

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Peter Sharp a prisoner at HMP Lindholme on 17 April 2016

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## 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 Peter Sharp had been released on licence on 23 March 2016. He was recalled to custody to HMP Hull on 5 April. On 12 April, Mr Sharp was then transferred to HMP Lindholme. On 17 April, he was found hanging in his cell. Paramedics were called but they pronounced Mr Sharp dead. He was 39 years old. I offer my condolences to Mr Sharp's family and friends.

The investigation found that Mr Sharp had a history of mental illness, a significant history of self harm, and a history of drug abuse. Reception staff at HMP Hull did not identify Mr Sharp as being at risk of suicide and self-harm and do not appear to have considered his well-documented history of risk when he was recalled to prison. We cannot know whether a different assessment would have prevented Mr Sharp's actions twelve days later at HMP Lindholme but, as is too often the case, prison staff placed too much reliance on personal presentation, rather than known risk factors. It is unacceptable that Mr Sharp did not receive his prescribed medication.

I also note the ease with which Mr Sharp appeared to have been able to acquire illicit drugs in both prisons and once again we identify the risks posed to prison safety by new psychoactive substances.

Finally, I am concerned that the investigation once again found deficiencies in Lindholme's emergency response and its post fatal incident reporting.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**January 2017**

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# Summary

## Events

1. Mr Peter Sharp served numerous custodial sentences from 1996 onwards. He was released on licence on 23 March 2016 from HMP Humber and was required to report to South View Approved Premises the same day. He never arrived and, as a consequence, on 5 April he was recalled into custody at HMP Hull.
2. Mr Sharp had a history of mental illness, a significant history of self-harm, and a history of drug abuse. He had been diagnosed with a personality disorder and depression and was prescribed the appropriate medication. When Mr Sharp arrived at Hull, staff did not identify him as being at risk of suicide and self-harm.
3. On 12 April, Mr Sharp was transferred to HMP Lindholme. On transfer, his Personal Escort Record (PER) completed at Hull was inaccurate and incomplete. Nor was any prescribed medication or medical summary sent with him. He appeared to settle at Lindholme, had a job in the workshops and no one considered him to be at risk of suicide. Two prisoners give accounts of Mr Sharp smoking “spice” following his arrival at Lindholme.
4. On 17 April, an officer found Mr Sharp hanging in his cell and called for emergency medical assistance. Staff did not commence cardiopulmonary resuscitation (CPR) as it was evident that Mr Sharp had been dead for some time. An emergency ambulance was called and paramedics arrived. They made no attempt at resuscitation either and Mr Sharp was pronounced dead.

## Findings

5. The investigation found that staff failed to give sufficient weight to Mr Sharp’s level of risk when he arrived at Hull on 5 April and, in the circumstances, we believe Mr Sharp should have been managed under ACCT procedures. We find it unacceptable that Mr Sharp did not receive the medication he was prescribed by a prison doctor. While Mr Sharp gave no direct indication to staff or other prisoners that he had thoughts of suicide, staff were too reliant on his presentation in making an assessment.
6. On Mr Sharp’s transfer to Lindholme, the inaccuracy and incompleteness of the records which accompanied him, prevented prison staff there from making an appropriate assessment of risk, although he was referred to the mental health team for assessment. Again, Mr Sharp gave no indication to staff or other prisoners that he had thoughts of suicide and we consider that the provisional assessment made by Lindholme was appropriate under the circumstances and do not consider that Lindholme could have predicted or prevented his actions.
7. We are concerned at the evident availability of illicit drugs at both Hull and Lindholme, particularly new psychoactive substances (NPS). Although post-mortem tests suggested that Mr Sharp had not used NPS or other illicit drugs at the time of his death, other prisoners clearly stated that he had used them.
8. We are concerned about the emergency response. After officers called an emergency it took seven minutes before support staff called an ambulance. It

then took a further 25 minutes before paramedics arrived at the prison. While a quicker response would not have affected the outcome for Mr Sharp, it could be life saving in the future.

