell or access to any purposeful activity.

19. The quality of ACCT documents was variable and many still had weaknesses. Quality assurance procedures were not yet producing the necessary improvement. The quality of ACCT documents had improved but there were still weaknesses. Reviews were often not multidisciplinary, case management was inconsistent and care maps were often limited. There was often limited evidence that staff engaged meaningfully with prisoners. Some prisoners on ACCTs told inspectors that they did not feel supported by staff and had nothing to keep them occupied.

Independent Monitoring Board

20. 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 the most recently published annual report for the year to February 2016, the IMB reported that offence-related vulnerable prisoners on the induction wing had a poor regime.

Previous deaths at HMP Nottingham

21. There was another self-inflicted death at HMP Nottingham in February 2017, which is still being investigated. We have previously recommended that staff should place less emphasis on a prisoner's presentation when determining their level of risk of suicide and self-harm.

Assessment, Care in Custody and Teamwork

22. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and self-harm. The purpose of the ACCT is to try to determine the level of risk, how to reduce the risk and how to best monitor and supervise the prisoner.

23. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in

place. The ACCT plan should not be closed until all of the actions of the caremap have been completed.

24. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

25. On 19 November 2016, Mr Ricky Slade was arrested and charged with sexual offences. His arrest received national media coverage. After Mr Slade pleaded guilty on 19 December, he failed to appear at crown court for sentencing on 24 January and police issued a warrant for his arrest.

26. On 25 January, Mr Slade handed himself into police custody. He appeared at court via video link and was remanded to HMP Nottingham to await his sentence. A police officer noted that Mr Slade had self-harmed that morning on his person escort record (PER – a document that goes with prisoners when they go between police stations, courts and prisons). An escort officer asked Mr Slade about the self-harm and he said he felt down, but now he felt better. When the escort officer explained that Mr Slade was going to prison, he was shocked and became very upset.

27. As soon as Mr Slade arrived at the prison, a reception officer assessed him as at risk of suicide and self-harm and started suicide prevention measures, known as ACCT. He recorded that Mr Slade had cut his wrists that morning and recorded that he was a vulnerable prisoner due to the nature of his offence. A Supervising Officer (SO) recorded that Mr Slade should share with a suitable cellmate and instructed staff to check him hourly until his level of risk had been fully assessed.

28. Mr Slade was tearful during his initial health screen with a nurse. She did not see his PER, but knew he was subject to ACCT monitoring. Mr Slade said he was suicidal because he could not believe he was in prison. She told the investigator that she did not know about his recent self-harm, but they discussed his self-harm nine or ten years ago. She said that he calmed down during their conversation and she referred Mr Slade to the mental health team for an assessment, but did not note their conversation or his referral on his ACCT record. She requested Mr Slade's community medical records.

29. Mr Slade was taken to a shared cell in an area of the induction unit reserved for prisoners who were considered vulnerable due to the nature of their offence. Officers checked him every hour overnight and one officer noted that he was chatting with his cellmate.

30. On 26 January, an officer assessed Mr Slade as part of ACCT procedures. Mr Slade said that he felt low because he could not contact his three children, it was his first time in prison and he was anxious about what was going to happen to him. Mr Slade said he cut his arm the day before because he had been so stressed since his arrest. He told the officer that he gone to a multi-storey car park because he was thinking about jumping off it, but he was too scared (he did not say when). Mr Slade said he did not plan to kill himself, but felt he had no reason to live without his children. Mr Slade said he got on well with his current cellmate.

31. A SO held an ACCT case review shortly after the ACCT assessment. Only he and Mr Slade were at the review. The officer who had assessed Mr Slade spoke to the SO beforehand. The SO told the investigator that healthcare staff do not normally attend the first case review (contrary to Prison Service instructions), but are routinely invited to the second ACCT review. Mr Slade again said that he

was upset because he did not know when he would see his children, but the thought of them stopped him killing himself. He said he would speak to staff if he felt like harming himself, so the SO considered he was no longer at risk of suicide and self-harm and stopped ACCT monitoring. There is no record that they discussed the nature of his offence, his anxiety about being in prison for the first time, or clarified when he would be able to see his children. The SO recorded on Mr Slade's caremap that he had no issues.

32. On the 27 January, a member of the offender management unit notified Mr Slade that the prison would monitor all of his post and telephone calls (except legal communication) and he had to apply for contact with any child due to the nature of his offence. The SO who closed the ACCT was with her when she explained the restrictions to Mr Slade in his cell and Mr Slade said he did not want to apply for contact at that time. They both told the investigator that Mr Slade seemed to understand the restrictions and neither of them were concerned that he was at increased risk to himself after that conversation.

33. On 31 January, a SO completed Mr Slade's ACCT post closure interview and recorded that he had settled in prison. Mr Slade told the supervising officer that he felt supported by other prisoners and his cellmate.

