Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Davide Parra, a prisoner at HMP Erlestoke, on 5 August 2019

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

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 Davide Parra died after he hanged himself in his cell on 5 August 2019 at HMP Erlestoke. He was 46 years old. I offer my condolences to his family and friends.

Mr Parra had a history of substance misuse and mental health issues and had previously been managed under suicide and self-harm prevention procedures, known as ACCT. He had a history of using psychoactive substances (PS) while in custody.

Two hours before his death, staff started ACCT procedures because Mr Parra, who felt that the prison healthcare team was ignoring his request for an antihistamine, intentionally ate a pepper (which he said he was allergic to). Mr Parra then became upset and agitated at being subject to ACCT monitoring. He later blocked his cell observation panel and cell door and, after an officer sought assistance from colleagues, he was found to have hanged himself.

The clinical review into Mr Parra's death concluded that his care was equivalent to that which he might have expected to receive in the community.

I consider that prison staff acted appropriately in the hours leading to Mr Parra's death by monitoring him under ACCT procedures and in offering to take him to take him to see healthcare staff.

However, I am concerned about the delay in entering Mr Parra's cell after staff realised that he had blocked his observation panel, had barricaded his cell door and was not responding to them, especially as he was being monitored under ACCT procedures.

Although there is no evidence that Mr Parra's death was caused by his use of illicit substances, I am also concerned about the ease in which Mr Parra appears to have obtained illicit drugs during his time at Erlestoke.

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 **January 2021**

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Summary

Events

1. In October 2017, Mr Davide Parra, an Italian national, was transferred to HMP Erlestoke while serving a five-year sentence.

2. Mr Parra had a history of self-harm and substance misuse and frequently used psychoactive substances (PS) at Erlestoke. Mr Parra often raised concerns with staff about whether he would be deported to Italy. His immigration status was being considered at the time of his death.

3. In the weeks leading to his death prison staff noted a general improvement in Mr Parra's behaviour and attitude and he told officers that he had stopped using illicit drugs.

4. On 5 August, Mr Parra asked for antihistamines for a rash on his hand. When he was refused access to the healthcare unit immediately, he intentionally ate peppers, which he said he was allergic to. As a result, staff started ACCT procedures. Mr Parra became upset and agitated about this and although staff arranged for the healthcare team to assess him, he refused to attend. He and other prisoners were locked in their cells for the night at about 7.00pm.

5. At around 8.00pm, an officer found that Mr Parra had blocked his cell observation panel and cell door. He alerted colleagues and when staff eventually entered Mr Parra's cell, they found that he had hanged himself. Staff tried to resuscitate Mr Parra but shortly afterwards paramedics arrived and pronounced that he had died.

Findings

6. Mr Parra's worries that he would be deported may have played on his mind in the weeks before his death, but he did not mention them on the day of his death and it is not possible to say if they contributed to his decision to take his life.

7. Although there is no evidence to suggest that the use of illicit substances contributed to Mr Parra's death, we are concerned about the availability of PS at Erlestoke.

8. We found that staff acted appropriately in starting suicide and self-harm monitoring procedures after Mr Parra intentionally ate a pepper which he said he was allergic to.

9. The clinical reviewer concluded that the healthcare that Mr Parra received at Erlestoke was equivalent to that which he could have expected to receive in the community. We are satisfied that adequate plans were made for healthcare staff to assess Mr Parra and give him antihistamine medication, if appropriate, on 5 August but that Mr Parra refused to go to the healthcare centre.

10. We are concerned, however, about aspects of the emergency response. We consider that officers should have acted with more urgency in entering Mr Parra's

cell when he blocked his observation panel and did not respond, especially as he was being monitored under ACCT procedures and was known to be very agitated.

Recommendations

- The Governor should ensure that the key drug issues at Erlestoke are identified and that their drugs strategy is kept under review to ensure that these key issues are addressed.
- The Governor should ensure that a local protocol is developed and shared with staff to instruct them on what to do if they find a cell observation panel obscured.
- The Governor should ensure that, subject to a risk assessment, staff enter cells as quickly as possible if there is reason to consider that a prisoner may be at risk.
- The Governor should ensure that a copy of this report is shared with the CM, Officer C, the SO and Officer D and that a senior manager discusses the Ombudsman's findings with them.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Erlestoke informing them of the investigation and asking anyone with relevant information to contact him.

12. The investigator visited Erlestoke on 14 August 2019. He obtained copies of relevant extracts from Mr Parra's prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Parra's clinical care at the prison.

14. The investigator interviewed 16 members of staff and six prisoners, some jointly with the clinical reviewer.

15. We informed HM Coroner for Wiltshire and Swindon of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. We contacted Mr Parra's sister to explain the investigation. His family asked questions about his deportation status, his use of drugs, mental health care and the events of 5 August, including whether he had access to antihistamine medication. We have addressed their questions in this report.

17. Mr Parra's family received a copy of the initial report. The solicitor representing Mr Parra's family wrote to us raising 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.

Background Information

HMP Erlestoke

18. HMP Erlestoke in Wiltshire is a Category C prison which holds sentenced prisoners. Erlestoke's aim is to reduce prisoners reoffending by preparing them for release through accredited intervention programmes, skills and vocational-based training and education in a pro-social environment.

