Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ross Parker on 7 April 2024, following his release from HMP Holme House

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

Summary

1. 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.

2. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of the person's release from prison.

3. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

4. Mr Ross Parker died in hospital on 7 April 2024, from injuries sustained when he was hit by a Metro train the day before, four days after his release from HMP Holme House. He was 26 years old. We offer our condolences to those who knew him.

5. The toxicology report showed that Mr Parker had consumed alcohol and ketamine prior to his death. Mr Parker had a history of substance misuse, however he declined support from the prison's substance misuse team and appeared to remain drug-free in prison. He was provided with details of community substance misuse services if he wanted to self-refer on release.

6. We did not identify any significant learning relating to the pre-release planning or post-release supervision of Mr Parker. We make no recommendations.

The Investigation Process

7. HMPPS notified us of Mr Parker's death on 11 September 2024.

8. The PPO investigator obtained copies of relevant extracts from Mr Parker's prison and probation records.

9. We informed HM Coroner for Newcastle of the investigation. She gave us the cause of death. We have sent the Coroner a copy of this report.

10. The Ombudsman's office contacted Mr Parker's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

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

Background Information

HMP Holme House

12. HMP Holme House is a category C resettlement prison which holds convicted male prisoners. It is managed by HMPPS.

Probation Service

13. The Probation Service works with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, prepare reports to advise the Parole Board and have links with local partnerships to which they refer people for resettlement services, where appropriates. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

Key Events

Background

14. On 1 February 2024, Mr Ross Parker was recalled to prison because he did not attend the Approved Premises (accommodation that provides additional supervision to those who present a high or very high risk of harm) on the day of his release as required.

15. Mr Parker remained unlawfully at large for five weeks before being arrested on 7 March. He was sent to HMP Durham. On arrival, his urine tested positive for benzodiazepines (prescription drugs used to treat anxiety but also widely abused).

16. On 8 March, a member of the Drug and Alcohol Recovery Team (DART) completed an induction with Mr Parker. He declined to engage with DART because he said he had no issues that required support. The DART worker told him how to self-refer if he needed support.

HMP Holme House

17. On 13 March, Mr Parker was moved to HMP Holme House.

18. At his reception health screen, Mr Parker told the nurse he had ADHD and was not taking his medication. Mr Parker also said he had a history of substance misuse including cannabis, cocaine, crack cocaine, benzodiazepines and amphetamines. The nurse referred Mr Parker to the mental health team and the DART team.

19. On 14 March, a DART worker saw Mr Parker for a drug harm reduction induction. She gave him harm reduction advice, and they discussed the risks of reduced tolerance levels.

20. On 15 March, a DART worker saw Mr Parker. He declined any treatment but said he required support from the DART team to remain drug free in the community. The plan was for Mr Parker to be allocated a recovery worker for harm reduction support.

Pre-release planning

21. Mr Parker's community offender manager (COM) had arranged a video link appointment with Mr Parker on 18 March. However, she had arranged this with Durham and was unaware he had been moved to Holme House in the meantime. She was not able to rebook a video link appointment before she took her annual leave from 25 March to 2 April.

22. On 22 March, the Offender Management Unit (OMU) at Holme House told Mr Parker's COM that from 2 April 2024, legislation would be changing which would impact the recall of individuals serving a sentence of less than 12 months. This change applied to Mr Parker, whose release date was now 2 April rather than 27 May. The OMU asked Mr Parker's COM to review Mr Parker's case and complete the necessary forms. The COM told the investigator she was not able to complete those tasks as she was in meetings all day and was then on annual leave.

23. In the COM's absence, the prison emailed her line manager to complete Mr Parker's licence conditions and provide reporting instructions for the day of his release. This was completed by a colleague.

24. On 23 March, a nurse completed a mental health assessment with Mr Parker. He told her that he was not using drugs in prison but in the community, he took illicit pregabalin for nerve damage in his hand, as well as cocaine, cannabis, ecstasy, MDMA, Spice (synthetic cannabinoids), Subutex (a heroin replacement medication), and he also smoked crack cocaine. Mr Parker spoke about restarting his ADHD medication, however because he was due for release it was not possible to complete a further assessment and the nurse noted that a referral to Mental Health Care Navigators (MHCN) was needed. The nurse told the investigator that the referral was completed the next day. Mr Parker was discussed at their Integrated Management Panel (IMP) on 25 March. All patients discussed in the meeting were added to the Reconnect MHCN waiting list, and then the care navigators would assess those people and take any appropriate actions.

25. On 27 March, a MHCN visited Mr Parker to complete an induction and discuss individual therapies. However, Mr Parker was at work and the MHCN was unable to visit him again before his release. Therefore, he left his details in the wing office for Mr Parker to contact him on release if he wanted to.

