Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Jordan, a prisoner at HMP Durham, on 3 July 2024

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.

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.

Mr Brian Jordan died on 3 July 2024, after he was found hanging in his cell at HMP Durham. Staff and paramedics tried to resuscitate him but were unsuccessful. He was 60 years old. I offer my condolences to Mr Jordan's family and friends.

Mr Jordan had been in prison for around three weeks, and died seven days after he was convicted of his offences. In that time, he gave no indication to staff that he was at risk of suicide or self-harm. I am satisfied that staff could not have foreseen his actions.

I make no recommendations.

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

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

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Summary

Events

1. On 14 June 2024, Mr Brian Jordan was remanded in custody, charged with sexual offences, and sent to HMP Durham. When he arrived, Mr Jordan said he had no thoughts of suicide or self-harm and declined the offer to be seen by the mental health team.

2. On 27 June, Mr Jordan was convicted of sexual offences and sentenced to seven years and seven months in prison.

3. At around 9.30am on 3 July, Mr Jordan rang his family. He asked his son to check online for details of his cellmate's offence. His son told him that there was no information about his cellmate but there were details of Mr Jordan's offence and conviction in the local online paper. Mr Jordan became distressed and said he was scared he would be attacked by other prisoners. He asked his son to buy the local paper and said he would ring back later that morning.

4. At 10.43am, an officer unlocked Mr Jordan's cell and saw him hanging from the top bunk. She immediately called a medical emergency code, entered the cell and cut the ligature. Another officer arrived quickly and they started CPR.

5. Staff and paramedics continued with the resuscitation attempts but were unsuccessful. At 11.58am, paramedics pronounced Mr Jordan's death.

Findings

6. Mr Jordan gave no indication to staff that he was at risk of suicide or self-harm. They would have been unaware of the contents of his last phone call until after his death. We are satisfied that staff could not have foreseen his actions.

7. We make no recommendations.

The Investigation Process

8. HMPPS notified us of Mr Jordan's death on 4 July 2024.

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

10. The investigator visited Durham on 17 July. She obtained copies of relevant extracts from Mr Jordan's prison and medical records. She spoke to his cellmate.

11. NHS England commissioned an independent clinical reviewer to review Mr Jordan's clinical care at the prison. The clinical reviewer and investigator conducted a joint interview at Durham on 11 September 2024.

12. We informed HM Coroner for County Durham and Darlington of the investigation. The Coroner gave us the results of the post-mortem examination and the toxicology report. We have sent the Coroner a copy of this report.

13. The Ombudsman's office contacted one of Mr Jordan's sons to explain the investigation and to ask if he had any matters he wanted us to consider. He said that on the day he died, Mr Jordan had spoken to them and had said he did not feel safe and this might have been because a newspaper article contained details of his conviction and sentence. He had told them he was going to speak to prison officers about being moved. They wanted to know why he had not been moved. This has been addressed in the report.

14. We shared our initial report with HMPPS and the prison's healthcare provider, Spectrum CIC. They found no factual inaccuracies.

15. We sent a copy of our initial report to one of Mr Jordan's sons. He did not notify us of any factual inaccuracies.

Background Information

HMP Durham

16. HMP Durham is a local prison, serving the courts of Tyneside, Durham and Cumbria. Spectrum Community Health CIC provides primary healthcare services. Tees, Esk and Wear Valleys Foundation NHS Trust provides mental health services.

HM Inspectorate of Prisons

17. The most recent inspection of Durham was in November 2021. Inspectors reported that new arrivals had the opportunity to discuss their concerns but late admissions and a busy first night centre sometimes impacted on the quality of the service provided. Recorded levels of self-harm were lower than at similar prisons, and there was good interrogation of self-harm data. Prisoners' healthcare was affected by serious staff shortages in the department.

Independent Monitoring Board

18. 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 31 October 2023, the IMB reported that the prison generally felt a safe environment. However, the Board raised concerns about the level of overcrowding which had led to the accommodation of vulnerable prisoners in the main body of the prison.

Previous deaths at HMP Durham

19. Mr Jordan was the 13th prisoner to die at Durham since July 2021. Of the previous deaths, five were self-inflicted and seven were from natural causes. There was another self-inflicted death at Durham the day after Mr Jordan's, but they were unconnected with no similarities.

Key Events

20. On 10 April 2024, Mr Brian Jordan was remanded in custody on historic sexual offences charges. The next day, he attended court and was released.

21. On 14 June, Mr Jordan was again remanded in custody on sexual offences charges and sent to HMP Durham. Mr Jordan had no known history of suicide or self-harm and no risk factors. He told the reception nurse that he had no thoughts of suicide or self-harm and he declined the offer to be seen by the mental health team.

22. Mr Jordan was allocated a shared cell on the Vulnerable Prisoners (VP) section of F Wing (the induction wing for new arrivals) due to the nature of his offence. (There is no evidence that Mr Jordan and his cellmate were close or had shared personal information.)

23. On 27 June, Mr Jordan appeared in court by video link. He was convicted of sexual offences and sentenced to seven years and seven months in prison. A healthcare support worker completed a review of Mr Jordan after his change in status and no concerns were noted.

