

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Luke Sparks, a prisoner at HMP Swaleside, on 2 April 2022

A report by the Prisons and Probation Ombudsman



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



© Crown copyright, 2023

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Luke Sparks was found hanged in his cell at HMP Swaleside on 2 April 2022. He was 31 years old. I offer my condolences to Mr Sparks' family and friends.

Mr Sparks had a history of illicit substance misuse and mental health issues. Despite significant support from substance misuse services, psychological services and the mental health team, he continued to use drugs. There is evidence that Mr Sparks might have built up drug debts and been threatened by other prisoners as a result, but he declined the support offered by staff.

I am satisfied that Mr Sparks gave no indication to staff that he was at an increased risk of suicide in the days before his death.

However, I am concerned that staff did not immediately go into Mr Sparks' cell when they saw him hanging. While the delay did not affect the outcome for Mr Sparks as he was dead when found, a similar delay could be critical in a future medical emergency.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman

December 2022

Contents

Summary	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	6
Findings	11

Summary

Events

1. Mr Luke Sparks was recalled to prison on 21 January 2019 after he set fire to his probation accommodation. He was moved to HMP Swaleside on 4 April.
2. Mr Sparks had a history of substance misuse and mental health issues, including self-harm. Staff at Swaleside managed Mr Sparks as a prisoner with complex needs. They held regular multidisciplinary meetings to discuss his progress and agree ways of supporting him. Despite this support, Mr Sparks continued to use illicit substances, which resulted in numerous negative behaviour warnings, poor mental health (including incidents of self-harm) and debt.
3. Staff monitored Mr Sparks under suicide and self-harm prevention procedures (known as ACCT) on six occasions at Swaleside, including three occasions when he set fire to his cell. He was last monitored under ACCT procedures in May 2021.
4. On 28 January 2022, staff found Mr Sparks unresponsive in his cell and thought he was under the influence of drugs. He was sent to hospital for treatment. When he returned to the prison on 30 January, he told a safer custody officer that he had taken an excessive amount of his medication to feel drowsy as he had intended to hang himself. The officer assessed that Mr Sparks did not need the support of ACCT monitoring as he was no longer in crisis and was also being monitored in the healthcare inpatient unit.
5. At around 7.20am on 2 April, while carrying out a roll check, an officer looked into Mr Sparks' cell and saw him hanging from the light fitting. The officer immediately called a medical emergency code blue. The officer waited until other colleagues arrived before going in.
6. Staff cut down Mr Sparks and immediately started cardiopulmonary resuscitation (CPR). A nurse arrived shortly afterwards and saw that Mr Sparks had signs of rigor mortis (stiffening of the body that occurs after death). The nurse asked the officers to stop CPR. At approximately 7.34am, the nurse declared that Mr Sparks was dead. Paramedics arrived shortly afterwards and confirmed that Mr Sparks had been dead for some time.

Findings

7. While we would have expected ACCT monitoring to have been started on 28 January if Mr Sparks had told staff then that he had intended to self-harm, we accept that staff did not know this until two days later. We consider that the safer custody officer who spoke with Mr Sparks on 30 January fully assessed his risk of suicide and self-harm, and that her decision not to start ACCT monitoring was reasonable in the circumstances.
8. We found some evidence that Mr Sparks may have been in debt due to his continued use of illicit drugs, resulting in possible threats and assaults from other prisoners. However, we are satisfied that the prison acted in accordance with their

own policies by recording relevant information and offering Mr Sparks appropriate support, although he declined this.