19. When Mr Parra was admitted to HMP Erlestoke on 30 October 2017, prison GPs provided primary mental health services and Avon and Wiltshire Mental Health Partnership NHS Trust provided secondary mental health and substance misuse services. On 1 April 2018, the arrangements changed and Inspire Better Health provided integrated primary healthcare, primary and secondary mental healthcare and the substance misuse services.

HM Inspectorate of Prisons

20. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Erlestoke in June and July 2017. Inspectors raised concerns about the widespread availability of illegal substances and noted that, at the time, the prison had no effective strategy to address its drug issues. (A new substance misuse strategy was introduced in May 2018.)

21. Despite some criticisms, inspectors reported that Erlestoke remained a reasonably respectful prison and they noted that there was much that was positive in the prison.

Independent Monitoring Board

22. 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 ending March 2019, the IMB reported that mental health services had started the year under considerable pressure due to staff shortages. The IMB reported that overall, prisoners at Erlestoke were treated fairly.

Previous deaths at HMP [Prison]

23. The last self-inflicted death at Erlestoke was in May 2015. Since then there have been two deaths from natural causes and a further natural cause death since the death of Mr Parra. There were no similarities between the previous deaths and that of Mr Parra.

Assessment, Care in Custody and Teamwork

24. 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. 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.

Psychoactive Substances (PS)

25. Psychoactive substances are a serious problem across the prison estate. They are difficult to detect and can affect people in many ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

26. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.

27. HM Prison and Probation Service (HMPPS) has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

Key Events

28. Mr Davide Parra was a 46-year-old Italian national who had lived in the United Kingdom since he was a child. Mr Parra had served many previous custodial sentences.

29. On 21 April 2017, Mr Parra committed grievous bodily harm with intent. The police found him unconscious in an alleyway afterwards. He was taken to hospital and treated for a suspected drug overdose. However, Mr Parra maintained that he had not tried to take his own life.

30. On 24 April, Mr Parra was remanded into custody at HMP Winchester. On 16 October, he was convicted and sentenced to five years in prison.

31. On 30 October, Mr Parra was transferred to HMP Erlestoke. At an initial health screen, the reception nurse noted several physical health conditions and that he had a history of substance misuse and depression. Mr Parra was referred to the prison's mental health team.

32. On 6 November, a mental health nurse and a prison GP reviewed Mr Parra's medical records and agreed that, as he had no serious mental health issues, a prison GP and primary health services could treat his low mood. Mr Parra's primary diagnosis was recorded as substance dependency and it was noted that his needs were best met by the substance misuse team. However, Mr Parra declined any structured psychosocial intervention from the prison's mental health and substance misuse team and missed some appointments with them.

33. In November, intelligence reports were submitted about Mr Parra's use of PS and in December, he collapsed in his cell after using PS. Mr Parra continued to be found under the suspected influence of PS throughout January 2018. In February, he failed to attend healthcare appointments and was charged with damaging his television while under the suspected influence of PS. Mr Parra was told that if his negative behaviour continued, he would lose his job in the prison's workshop. Later that day, healthcare staff treated him when he was again found under the suspected influence of PS. Mr Parra's drug use continued and in March, he tested positive for PS.

34. In January 2018, after Mr Parra refused to attend two appointments with a mental health nurse, the mental health team reviewed him and concluded that he did not meet the criteria for secondary mental healthcare. Mr Parra was told to contact the prison GP if he needed mental health support. Mr Parra requested a further appointment but did not attend.

35. On 16 March 2018, Mr Parra tried to enter the prison's healthcare unit without permission. Staff restrained him and took him back to his wing. Mr Parra later made cuts to his forearm and staff started suicide and self-harm monitoring procedures, known as ACCT. Mr Parra told staff that he cut his arm because he was frustrated about his medication. On 10 April, ACCT monitoring was stopped.

36. On 25 May, Mr Parra inadvertently ate peppers in his lunch and reported to healthcare staff that he was allergic to them and had a "tingling of the tongue". Healthcare staff prescribed Mr Parra antihistamines as a precaution.

37. On 8 June, Mr Parra failed to attend a healthcare appointment and on 18 June, a drug test was requested after he was found stumbling around his cell. Between April and September, Mr Parra engaged and disengaged with the mental health team and substance misuse team.

38. On 19 June, Mr Parra asked an officer from the prison's Offender Management Unit if the prison had heard anything about his possible deportation to Italy. Mr Parra was told that the Home Office had not contacted them.

39. On 27 June, Mr Parra missed a healthcare appointment. On 19 July, it was noted that he had been abusive to a nurse after he was told to leave the healthcare unit. The following day, he tested positive for PS.

40. On 30 July, an officer introduced himself to Mr Parra as his keyworker. Mr Parra asked about his deportation to Italy and said that he hoped to be deported.

41. On 23 August, Mr Parra told his keyworker that he still wanted to be deported to Italy and to be transferred to a 'deportation prison' in the UK. Mr Parra told the officer that he had been in a comparable situation during his previous prison sentence but that because of his violence, he had not been considered suitable for an immigration removal centre (IRC). (Mr Parra would not have been eligible for a move to an IRC until he had completed his custodial sentence.) The keyworker noted that Mr Parra continued to receive both negative and positive comments from staff about his behaviour.