Thursday 2 February

34. Mr Slade's cellmate was released on the morning of 2 February. As he was not assessed as at risk of suicide or self-harm, there was no requirement to review whether he should share a cell and he remained in the double cell on his own.

35. At 9.10am, Mr Slade's offender manager (probation officer) interviewed him via video link for his pre-sentence report. The officer who escorted Mr Slade told her that Mr Slade had a healthcare appointment directly after the interview. When she asked Mr Slade about the appointment, Mr Slade it was because he had cut his arm the day before. She could not see any cuts on the video link. She understood from Mr Slade that the healthcare appointment was to treat the cuts, discuss his self-harm and assess his mental health.

36. When the offender manager asked Mr Slade about his offences, he became very upset and was unable to speak. He wept and put his head on the desk. Mr Slade said he just wanted to go back to how his life was before, that he had had enough of everything and just wanted it to be over. When asked about his mental health, Mr Slade told her that he had depression about two years before, antidepressants had not helped, but he had recovered and was not depressed at the time of the offence. He said he had never self-harmed before his offence, but he thought about suicide and had self-harmed while he had been in prison. (There is no record that Mr Slade self-harmed in prison.)

37. After the interview, the offender manager recorded her concerns about Mr Slade on his probation record (DELIUS), and completed an electronic notification of risk form for the court. Only staff in the offender management unit have access to DELIUS and they did not review Mr Slade's records that day. She did not speak to anyone at the prison about her concerns. She told the investigator that it was difficult to speak to someone at the prison when you had concerns and she

assumed the prison were aware of Mr Slade's risk of suicide and self-harm and were managing it.

38. Following the nurse's referral, a trainee mental health nurse assessed Mr Slade's mental health immediately after the offender manager's interview. A nurse supervised the assessment, as she was a trainee. She noted from his GP records that Mr Slade had been prescribed antidepressants about three years previously, but he said he was not receiving any mental health services. She recorded that Mr Slade was stable and that he had thoughts of self-harm when he came into prison, but said that he had settled in and knew how to access to support. He told her that he had no thoughts of suicide at the time of the assessment, although during the mental health screen he had said that he thought he was better off dead or wanted to hurt himself more than half of the time. He was upset about not contacting his children and talked about arranging to see them through his ex partner. She concluded that he was not at risk of suicide or self-harm and did not need the support of the mental health team. She discharged him from their care.

39. Mr Slade went to an education induction assessment at 2.45pm with other vulnerable prisoners on the induction unit. An officer described Mr Slade as very quiet during the session and said he did not speak to other prisoners.

40. At 4.23pm, Mr Slade was locked in his cell for the night. An officer checked him at 6.30pm and had no concerns. An operational support grade (OSG) checked all prisoners were in their cells at 8.45pm and 10.00pm.

Friday 3 February

41. During the morning roll check at 5.45am on 3 February, the OSG saw Mr Slade hanging with a bed sheet around his neck attached to the window latch. He shouted to an officer who was nearby, then radioed that there was "one hanging". He did not use an emergency code. Staff in the control room called an ambulance.

42. Despite carrying a cell key, the OSG did not go into Mr Slade's cell. He told the investigator he understood that he needed permission from the night manager to go into a cell and he should not go into a cell alone in any circumstance. The night manager radioed permission to go into the cell as more staff arrived. The night manager went into the cell first and cut the ligature. Despite signs of rigor mortis, staff attempted to resuscitate Mr Slade.

43. Two nurses got to the cell at 5.47am. Although the nurses told officers that resuscitation was likely to be futile, so they should stop; officers continued. At 6.01am, paramedics arrived and pronounced Mr Slade dead at 6.02am.

Contact with Mr Slade's family

44. Mr Slade nominated his ex partner as his next of kin when he arrived in prison. A prison manager visited her at home that morning. She gave Mr Slade's parents' address to him. He went directly to their home to break the news of their son's death. Mr Slade's parents visited his cell and the prison returned his property to them. The prison contributed towards funeral costs in line with national instructions.

Support for prisoners and staff

45. After Mr Slade's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

46. The prison posted notices informing other prisoners of Mr Slade'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 Slade's death.

Post-mortem report

47. The post mortem examination concluded that Mr Slade's cause of death was hanging. Toxicology tests resulted in no significant toxicological findings.

Findings

Assessing and managing the risk of suicide and self-harm

48. This was Mr Slade's first time in prison; he was convicted of sexual offences and understood that his access to his children might be restricted. He had self-harmed and had suicidal thoughts just before arriving in prison, and his escort record indicated that he was at risk. It was the right decision of an officer to begin ACCT procedures after his assessment of Mr Slade in reception.