9. We are concerned that the officer who saw Mr Sparks hanging did not enter the cell immediately. We consider that it would have been safe for him to do so given Mr Sparks was clearly hanging. We accept that the short delay did not change the outcome for Mr Sparks, who was dead when found, but we are concerned that any delay in a future medical emergency could be crucial.
10. Although the nurse who attended the emergency response said she felt supported, she was not invited to the debrief that was held following the incident.
11. The clinical reviewer found that Mr Sparks received a good level of care which was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor should ensure that staff enter cells as quickly as possible in medical emergencies, when safe to do so.
- The Governor should ensure that all relevant staff, including healthcare staff, are invited to attend a debrief after a death in custody.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator obtained copies of relevant extracts from Mr Sparks' prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Sparks' clinical care at the prison.
15. The investigator and clinical reviewer interviewed ten members of staff. The interviews were conducted remotely by video conference between July and September 2022.
16. We informed HM Coroner for Mid Kent and Medway of the investigation. The Coroner provided us with a copy of the post-mortem report. We have sent her a copy of this report.
17. The Ombudsman's family liaison officer contacted Mr Sparks' ex-partner and a family friend to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Sparks' ex-partner did not have any specific questions, but his friend wanted to know:
 - Did something happen to trigger him taking his own life?
 - What support did he get for his mental health?
 - As he had previously taken an overdose, why was he not being monitored?

We have addressed these questions in our report.

18. We shared our initial report with Mr Sparks' friend and his ex-partner. They did not raise any factual inaccuracies. Mr Sparks' friend raised other issues which did not affect the factual accuracy of the report and these have been addressed in separate correspondence.
19. We shared our initial report with the Prison Service. The Prison Service pointed out some factual inaccuracies with our report which have been amended.

Background Information

HMP Swaleside

20. HMP Swaleside, on the Isle of Sheppey, is part of the Long-Term and High Security estate. It houses up to 1,090 men serving sentences of four years or more. Up until 31 March 2022, Integrated Care 24 Ltd provided primary healthcare, Oxleas NHS Foundation Trust provided mental health services, and Forward Trust provided substance misuse treatment. From 1 April 2022, Oxleas became the primary healthcare provider and Change Grow Live (CGL) now provide psychosocial support. There is 24-hour nursing cover and a 17-bed inpatient unit. GPs work in the prison Monday to Friday, and Medway on Call Care provides an out-of-hours GP service.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Swaleside was in October 2021. Inspectors commented that their independent review of progress in 2019 found that good progress was being made towards reducing the supply of illicit drugs and embedding the prison's drug strategy. However, some of the work (for example, suspicion drug testing) had stopped during COVID-19 restrictions. In HMIP's survey, 37% of respondents said that it was easy to get illicit drugs, and 41% alcohol, in the prison. Drugs and hooch were the most frequent finds over the previous 12 months, with over 2,800 litres of alcohol found. A three-day lockdown search of the prison, carried out just before the inspection, indicated the level of concern about the availability of illicit items and their impact on the prison.
22. The drug strategy was up to date and there was good attendance at drug strategy meetings, which provided oversight of local issues. Mandatory drug testing was reintroduced in July 2021 but was sometimes dropped if staff were needed elsewhere in the prison. Prisoners who were suspected of having used illicit substances were referred to the Forward Trust for support.
23. The level of self-harm had almost doubled since the last inspection, with around 550 ACCT documents opened in a 12-month period. Inspectors noted that the quality of the ACCT documents was variable with around half the prisoners saying they felt supported by the process.
24. Some night shift staff were not wearing an anti-ligature tool and not all said that they would enter a cell in an emergency before other staff arrived. Inspectors were concerned that this would result in a delay in providing the prisoner with the help they needed.

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 30 April 2021, the IMB found the prison had had a difficult year coping with the COVID-19 pandemic; at one point, 150 staff were not working. Although they considered that Swaleside had still

managed to forge ahead and make some improvements in terms of physical repairs and collaborative working, they remarked on the lack of meaningful activity/work available for prisoners which had been necessary to keep staff and prisoners safe.

Previous deaths at HMP Swaleside

26. Mr Sparks was the eleventh prisoner to die at Swaleside since April 2020. Five of the previous deaths were from natural causes, one was drug-related and four were self-inflicted. There have been six further deaths at Swaleside since Mr Sparks' death, two of which were self-inflicted. In a previous investigation, we found that staff had delayed entering the cell when they found the prisoner unresponsive.

