Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gareth Slater, a prisoner at HMP Dovegate, on 20 September 2020

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*

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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 Gareth Slater died in hospital on 20 September 2020 of septic shock caused by a middle ear abscess while a prisoner at HMP Dovegate. He was 34 years old. I offer my condolences to Mr Slater's family and friends.

When Mr Slater complained about ear pain and facial weakness on 7 September, a nurse assessed him and could not find anything wrong. The clinical reviewer found that in this respect Mr Slater's healthcare was not equivalent to that which he could have expected to receive in the community. She said that facial weakness can be a symptom of a serious condition. She concluded that if Mr Slater had been seen by a doctor or appropriately trained nurse and been diagnosed with an ear infection at this point, it is likely that the abscess would not have developed.

A further healthcare appointment was arranged for 10 September, but Mr Slater cancelled it. He did not contact healthcare again before he became seriously ill on 18 September.

Prison officers had significantly less contact with prisoners due to the very restricted regime in place during the COVID-19 pandemic, and this may have been a missed opportunity to identify that Mr Slater was unwell.

Although prison staff responded quickly when Mr Slater became seriously ill on 18 September, I am concerned that there was a short delay before healthcare staff reached his cell because of confusion about the location of the emergency. However, it is unlikely that this affected the outcome for Mr Slater.

We also identified shortcomings in the healthcare record-keeping, and I am concerned that this is not the first time we have made recommendations about this at Dovegate.

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 **August 2021**

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Summary

Events

1. In December 2018, Mr Gareth Slater was sentenced to 10 years in prison for wounding with intent. He was sent to HMP Doncaster.

2. In July 2019, Mr Slater complained of an ear infection. A nurse prescribed an antibiotic and ear spray to reduce the inflammation. When he later complained of hearing loss, she arranged a GP appointment, which Mr Slater failed to attend.

3. On 4 December 2019, Mr Slater transferred to HMP Dovegate. When he arrived, he said he had no ongoing health concerns.

4. On 7 September 2020, Mr Slater complained of ear pain and facial weakness. He was seen by a nurse who took his clinical observations and found no cause for concern. She booked a nurse review for the following day. This did not take place for reasons that are unclear. Mr Slater was given a further appointment on 10 September, which he cancelled. Mr Slater made no further requests to see healthcare staff.

5. At approximately 6.00pm on 18 September, Mr Slater began vomiting in his bed. His cellmate pressed the cell bell for assistance. Prison officers attended and called a nurse. Mr Slater refused any medical help, and it was agreed that staff and his cellmate should monitor him and call healthcare if he deteriorated.

6. At approximately 7.45pm, Mr Slater's cellmate pressed the cell bell again because Mr Slater was no longer responsive. An officer used a portable telephone to ask the control room to call an emergency medical code. The control room called an ambulance.

7. Healthcare staff initially went to the wrong wing because there was confusion over the location of the emergency.

8. Prison nurses tried to stabilise Mr Slater until ambulance paramedics arrived and took Mr Slater to hospital. His condition deteriorated and he died in hospital on 20 September.

9. The post-mortem examination found that Mr Slater's cause of death was septic shock due to a left middle ear abscess.

Findings

Clinical care

10. The clinical reviewer found that when Mr Slater started to experience ear pain, the standard of care he received at Dovegate was not equivalent to that which he could have expected to receive in the community.

11. The nurse who saw Mr Slater on 7 September was not trained to assess facial weakness. Although she booked him an appointment with a nurse the following day, this did not take place for reasons that are unclear. A further appointment booked for 10 September, was cancelled by Mr Slater. Mr Slater did not contact

healthcare staff again after this. As a result, Mr Slater's ear infection was not diagnosed, and the cause of his facial weakness was not explored.

Impact of COVID-19

12. There was a very limited regime in place in response to the COVID-19 pandemic and prisoners spent long periods in their cells. There is no record of prison staff having any meaningful contact with Mr Slater between 7 September when he first complained of ear pain and 18 September when he collapsed. This may have been a missed opportunity to identify that he was becoming very unwell.