## Recommendations

- The Governor of Hull should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them on arrival. In particular, this should ensure that reception and first night staff:
  - Have a clear understanding of their responsibilities and the need to share all relevant information about risk;
  - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from Person Escort Record forms (PER) and other sources;
  - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.
- The Heads of Healthcare at HMP Hull and HMP Lindholme should review the process for the prescribing and dispensing of medicines to ensure there are no delays in prisoners receiving their medication, supported by an accurate audit trail.
- The Head of Healthcare at HMP Hull should ensure all practitioners maintain medical records, in accordance with national medical practice and code of conduct, and that all documentation is completed accurately.
- The Governors of Hull and Lindholme should ensure there are effective supply and demand reduction strategies to help eradicate the availability of new psychoactive substances, and that staff are vigilant to signs of its use and know how to respond when a prisoner appears to be under the influence of such substances
- The Governor of Lindholme should ensure that all prison staff are made aware of and understand PSI 03/2013 *Medical Emergency Response Codes*, and their responsibilities during medical emergencies which:
  - Ensures staff immediately call for an emergency ambulance when a medical emergency code is used;
  - Ensures that an emergency response protocol is in place with the ambulance service;
  - Ensures that all emergency equipment, including radios, is in good working order.
- The Governor of Lindholme should ensure that all relevant mandatory actions in PSI 64/2011 *Management of prisons at risk of harm to self, to others and from others (Safer Custody)* are completed after a prisoner's death.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Lindholme informing them of the investigation and asking anyone with relevant information to contact him. No one came forward.
10. The investigator visited Lindholme on 8 December. He obtained copies of relevant extracts from Mr Sharp's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Sharp's clinical care at the prison.
12. The investigator interviewed thirteen members of staff and two prisoners at HMP Lindholme and HMP Hull in May. Six of these were interviewed jointly with the clinical reviewer.
13. We informed HM Coroner for South East Yorkshire of the investigation and he gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Sharp's father to explain the investigation and to ask whether the family had any matters they wanted the investigation to consider. Mr Sharp's father requested details around the circumstances of his son's death. He also enquired whether Mr Sharp knew how long he had left to serve in prison. He felt that if his son had known he was due to serve the full term of his sentence following recall from licence then this would have been, in his view, "the final straw". Mr Sharp's father received a copy of the Initial report. He did not make any comments.

## Background Information

### HMP Lindholme

15. HMP Lindholme is a medium security prison near Doncaster, which holds approximately 1,000 men. Nottinghamshire Healthcare Foundation NHS Trust provides healthcare services. These include a daily GP clinic, some specialist services and out-of-hours GPs.

### HM Inspectorate of Prisons

16. The most recent inspection of HMP Lindholme was carried out in March 2016. Inspectors found very high levels of victimisation and incidents of self-harm. These were linked to an influx of illicit drugs, in particular of NPS which has destabilised the prison. Inspectors noted that although the authorities at Lindholme had seized considerable amounts of such drugs, they still remained readily available. Inspectors found that security was well-managed and focused on the significant threats from prisoners associated with organised crime groups and their links to violence and drug-related activity. The quality of relationships between staff and prisoners was found to be good. Health services were reasonably good overall.

### Independent Monitoring Board

17. 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 most recently published report for the year to January 2016, the IMB commented that a major concern at Lindholme is the supply and use of illicit drugs, particularly NPS. It has been the cause of some disturbing incidents for a number of prisoners and is rife throughout the prison. The IMB are concerned that there does not appear to be a realistic plan in place to combat the use of drugs.

### Previous deaths at HMP Lindholme

18. Mr Sharp's death was the fourth at Lindholme since December 2013. Two of previous deaths were from natural causes, the other from mixed drug toxicity. There were similarities between the mixed drug toxicity death and that of Mr Sharp as in both cases there were delays in calling an emergency ambulance, delay in the ambulance arriving at the prison, and a failure to complete the mandatory actions following a death in custody.