Assessment, Care in Custody and Teamwork (ACCT)

27. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

Key Events

28. On 9 February 2015, Mr Luke Sparks was sentenced to six years and one month in prison for robbery and assault.
29. Mr Sparks had a history of substance misuse and mental health problems. Probation records show that he had spent most of his life in care homes, prison, or secure hospitals, and he struggled to cope in the community.
30. On 27 December 2018, Mr Sparks was released on licence from HMP Bristol to an Approved Premises (AP, a probation hostel). However, he was recalled to prison a few weeks later after setting fire to the AP and causing criminal damage.

2019

31. Mr Sparks arrived at HMP Exeter on 21 January 2019. Staff noted his mental health problems, substance misuse issues and history of self-harm and immediately started suicide and self-harm monitoring (known as ACCT) which continued until 1 February.
32. On 18 February, staff at Exeter started ACCT monitoring again after Mr Sparks made cuts to his arms. Staff managed him on an ACCT until 4 March, but records show that staff had ongoing concerns about his complex needs. Mr Sparks began to self-isolate and refused to engage with staff and support services.
33. On 4 April, Mr Sparks was moved to HMP Swaleside. The reception nurse noted that he had mental health and substance misuse issues, but he initially declined support from the relevant teams. However, he later asked to be referred to the mental health and substance misuse teams and began engaging with both teams.
34. On 17 April, Mr Sparks had an initial assessment by the substance misuse service. A substance misuse worker told the investigator that Mr Sparks was subsequently put forward to attend the Substance Dependency Treatment Programme which required him to stop using illicit drugs. He was moved to E Wing, the prison's substance misuse wing, so that he could be fully supported to stay drug-free. However, he continued to use psychoactive substances (PS) and was often found in possession of fermenting liquids to make illicit alcohol.
35. On 8 May, Mr Sparks had an assessment with a mental health nurse. He told her that he was diagnosed with emotionally unstable personality disorder, anxiety and depression and had previously spent time in secure hospitals for treatment. He said he did not want to take medication as he feared he would become addicted. The nurse referred him for an emotional wellbeing programme and one-to-one work.
36. On 3 July, a psychiatrist saw Mr Sparks to discuss possible treatment options. He suggested focused psychological work to address Mr Sparks' personality disorder issues and recommended a referral to the Psychologically Informed Planned Environment (PIPE unit), located in F Wing at Swaleside. Mr Sparks was keen to be referred and he was subsequently put on the waiting list.

37. On 20 November, Mr Sparks was removed from the substance misuse programme due to his continued use of illicit substances. However, the service continued to offer him one-to-one support.
38. On 6 December, staff noticed that Mr Sparks had injuries to his face and neck, but he refused to say what had happened to him. The following day, he became aggressive towards staff resulting in him being restrained and taken to the segregation unit. Staff submitted an intelligence report suggesting that he may be under threat and wanted to move to segregation for his own safety.
39. On 12 December, a member of the safer custody team interviewed Mr Sparks about the suspected assault. Mr Sparks said he was not in debt or being threatened. He did not want to talk further and refused any support.