42. On 25 September, at Mr Parra's request, the mental health and substance misuse team assessed him. The mental health nurse noted Mr Parra's long-standing history of substance misuse and current use of PS in prison which he felt destabilised him and caused him to make reckless decisions. The nurse assessed Mr Parra as sensible and mentally able to know that he should stop his substance misuse. However, the nurse noted that Mr Parra had a laissez-faire attitude and that he was physically unable to stop using drugs. During September and October, Mr Parra continued to miss appointments with the mental health team and substance misuse team.

43. On 10 October, Mr Parra tested positive for PS during a mandatory drug test.

44. On 11 October, Mr Parra reported, for a second time, that he had accidently eaten soup with peppers in it. Healthcare staff assessed him and noted that his airway was not compromised, his oxygen levels were satisfactory and that he had no swelling of his lips. They gave Mr Parra an antihistamine tablet.

45. On 17 October, Mr Parra threatened to harm himself and he was referred to the mental health and substance misuse team. It was noted that he said he had used PS for pain relief to manage thoughts of sexual abuse as a child. Mr Parra failed to attend two further appointments with the mental health and substance misuse team. At his request, the team saw him on 20 November. He told them that he had difficulty in stopping his use of PS.

46. On 26 November, Mr Parra told an offender manager that he was worried about what was happening about his possible deportation, which he said happened every time he was sentenced. However, two days later, Mr Parra told his keyworker that

he still wanted to be deported. The keyworker told Mr Parra that he would be told when a decision had been made.

47. On 6 December, Mr Parra did not attend an appointment with the mental health and substance misuse team. On 17 December, he tested positive for opiates, although none had been prescribed to him. The mental health and substance misuse team were made aware and appointments were made to see Mr Parra on 11 and 24 January 2019. However, Mr Parra failed to attend.

48. On 18 December, Mr Parra failed to attend a GP appointment. He was found under the influence of drugs on several occasions in December, which continued into 2019. He was placed under illicit substance monitoring procedures.

2019

49. In the first half of 2019, Mr Parra's attitude to staff varied from being cooperative, to being aggressive and unengaged.

50. On 28 March, the mental health and substance misuse team discharged Mr Parra to primary healthcare after he failed to attend his last three appointments.

51. On 20 May, Mr Parra told his keyworker that he did not want to be deported when he completed his sentence. The keyworker noted that issues about his deportation appeared to weigh heavily on his mind. He spoke to Mr Parra again on 24 June. He noted that Mr Parra had little to say but again talked about now not wanting to be deported.

52. On 26 June, Mr Parra refused to show an officer a movement slip (written permission authorising movement to a particular area of the prison) and was aggressive when confronted about it.

53. Mr Parra was again found under the influence of drugs on several occasions in July. On 10 July, the keyworker told Mr Parra that there had been no update from the Home Office about his deportation status.

54. From the middle of July, Mr Parra's behaviour improved, he was noted to have assisted staff and had regularly volunteered to clean the food servery. (Mr Parra did not have a prison job.)

55. On 30 July, Mr Parra asked to see the mental health and substance misuse team. He said that he wanted regular drug tests so that he could prove to the Home Office that he was not using drugs.

56. On 1 August, Mr Parra was put back on the prison's standard Incentives and Earned Privileges regime because he was not taking illicit substances, had not received negative behaviour reports and his behaviour and attitude had generally improved.

57. An officer who worked on Silbury Unit, Mr Parra's wing, told the investigator that in the weeks leading to Mr Parra's death, he seemed in a good mood and he could not recall ever seeing Mr Parra under the influence of drugs.

58. Another officer told the investigator that Mr Parra got on well with staff and prisoners and described him as a “bit of a joker”. The officer said that Mr Parra pushed boundaries but very rarely “overstepped the mark” and he was generally not aggressive towards staff or prisoners. The officer said that Mr Parra sometimes became frustrated but not towards staff. He said that he had never heard Mr Parra talk about suicide or self-harm. He said that he recalled Mr Parra telling him that he was allergic to peppers some months earlier. The officer said at the time of his death, Mr Parra was “on an up”.

Events of 5 August

59. At around 2.00pm, Mr Parra tried to enter the healthcare unit without a valid movement slip. He told an officer that he wanted to see a nurse about obtaining antihistamines as his hands were a “funny colour”. She spoke to a nurse about his request. She told Mr Parra that he could not come into the healthcare unit without a valid movement slip. She gave him one so that he could return the following day. Mr Parra told the officer that he was not happy about having to return the next day and that he would complain.

60. At around 2.30pm, a nurse met Mr Parra on her way to Silbury Unit. He told her that he was not able to get his medication because he did not have a movement slip. She said that Mr Parra was a little angry but accepted that he needed a movement slip. Mr Parra showed her his hands, which she described as looking as if he had just washed them in hot water. She did not see a rash. Mr Parra walked a short way with the nurse before leaving her to go to a music lesson in the chapel.

61. Mr Parra’s music teacher said that Mr Parra arrived at the chapel around ten minutes before the music lesson ended. He said that Mr Parra was not noticeably upset.