### HMP Hull

19. HMP Hull is a local prison, which holds approximately 1,000 unconvicted and sentenced men in ten residential wings.

### HM Inspectorate of Prisons

20. The most recent inspection of HMP Hull was carried out in October 2014. Inspectors found the levels of self-harm were lower than the average for local prisons. Assessment, care in custody and teamwork (ACCT) case management documentation for prisoners at risk of suicide or self-harm demonstrated varying

degrees of care. Not all night staff carried ligature knives or understood why it was important to do so. Prisoners at risk said peer workers provided them with good support but staff did not. Levels of violence were similar to other local prisons and levels of self-harm were lower. Though the prison had a rigorous supply reduction policy, prisoners told inspectors that drugs were easily available.

### **Independent Monitoring Board**

21. 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 most recently published report for the year to December 2015, the IMB commented that ACCT training was a high priority and 50 staff had been trained during 2015. A major concern for the IMB was the availability of drugs and mobile phones at Hull.

### **Assessment, Care in Custody and Teamwork**

22. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. 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 multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. 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.

### **New Psychoactive Substances**

23. New Psychoactive Substances (NPS) are an increasing problem across the prison estate. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting.
24. As well as emerging evidence of dangers to both physical and mental health, it is possible that there are links to suicide or self-harm. Trading in these substances, while in prison can lead to debt, violence, and intimidation.
25. In July 2015, we published a Learning Lessons Bulletin about the use of NPS including the dangers to both physical and mental health and the possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services;

and effective violence reduction strategies because of the links between NPS and debt and bullying.

## Key Events

26. Mr Sharp had served numerous custodial sentences since 1996. He had been in custody since 25 March 2013 and, on 23 March 2016, was released on licence from HMP Humber. His licence conditions required him to report to South View Approved Premises the same day but Mr Sharp never arrived. On 24 March, his licence was revoked, meaning that he had to serve the remaining three years of his sentence in prison. On 4 April, he was arrested and taken into police custody and, on 5 April, he was sent to prison at HMP Hull.
27. Mr Sharp had a history of mental illness, a history of drug abuse and a significant history of self-harm while in prison custody. He had a personality disorder, depression and was prescribed olanzapine (an antipsychotic) and mirtazapine (an antidepressant). Mr Sharp had received extensive interventions by the mental health teams and visiting psychiatrists at both HMP Hull and HMP Humber and, from March 2013 until the date of his release, he had been monitored under ACCT procedures on 13 separate occasions. The last of these was closed on 12 February 2016.
28. Before he left police custody for Hull, a Person Escort Record form (PER) was completed. This document is intended to alert staff in all criminal justice agencies who come into contact with a prisoner, as to their risk of suicide and self-harm. The PER form noted that Mr Sharp had attempted suicide in March 2013 and had last self-harmed on 9 February 2016 – three months earlier. It also stated that Mr Sharp had mental health issues and was prescribed mirtazapine and olanzapine, but he had not taken any medication for six days. The PER form accompanied Mr Sharp to Hull.
29. Mr Sharp had served sentences at Hull in the past. When he arrived there on 5 April, a nurse saw him for an initial health screen, which included an assessment of risk of suicide and self-harm. The nurse noted that Mr Sharp had a small cut to the right side of his head which Mr Sharp said had been caused when he fought with the police. Mr Sharp said that he had used heroin during the previous two weeks. The nurse recorded that Mr Sharp did not have any medication and had only used what was given to him on his release. She also recorded that Mr Sharp showed no signs of withdrawal and no signs of mental illness. Mr Sharp said he had no thoughts of self-harm or suicide, although the nurse recorded that he had a history of cutting himself. She did not open an ACCT, nor is there any record of her referring Mr Sharp to be seen by a doctor or the mental health team. She completed the cell sharing risk assessment (CSRA) form and noted that there were no immediate risks or concerns.
30. The nurse told the investigator that she had worked at Hull for 19 years and that she remembered Mr Sharp from his previous sentences. She said she knew that Mr Sharp had self-harmed regularly in the past. She said her assessment of Mr Sharp was based only on his presentation at the time and not his past history or other risk factors. As Mr Sharp had said he had no thoughts of self-harm, she said she had no concerns about his well-being. She said that the initial health screen is intended to ensure a prisoner is safe that first night and that she was unable to access his past medical record.

