Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Slade, a prisoner at HMP Parc, on 11 July 2019

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*
Fair: *we are honest and act with integrity*

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 Christopher Slade died on 11 July 2019, after being found hanging in his cell at HMP Parc. He was 25 years old. I offer my condolences to Mr Slade's family and friends.

Mr Slade was monitored under Prison Service suicide and self-harm prevention procedures (known as ACCT) from 30 June to 1 July, after he self-harmed by cutting his arm.

I am concerned that staff stopped ACCT procedures only 24 hours after they started them. No caremap was created and no one considered making a mental health referral. I consider that staff stopped ACCT monitoring prematurely and missed an opportunity to put supportive measures in place for Mr Slade.

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

Sue McAllister CB
Prisons and Probation Ombudsman **October 2020**

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Summary

Events

1. Mr Christopher Slade was serving a sentence of eight years and six months for grievous bodily harm. He was moved to HMP Parc on 27 January 2017.

2. On 18 June 2019, Mr Slade lost his job in the kitchen because of his aggressive behaviour. He was put onto the basic level of the incentives and earned privileges (IEP) scheme.

3. Mr Slade was suspected of using psychoactive substances (PS) on 28 and 29 June, and 3 July.

4. Between 30 June and 1 July, staff monitored Mr Slade under suicide and self-harm prevention procedures (known as ACCT) after he made cuts to his arm. He said he had cut himself because he was frustrated at being locked in his cell because he was on the basic regime.

5. On the morning of 11 July, staff spoke to Mr Slade as he was upset and frustrated at being on the basic regime. His cousin, who was also a prisoner at Parc, said that Mr Slade was crying, although he subsequently socialised on the unit.

6. Later that morning Mr Slade was taken to a disciplinary hearing (because he had refused to provide a urine sample for a drug test) but he asked to return to the wing as he said he was unable to stay in the crowded holding cell. The hearing went ahead in his absence and 34 days were added to Mr Slade's sentence, although he would not have known this before he died.

7. During a routine roll check at just after 7.00pm that evening, an officer found that Mr Slade had obscured his observation panel and blocked his door. She called for assistance. Officers freed the door at 7.05pm and when they entered the cell, they found Mr Slade hanging. Officers began cardiopulmonary resuscitation (CPR) and called for nurses to attend. Paramedics arrived at 7.20pm and assisted with CPR. Their efforts were unsuccessful and at 7.40pm, the paramedics pronounced that Mr Slade had died.

Findings

8. The officer who started ACCT procedures for Mr Slade on 30 June did not complete the paperwork to explain why.

9. We consider that the decision to stop ACCT monitoring on 1 July, after only 24 hours, was premature. No caremap was created and no one considered making a mental health referral. We consider that staff missed an opportunity to put supportive measures in place for Mr Slade.

10. On 10 July, Mr Slade telephoned a prisoner-led helpline asking to see a LIFT worker (prisoners who support other prisoners with mental health needs or who might be at risk of self-harm). The call handler told the investigator that he tried to tell staff by making several telephone calls to Mr Slade's wing, and another wing, but none of the calls were answered. He forgot to follow it up the next day.

Prison staff were not therefore aware that Mr Slade had asked for help and might need additional support.

11. Toxicology tests showed that Mr Slade had used PS before his death. It is not possible to say whether this affected his state of mind.

12. The staff who discovered Mr Slade hanging did not call a medical emergency code straightaway and then called the wrong code.

13. Staff involved in the emergency response did not complete incident statements.

Recommendations

- The Director should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, in particular that they:
    - complete ACCT paperwork in a timely manner;
    - ask a nurse to examine the prisoner for injuries following an act of self-harm;
    - identify risk factors and assess a prisoner's risk based on their risk factors and not just personal presentation; and
    - take appropriate action to address known risk factors, such as referrals to the mental health team.
- The Head of Healthcare should ensure that:
    - entries in prisoners' medical records accurately reflect the consultation; and
    - where the consultation is related to an incident of self-harm, that the entry explains the reasons for starting or not starting ACCT monitoring.
- The Director should produce clear guidance to ensure that all prisoner requests for support from the RALPH and LIFT teams are actioned on the day the request is made.
- The Director should ensure that all staff are aware of and use the appropriate medical emergency code when they discover an apparent medical emergency.
- The Director should ensure that staff directly involved in a death in custody complete incident statements as soon as practicable following the death.