26. The community lead for MHCN told the investigator the service would have tried to contact Mr Parker in the community if his contact details were provided on the referral, however the prison did not have these, and therefore they were not able to contact him directly on release. She said that contact could also be attempted through probation, however this did not take place prior to his death.

27. Later that day, a DART worker met with Mr Parker and gave him harm reduction advice. She also provided Mr Parker with the details of the local drug and alcohol service in the community if he wanted support on release.

28. Mr Parker was subject to additional licence conditions on release; to provide samples for drug tests as required, and to attend the North Tyneside Recovery Programme as directed to address his substance misuse:

Post-release management

29. On 2 April, Mr Parker was released from Holme House. He had an initial appointment with probation at 2.30pm. However, he called the probation office and told them he was not going to make his appointment as he had an appointment with the Job Centre at 3.00pm. He was advised to attend the probation office at 6.00pm.

30. As Mr Parker's COM was on annual leave, a colleague completed Mr Parker's initial appointment and gave him another appointment with the COM on 5 April at 1.30pm.

31. Mr Parker went to his parents' address. The COM told the investigator she would not have approved that address, because Mr Parker had previously assaulted his sister in the family home. However, she was not able to complete the necessary housing referrals prior to his release due to the short time frame given.

32. The COM told the investigator that during the next probation appointment with Mr Parker she planned to discuss his support needs which, at that time, included housing, substance misuse, relationships and thinking and behaviour. She said referrals would have been made following the appointment.

33. Mr Parker failed to attend the appointment with the COM on 5 April.

Circumstances of Mr Parker's death

34. At approximately 12.10am on 6 April, Mr Parker was taken to A&E after being hit by a Metro train at North Shields Metro station. Mr Parker was trapped under the Metro for approximately one hour before he could be removed and was unconscious.

35. Mr Parker's family told the doctors that Mr Parker would occasionally take a short cut over the Metro line to get home, and it was not considered a suicide attempt.

36. The consultants at the hospital reviewed Mr Parker's CT scan and considered that the extent of his brain injury along with his reduced consciousness level and unreactive pupils represented an unsurvivable injury. It was agreed with his family that his life support should be switched off.

37. Mr Parker died at 12.26pm on 7 April.

Cause of death

38. A post-mortem examination was not carried out as the coroner accepted the cause of death provided by a doctor. The doctor gave Mr Parker's cause of death as traumatic brain injury.

39. The toxicology report showed that Mr Parker had consumed alcohol and ketamine.

40. At the inquest held on 24 June 2024, the coroner concluded that Mr Parker's death was due to an accident.

Findings

Early release

41. Due to new legislation put in place around recall, Mr Parker was released eight weeks earlier than expected. As a result, his COM was given only one week's notice of Mr Parker's new release date. The legislative change and earlier release date impacted the COM's ability to put risk management plans in place and did not allow sufficient time to complete all necessary release planning. In addition, the COM had pre-planned annual leave during this time, and therefore was not able to complete the necessary tasks before Mr Parker's new release date.

42. A colleague completed Mr Parker's licence conditions using EPF (standardised tool to generate licence conditions) and provided the prison with reporting instructions. Although the COM said she would not have approved Mr Parker returning to his parents' address, his mother was fully supportive of this. On her return from leave, the COM concluded that it was better for Mr Parker to reside with his parents temporarily, until alternative accommodation was found.

43. The COM booked Mr Parker's next appointment for the earliest opportunity (three days later), in order to explore the necessary referrals and support he required in the community; however, he did not attend that appointment and therefore no referrals were completed prior to his death.

Substance misuse

44. Mr Parker had a history of substance misuse. While he was in prison, he was seen by the DART team and warned about the risks and dangers of taking drugs. He declined any treatment or intervention in prison. Prior to his release he was provided with the details of the community substance misuse service if he wanted support in the community.

45. We are satisfied that probation staff put appropriate measures in place to address Mr Parker's substance misuse issues when he was released from prison. Although he was abstinent in prison, probation staff took precautionary measures because of the change in circumstance back into the community. This included adding licence conditions to comply with any requirements relating to addressing his substance misuse issues, should he need support if he relapsed in the community.

46. We are satisfied that both the prison and probation services did all they could to manage the risks associated with his substance misuse.

Mental health

47. We found that Mr Parker was promptly assessed by the mental health services at Holme House, and they appropriately referred him for continued support in the community.

48. We are satisfied that the mental health team at Holme House liaised with MHCN ahead of his release from prison, following an assessment completed by the mental health team, where Mr Parker said he would like to recommence his ADHD medication. This ensured he would have had access to mental health support in the

community. Unfortunately, Mr Parker was not able to access the support he needed prior to his death.

49. We make no recommendations.

Adrian Usher
Prisons and Probation Ombudsman **April 2025**

Inquest

The inquest, held on 26 June 2024, concluded that Mr Parker's death was due to an accident.

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