62. At around 3.20pm, Mr Parra, who was walking with his keyworker, stopped a medicines’ management assistant and a healthcare assistant. The medicines’ management assistant said that Mr Parra asked if he could come to the healthcare unit for antihistamines as his hands were itchy, blotchy and red, which he thought might have been the result of taking medication for a urinary infection. The healthcare assistant told the investigator that Mr Parra’s hand had what looked like pen dots on it. The medicines’ management assistant did not have a movement slip with her but told Mr Parra to ask wing staff to complete one for him later that afternoon or the following morning so that he could collect some antihistamines. She said that when they left Mr Parra, he thanked them, saying, “I knew I could count on you to sort it for me”. The healthcare assistant and keyworker described Mr Parra as relaxed during the conversation.

63. The keyworker said that as he walked Mr Parra back to Silbury Unit, he held an informal keyworker session with him. He told Mr Parra to continue with his recent good behaviour, that he had never seen such positivity from him and that his recent progression had been “brilliant”. Mr Parra told him that he wanted to continue with his good behaviour and asked to have frequent drug tests to prove to the Home Office that he no longer used drugs. The keyworker said that Mr Parra had never raised any issues about medication with him before 5 August.

64. The healthcare assistant said that when she and the medicines' management assistant returned to the healthcare unit, a nurse was speaking on the phone to Silbury Unit. She said that the nurse agreed to give Mr Parra one antihistamine and that he could collect the remainder the following morning. The healthcare assistant called Silbury Unit to tell them to bring Mr Parra to the healthcare unit. The medicines' management assistant said that when they returned to the healthcare unit, she had been surprised by Mr Parra's "quick change of mood". She then went to the pharmacy to prepare his antihistamines and other medication so that Mr Parra could either collect them later that day or the following morning.

65. At around 5.30pm, an officer said that Mr Parra complained to him about a rash on his hand and that it felt like it did when he ate peppers and had an allergic reaction. The officer said that he tried unsuccessfully to get hold of healthcare staff so left a note for his colleagues to contact them later that evening.

66. At around 6.10pm, Officer A unlocked Mr Parra for evening association. He told the investigator that Mr Parra asked him to ring healthcare staff for some antihistamines and that as Mr Parra walked away, he made a passing comment to the officer that he had eaten some peppers.

67. Officer A told the investigator that he then told Mr Parra, who was playing pool, that arrangements had been made for an officer to escort him to the healthcare unit. He said that Mr Parra was grateful about this. He said that when Mr Parra was playing pool, he touched his tongue a couple of times and said, "It's swollen up a little bit". The officer said that he was not medically trained to confirm whether this was the case.

68. Officer A told a Supervising Officer (SO), who was the assistant Duty Manager of the evening, about Mr Parra's actions and it was agreed that, as he had eaten something which he knew he was allergic to, this amounted to self-harm. Staff therefore started suicide and self-harm monitoring procedures. (Staff agreed to monitor him four times an hour, but this did not start until 7.20pm when staff started ACCT procedures. Until this time, Mr Parra had frequent contact with staff.)

69. Officer A told Mr Parra that staff would start ACCT procedures because of his actions. He said that Mr Parra reacted to this news in a very negative and abusive way and said that they had "done nothing for him", were "punishing him" and the prison did nothing but bully people. Mr Parra told the officer that "he had to do something drastic, he had to put his life in danger to get a response from healthcare". The officer said that he had no idea why Mr Parra's had attitude changed so quickly and this took him by surprise. He said that Mr Parra was verbally abusive to him before he left.

70. A prisoner on the unit said Mr Parra told him he had eaten a chilli because staff knew he was allergic to them and could die and that he had wanted to show staff how "pissed off" he was. He told the investigator that Mr Parra's death had come as a shock and was out of character. He said that although Mr Parra was anxious about deportation, he dealt well with the issue.

71. At around 6.30pm, Officer A told a healthcare assistant by telephone that Mr Parra had intentionally eaten some pepper and wanted antihistamines. He said that Mr Parra calmly ate more peppers in front of him while he was on the phone. He told

the healthcare assistant that Mr Parra refused to go to the healthcare unit to be assessed because staff had started ACCT procedures.

72. Although she did not speak to Officer A, a nurse agreed with the healthcare assistant that Mr Parra should be brought to the healthcare unit for assessment and an antihistamine, if appropriate.

73. The nurse told the investigator that Officer A was told that there would be no healthcare staff after 7.00pm and that if Mr Parra showed any signs of anaphylaxis, throat swelling or breathing difficulties, the out-of-hours doctor or an ambulance should be called immediately. She also checked Mr Parra's medical records and, although there was no formal diagnosis of a pepper allergy, she saw that there were historic entries that he had told staff he was allergic to them. Another nurse who was also present, agreed with her plans for Mr Parra.

74. At 6.36pm, Mr Parra made a 26 second call to his sister. (The investigator was unable to confirm the content of the call.) At around this time, Officer B arrived on the wing to escort Mr Parra to the healthcare unit. He said that Mr Parra was "flying between the phones and his cell; he was obviously agitated" and that a lot of what he said did not make sense. He said that Mr Parra told officers that his medication had been messed up and he was very angry that he was being monitored under ACCT procedures. Mr Parra later told him and Officer A that he blamed healthcare staff.

75. Officer B said that he stayed on the wing so that Mr Parra could be taken to the healthcare unit for an assessment. Although he offered to take him several times, Mr Parra refused to go. He described Mr Parra as being emotional and frustrated.