31. The Head of Healthcare at Hull told the investigator that healthcare staff can indeed access a prisoner's medical record before they begin to complete the health screen template. She said the nurse who conducted the initial health screen should have opened an ACCT because of the presence of known risk factors of recall to custody: self-harm, mental illness and substance misuse.
32. An officer saw Mr Sharp and completed a first night and induction with Mr Sharp. Mr Sharp said that he had no immediate family issues such as a partner or dependant children, and that his family was aware that he was in custody. The officer recorded that Mr Sharp had said he did not have any thoughts of, or intention to, self-harm. The officer explained to Mr Sharp how to seek help from staff, and how to contact the Samaritans and Listeners (prisoners trained by the Samaritans). He gave him information about the prison regime, including how to use the phone system.
33. The officer told the investigator that he looked at the CSRA risk assessment and PER forms. He said the interview with Mr Sharp had lasted about 20 minutes and that he remembered Mr Sharp from previous sentences. He said that Mr Sharp had given him no concerns and he had based his assessment only on how Mr Sharp presented at the time and did not consider any other risk factors.
34. The Head of Residence and Safety at Hull, told the investigator that when a prisoner arrives in custody, prison staff can access the prison computer record to check on that prisoner's previous custodial history. She said that staff are aware that recall to custody, mental health and history of self harm are known risk factors for self-harm and suicide. She said that, based on the information available regarding Mr Sharp, staff should have opened an ACCT on his arrival at Hull.
35. On 6 April, a nurse saw Mr Sharp for a second health screen. The nurse recorded that Mr Sharp had disclosed no thoughts of self-harm, but had mental health issues and had previously been prescribed olanzapine and mirtazapine. (This prescription had automatically ended upon Mr Sharp's release on licence from HMP Humber and he had not registered with a GP during his brief spell in the community.) The nurse referred Mr Sharp to the mental health team and to a doctor to prescribe his medication. She also noted that Mr Sharp was not to retain his medication within his possession.
36. On 7 April, a prison doctor prescribed 28 days of medication. He prescribed mirtazapine at 30mg and olanzapine 10mg, each tablet to be taken once daily. Although the doctor prescribed the medication, no evidence could be found that Mr Sharp had actually received any medication.
37. The Head of Healthcare explained that, after a doctor has prescribed medication, a medication chart is written up by the pharmacy. This chart, along with the medication itself, is then sent to the wing treatment room for storage. The medication chart is updated each time the medication is dispensed to the prisoner. The Head of Healthcare said that there was no evidence to confirm that Mr Sharp had been given his medication while at Hull.
38. On 12 April, a nurse saw Mr Sharp before he was transferred to HMP Lindholme. The nurse recorded in Mr Sharp's medical record that he had disclosed no

thoughts of self-harm, had not declared any health concerns and was fit to be transferred. She also recorded that Mr Sharp was prescribed medication and that it was included within his belongings. She completed the PER form. On the form, however, she indicated that Mr Sharp had no health concerns and no prescribed medication.