2020

40. On 20 January 2020, Mr Sparks attended an initial session for mentalisation-based therapy (MBT). However, he failed to attend further weekly sessions and was removed from the group.
41. On 20 March, staff started ACCT monitoring after Mr Sparks made cuts to his arm. He said that he was worried that he had COVID-19 and frustrated by the lockdown regime. Mr Sparks told staff that he was worried about his mental health and was using illicit drugs. Staff stopped ACCT monitoring on 4 April.
42. On 1 May, Mr Sparks was sentenced to two years and one month in prison for arson with intent to endanger life, criminal damage, and affray in relation to the offence at the AP that led to his recall to prison.
43. On 16 May, Mr Sparks set fire to his cell and staff started ACCT monitoring. He said that he wanted to die as he was struggling with his mental health. He asked to be moved to the healthcare unit and he was subsequently moved there for a period of monitoring and to stabilise his mental health. On 20 May, the psychiatrist prescribed an antipsychotic (quetiapine) to help regulate Mr Sparks' emotionally unstable personality disorder. Staff stopped ACCT monitoring on 17 June.
44. On 4 August, Mr Sparks had a telephone conference with his community offender manager (COM) and his prison offender manager (POM). The POM noted that he said he was still using PS and needed ongoing support from the substance misuse team but, due to COVID-19 restrictions, he was frustrated that he could only do in-cell work. She described Mr Sparks as polite and engaging throughout and she noted that he appeared to want to make progress through his sentence.
45. On 31 October, Mr Sparks made a deep cut to his chest and staff started ACCT monitoring. He said that he was struggling due to COVID-19 restrictions. Staff stopped ACCT monitoring on 17 November.

2021

46. On 10 January 2021, Mr Sparks attended another telephone conference with his POM and his new COM to discuss his progress and prepare for his parole hearing.

The POM noted that he was engaging with substance misuse, psychological and mental health services on a regular basis and carrying out in-cell work. She said that she would chase up the outcome of the referral to the PIPE unit.

47. On 15 January, Mr Sparks set fire to his cell and staff started ACCT monitoring. He said that he wanted to die as he was frustrated with his mental health and change of medication. He said he wanted to move to the PIPE unit but was still being assessed for it. Staff moved him to the healthcare unit and initially monitored him under constant watch.
48. On 27 January, Mr Sparks met a psychology clinician working on the PIPE unit. She invited him to attend an assessment for the PIPE unit and noted that he was enthusiastic about this and looking forward to moving there. He attended the assessment on 3 February and Ms Price told him he would need to await the outcome.
49. Staff stopped ACCT monitoring on 11 February. The psychiatrist reviewed Mr Sparks' medication during the time he was in the healthcare unit. He was discharged from the healthcare unit to the substance misuse wing in early March.
50. On 10 March, the psychology clinician met Mr Sparks to let him know that he had been assessed as unsuitable for the PIPE unit. She offered to do some one-to-one psychological work with him and encouraged him to address his substance misuse. She noted that Mr Sparks was agreeable to this. She continued to meet Mr Sparks around once a week. She said that this was intended to stabilise him and help him move to the PIPE unit in the future.
51. On 15 March, Mr Sparks made cuts to his arm and staff started ACCT monitoring. He said that his mental health was suffering, and he did not feel supported. He later said that he had cut himself as he had felt guilty about being caught tampering with the DVD player in the staff room the previous day. Staff stopped ACCT monitoring on 23 March.
52. On 24 April, the POM met Mr Sparks to tell him that his COM was not recommending him for release due to his ongoing negative behaviour in custody. She said that Mr Sparks seemed fine with this decision.
53. On 13 May, Mr Sparks set fire to his cell again and staff started ACCT monitoring. He said that he was not trying to take his life but that he wanted to move to the segregation unit as he was in debt. Staff agreed to move him to another area of the prison and closed the ACCT later that day.
54. On 7 June, Mr Sparks had an oral parole hearing, but he refused to attend. He said that he could not cope with it and that professionals had already decided they were not going to recommend his release. The hearing went ahead in his absence.
55. In July, Mr Sparks started on the Substance Dependency Treatment Programme again. However, he was deselected again in October due to ongoing use of illicit drugs.
56. On 25 October, the POM told Mr Sparks that due to ongoing substance misuse, negative behaviour and fire-setting, he would not be accepted by any AP on

release. Mr Sparks said that he needed the support of an AP and would appeal the decision.

57. On 27 October, the POM and the psychology clinician met Mr Sparks to tell him he had not been accepted onto the PIPE unit. The clinician told the investigator that this was due to a previous assault on a member of staff who worked on the PIPE unit. She said Mr Sparks was disappointed with this news and said he would appeal the decision.
58. On 9 December, staff submitted an intelligence report after Mr Sparks was seen with a black eye. He said he had hit his head in his cell, but staff thought he may have been the victim of an assault. Mr Sparks did not want to talk about it and declined support.

2022

59. On 28 January 2022, Mr Sparks was taken to hospital after staff suspected he had taken illicit drugs. During the journey and when he arrived at the hospital, Mr Sparks lashed out and assaulted two members of staff. He remained in hospital until 30 January, and, on his return, he told a safer custody officer that he had taken an excessive amount of his prescribed medication (quetiapine) to get high. He was admitted to the prison's healthcare unit.
60. Officer A, a member of the safer custody team, spoke to Mr Sparks on the afternoon of 30 January. Mr Sparks told her that he had taken an overdose of his quetiapine so that he could be drowsy as he planned to hang himself. She noted that Mr Sparks said he had no further thoughts of self-harm and he was being monitored in the healthcare unit. On that basis, she assessed that Mr Sparks did not need the additional support of an ACCT at that time. She told the investigator that she knew Mr Sparks quite well and felt her assessment was correct. She said she would not have hesitated to start ACCT procedures if she felt it was necessary.
61. Officer A spoke to Mr Sparks again on 4 February and he told her he wanted to leave the healthcare unit and return to the prison wing. He was later discharged from the healthcare unit back to the substance misuse wing.
62. On 16 February, Mr Sparks was again found to be under the influence of illicit substances. He was unconscious and an ambulance was called. The ambulance was later stood down after he recovered, and healthcare staff treated him at the prison.
63. On 26 February, Officer A noticed that Mr Sparks was trying to conceal his quetiapine medication. She challenged him about it, and he appeared to swallow his medication. She submitted an intelligence report.
64. On 22 March, Mr Sparks had a positive meeting with the psychology clinician. He spoke to her about his hopes for parole and living in the community again. She said she had no concerns about him at this time and thought that he was planning for the future.
65. On 1 April, Mr Sparks had a positive meeting with the mental health in-reach team. A nurse noted that he was relaxed and cheerful and he spoke positively about his

release plan. He told her he had no issues with his medication or anything else and she had no concerns about him.

66. Night staff carried out the evening roll check (a count of prisoners) at around 8.00pm. They reported no issues.

Events of 2 April

67. At around 7.20am on 2 April, Officer B carried out the morning roll check. When he looked into Mr Sparks' cell, he saw that he was hanging from the light fitting. He immediately called a medical emergency code blue (used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and tells the control room to call an ambulance) which was received by the control room at 7.27am. He waited outside the cell for other staff to arrive. He said that he would never open a cell door until he had another member of staff with him.
68. Three members of prison staff arrived within two minutes of the code blue call. Officer B opened the door, and they all went into the cell. They cut down Mr Sparks from the light fitting and immediately started CPR.
69. The designated first response nurse attended shortly afterwards. She said that she thought that Mr Sparks had been dead for some time as he had rigor mortis (a stiffening of the body that occurs after death). She assessed Mr Sparks and asked staff to stop CPR at 7.34am. Paramedics arrived shortly afterwards and confirmed that Mr Sparks had been dead for some time.

Contact with Mr Sparks' family

70. At 10.10am on 2 April 2022, the prison's appointed family liaison officer telephoned Mr Sparks' ex-partner to break the news of his death. At around 10.45am, she also contacted a family friend who was listed as Mr Sparks' next of kin, to inform her of his death. The prison contributed to the funeral expenses in line with national instructions.

Support for prisoners and staff

71. A prison manager debriefed the majority of staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. The first response nurse told the investigator that, although she had felt supported, she was not invited to the debrief.
72. The prison posted notices informing other prisoners of Mr Sparks' death and offered support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Sparks' death.

Post-mortem report

73. The pathologist concluded that Mr Sparks died due to hanging. Toxicology results showed no trace of any illicit substances.