76. Officer A also said that Mr Parra was very angry and upset that he was subject to ACCT procedures. The officer said that he and Officer B spent around five minutes explaining to him that arrangements had been made for him to be assessed by the healthcare team but Mr Parra continued to say that he did not want to go, that staff did nothing for him and that they were bullies. He said that he then left, leaving Mr Parra talking to Officer B and Officer C, who had now arrived on the wing.

77. Officer A said that having told Mr Parra that he had done everything he could to help him, Mr Parra said that he did not want help and, so the officer withdrew from the situation. (Officer C told the investigator that he could not recall speaking to Mr Parra then.)

78. A prisoner who lived opposite Mr Parra's cell, said that at around 6.40pm he was with another prisoner when they heard Mr Parra slam his cell door shut, which was unusual for him.

79. At 6.52pm, Mr Parra told his sister by telephone that the prison was "fucking" up his medication, that his antibiotics had given him side effects, including a rash, and that healthcare staff would not give him antihistamines. He said that the healthcare team had refused to see him during the day because he did not have a valid movement slip, but he had been told they would arrange for him to be given some. Mr Parra said that he had told the nurses that they were putting his life in danger and questioned what would happen if he had a panic attack.

80. Mr Parra told his sister that he was "clearly having an asthmatic shock" - it is likely he meant anaphylactic shock - that he was allergic to the peppers that he had eaten and that healthcare staff needed to see him but had refused. Mr Parra told his sister that staff were now monitoring him under ACCT procedures because he had "endangered his life" but he said that staff had endangered his life all week.

81. Mr Parra told his sister that he was being "pushed and pushed" and that his "mental health was about to break". He said that he blamed healthcare staff and he was concerned that he would end up on the basic Incentives and Earned Privileges level and in segregation for his actions. He told her that he did not know what to do. When his sister tried to calm him, he told her, "No listen, I've had enough of it. That's it. I'm ending it tonight. It's done." Mr Parra also said, "I'm done, I'm done. I can't take any more of this shit. I'm done. It's either the mental hospital or fucking, I'm done, I'm dead." Mr Parra's sister tried again to calm Mr Parra before the call was ended.

82. A prisoner who lived opposite Mr Parra, said that he told him not to do anything stupid and Mr Parra had replied that he would be alright. He said that while Mr Parra was talking on the phone, he told Officer A that he would kill himself that evening, before continuing to talk to his sister. He said the officer asked Mr Parra what he wanted him to do but that Mr Parra told him there was nothing he could do and told him to "fuck off" before he continued the call to his sister. (These interactions were not recorded in the transcript of the phone recording that Mr Parra made with his sister. The prisoner said that he was locked up that evening at 4.55pm and that this was the last time he saw Mr Parra. However, Mr Parra did not make the phone call to his sister until 6.52pm.)

83. A prisoner said that at around 6.55pm, he saw Mr Parra looking out of the window, on the landing, and told him not to do "anything silly" or get himself into trouble. He said that he had seen Mr Parra on the telephone, looking distressed.

84. Officer A said that just before Mr Parra was locked up for the night, he saw him filling his flask with hot water before he walked back to his cell.

85. Officer A said that at around 7.00pm, just before prisoners were locked back in their cells, Mr Parra told Officer B that he now wanted to go to the healthcare unit. Officer A said that when he heard this, he called healthcare again but was told that it was now too late for Mr Parra to attend. He noted in his statement that it could not be facilitated as healthcare staff were busy and officers were locking up the unit.

86. Officer B went back to Mr Parra's cell. He told the investigator that in a "throwaway comment", Mr Parra told him he would barricade his cell and now wanted to see healthcare staff. He told Mr Parra that healthcare staff were now no longer available and that he should let staff know if he needed anything. He said Mr Parra told him he was sure "he was going to get lightheaded and that his tongue would swell as a reaction to the peppers he had eaten".

87. Officer B went back to the office and told Officer A and Officer C what Mr Parra had said about barricading his cell and getting lightheaded. They decided to let the SO know.

88. The SO said that at around 7.00pm, Officer B called him to say that Mr Parra was "being a bit difficult". The SO said that he would go to the unit to help with locking up the prisoners.

89. Officer B said at around 7.10pm, a prisoner on the unit tried to talk to Mr Parra as he was being locked up and asked the officer if Mr Parra was okay. He told the prisoner that Mr Parra was not in a good place and did not want to talk to anyone. The officer said that the prisoner tried to talk to Mr Parra, but he did not want to talk to anyone and was probably going to the segregation unit.

90. Officer B said he went to get hot water for the prisoner and, when he returned, Mr Parra was passing a DVD to him under the door. He said he locked the prisoner in his cell and told him to let staff know if he heard anything or had any concerns about Mr Parra. He said that the prisoner told him that he was sure Mr Parra was "just letting off steam and once he had calmed down, he would be fine".

91. The prisoner told the investigator that he followed Mr Parra back to his cell and because his observation panel was blocked, he spoke to him through a gap in the door. He said Mr Parra spoke to him in an unusually "horrible way" which had shocked him. He said that Mr Parra gave him a DVD and said he no longer needed it because he was going to kill himself.

92. The prisoner said he told Officer B that Mr Parra was going to kill himself. He said the officer told him to press the cell bell if he heard anything. He said that when he later heard a bang, he rang his cell bell but no one answered it until the following day. (The investigator was unable to verify when the prisoner's cell bell was answered. The cell bell recordings were not available from the prison due to outdated software, which meant that Erlestoke were unable to download the cell bell timings.)

93. At 7.20pm, Officer A formally started ACCT procedures. The officer noted that Mr Parra was "annoyed at not getting his medication. Informed me that he was allergic to peppers and then proceeded to eat one".

94. Officer B said that at around 7.25pm, he went to Mr Parra's cell with Officer C and the SO to check on Mr Parra. He said that the SO asked Mr Parra if the officers could come into his cell to talk to him, and Mr Parra replied, "You're not listening now, what difference does it make if you open the door." He said the SO tried unsuccessfully to open the cell door but it was partially blocked. He said it was clear that Mr Parra was not willing to engage so the officers returned to the unit office and gave Officer C a full handover. He said that at that time, Mr Parra did not complain of an allergic reaction.

95. The SO said that he tried to speak to Mr Parra, but he refused to engage and was irate and angry. Officer B said that the SO decided that the officers should not try to enter the cell at that point as Mr Parra had calmed down a lot compared to earlier and the situation might have escalated if the officers had done so against Mr Parra's wishes. He said that, although Mr Parra had not barricaded his cell, there were a few things in the way of the door but that it would have been easy enough to get in. The SO told the investigator that he discussed with Officer B the possibility of opening the cell door outwards, if necessary. Officer B said that words to the effect of, "Oh well, the door can swing both ways," were used as they left the cell.

96. A prisoner said that around 7.00pm in the context of Mr Parra barricading his cell door, he heard officers laughing and saying, “It swings both ways,” before leaving to get a drill which he presumed might have been for the door. He said that he felt this was disrespectful.

97. Officer B and the SO left the unit at around 7.35pm.

98. At 7.30pm, Officer C noted in the ACCT ongoing record that Mr Parra was very agitated and had put his belongings, which were in plastic bags, on the floor of the cell, including in front of the cell door. When he checked Mr Parra at 7.45pm, he noted that he was standing in his cell, going through his belongings and was pacing up and down. He said that he could not recall speaking to Mr Parra during the ACCT checks.

99. Officer C said that when he checked on Mr Parra at 8.00pm, his observation panel was covered with toilet roll and empty toilet roll tubes had been put into the gaps to the side of the door. He said that through a small gap, he saw that Mr Parra had barricaded the door by placing a chair in front of it. He said that he called Mr Parra’s name several times and kicked and banged the door to obtain a response but there was none.

100. Officer C returned to the wing office and telephoned the communications room, asking for the Custodial Manager (CM), the evening Custodial Manager, to contact him. He told the CM that Mr Parra was on 15-minute ACCT observations, that his cell observation panel was blocked and that he could not see or hear anything, despite kicking the door for a response. The CM told him that he would arrange for other officers to come to the wing to help him. The officer remained in the wing office on the ground floor of the unit for around 10 minutes until the SO and Officer D arrived.

101. The SO said that at 8.05pm, an OSG in the communications room told him that Officer C could not get a response from Mr Parra, that he had blocked his observation panel and that the officer thought it likely that Mr Parra had barricaded his cell. The SO said that he and Officer D would go to the wing immediately as three members of staff were needed to open Mr Parra’s cell door.

102. At around 8.10pm, the SO and Officer D met Officer C in the communal area of the ground floor as they arrived on the unit. Officer C said that before the officers went upstairs to Mr Parra’s cell, he briefed them for around two to three minutes that Mr Parra may have barricaded his cell, was not responding and was being monitored under ACCT procedures.

103. Officer D and the SO knocked on Mr Parra’s cell door because the observation panel was covered. The SO shouted to Mr Parra, but there was no response. He said the observation panel was covered in toilet paper and something had been jammed around the cell door which he believed had been barricaded. He then stood on a chair to see if he could see Mr Parra in the cell, but he could not.

104. A prisoner said that he heard Officer C call to Mr Parra in his cell between 7.45pm and 8.10pm, saying he knew he was in there, but Mr Parra did not respond. He said the officer returned around ten minutes later, said the same words but again got no response. He said that soon afterwards, other officers got a chair to stand

on to look through the top of the door and he heard one officer say, “I can see you Dave, sat on the bed” and “What are you doing, playing hide and seek?”

105. The SO told the investigator that he shouted to Mr Parra, “I can see you on the bed”. He said that this was something he would regularly do if a prisoner had blocked their observation panel because if a prisoner thought they could be seen then they would usually respond. However, he said he did not say to Mr Parra that he was “playing hide and seek”.

106. Another prisoner said that Mr Parra was not responding to the officers. He said that the officers were laughing and joking at his door and he heard someone shout through the door, “He’s going to kill himself”. He said that he went to the door of his cell and told officers, “You know what he’s going do, he’s told you what he’s going to do”. He said that the officers left the cell and around 15 to 20 minutes later, he heard them open the cell door.

107. Officer C said that he and the officers were at the cell door for about six minutes. Officer D said they were outside the door for two or three minutes before they tried to go in.

108. The SO said he could not open the cell door because of the barricade. He then left the area to fetch the key to the inundation point (so he could look through that). At the same time, Officer D forced the door open and he signalled to the SO to return to the cell. At 8.18pm, the SO went into the cell, followed by Officer D.

109. The SO said that the shower curtain was taped and he pulled it back tentatively, fearing that he might be attacked. He then pulled the shower curtain back fully and they saw that Mr Parra was hanging by a ligature, made from bed sheets, from the shower head fitting. He cut the ligature and they carried Mr Parra from the cell to the landing outside.

110. At 8.19pm Officer C radioed an emergency code blue and within a minute, an ambulance was called. At 8.20pm, an OSG called the emergency services to enable the ambulance operator to speak to the SO.

111. The SO said that he checked for a pulse and unable to find one, asked Officer D to check. He too found no pulse or other signs of life and the officers started CPR. Officer D said that his first thought was that Mr Parra was dead. He told the investigator that Mr Parra was lifeless and that the ligature mark around his neck was very deep but his body was still warm.

112. The SO returned with the defibrillator and passed it to Officer C, who attached it to Mr Parra. It detected no electrical pulse and did not advise to shock.

113. Officers continued CPR efforts until paramedics arrived at 8.38pm and told them to continue whilst they set up their equipment. At 9.06pm they pronounced that Mr Parra had died.

114. Mr Parra had written on the wall of his cell before his death:

“Help!!! But no, this jail just provokes ppl [people] with mental health to take matters into thee [sic] own hands. I’ve begged and begged for help but to no prevail so

forgive me Lord God! For I can't take any more of this shit life, they bully you and push you until you brake [sic]. It's institutional bullying to the extreme. Fuck you."

Contact with Mr Parra's family

115. The Deputy Governor asked HMP Leicester (a closer prison) to break the news of Mr Parra's death to his sister who was his next of kin. The duty governor and a family liaison officer from Leicester broke the news to her in the early hours of 6 August. Staff from Erlestoke later visited her. Erlestoke contributed to the cost of Mr Parra's funeral in line with national instructions.

Support for prisoners and staff

116. The Head of Residence and Services debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered them support. Notices were issued to staff and prisoners to inform them of Mr Parra's death.

Post-mortem report

117. A post-mortem examination found that Mr Parra had died from compression of the neck caused by suspension from a ligature. Toxicology tests, which included tests for PS, found no illicit substances in his body.

Inquest into Mr Parra's death

118. The inquest into Mr Parra's death was held on 24 March 2025 and a verdict of suicide was recorded. The jury concluded that on the day of his death there were occasions when officers failed to deal with Mr Parra appropriately and that this and the inadequacy of the ACCT was a probable contributing factor to Mr Parra's death.

Findings

Deportation concerns

119. When Mr Parra first arrived at Erlestoke in 2017 he told staff that he wanted to be deported to Italy. However, over time, he changed his mind and later told his keyworker and others that he did not want to be deported. In May 2019, he told his keyworker that issues about his deportation weighed heavily on his mind.

120. Mr Parra's possible deportation was being considered at the time by the Home Office. We understand that no decision had been made at the time of his death.

121. During previous sentences, Mr Parra had also been considered for deportation. The keyworker said that Mr Parra knew the process well, having gone through it before. He said that Mr Parra told him that he knew how the system worked and that it was unlikely he would hear anything until early 2020.

122. Although Mr Parra was clearly concerned about his possible deportation, staff, including healthcare staff, supported him and were proactive in making enquiries on his behalf and updated him accordingly. The keyworker last updated Mr Parra on 10 July when he told him that there had been no news from the Home Office.

123. Although we cannot be sure if Mr Parra's worries about deportation contributed to his actions on 5 August, the evidence suggests that other factors were in play that afternoon: Mr Parra wanted antihistamines and he was unhappy that staff were monitoring him under ACCT procedures.

Availability of illicit substances at Erlestoke

124. Mr Parra had a significant history of substance misuse and numerous entries in his prison records refer to his frequent use of PS at Erlestoke. However, just a week before his death, Mr Parra asked to see the substance misuse team and wanted regular drug tests to prove to the Home Office he was drug free. Because Mr Parra had not been seen under the influence of drugs for several weeks and there had been a general improvement in his behaviour and attitude, he was taken off basic and put back on the standard regime.

125. Toxicology tests taken after Mr Parra's death showed that he had no illicit substances, including PS, in his system. However, the possibility remains that he might have used PS sometime before he died but that it was not detected in toxicology tests (as there are very many different types of PS and not all can be tested for).

126. The clinical reviewer noted that the substance misuse team continued in their efforts to engage with Mr Parra, despite the numerous occasions that he failed to attend appointments or chose not to engage with them.

127. In 2017, HMIP inspectors reported that the prison had no effective strategy to address its drug problems and recommended that the prison should give strategic and operational priority to addressing the serious problems caused by illicit substances. In May 2018, the prison introduced its substance misuse strategy

which aims to tackle substance misuse by reducing demand and supply and by promoting recovery for prisoners through clinical intervention, education, motivation and support while managing safety and harm prevention.

128. Although we are satisfied that Erlestoke continues to make efforts to challenge the availability of and demand for PS, we are concerned that Mr Parra appears to have had no difficulty in obtaining and using PS. It is therefore clear that more needs to be done to reduce both the supply and demand for PS.

129. Drug taking and trading is a severe problem across much of the prison estate and Erlestoke is not alone in facing this problem. In April 2019, HMPPS published a National Drug Strategy setting out their plans to reduce substance misuse by sharing best practice and providing direction and detailed guidance for prisons. In relation to reducing the supply of drugs, the Prison Service strategy says:

> "Every prison is different and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

130. We therefore recommend that:

The Governor should ensure that the key drug issues at Erlestoke are identified and that their drugs strategy is kept under review to ensure that these key issues are addressed.