Emergency response

13. Although staff responded quickly when Mr Slater became unwell on 18 September, the officers who were first on scene were unable to call an emergency medical code because they did not have radios. As a result, there was confusion about the location of the emergency, and this caused a short delay before healthcare staff reached Mr Slater's cell.

Record keeping

14. There were examples of poor record keeping as nurses failed to fully update Mr Slater's medical record.

15. The prison was unable to provide the PPO with a number of documents, including the escort risk assessments, prisoner escort record and bedwatch logs.

Recommendations

- The Head of Healthcare should ensure that nurses are aware of the significance of the symptom of facial weakness and that robust arrangements are made for patients complaining of facial weakness to be assessed by a doctor or suitably trained nurse.
- The Director should ensure that all operational staff have access to a working radio at night.
- The Director should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies including that staff:
    - use a medical emergency code immediately, by radio where possible, where there are serious concerns about the health of a prisoner; and
    - efficiently communicate the nature and location of a medical emergency so that there is no delay in healthcare staff attending.
- The Director should ensure that this report is shared with Officer A and that a senior manager discusses the Ombudsman's findings with him.
- The Head of Healthcare should ensure that staff:
    - understand their professional requirement, in line with the Nursing and Midwifery Council's guidance on record keeping, to make accurate, timely and contemporaneous notes in prisoners' medical records; and

    - record the reasons for missed appointments.
- The Director should ensure that all evidence, including electronic evidence, relevant to a death in custody is retained and made available to the PPO, in line with PSI 58/2010.

The Investigation Process

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

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

18. NHS England commissioned a clinical reviewer to review Mr Slater's clinical care at the prison. The investigator interviewed four members of staff and a prisoner on 28 October 2020. She and the clinical reviewer jointly interviewed healthcare staff. All the interviews were conducted by telephone because of the COVID-19 restrictions in place.

19. We informed HM Coroner for Staffordshire South of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

20. One of the Ombudsman's family liaison officers contacted Mr Slater's next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked:

    - Did Mr Slater have any medical assessments when he complained about headaches, earaches and pus in his ears?
    - Did Mr Slater have any GP appointments connected to headaches or his ears?
    - Did Mr Slater have a tumour?
    - What medication did Mr Slater receive in prison?
    - What were the circumstances of Mr Slater's death?
    - Did staff try to resuscitate Mr Slater and how long had the ambulance taken to arrive at the prison?

21. We have addressed these questions in this report and in the clinical review.

22. Mr Slater's family received a copy of the initial report. The solicitor representing them wrote to us pointing out some factual inaccuracies and/or omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

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

Background Information

HMP Dovegate

24. HMP Dovegate is a category B prison in Staffordshire, managed by Serco. The main prison holds around 930 remanded and sentenced adult men. There is also a separate therapeutic community which holds up to 220 men. Care UK provides 24-hour healthcare services. South Staffordshire and Shropshire Foundation Trust provides mental health services.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Dovegate was in October 2019. Inspectors reported some notable improvements since their last inspection in 2017. They reported that healthcare provision was reasonably good overall. Non-attendance rates for healthcare appointments were low and waiting times were acceptable.

Independent Monitoring Board

26. 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 September 2019, the IMB reported that healthcare services were good. There had been a reduction in the waiting time for dental and GP appointments and only 5% of internal appointments were missed. They also reported an increase in the availability of external escorts, resulting in very few cancellations of external hospital appointments.

Previous deaths at HMP Dovegate

27. Mr Slater was the ninth prisoner to die at Dovegate since September 2018. Of the previous deaths, three were self-inflicted, two were drug-related and three were from natural causes. Three natural causes deaths have occurred since Mr Slater’s death and are still under investigation.