49. Prison Service Instruction (PSI) 64/2011 contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. It requires ACCT case reviews to be multidisciplinary where possible and says that, for the first case review, a healthcare representative must attend. A SO chaired what he described as a case review, but it was not in line with the requirements of a multidisciplinary case review set out in PSI 64/2011. Only he and Mr Slade attended the case review. He did not invite anyone from the healthcare team to attend the review, so did not learn of Mr Slade's outstanding mental health referral.

50. In a PPO thematic report, published in April 2014, about risk factors in self-inflicted deaths, we found that too often assessments of risk place insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. Mr Slade was a vulnerable man in the early days of his first time in prison, who had discussed suicidal thoughts before coming into prison and his anxiety about not having contact with his children. Mr Slade might well have been feeling positive at the time of the review, but he had only been in prison for one day and we consider that his documented risk factors outweighed his positive presentation. In spite of these risk factors, the SO recorded that Mr Slade had no issues and stopped ACCT monitoring prematurely without addressing key risk factors, including contact with his children.

51. We do not consider that Nottingham managed Mr Slade's risk effectively, in line with Prison Service national policy and procedures. We make the following recommendation:

    The Governor should ensure that effective mechanisms are in place to identify risk factors, that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff, including medical staff, should:

    - **Ensure case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including healthcare staff attending first case reviews.**
    - **Assess risk of suicide and self-harm based on available information and all known risk factors and not just on the prisoner's presentation.**

52. On 2 February, the day before he died, Mr Slade told his probation officer that he had cut himself the previous day and that he was thinking about killing himself (although he did not have a plan). He also told her that prison staff knew about his risk and were managing it and she assumed he was going to have a

healthcare appointment directly after their interview to discuss his self-harm. Although she recorded their conversation in Mr Slade's probation records and alerted the court to his risk, she did not contact the prison about his distress or reported self-harm. She explained to the investigator that she thought the prison already knew about his risk and were managing it.

53. The offender manager said that she would usually contact a prisoner's offender supervisor with any concerns, but Mr Slade was awaiting sentencing, so he did not have an offender supervisor for her to contact. She told the investigator that she her experience of the prison's safer custody telephone line, was only ever to get through to an answerphone and the prison did not return messages until the next day. As she did not know who to contact and thought the prison was already managing Mr Slade's risk of suicide or self-harm, she did not communicate this key information.

54. The prison told the investigator that they have reviewed and strengthened their safer custody message system since Mr Slade's death.

The Governor and the probation divisional office for the Midlands should ensure that effective arrangements are in place so that offender managers can share all urgent risk information and such information is acted on with sufficient urgency.

Emergency response

55. The OSG found Mr Slade hanging in his cell at 5.45am. He radioed that a prisoner was hanging, but did not use the appropriate emergency code, in line with the prison's emergency response procedure. The control room officer called an ambulance straight away in this case because he communicated the nature of the emergency, but he should have used the appropriate emergency response code, code blue, indicating that a prisoner is unconscious or having difficulties breathing, to ensure that medical responders brought appropriate equipment with them.

56. The OSG did not go into Mr Slade's cell as he told the investigator that night patrol officers do not go into cells on their own without authority from the night manager. At night, officers have a cell key in a sealed pouch for use in an emergency. Prison Service Instruction (PSI) 24/2011, which covers the management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff.

57. Nottingham's local instruction states that, at night, staff have a duty of care to prisoners to themselves and to other staff. The preservation of life must take precedence over security concerns. Night staff should not take action that they feel would put themselves or others in unnecessary danger. Where there is or appears to be immediate danger of life, cells may be unlocked without the authority of a manager and the individual member of staff may enter on their own.

58. In practice, Nottingham instructs night patrol officers not to go into a cell on their own, but to raise the alarm and wait for other staff to arrive. We are concerned that, as a result, staff at Nottingham do not understand or comply with national

instructions and the prison's own local policy where there is risk to life and we make the following recommendation:

The Governor should ensure that all staff are aware of and understand PSI 24/2011 and Nottingham's local instructions for entering a cell alone. In particular, staff, including operational support grades should understand that, subject to a personal risk assessment, they should always enter a cell at when there is potentially a risk to life.

Resuscitation

59. The Oxleas NHS Foundation Trust emergency response operating procedure (August 2016) is clear that staff should not attempt resuscitation if rigor mortis is present. European Resuscitation Council Guidelines 2015 say, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile, such as the presence of rigor mortis". In 2016, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued revised guidance to prison governors and healthcare staff about making appropriate resuscitation decisions. The guidance says that every decision should be made based on a careful assessment of each individual's situation.

60. Despite the nurses' advice that resuscitation was futile, officers felt that they should continue until paramedics arrived. We understand the commendable wish to attempt and continue resuscitation until death has been formally pronounced, but staff should understand that they are not required to carry out cardiopulmonary resuscitation in all circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not necessary or appropriate.

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