39. The nurse told the investigator that she had made a mistake in what she had recorded. She said that Mr Sharp's medication was not within his possession and she had completed the PER incorrectly. She said she had put Mr Sharp's medication, together with a copy of his medical summary, in a sealed envelope to be given to prison escort staff. This was also incorrect. She said she was not aware that Mr Sharp was at risk and her assessment was that he was fit to be transferred.
40. The Head of Healthcare explained the procedure that healthcare staff should follow when a prisoner is to be transferred. Any medication and the medication chart should be sent from the wing treatment room on the evening prior to release. Prisoners should be accompanied by a minimum of seven days supply of medication. In Mr Sharp's case, as the doctor had given a prescription for 28 days of medication on 7 April, Mr Sharp should have had 23 days of medication to go with him to Lindholme. The Head of Healthcare said that, from the evidence available, no medication for Mr Sharp accompanied him on leaving Hull for Lindholme.
41. Prison phone records show that, throughout his time at Hull, Mr Sharp made no phone calls and did not have any visits.
42. On arrival at Lindholme on Tuesday 12 April, Mr Sharp saw a nurse in reception. The nurse recorded that Mr Sharp had a history of mental illness, a history of self-harm and attempted suicide, and a history of drug abuse. Mr Sharp said he had no current thoughts of self-harm. The nurse also recorded that Mr Sharp had previously been prescribed olanzapine and mirtazapine. The nurse referred Mr Sharp to the doctor and the mental health team. She told the investigator that she had checked the PER and Mr Sharp had not arrived with any medication or medical summary.
43. The Head of Healthcare at Lindholme told the investigator that the mental health team at Lindholme only work between Monday and Friday. There was also a five working day wait for appointments. She confirmed that the reception nurse did make a referral to the mental health team and Mr Sharp had an appointment scheduled for Tuesday 19 April. She also confirmed that the nurse had referred Mr Sharp to the prison doctor to have his medication prescribed. No doctor had actioned this by the time Mr Sharp died. The Head of Healthcare said that Hull had not sent across any medication for Mr Sharp.
44. An officer saw Mr Sharp and completed the induction process. He explained to Mr Sharp how to seek help from staff and how to contact the Samaritans and Listeners. He gave him information about the prison regime, including how to use the phone system. The officer said that Mr Sharp engaged well with the induction process, asked questions and said he looked forward to working in the kitchens or gardens.

45. Another prisoner was transferred from Hull to Lindholme on the same day as Mr Sharp. He told the investigator that he and Mr Sharp went through the induction process together. The prisoner said that Mr Sharp had told him that when he was released from Humber he had not wanted to go the approved premises. On release, he had gone out and got drunk instead. Mr Sharp told the prisoner that while he was at Humber he had used spice (a form of NPS) and pulled out some of his teeth because he thought the dentist had inserted surveillance bugs into them. The prisoner told the investigator that as soon as Mr Sharp reached the wing at Lindholme he had exchanged a packet of tobacco for spice.
46. A second prisoner, said he was on the same wing as Mr Sharp and knew him from previous custodial sentences. The second prisoner said Mr Sharp had smoked spice from the day he arrived at Lindholme. He said that he and Mr Sharp had smoked spice together on the evening of 15 April.
47. Prison phone records show between 5 April and 16 April, Mr Sharp made no phone calls and received no visits.
48. On 17 April, at approximately 5.51am, an operational support grade began the roll check at the end of the night shift. When she reached Mr Sharp's cell, she opened the observation panel and found that Mr Sharp had partially covered the glass from inside the cell with what appeared to be a piece of card. She could not see Mr Sharp and said she assumed he may have been at the toilet. She continued with her checks and returned to Mr Sharp's cell. The operational support grade looked over the piece of card and saw Mr Sharp hanging from the cell door bracket by a ligature made from bedding. At 5.58am, she used her radio to summon assistance from the Night Intervention Team.
49. The operational support grade told the investigator that there are two emergency codes in use: code red for blood loss, and code blue for prisoners who are unconscious or having difficulty breathing. These codes summon assistance and prompt a 999 call made by prison officers for an emergency ambulance. However she did not use a code.
50. At 6.00am, an officer and a custodial manager arrived. When the officer saw that Mr Sharp was hanging from the cell door bracket, he immediately entered the cell, cut Mr Sharp down and used his radio to call a code blue situation. The officer said there were clear signs of rigor mortis and Mr Sharp's body was cold to the touch. He said that based on his first aid training it would have been futile to begin CPR.
51. The prison communications log shows that the initial call for assistance was made at 5.58am, the code blue radio call was made at 6.01am, and the 999 call was made at 6.04am. Yorkshire Ambulance Service records show that the 999 call was received at 6.05am. The paramedics arrived at the prison at 6.30am and it took them ten minutes to reach Mr Sharp's cell. As it was clear to them that Mr Sharp was dead, no attempt was made to resuscitate him and he was pronounced dead at 6.40am.