28. Another prisoner died at Dovegate in July 2019 after developing an ear infection. Our investigation found that the care he received was not equivalent to that which he could have expected to receive in the community. We also found that the prisoner had not been adequately assessed by nursing staff who had failed to recognise that he was acutely ill, and there had been poor record keeping. We made recommendations about these issues.

29. In another investigation into a death at Dovegate in November 2019, we found that healthcare staff had failed to fully document events in the prisoner’s medical record.

30. We are concerned that we have found the same issues in this investigation.

Key Events

31. On 18 December 2018, Mr Gareth Slater was sentenced to 10 years in prison for wounding with intent. He was sent to HMP Doncaster.

32. In July 2019, Mr Slater complained of an ear infection. A nurse prescribed an antibiotic and ear spray to reduce the inflammation. When he later complained of hearing loss, she booked him a GP appointment, but Mr Slater failed to attend.

33. Mr Slater transferred to HMP Dovegate on 4 December 2019. At an initial health screen, a nurse recorded that Mr Slater had said that he did not have any ongoing medical conditions. At a secondary health screen Mr Slater told a healthcare assistant that he had mental health problems. She referred him to the mental health team. However, Mr Slater later said that he did not want any help from the mental health team.

34. In March 2020, Mr Slater and Prisoner A began sharing a double cell with bunk beds. Mr Slater slept on the top bunk.

35. Mr Slater had no contact with healthcare staff until 24 April when he complained of a respiratory infection. A nurse examined him and noted that his temperature, breathing and oxygen saturation were normal. The nurse advised him to self-isolate in line with government and NHS COVID-19 guidelines. Over the next two weeks nurses saw Mr Slater daily. He had a COVID-19 test on 5 May, which was negative. He recovered from his chest infection.

36. Prisoner A said that Mr Slater began complaining to him about ear pain and then about headaches from the end of August.

Events from 7 September 2020

37. On 7 September, a prison officer asked Nurse A to examine Mr Slater after he complained of facial weakness. Mr Slater told the nurse that he had poked an ear bud in his ear the previous night and now had pain in his ear and the side of his face. He also said his head was throbbing. She checked his observations, which were all normal, and she could see no evidence of facial weakness. She did not have an auroscope instrument with which to examine Mr Slater's ear in detail. She scheduled another nurse review for the next day.

38. The healthcare manager said that the next day a nurse, whose name is not recorded in Mr Slater's medical records, attempted to visit him in his cell but there was no reply. At interview Mr Slater's cellmate, Prisoner A, said that both he and Mr Slater were in their cell all day and he was not aware of a nurse attempting to see Mr Slater. Mr Slater was allocated a further nursing assessment appointment on 10 September. The healthcare manager noted in his record that Mr Slater did not attend this appointment and Mr Slater's cellmate told us Mr Slater had cancelled it.

39. Prisoner A said that Mr Slater continued to complain of a headache and that his behaviour changed. He became very drowsy, sleeping for long periods during the day and often refusing to eat or engage in any of his usual activities. Prisoner A also said that he could see a change in Mr Slater's facial muscles for

four to five days before he collapsed, with the left side of his face drooping and appearing swollen.

40. Mr Slater's father said that Mr Slater spoke to his girlfriend on 14 or 15 September and told her he was having headaches and had pus coming from his ears.

Events on 18 September

41. On 18 September, Prisoner A said that Mr Slater had been sleeping on his bunk when he woke up at around 2.30pm and told him that he felt unwell. Prisoner A rang the cell bell to summon staff assistance.

42. Prisoner A said an officer came to the cell and said he would telephone healthcare staff. The officer returned to the cell and relayed a message from healthcare staff that Mr Slater must go to the treatment hatch during the teatime medication round and talk to a nurse then. Sometime later, Mr Slater tried to get back on the top bunk and nearly fell. Prisoner A said that he called for help again and the officer told him that healthcare staff insisted Mr Slater had to go to the medication hatch.

43. Prisoner A said that he went to see the nurses at the medication hatch at about 4.15pm. A nurse told him that they were aware of Mr Slater's situation and someone would come to see Mr Slater after they had finished the medication rounds. This did not happen before Mr Slater's condition deteriorated further.

44. At approximately 6.00pm, Mr Slater was lying on his top bunk and began vomiting. Prisoner A tried to help him, but he said Mr Slater was unresponsive, so he pressed the emergency cell bell.

45. Officers A and B responded. At interview Officer A said that he was the prison movement coordinator, based in the central hub of Mr Slater's houseblock. He said he saw Mr Slater on the top bunk, covered in vomit. Mr Slater said he was "fine" and did not want any help.

46. At interview, Officer A said that he telephoned the control room and asked them to call a medical emergency code. However, in his statement written shortly after Mr Slater's death, he said that he telephoned the nurse on duty in reception, Nurse B, explained Mr Slater's symptoms and asked her to attend and if she wanted him to call a medical emergency code (which prompts the control room to call an ambulance immediately). She said no and that she would attend straight away. He said he then rang the duty manager, a Custodial Manager (CM) and asked him to attend. In her written statement Officer B said that Officer A telephoned staff in the control room to inform them that Mr Slater was unwell.

47. Nurse B noted in Mr Slater's medical record that she received a telephone call at approximately 6.30pm to visit Mr Slater. When she arrived, he was on the top bunk, facing the wall and lying in his own vomit. She said he turned his head slightly towards her, but he refused to talk to her or the officers and said he wanted to sleep. She was unable to check his observations. Prisoner A told her that he was concerned because Mr Slater was sleeping a lot more, which was unusual. She checked Mr Slater's medical record and could not find any information about his current condition. She agreed that Mr Slater's cellmate and

the officers should monitor his condition and call for help if he deteriorated and said she would hand over to healthcare night staff to monitor him.

48. At approximately 7.45pm, Mr Slater vomited again. Prisoner A said he was snoring loudly and was not responding. He pressed the emergency cell bell. Officers A and B responded. Officer A said he used the cordless telephone in the wing office to call the control room again to ask them to call another medical emergency code.

49. The prison's record of events log notes that an emergency code blue was called at 7.45pm, but it gave the incorrect location as C wing. There were repeated radio requests to clarify the emergency location but neither officers responded as neither had a radio.

50. A nurse said that she heard the radio emergency call from the control room at approximately 7.45pm, but when she and other healthcare staff arrived at the houseblock given it was the wrong location. She said she repeatedly asked for the location over the radio. When there was no response, she and her colleagues split into two teams to visit two other houseblocks to try to find the emergency. She arrived at House Block 3 and an officer confirmed the emergency was on the wing. She repeated the radio emergency code with the correct location.

51. The nurse said that when she arrived at the cell, Mr Slater was on his bunk bed, facing the wall. She called his name and when he did not respond she rolled him over and he vomited. She made sure his airway was clear, placed him on his side so she could see him and checked his breathing. Prison staff lifted Mr Slater to the floor so the nurses could attend to him more easily. She said at this point Mr Slater was able to squeeze her hand in response to questions. She noted that his oxygen saturation levels were very low. Another nurse administered oxygen, but Mr Slater's respiratory rate dropped, his oxygen levels were not increasing, and he stopped responding to questions.

52. Ambulance records show that the prison requested an ambulance at 7.49pm. The prison rang again at 8.05pm asking for the estimated arrival time of the ambulance. Paramedics arrived at 8.12pm and asked for a crew with full personal protective equipment (PPE) and a doctor to attend. At 8.55pm and 8.57pm further ambulance crews arrived.

53. Mr Slater's condition continued to deteriorate. A nurse attached defibrillator paddles to his chest (a machine that can restart the heart in certain circumstances), but no shock was recommended, and Mr Slater's heart continued to beat so CPR was not required. He remained unconscious and was foaming at the mouth. At 9.00pm, Mr Slater was taken to the Royal Derby Hospital by ambulance.

54. At 9.10pm, Mr Slater's mother rang the prison as his cellmate had telephoned Mr Slater's girlfriend to tell her that he was unwell. Prison staff told her that Mr Slater was on the way to hospital and staff would update her.

55. Mr Slater was admitted to the hospital's intensive care unit and was placed in an induced coma. Hospital staff diagnosed a brain abscess and tests showed no

brain activity. On 20 September life support was withdrawn, and Mr Slater died at 6.00pm.

Contact with Mr Slater's family

56. On 18 September, the prison appointed an officer as the family liaison officer (FLO) and another officer as the deputy FLO. After receiving an update from hospital staff about Mr Slater's condition on the morning of 19 September, the deputy FLO rang Mr Slater's next of kin to tell them that Mr Slater was seriously ill. She arranged for Mr Slater's family to visit Mr Slater in the intensive care unit. Both FLOs attended and offered support to his family.

57. When Mr Slater died, the FLO telephoned Mr Slater's next of kin, offering her condolences. She maintained contact with Mr Slater's family, offering support and information.

58. Mr Slater's funeral was held on 12 October. The prison contributed to the costs of Mr Slater's funeral in line with national policy.

Support for prisoners and staff

59. After Mr Slater's death, a prison manager debriefed the staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

60. The prison posted notices informing other prisoners of Mr Slater'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 Slater's death.

Post-mortem report

61. The pathologist concluded that Mr Slater died of septic shock due to a left middle ear abscess.

Findings

Clinical care

62. The clinical reviewer found that there was evidence of good clinical practice when Mr Slater had a chest infection in April 2020. However, she concluded that aspects of Mr Slater's clinical care from September 2020 were not equivalent to that which he could have expected to receive in the community.

Events on 7 September

63. The clinical reviewer said that the fact that Mr Slater might have already been suffering from facial weakness on 7 September, suggests that the ear infection had already spread beyond the middle ear and was affecting the facial nerve. If he had been diagnosed with an ear infection prior to his collapse on18 September and received prompt treatment, it is likely that the brain abscess would not have developed.

64. The clinical reviewer said that Nurse A was not trained to conduct a full neurological examination of Mr Slater's facial nerves. Mild facial weakness may only cause subtle signs and Mr Slater did not have access to a doctor or appropriately trained nurse capable of diagnosing facial weakness, which would have triggered urgent further investigation.

65. The clinical reviewer accepted that Nurse A arranged for Mr Slater to be reviewed further the following day. She said it is not clear why this did not happen or why Mr Slater cancelled a further appointment on 10 September, but that this meant that his ear infection was not diagnosed. She also said that in the light of the COVID-19 pandemic, equivalence with treatment in the community is a difficult concept to assess.

66. We recommend:

    The Head of Healthcare should ensure that nurses are aware of the significance of the symptom of facial weakness and that robust arrangements are made for patients complaining of facial weakness to be assessed by a doctor or suitably trained nurse.

Impact of COVID-19

67. Mr Slater did not contact healthcare again after 7 September. However, his cellmate said that Mr Slater continued to complain of a headache, and he slept a lot and did not engage in his usual activities. He also said that the side of Mr Slater's face drooped and looked swollen in the four or five days before he died.

68. We would normally have expected that staff would have noticed this. However, the very restricted COVID-19 regime in place at this time meant that prisoners were locked in their cells for very long periods and were not attending work or education. Staff therefore had significantly less contact with prisoners than they would have done pre-pandemic.

69. The last record of staff having a conversation with Mr Slater was on 26 July, when an officer made a welfare check. Another officer made a routine call to Mr

Slater's mother on 18 August to tell her that Mr Slater had no issues (although there is no record that he spoke to Mr Slater first). There are no further entries in Mr Slater's prison records until 18 September when he collapsed.

70. We consider that the very restricted regime may have meant that staff failed to notice signs that Mr Slater was unwell between 7 and 18 September. However, we note that Mr Slater himself made no attempt to contact healthcare during this period.

Emergency response

71. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol to ensure that healthcare staff attend immediately with the appropriate equipment and an ambulance is called automatically in a life-threatening emergency. It says that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies.

72. In the event of a life-threatening situation the first member of staff on scene is responsible for calling a medical emergency code

73. Officers A and B were the first officers to arrive at Mr Slater's cell when his cellmate pressed the cell bell at about 6.00pm. Neither had a radio. Officer B said that there was a shortage of batteries and Officer A said that he was not required to carry a radio.

74. Officer A said at interview that he used a cordless phone in the wing office to telephone the control room and ask them to call a medical emergency code. However, in his written statement he said he simply called the control room to ask for nurses and duty managers to attend Mr Slater's cell. This account was confirmed by Officer B.

75. When Officer A responded to Mr Slater's cell bell again at about 7.45pm, Mr Slater had deteriorated, and he appropriately telephoned the control room and asked them to call a code blue. At interview he described this as the second code blue. However, there is only one record of a code blue being called and healthcare staff said they only heard one.

76. Mr Slater was still responding when Officer A saw him the first time at around 6.00pm and he was seen by a nurse. We do not, therefore, criticise him for not calling a medical emergency code on this occasion. However, we are concerned that he was unclear whether he had called a code or not.

77. We are also concerned that when a medical emergency code was called at 7.45pm, the incorrect location was given. This led to a delay in healthcare staff finding the correct cell. Officers A and B could not respond to radio requests for the correct location because neither had a radio.

78. We are concerned that the absence of a radio caused an unnecessary delay in healthcare staff reaching Mr Slater. We consider that all operational members of staff should have access to a radio at night to allow emergency codes to be called without delay.

79. It is important that prison staff understand their roles in a medical emergency, as early intervention when someone is found unresponsive might save their life. The confused medical emergency code messages that sent nurses to the wrong wing should not have happened. The clinical reviewer said that the slight delay is unlikely to have affected the outcome for Mr Slater. However, a delay of even a few minutes may make a crucial difference in another medical emergency.

80. We make the following recommendations:

The Director should ensure that all operational staff have access to a working radio at night.

The Director should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies including that staff:

- **use a medical emergency code immediately, by radio where possible, where there are serious concerns about the health of a prisoner; and**
- **efficiently communicate the nature of a medical emergency so that there is no delay in healthcare staff attending.**

The Director should ensure that this report is shared with Officer A and that a senior manager discusses the Ombudsman's findings with him.

Record keeping

81. An unnamed nurse was said to have visited Mr Slater in his cell on 8 September. The healthcare manager made a late entry in Mr Slater's medical record on 9 September recording that a "home visit" had been attempted but there was no reply. However, Mr Slater's cellmate said that they were in their cell all day because of the very restricted COVID-19 regime and that no nurse visited.

82. At interview the healthcare manager said that a nurse had told her about the visit, but she could not recall who. She also said that after the missed appointment, Mr Slater had been allocated another appointment for 10 September, but that he had cancelled this appointment. This information is not recorded in his medical records and the reason for the cancellation is not known. These events should have been fully documented in his medical record, but they were not.

83. We are concerned that this is not the first time we have found shortcomings in healthcare record-keeping at Dovegate. We recommend:

The Head of Healthcare should ensure that staff:

- **understand their professional requirement, in line with the Nursing and Midwifery Council's guidance on record keeping, to make accurate, timely and contemporaneous notes in prisoners' medical records; and**
- **record the reasons for missed appointments.**

84. We are also concerned that prison officers who were present when Mr Slater died did not make written statements, and that the prison was unable to provide

the PPO with any escort risk assessments, prisoner escort records or bedwatch logs. These records can provide crucial evidence for investigations, and we would expect the prison to ensure that evidence is preserved following a death in custody to enable appropriate scrutiny and accountability. We are therefore unable to comment on the use of restraints and the events when Mr Slater left the prison for hospital. We make the following recommendation:

The Director should ensure that all evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.

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