24. Over the following days, staff had no concerns about Mr Jordan's risk of suicide and self-harm and he raised no issues with them.

Events of 3 July 2024

25. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to the staff radio communications and 999 call from 3 July. She also obtained information from the North East Ambulance Service.

26. At around 8.30am, Mr Jordan's cellmate left the cell to go to his English lesson. He was due back between 11.15am and 11.30am.

27. CCTV shows that no one entered Mr Jordan's cell after his cellmate left. At 9.27am, Mr Jordan rang one of his sons from his in-cell phone. All calls are recorded and the investigator listened to the call.

28. Mr Jordan asked his son to check online for the offence details of his cellmate. His son told him that there was no information about his cellmate online in the local press but that details of his offence and conviction had been reported. Mr Jordan asked his son to read out the article. As his son did so, Mr Jordan became distressed. He repeatedly said he was scared he would be attacked by other prisoners. He said he felt sick and that he had a shoelace. He asked his son to go and buy a copy of the local newspaper and he would ring back later. He was anxious about whether he would be able to ring back as it was likely to be after 11.00am (presumably this was because he knew his cellmate was due to return to the cell). Mr Jordan's son told him if he felt unsafe he should request a prison move.

29. During the telephone call recording, in the background an officer can be heard coming to the cell and asking Mr Jordan if he wanted to go for exercise. Mr Jordan refused and remained on the telephone call. This was at approximately 9.40am. The telephone call lasted for 15 minutes and 47 seconds and ended at 9.42am.

30. At 10.43am, Officer A unlocked Mr Jordan's cell to ask him if he wanted to come out for association time. In her written statement, she said she opened the door and saw Mr Jordan slumped on the floor at the foot of the bunkbeds with a ligature around his neck, tied to the top bunk. She radioed a Code Blue (a medical emergency code used when a prisoner is unconscious that alerts other staff and tells the control room to call an ambulance immediately) and then shouted to her colleagues for assistance. She entered the cell and cut the ligature attached to the bunkbeds. Staff in the control room immediately telephoned for an ambulance.

31. In her written statement, Officer B said that she heard Officer A's emergency radio call and her shout for staff. She ran to the cell and saw that Mr Jordan had what appeared to be a black shoelace around his neck as Officer A had already cut the ligature from the bunk bed. She took the knife from Officer A and cut the lace from around Mr Jordan's neck.

32. Officer A began CPR, followed by Officer B until the nurse arrived. The nurse asked the staff to move Mr Jordan out onto the landing as there was more room. Officer B continued with CPR. Officer C then relieved Officer B and he continued with CPR.

33. At interview the nurse said she heard the emergency radio call and ran to the wing. When she arrived at the cell, Mr Jordan was already on the landing and staff were giving CPR. She used a suction device to clear the secretions in his mouth and applied the defibrillator pads.

34. Ambulance service records show that the prison made the call at 10.43am. Ambulance paramedics arrived at 10.48am and assisted with the resuscitation attempts. The paramedics declared Mr Jordan dead at 11.58am.

35. Mr Jordan was scheduled to transfer to HMP Northumberland on 5 July to complete his sentence and access relevant offending behaviour programmes. He did not know this.

Contact with Mr Jordan's family

36. The prison appointed two family liaison officers. They visited Mr Jordan's family home at approximately 3.15pm on 3 July and broke the news to his sons that their father had died.

37. The prison contributed to the cost of Mr Jordan's funeral, in line with national guidelines.

Support for prisoners and staff

38. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case by case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

39. After Mr Jordan's death, the duty governor debriefed the prison and healthcare 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. Listeners were sent to the wing to offer support to prisoners.

40. The prison posted notices informing other prisoners of Mr Jordan's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Jordan's death.

Post-mortem report

41. The post-mortem report concluded that Mr Jordan died from pressure to the neck caused by hanging.

42. The toxicology report noted that at some point Mr Jordan had used cannabis. However, it was unlikely that he was under the influence of this drug at the time of death.

Findings

Assessment of risk

43. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that staff must follow if they identify that a prisoner is at risk of suicide or self-harm.

44. Mr Jordan had no risk factors for suicide or self-harm, other than that he had not been in prison for very long. During his three weeks at Durham, Mr Jordan shared no concerns with staff and expressed no thoughts of suicide or self-harm.

45. It would appear finding out that details of his offence were in the local press was the trigger for Mr Jordan's actions. However, staff would have been unaware of the contents of the telephone call Mr Jordan had with his son on the morning of 3 July. Mr Jordan raised no concerns with staff or his cellmate. We are satisfied that staff could not have foreseen his actions.

Clinical care

46. The clinical reviewer concluded that the emergency response was good.

47. The clinical reviewer made three recommendations about aspects of Mr Jordan's physical healthcare which are not relevant to his death but which the Head of Healthcare will wish to address.

Inquest

48. At the inquest, held from 9 to 11 September 2025, the jury concluded that Mr Jordan died by suicide.

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