Findings

Assessment and management of Mr Sparks' risk of suicide and self-harm

74. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, requires that all staff who have contact with prisoners are aware of the risk factors and triggers that might increase a prisoner's risk of suicide and self-harm and sets out the procedures (known as ACCT) that they should follow when they identify a prisoner at risk.
75. Overall, we found that staff responded appropriately when Mr Sparks harmed himself by starting ACCT monitoring. We had no concerns about the management of the six ACCTs that were opened for Mr Sparks during his time at Swaleside.
76. We have considered whether staff should have started ACCT monitoring when Mr Sparks returned from hospital on 30 January. Initially, he told staff that he had taken excessive quetiapine to get high but then he told Officer A that he had taken the medication to make him drowsy as he had intended to hang himself. She concluded that ACCT monitoring was not necessary as Mr Sparks was no longer in crisis and was also being monitored in the prison's healthcare unit.
77. Had Mr Sparks told staff when he was taken to hospital on 28 January that he had taken excessive medication because he wanted to end his life, we would have expected them to start ACCT monitoring. We accept that the situation was unclear at that stage and Mr Sparks only admitted this two days later, when he was back at the prison and being monitored in the healthcare unit. We accept that Officer A considered whether Mr Sparks was still at risk and concluded that he was not. We consider that her assessment was thorough and that she recorded her rationale in Mr Sparks' prison record. Furthermore, Mr Sparks did not take his life until more than two months after her assessment and we consider it unlikely that an ACCT at that time would have prevented his death. We therefore accept that it was a reasonable decision not to start ACCT monitoring and we make no recommendation.

Debt and antisocial behaviour

78. We found some evidence that Mr Sparks was in debt, probably due to his ongoing use of illicit substances. In the months before his death, he was seen with cuts and bruises that he refused to talk about. He also frequently asked to move to different wings of the prison and, at times, orchestrated moves to the segregation unit by setting fire to his cell and engaging in other negative behaviour.
79. We found that staff provided Mr Sparks with a good level of support, in line with their guidance on dealing with antisocial behaviour. Staff discussed their concerns at multidisciplinary meetings and Mr Sparks was offered formal support. However, he declined this support and staff were therefore unable to further investigate any threats or assaults. We therefore make no recommendations.

Delay in entering cell

80. When Officer B saw that Mr Sparks was hanging in his cell, he immediately called a medical emergency code blue. However, he did not go into the cell but instead waited for colleagues to arrive. Swaleside's policy on entering cells in an emergency says that staff should assess the risk to themselves or others before entering a cell on their own. The officer said that he had previously experienced situations where prisoners had appeared to be in trouble but, on entering a cell, he had been assaulted by the prisoner. He said that he would always wait for other staff to arrive before going into a cell.
81. We are concerned that Officer B said he would not enter a cell alone in any circumstances. In a medical emergency, staff should enter a cell immediately if safe to do so. Given that Mr Sparks was clearly hanging from the light fitting and he was alone in the cell, we consider that it would have been safe for him to enter the cell immediately, particularly as he knew that other staff were close behind. We accept that this would not have made a difference to Mr Sparks as he had already been dead for some time. However, such a delay could be critical in a future medical emergency.
82. We therefore recommend:

The Governor should ensure that staff enter cells as quickly as possible in medical emergencies, when safe to do so.

Support for staff

83. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed. It also provides those directly involved with an opportunity to process events.
84. While the prison held a debrief after the death of Mr Sparks, the first response nurse was not invited to attend. We therefore recommend:

The Governor should ensure that all relevant staff, including healthcare staff, are invited to attend a debrief after a death in custody.

Clinical review

85. The clinical reviewer concluded that the care Mr Sparks received was of a good standard and equivalent to that which he could have expected to receive in the community. He considered that the care Mr Sparks received was diligent and compassionate, particularly from the mental health team, despite Mr Sparks' often challenging behaviour.

Inquest

At the inquest held on 5 June 2023, the coroner concluded that Mr Sparks' death was due to suicide.

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100