### **Contact with Mr Sharp's family**

52. The Deputy Governor and a prison family liaison officer visited Mr Sharp's father's home address at 9.50am on 17 April to break the news that Mr Sharp had died. Mr Sharp's father was not there and neighbours confirmed that he frequently worked away from home. Lindholme therefore asked the police to trace Mr Sharp's father. On 20 April, the police contacted Mr Sharp's father in Burton-on-Trent. On 21 April, the Governor and the family liaison officer visited Mr Sharp's father at home offer condolences. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

### **Support for prisoners and staff**

53. A prison manager debriefed the staff who had been involved in the emergency response. The staff were not asked to complete incident report forms, however, as required by Prison Service instructions. The staff were offered the support of the prison's care team.
54. The prison posted notices informing other prisoners of Mr Sharp's death, and offered support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Sharp's death.

### **Post-mortem report**

55. A post-mortem examination, conducted by a Home Office Forensic Pathologist, confirmed that the cause of Mr Sharp's death was hanging. The pathologist noted that the toxicology results found no evidence of illicit drugs or new psychoactive substances, or of any other medication whatsoever. However, given the existence of more than one account of Mr Sharp being a regular NPS user (including an instance two days before he died) together with the toxicological challenges in identifying new forms of NPS, we cannot conclusively state that the use of NPS was not a factor in Mr Sharp's death.

# Findings

## Assessment of Risk of Suicide

56. The Prison Service Instruction covering safer custody, Prison Service Instruction (PSI) 64/2011, lists a number of risk factors and potential triggers for self-harm and suicide. These include recall to custody, mental health issues, a history of self-harm, and drug abuse. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.
57. PSI 07/2015, *Early Days in Custody*, sets out mandatory reception procedures and requires reception staff to examine the PER form that must accompany each new prisoner, and any other available documentation. This is: "...to identify any immediate needs and risks already recorded". When Mr Sharp arrived at Hull on 5 April, reception staff did not fully assess his risk of suicide and self-harm and did not take any action to support him despite their previous knowledge of his history of mental health and self-harm, from both the accompanying paperwork and their previous dealings with Mr Sharp.
58. Mr Sharp had a number of factors known to increase the risk of suicide and self-harm which are identified in our thematic report about risk factors in self-inflicted deaths published in April 2014, and in Prison Service instructions. He had been recalled to prison, had mental health issues, had an extensive history of self-harm, and abused drugs. Although we do not know whether this would have affected the outcome for Mr Sharp, the failure to open an ACCT meant that he did not receive structured, ongoing support.
59. In the thematic report, we also identified 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. Following Mr Sharp's death, Hull have provided staff with training on identifying risks and triggers in the early days of custody.
60. When Mr Sharp was transferred to Lindholme, the inaccuracy and incompleteness of the records which accompanied him prevented prison staff there from making an appropriate assessment of risk, although he was referred to the mental health team for assessment. We consider that the provisional assessment made by Lindholme was appropriate under the circumstances and do not consider that the prison could have predicted or prevented his actions. We make the following recommendation:

**The Governor of Hull should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them on arrival. In particular, this should ensure that reception and first night staff:**

- **Have a clear understanding of their responsibilities and the need to share all relevant information about risk;**

- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from Person Escort Record forms (PER) and other sources;**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

## Clinical Care

61. The clinical reviewer judged that the care Mr Sharp received at Lindholme was equivalent to what he could have expected to receive in the community.
62. However, the standard of care provided at Hull was not equivalent. The clinical reviewer was concerned that Mr Sharp was not provided with his medication after he was recalled to custody. It is unclear whether Mr Sharp received the medication prescribed by the doctor on 7 April, as the audit trail ends after the medication was dispensed from the pharmacy. Mr Sharp's prescription was intended to last for 28 days, therefore on his transfer to Lindholme he should have had 23 tablets to accompany him. No explanation could be provided as to why this had not occurred or what had happened to the medication. We judge that this is a serious failing and make the following recommendation:

**The Head of Healthcare at HMP Hull should review the process for the prescribing and dispensing of medicines to ensure there are no delays in prisoners receiving their medication, supported by an accurate audit trail.**