Identifying risk of suicide and self-harm – ACCT monitoring

131. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self-harm, and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk.

132. Although Mr Parra had a history of self-harm, none of the staff or prisoners we interviewed at Erlestoke considered that he was at risk of self-harm in the weeks leading to his death. However, given Mr Parra's actions on 5 August, when he intentionally ate a pepper which he said that he was allergic to, we consider that staff acted appropriately in starting ACCT procedures despite Mr Parra's objections.

Healthcare response to request for antihistamines

133. On 5 August when Mr Parra was refused entry to the healthcare unit, he asked for antihistamines for a rash on his hands but was told to return the following day. That

afternoon, Mr Parra again asked for antihistamines but was told to ask the officers on his unit to issue him with a movement slip so that he could be assessed and given medication, if appropriate, later that afternoon. However, Mr Parra did not attend that afternoon, as arranged.

134. At around 6.10pm, Officer A contacted healthcare to tell them that Mr Parra had eaten a pepper which he said he was allergic to and asked for antihistamines. Healthcare staff told the officer to bring Mr Parra to the healthcare unit for assessment, but Mr Parra refused several times to attend. In the absence of healthcare cover at night, officers were told that if Mr Parra's condition worsened or he had an allergic reaction, they were to call emergency services.

135. Officer B said at interview that he had offered to take Mr Parra to the healthcare unit at least twice that evening, but Mr Parra refused.

136. When the clinical reviewer asked a nurse why she did not visit Mr Parra on the wing, she explained that nursing staff only provide medication on the units when a patient is bed-bound or has a clinical reason which prevents them from accessing healthcare services. She said that if she had been told that the situation was a medical emergency, she would have attended.

137. When Mr Parra knowingly ate peppers and asked to see healthcare staff, prison staff offered to take him on several occasions, but Mr Parra refused to attend and only agreed to do so when healthcare staff had finished working for the day.

138. The clinical reviewer concluded that the healthcare team provided appropriate care to Mr Parra on 5 August.

Emergency response

139. Erlestoke does not have a local policy to tell staff what to do if they find a cell observation panel obscured. In such circumstances, we would usually expect staff who cannot see or speak to a prisoner to radio for help from other staff and remain at the cell door. If they believe the prisoner may be at risk, they should assess the risk of opening the cell door themselves before help arrives, particularly if the prisoner is subject to ACCT monitoring.

140. When Officer C found that Mr Parra had blocked his observation panel and could not get a response from him, he left the landing to call for assistance from colleagues by using the telephone in the unit's office and said that this was the normal way to get hold of the evening duty manager. He said that he did not consider opening the cell door because the situation did not concern him enough to do so, the prison was in patrol state and he did not know Mr Parra's history.

141. We consider that Officer C should have acted with more urgency, especially as he knew Mr Parra was being monitored under ACCT procedures, that he was agitated and had probably barricaded his cell. Any situation in which a prisoner on an ACCT cannot be seen should be taken seriously. He should have radioed for assistance and considered trying to enter Mr Parra's cell immediately because he was subject to ACCT procedures.

142. PSI 24/2011 says that under normal circumstances, cells must not be opened at night without the authority of the night manager and unless a minimum of two or three (depending on local policy) staff are present. However, it goes on to say that the preservation of life must take precedence and where there is, or appears to be immediate danger to life, staff may enter cells on their own, subject to a rapid dynamic risk assessment of the situation. However, night staff should not take action they feel would put themselves or others in unnecessary danger.

143. We do not say that Officer C should have entered the cell on his own, but we do think that he should have considered doing so. We are also concerned that the SO said that three members of staff were needed to open Mr Parra's door and that the CM told Officer C to wait for other staff to arrive when he reported that Mr Parra could not be seen and was not responding. This suggests that they did not understand that it is possible for an officer to enter a cell alone when there appears to be an immediate risk to life.

144. Although there is no evidence to confirm prisoners' accounts that staff laughed about Mr Parra's situation, we consider that the officers should have responded more quickly when they arrived on the wing in response to Officer C's request, particularly in the context of their interactions with Mr Parra earlier that evening.

145. We make the following recommendations:

The Governor should ensure that a local protocol is developed and shared with staff to instruct them on what to do if they find a cell observation panel obscured.

The Governor should ensure that, subject to a risk assessment, staff enter cells as quickly as possible if there is reason to consider that a prisoner may be at risk.

The Governor should ensure that a copy of this report is shared with the CM, Officer C, the SO and Officer D and that a senior manager discusses the Ombudsman's findings with them.

Clinical care

146. The clinical reviewer concluded that the overall standard of healthcare at Erlestoke was equivalent to that which Mr Parra could have expected to receive in the community.

147. However, the clinical reviewer identified some areas of care which were not equivalent. These included that the mental health assessment when Mr Parra arrived at Erlestoke was not carried out with Mr Parra present but was simply a review of his medical records; that healthcare staff did not follow-up when Mr Parra failed to attend appointments or engage with services; and that there was no access to a specialised sexual abuse trauma service.

148. The clinical reviewer also identified a number of other clinical concerns, which the Head of Healthcare will need to address.

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