The Investigation Process

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

15. The investigator obtained copies of relevant extracts from Mr Slade's prison and medical records. He interviewed 14 members of staff and three prisoners at Parc between 27 August and 22 October 2019. He subsequently spoke to another member of staff by telephone.

16. Health Inspectorate Wales commissioned an independent clinical reviewer to review Mr Slade's clinical care at the prison. They jointly interviewed clinical and other staff.

17. We informed HM Coroner for South Wales Central of the investigation. The Coroner sent us the results of the post-mortem examinations. We have given the Coroner a copy of this report.

18. We contacted Mr Slade's mother and father to explain the investigation process and to ask if they had any matters they wanted the investigation to consider.

19. Mr Slade's mother contacted us through her solicitor and asked:

    - What mental health treatment had Mr Slade received.
    - What support had he received following his last act of self-harm.
    - What support had he received for his dependency on 'Spice' (psychoactive substances - PS).
    - Whether there were indications he was about to harm himself and whether appropriate support was given.
    - Whether policy was followed on checks on prisoners on the basic level of the incentives and earned privileges (IEP) scheme.
    - What alerted staff to the fact that he had harmed himself.
    - Whether it was appropriate to move him back into his cell after he was pronounced dead.
    - Why the news of his death was broken to the family by telephone.

20. Mr Slade's father asked whether his history had been considered by Parc in caring for him and whether appropriate checks were made on him.

21. These issues have been covered in the report.

Background Information

HMP Parc

22. HMP Parc is a medium security training prison near Bridgend, which holds over 1,600 convicted and remanded adults and young people. Parc is operated under contract by G4S Care and Justice Ltd.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Parc was in November 2019. Inspectors noted that there had been a recent decline in levels of self-harm, though the levels of self-harm were still concerning at around 100 incidents a month. Reducing self-harm was regarded as a priority, and over the previous 12 months a more integrated approach, based on trauma-informed principles, had been adopted, to try to achieve this. This involved greater use of specialist staff, including a psychologist and a behaviour analyst, who provided guidance and advice to support operational staff. There was a clear recognition about the potential links between prisoners using drugs, getting into debt and then resorting to self-harm. As a result of this, action had been taken to try to reduce the use of illicit drugs, including the introduction of a body scanner, as well as providing educational input for prisoners about the dangers of drug use.

24. During the inspection, there were 60 prisoners on ACCT documentation. Those spoken to were positive about their treatment, particularly those with complex needs. The quality of ACCT documentation was mixed. Although quality assurance measures were in place, care maps lacked detail and observations were not always conducted at unpredictable intervals.

Independent Monitoring Board

25. 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 28 February 2019, the IMB reported that it had seen further positive developments in safety and the reduction of self-harm. The growth in the size and skill base of the safer custody team had enabled a wider understanding of both the reasons for this and the interventions most likely to achieve improvement.

Previous deaths at HMP Parc

26. Mr Slade was the 13th prisoner to die at Parc since November 2017. Of the previous deaths, one was self-inflicted, four were drug-related and seven were from natural causes. There are no similarities between our findings in the investigation into Mr Slade's death and our investigation findings from the previous deaths.

Assessment, Care in Custody and Teamwork

27. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to

reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Checks made on prisoners should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

28. On 9 November 2016, Mr Christopher Slade was remanded in prison custody charged with grievous bodily harm. He was sent to HMP Cardiff. He was later convicted and sentenced to eight years and six months in prison.

29. On 27 January 2017, Mr Slade was moved to HMP Parc. The reception nurse noted that Mr Slade had a history of self-harm (he had tried to hang himself on 10 January at Cardiff) and a possible diagnosis of post-traumatic stress disorder (PTSD). His prescription of sertraline (antidepressant) was continued.

30. A mental health nurse saw Mr Slade on 1 March. She considered that he did not need mental health input at that time.

31. Between 23 and 31 May, staff monitored Mr Slade under suicide and self-harm procedures (known as ACCT) because he was low in mood and an officer had seen a ligature in his cell. He told staff that his PTSD "came in waves".

32. Mr Slade was suspected of being under the influence of psychoactive substances (PS) on three occasions, in April 2017, March 2018 and November 2018.

2019

33. During a routine search of staff on 12 June 2019, Officer A was found in possession of a letter written to her by Mr Slade in which he said that he had strong feelings for her. Officer A told the search team that Mr Slade had given her the letter in the late afternoon of 10 June and that she had intended to pass the letter to the security office, but had forgotten to do so.

34. On 18 June, Mr Slade was dismissed from his job in the prison kitchen for aggressive and abusive behaviour and for throwing a chair. He was put onto the basic level of the Incentives and Earned Privileges (IEP) scheme and received a suspended punishment of 14 days' loss of privileges.

35. On 19 June, Officer A was interviewed by her immediate managers, a Senior Operational Manager (SOM) and an Operational Manager (OM) about the letter from Mr Slade. She told them that she had had no difficulties with Mr Slade and she felt comfortable about him remaining on the unit. Mr Slade's cell was searched for any inappropriate items and nothing was found. The managers considered that Mr Slade was doing well on the wing and they decided that it was appropriate and safe to allow him to remain.

36. At 4.10am on 28 June, a nurse was called to examine Mr Slade as he was seen by officers lying on the floor of his cell. She noted that his blood/oxygen saturation level was low and his pulse was slightly raised. She also noted that he was falling in and out of sleep.

37. Another nurse also checked Mr Slade. She noted that Mr Slade was screaming and shouting and was vomiting on the cell floor. Both nurses checked Mr Slade every 20 to 30 minutes until 8.00am, when he was noted to be asleep, breathing well and no longer giving cause for concern.

30 June – 1 July

38. Mr Slade's medical record suggests that he might have used an illicit substance at some time on 29 June. He was subject to frequent checks until 9.10am on 30 June when he was noted to be "fully combative".

39. A prisoner told the investigator that he had known Mr Slade for several years. He said that they shared a cell in June and at the end of the month, Mr Slade started using 'Spice' (PS) which caused him to behave erratically. He said that Mr Slade had had a particularly extreme reaction to 'Spice' on the night of 29 into 30 June; he was vomiting and screaming and the prisoner was scared.

40. At around 10.00am on 30 June, an officer saw Mr Slade standing by his hand basin with signs of blood on his arm. Mr Slade refused to show his arm. The officer telephoned healthcare staff to report the incident and he started ACCT procedures. He said that he should have completed the 'concern and keep safe' section of the ACCT document but he had been too busy at the time and he forgot to do it. (There is no entry in Mr Slade's medical records about this incident of self-harm.)

41. The OM spoke to Mr Slade on 30 June to ask whether he wanted to speak to a Listener (a prisoner trained by the Samaritans), but he declined. Staff checked his cell for medication, drugs and other illicit items. The OM said that staff found some tablets. She said that Mr Slade was very irate. He denied that he had taken an illicit substance saying that all he had taken was paracetamol. The prisoner asked to move to a different cell later that day and he was moved to another cell on B3 Unit.

42. An officer told the investigator that during the lunchtime patrol period on 30 June, Mr Slade began kicking his door as he wanted to speak to a manager. The officer was unable to contact a manager so he returned to Mr Slade's cell to ask him to wait until 2.00pm, when all the staff would return from their lunch breaks. The officer said that Mr Slade then began to shout and began to strike his arm with an object, possibly a razor blade, and he began to bleed. He called a code red (a medical emergency code used to indicate that a prisoner has severe bleeding).

43. A paramedic employed at Parc, responded to the code red. He examined Mr Slade and noted that he had superficial cuts to his left forearm and that no treatment was needed.

44. Another officer carried out Mr Slade's ACCT assessment interview later that afternoon. She told the investigator that Mr Slade was laughing and joking with other prisoners when she arrived, and she had to persuade him to attend the interview. She said Mr Slade did not engage properly; he laughed at her questions and answered that he was fine to every question. He said he had no thoughts of suicide or self-harm. She noted on her assessment that Mr Slade was happy on B3 Unit where he had a good network of friends. She noted that he was in a single cell on basic level IEP, but that he was okay with the situation. She said that at the end of the interview Mr Slade went straight back to his friends and she briefed the OM.

45. Mr Slade telephoned his father on the evening of 30 June and told him that his IEP level had been reduced to basic and he was due to have a mandatory drug test. Mr Slade said that he had been compliant with prison rules during the recent past but was now being punished for one mistake, which he said was a "kick in the teeth". Mr Slade's father told him to make sure he never returned to prison after this sentence, and Mr Slade agreed. For the rest of their conversation Mr Slade and his father spoke about art and Mr Slade also said that he was due to attend a book club.

46. At 10.00am on 1 July, the OM chaired an ACCT case review with Mr Slade and a nurse. The OM said that Mr Slade was very calm and respectful at the review. He said that the reason he had cut himself was through frustration at being locked in his cell and that he had no thoughts of suicide or self-harm. He said that he was aware of the support available through the Samaritans, the Listeners, and other prisoner support services. The OM noted that Mr Slade enjoyed an excellent rapport with staff and that she and a nurse agreed to stop ACCT procedures.

2 to 10 July

47. On 2 July, a substance misuse worker spoke with Mr Slade about his use of 'Spice' (PS). Mr Slade told her that he used 'Spice' regularly due to boredom. He said though that the drug was causing him severe constipation so he had decided to stop using it. She discussed with Mr Slade the risks associated with 'Spice' and she gave him an information leaflet. Mr Slade told her that he did not want any further support from the service but she explained to him that support would be available if he changed his mind.

48. It appears that Mr Slade used an illicit substance once more on the morning of 3 July. A nurse noted that Mr Slade was lying on his bed and was responsive, but his speech was slurred. Mr Slade refused to be examined but the nurse noted that he would be observed twice an hour until the afternoon. Monitoring ended at 2.30pm when Mr Slade was again noted to be "fully combative". (The investigator was provided with most of the logs completed while he was being monitored for the effects of PS, but Parc could not locate the monitoring log for 3 July.)

49. Mr Slade was asked to provide a urine sample for a mandatory drug test but he refused to supply one. He was placed on a disciplinary charge.

50. On 4 July, another substance misuse worker went to speak to Mr Slade to offer support but Mr Slade refused to engage with him.

51. On 5 July, Mr Slade's key worker tried to speak to him for a key worker session (key workers are officers with responsibility for up to six prisoners, who they should meet with weekly, to engage, support and motivate them during their time in prison). He noted that Mr Slade was lying on his bed and refused to speak to him and he turned over to face the wall. The key worker told the investigator that he was not alarmed at Mr Slade's response as he thought that Mr Slade might simply have wanted to continue sleeping. The key worker also said that he was unaware that an ACCT had been briefly opened and closed on Mr Slade a few days before.

52. On 8 July, the OM saw Mr Slade for an ACCT post-closure interview. The OM noted that Mr Slade was engaging in various activities and he stated that he had no current concerns. The OM told the investigator that she had no concerns about Mr Slade's safety that day.

53. Mr Slade telephoned his father on the evening of 8 July. He said that he was still on basic level IEP but said that it was okay as staff allowed some leeway. Mr Slade told his father about the book he had just finished reading and said that he had applied for an art course. Mr Slade told his father that he had 80 weeks left to serve but said that it was no problem as each week passed quickly.

54. On 9 July, a nurse saw Mr Slade and made an entry in his medical record to say that he had harmed himself by making superficial scratches to his forearm and which she had cleaned and treated. (Immediately following Mr Slade's death, the Head of Healthcare asked a nurse about her entry. The nurse said that this was not a new wound, instead, Mr Slade had been scratching an old wound and had disturbed it. Mr Slade had then submitted an electronic request for his arm to be checked as it was red and itchy.).

55. A prisoner told the investigator that in the summer of 2019 he was the lead coordinator for a prisoner-led advice line known as RALPH which provides services similar to those provided in the community by the Citizens Advice Bureau. He said that the RALPH team had an office and a dedicated telephone line so prisoners could contact them directly on their in-cell telephones. The prisoner also described another prisoner-led initiative known as LIFT which supports prisoners with mental health and behavioural needs or who might be at risk of self-harm. He said that there were LIFT team members on the various units in Parc. He said that there was no LIFT team member on B3 Unit, but there was one on B1. He said that the LIFT team did not have a telephone line so prisoners sometimes contacted the RALPH team to ask them to contact the LIFT team.

56. The RALPH team lead coordinator said that he took a call from Mr Slade at 3.00pm on 10 July asking to see a LIFT worker. He said that Mr Slade did not sound distressed but he had never asked for LIFT before so he wondered what the issue might be. He said that the RALPH office closed at 4.30pm and between 3.00pm and 4.30pm he made several calls to B3 and B1 Unit to ask staff to arrange for a LIFT worker to visit Mr Slade. He said that none of his calls were answered and he forgot to follow up the matter the following day. He said that if he had thought the matter was urgent, he would have been able to telephone the prison's communications line and they would definitely have answered his call.

11 July

57. Mr Slade's cousin was also on B3 Unit. He told the investigator that he had gone to Mr Slade's cell on the morning of 11 July. Two officers were in the cell with Mr Slade who was crying and saying that he had been blocked for a move to T Wing for failing a mandatory drug test. The officers asked his cousin to leave.

58. The investigator viewed the CCTV footage from B3 starting from 9.52am (footage from before this time was not available). Mr Slade's door was not

visible as a pillar was directly in line between the CCTV camera and the cell door. However, the footage confirms that his cousin went towards Mr Slade's cell and came away again almost immediately. During this time three officers all went towards the cell at different times.

59. An officer told the investigator that he believed Mr Slade might have been kicking his cell door and might then have activated the fire alarm by lighting some tissue beneath the smoke sensor. The officer said that he went into Mr Slade's cell and spoke to him for around ten minutes. The officer said that Mr Slade was not tearful, but he was frustrated because he was not having the same amount of time out of his cell as other prisoners due to being on basic level IEP. The officer said that their conversation was similar to other conversations he had had with Mr Slade where Mr Slade had initially flared up and had then calmed down again and began smiling. The officer said that the Mr Slade's cousin later returned to the cell and he asked him to cut Mr Slade's hair. He said that Mr Slade and his cousin were both good barbers and they always cut one another's hair.

60. Mr Slade's cousin confirmed that when he returned to Christopher's cell, they walked together to the association area where he cut Christopher's hair. (CCTV footage confirms this.)

61. Officer A told the investigator that in the late morning she took Mr Slade to the Phoenix Unit (Parc's segregation unit) for an independent adjudication hearing into his refusal on 1 July to provide a urine sample. When they arrived, Officer A took Mr Slade to the holding cell. Mr Slade asked how long he would have to stay in the cell and when she told him she did not know, he said that he could not stay in the holding cell as it was too crowded and he asked to return to B3. She asked him if he was sure and when he said he was, she took him back to B3. Mr Slade's adjudication hearing proceeded without him and the presiding district judge added 34 days to Mr Slade's sentence. (Notification of the adjudication outcome would have been sent to B3 in the late afternoon and Mr Slade would have been told the following morning.)

62. Officer A said that after they returned to B3 she asked Mr Slade if he wanted to collect his lunch. He said that he did not want lunch but she persuaded him to take a sandwich pack.

63. As Mr Slade was on the basic level of the IEP scheme, he was locked in his cell at just after midday and not unlocked again. As Mr Slade was not being monitored under ACCT, there was no reason for him to be subject to any checks in between standard roll checks (count of prisoners).

64. An officer told the investigator that between 4.00pm and 5.00pm, Mr Slade used the in-cell intercom on two occasions to make abusive comments to him and had also been abusive when he went to his cell to check on him. The officer said that he believed that Mr Slade was simply angry about being locked in his cell due to being on basic level of the IEP scheme.

65. CCTV footage shows Officer A going towards Mr Slade's cell at 4.43pm and for around one minute she remains near Mr Slade's cell but she cannot be seen due to the pillar that obstructs the CCTV. Immediately after Mr Slade's death, the OM checked whether any of the staff had offered Mr Slade an evening meal.

Officer A told the OM that she offered Mr Slade a meal, but he declined to take one. (When the investigator later interviewed Officer A, she said that the last conversation she had with Mr Slade was when she persuaded him to take a meal at lunchtime.)

66. Mr Slade's cousin said that at about 6.30pm that evening, Mr Slade had been banging his cell door asking to speak to the officer.

67. At around 7.00pm, prisoners were locked into their cells at the end of afternoon association and officers then did a roll count by opening each cell and checking that the prisoners were present. Officer A was checking the cells on the ground floor landing and when she tried to unlock Mr Slade's door she found he had blocked the lock. Officer A opened the observation panel but Mr Slade had obscured the opening. Officer A called Mr Slade's name several times but he did not respond and she then called out to an OM to tell him what Mr Slade had done.

68. An officer said that the OM had called to him and an officer to help open Mr Slade's door. Another officer said that he kicked the door and a plastic fork fell out of the lock and the officers were then able to unlock it. He said that when they opened the door he saw Mr Slade hanging from a ligature that was tied to the window bars. He lifted Mr Slade's body and an officer cut the ligature. The officer was then able to pull the remains of the ligature away from Mr Slade's neck. The officers checked whether Mr Slade was breathing and checked for a pulse and then began giving chest compressions.

69. While the officers were assisting Mr Slade, the OM radioed the communications room for assistance. The investigator listened to a recording of the radio calls. In his first call, at 7.05pm, the OM asked for a nurse to attend B3 Unit as soon as possible. The OM made a second call 15 seconds later when he asked the communications room if they had received his code red call for all nurses to attend as soon as possible.

70. A prison paramedic heard the call for a nurse to attend B3 Unit followed a few seconds later by a call for all available nurses to attend. He said that when he arrived officers were performing chest compressions and they told him that they had checked Mr Slade with a defibrillator which had advised to continue with chest compressions. The paramedic employed said that he checked if Mr Slade was breathing and then inserted an airway tube to deliver oxygen. Just after this the staff moved Mr Slade from his cell onto the corridor so they would have more room to perform CPR.

71. Ambulance paramedics arrived at 7.20pm and efforts to try to resuscitate Mr Slade continued for a further 20 minutes. At around 7.40pm, the paramedics decided that further efforts should stop as Mr Slade was dead.

Contact with Mr Slade's family

72. While staff were still trying to resuscitate Mr Slade, his cousin telephoned his girlfriend to tell her that Mr Slade had hanged himself and he asked her to pass a message to Mr Slade's mother who lived just a few houses away. Shortly afterwards he spoke to Mr Slade's mother's partner and told him that he believed

that Mr Slade was dead. Mr Slade's mother then telephoned the prison several times asking for confirmation of the news.

73. The Director of Parc told the investigator that Mr Slade had not listed his current next of kin so Parc had listened to his telephone calls to try to determine his next of kin. All his recent calls had been to his father so Parc were planning to contact him, but when Mr Slade's mother telephoned again, the Director asked for the call to be put through to her. She said that it was clear from the conversation that Mr Slade's mother knew that the situation was very serious and in the circumstances she thought she should inform her that he was dead. She said that she believed she was only confirming news that Mr Slade's mother already knew. The Director said that she was very aware that such news should ordinarily be made by visiting the relative, but given all the circumstances she considered that to confirm the news then was the humane and decent thing to do.

74. As Mr Slade's parents had separated the Director then telephoned Mr Slade's father to obtain his address. He said that he would not disclose his address until he was told why he was being asked. Again, she broke the news that Mr Slade had died.

75. Following these conversations, the Director and a family liaison officer visited Mr Slade's mother at 11.00pm that evening. After spending time with Mr Slade's mother and her partner, they then went to the home of Mr Slade's father and his partner.

76. Parc contributed to the cost of Mr Slade's funeral in line with national instructions.

Support for prisoners and staff

77. An operational senior manager debriefed the staff who were involved in the response when Mr Slade was found. The staff care team also offered support.

78. The OM spoke that evening to Mr Slade's cousin to inform him that Mr Slade was dead. 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.

Events after Mr Slade's death

79. In the days following Mr Slade's death, prisoners wrote many messages of goodwill and support on his cell door which the prison photographed to share with his family.

80. On 23 July, an officer submitted an intelligence report after a prisoner told him that Mr Slade had been exchanging messages on social media with Officer A.

Post-mortem report

81. Mr Slade's post-mortem report gave his cause of death as hanging.

82. Results of toxicology tests showed the presence of PS. The toxicologist noted that that it was not possible to say how much PS Mr Slade had used before his death or what effect the drug might have had on his state of mind.

Findings

Management of Mr Slade's risk of suicide and self-harm

83. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the procedures (known as ACCT) that staff must follow where a prisoner is at risk of suicide and self-harm. It lists a range of factors that might increase a prisoner's risk of suicide and self-harm. Mr Slade had several risk factors including a history of substance misuse, a history of deliberate self-harm, anger problems and impulsive behaviour.

84. At around 10.00am on 30 June, an officer started ACCT procedures for Mr Slade when he saw signs of blood on his arm. He did not ask for a nurse to examine Mr Slade for injuries. He also failed to complete the 'concern and keep safe' page of the ACCT to explain why he had started ACCT procedures, because he said that he had been too busy at the time and forgot to complete it later. At lunchtime, another officer called a code red emergency code when Mr Slade became angry and started cutting his arm, which started to bleed. A prison paramedic examined Mr Slade and noted he had superficial cuts to his arm that did not require treatment.

85. An OM and a nurse held the first case review at 10.00am the next day. Mr Slade said that he had cut himself because he was frustrated at being locked in his cell because he was on the basic regime and said he no longer had thoughts of suicide or self-harm. They stopped ACCT procedures. We are concerned that this was only 24 hours after ACCT procedures were started.

86. The investigator asked the OM whether the decision to stop ACCT procedures might have been influenced by the fact that she knew Mr Slade. She said that that was not the case, the decision was based on the way Mr Slade presented on the day. She was aware that Mr Slade was no longer sharing a cell.

87. We consider that the OM might have placed too much emphasis on Mr Slade's presentation and his assurance that he had no thoughts of suicide or self-harm, rather than considering his risk factors and recent episode of self-harm. We are concerned that this was a missed opportunity to put support in place for Mr Slade. As staff stopped ACCT procedures at the first case review, they did not create a caremap and no one considered referring Mr Slade for a mental health assessment. We consider that the decision to stop ACCT monitoring was premature. We recommend that:

The Director should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, in particular that they:

- **complete ACCT paperwork in a timely manner;**
- **ask a nurse to examine the prisoner for injuries following an act of self-harm;**
- **identify risk factors and assess a prisoner's risk based on their risk factors and not just personal presentation; and**

- **take appropriate action to address known risk factors, such as referrals to the mental health team.**

Officer A

88. When it was discovered that Mr Slade had given Officer A a letter in which he set out his feelings for her, she was interviewed by her immediate line managers, an SOM and the OM. Officer A said that she had had no problems working with Mr Slade and that she did not consider that he posed a risk to her. The SOM and the OM decided against transferring Mr Slade to a new wing. In reaching their decision they took into account the absence of any evidence of any inappropriate relationship and also took into account that Mr Slade was progressing well on B3. We consider that this was a reasonable decision. Nothing occurred following this to suggest that Mr Slade was unduly affected by remaining on the unit.

89. Following Mr Slade's death, a prisoner told an officer that he believed that Mr Slade and Officer A had been exchanging messages on social media. The officer submitted a security report and Mr Slade's cell was searched for a mobile telephone, but nothing was found. Parc also referred the matter to the local police. At the time of writing this report, no evidence has emerged to support the prisoner's allegation about the exchange of messages.

Mr Slade's use of PS

90. We have been concerned for some time about the prevalence of PS in prisons and their effects on the behaviours and health of prisoners. In July 2015, we published a Learning Lesson Bulletin about the use in prisons of PS. The bulletin identified the need for better awareness among staff of the dangers of PS; the need for more effective drug supply reduction strategies; and better monitoring by drug treatment services. HMIP found during its last inspection of Parc in November 2019, that the prison had introduced measures to try to reduce the use of drugs. We therefore make no recommendation.

91. There were at least two instances between 30 June and 3 July when Mr Slade was suspected of being under the influence of PS. Mr Slade was monitored every two hours until he fully recovered. Substance misuse workers spoke to Mr Slade on 2 July and 4 July to offer him support. Mr Slade accepted an information leaflet but he declined any further support. We do not consider that there was anything further that the substance misuse team could have done without Mr Slade's cooperation.

Prisoner peer support

92. On the afternoon of 10 July, Mr Slade telephoned the lead coordinator on the RALPH peer support helpline. Mr Slade asked for a visit from a member of the LIFT team who support prisoners with mental health needs or who might be at risk of self-harm. The lead coordinator made several calls to the wing offices on both B3 and B1 Units but without success. He had still not been able to contact wing staff by the time the support team closed at 4.30pm and he forgot to follow up the matter the following day. Prison staff were, therefore, not aware that Mr Slade had sought help and might be at risk of suicide or self-harm. We make the following recommendation:

The Director should produce clear guidance to ensure that all prisoner requests for support from the LIFT team are actioned on the day the request is made.

Whether Mr Slade was crying on the morning of 11 July

93. Mr Slade's cousin told the investigator that when he went to Mr Slade's cell on the morning of 11 July, he was speaking to officers and was in tears. An officer told the investigator that he had gone to Mr Slade's cell after he had possibly activated the smoke alarm. He said that Mr Slade was frustrated with being on basic level of the IEP scheme and that he had calmed down after they had spoken for around ten minutes. He said that Mr Slade had not been in tears.

94. It is not possible to say with certainty which of these two accounts is correct, but the CCTV evidence shows that Mr Slade came out of his cell soon after this and he walked to the association area of the B3 landing where his cousin cut his hair. Mr Slade's cousin did not suggest that Mr Slade was still emotional by that time.

Evening meal

95. The investigator received contradictory evidence about whether Mr Slade was offered an evening meal. None of the officers said at interview that they had done so but the OM said that Officer A told her that she had offered Mr Slade a meal, which he had declined. The investigator viewed CCTV footage which shows that Officer A spent around a minute near Mr Slade's cell at 4.43pm. As stated before, a pillar obstructs sight of two cells: Mr Slade's cell and the adjoining cell. It is not certain therefore which cell Officer A attended at that time.

Use of emergency codes

96. When Mr Slade was discovered hanging in his cell, an OM initially radioed to ask for a nurse to attend immediately. Fifteen seconds later he radioed to ask if his code red call had been received for all nurses to attend. (A code red emergency call indicates a prisoner with severe blood loss; a code blue emergency call should be used where a prisoner is unconscious or experiencing significant breathing difficulties.)

97. Prison Service Instruction (PSI) 3/2013, *Medical emergency response codes*, requires Governors and Directors to have a protocol to provide guidance to staff on how to communicate the nature of a medical emergency efficiently so that staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. In his first call the OM did not specify a code and in his second call he used the wrong code it is unlikely that this affected the outcome for Mr Slade as officers had begun CPR as soon as they had cut Mr Slade down, but it could make a critical difference in future medical emergencies. We therefore make the following recommendation:

The Director should ensure that all staff are aware of and use the appropriate medical emergency code when they discover an apparent medical emergency.

Moving Mr Slade's body

98. When the paramedic arrived officers were performing CPR inside the cell. He decided that Mr Slade should be moved onto the landing so they would have more room. When it was decided that CPR should stop as Mr Slade was dead, his body was moved back into the cell and the cell sealed to help preserve evidence. The solicitors acting for Mr Slade's mother have questioned whether this was appropriate. We do not consider that there was anything inappropriate in returning Mr Slade's body to his cell.

Contact with Mr Slade's next of kin

99. Soon after staff found Mr Slade hanged, Mr Slade's mother heard from Mr Slade's cousin that something very serious had happened. She then made several phone calls to Parc to find out what had happened until she spoke to the Director of Parc. She was satisfied that the caller was Mr Slade's mother and she considered that the most compassionate option was to tell her by telephone that her son had died.

100. Prison Service Instruction (PSI) 64/2011 states that wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death. The PSI says that time will be of the essence in order to try to ensure that the family do not find out about the death from another source.

101. In Mr Slade's case his mother already knew that her son was either dead or was seriously unwell. The only options available to the Director were either to confirm the news by telephone or to ask his mother to wait while she and another member of staff drove to her home to inform her what had happened. We recognise that it was distressing for Mr Slade's mother to be told on the phone that her son had died, but given the circumstances, we consider that the Director made an appropriate decision.

Incident report forms

102. PSI 64/2011 says that staff directly involved in a death in custody, particularly those who were first on scene, must complete incident statements as soon as practicable. When the investigator made his initial visit to Parc on 18 July, he reminded the prison of this requirement but staff had still not completed statements by the time he returned to conduct staff interviews on 27 August. We make the following recommendation:

The Director should ensure that staff directly involved in a death in custody complete incident statements as soon as practicable following the death.

Clinical care

103. The clinical reviewer found that Mr Slade's care was equivalent to that which he could have expected to receive in the community. However, she noted that while Mr Slade had a history of failing to engage with professional staff, there were nevertheless missed opportunities to assess Mr Slade's mental state. There were no indications that Mr Slade's mental state was assessed after he made

superficial cuts to his arm on 30 June 2019, or following his use of PS in the last weeks of his life.

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