63. Mr Sharp was referred to the mental health team at Hull on 06 April, and again on 12 April after he arrived at Lindholme. Mr Sharp had an appointment with the mental health team scheduled for 19 April. Mr Service considered that the processes used at both Hull and Lindholme to assess and prioritise mental health needs was reasonable. The primary reason for the delay in Mr Sharp not having an appointment with a mental health team was the transfer between prisons.
64. The clinical reviewer commented that medical record keeping was of an acceptable standard. However the nurse's entry of 12 April was, by her own admission, incorrect but could not be explained. We are also concerned that the same nurse incorrectly entered medical information on the PER form when Mr Sharp transferred to Lindholme. The information entered on the PER form informs the receiving prison of a prisoner's known risk factors.
65. Following Mr Sharp's death, that nurse was made subject to clinical supervision and was observed to ensure her clinical practice and record-keeping were of a satisfactory standard. We make the following recommendation:

**The Head of Healthcare at HMP Hull should ensure all practitioners maintain medical records in accordance with national medical practice and code of conduct, and that all documentation is completed accurately.**

## New Psychoactive Substances

66. Mr Sharp had a history of using illicit drugs, including spice. Although toxicology results indicate Mr Sharp had not used illicit drugs prior to his death he told fellow prisoners that he had used spice from the day he arrived at Lindholme. There are concerns that use of NPS can produce a range of bizarre behaviours or paranoia. It is possible that if Mr Sharp's self-disclosed use of NPS was true it may have triggered his suicidal behaviour.
67. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff of the dangers of NPS; the need for more effective drug supply reduction strategies; and better monitoring by drug treatment services. We make the following recommendation:

**The Governors of Hull and Lindholme should ensure there are effective supply and demand reduction strategies to help eradicate the availability of new psychoactive substances, and that staff are vigilant to signs of its use and know how to respond when a prisoner appears to be under the influence of such substances**

## Emergency Response

68. PSI 03/2013 *Medical Emergency Response Codes*, issued in February 2013, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of, and understand, this instruction and their responsibilities during medical emergencies. The PSI also includes a mandatory instruction that the terms of the medical emergency response protocols must be written and agreed in conjunction with the local healthcare commissioner at the prison and the local ambulance trust.
69. When the operational support grade found Mr Sharp hanging in his cell at 5.58am on 17 April, she used her radio to summon urgent assistance. She did not use the emergency code as she should have done.
70. At 6.00am, when the officer arrived at the cell, he correctly used the emergency code. However the staff in the control room did not call an ambulance immediately. This led to a further delay before an emergency ambulance was called.
71. Yorkshire Ambulance Service records show they received the 999 call at 6.05am. However, it took 25 minutes for paramedics to arrive at Lindholme. This was an unacceptable delay. The emergency standard for a Red 1 emergency call (a respiratory issue or cardiac arrest) is eight minutes. This incident was investigated by Yorkshire Ambulance Service who confirm that the nearest ambulance crew had been dispatched to the call. Earlier intervention would not have changed the outcome for Mr Sharp, however, in future emergencies such a delay may be crucial. We make the recommendation:

**The Governor of Lindholme should ensure that all prison staff are made aware of and understand PSI 03/2013 *Medical Emergency Response Codes* and their responsibilities during medical emergencies which:**

- **Ensures staff immediately call for an emergency ambulance when a medical emergency code is used;**
- **Ensures that an emergency response protocol is in place with the ambulance service;**
- **Ensures that all emergency equipment, including radios, is in good working order.**

#### **Actions following a death in custody**

72. PSI 64/2011 sets out the actions that prisons should undertake after a prisoner's death. Chapter 12 of the PSI contains a mandatory action that staff directly involved, particularly those who were first on scene, must complete Incident Report Forms as soon as this is practicable. No members of staff were asked to complete the forms after the initial emergency incident following Mr Sharp's death. Again, we raised this issue in relation to the prisoner who died in Lindholme in December 2015, and we make the following recommendation:

**The Governor at Lindholme should ensure that all relevant mandatory actions in PSI 64/2011, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*, are completed after a prisoner's death.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations