

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Paul Jessop, on 30 December 2024 following his release from HMP Durham**

**A report by the Prisons and Probation Ombudsman**

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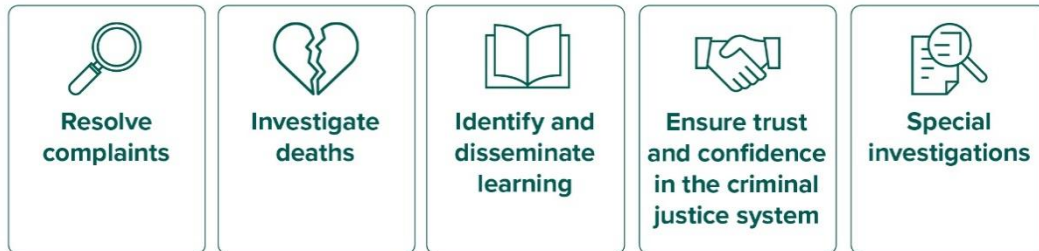
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## OUR VISION

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



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## 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. 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.
3. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of the person's release from prison.
4. Mr Paul Jessop died from multi-drug toxicity on 30 December 2024, following his release from HMP Durham on 23 December. He was 43 years old. We offer our condolences to those who knew him.
5. We did not identify any significant learning relating to the pre-release planning or post-release supervision of Mr Jessop.
6. We make no recommendations.

## The Investigation Process

7. HMPPS notified us of Mr Jessop's death on 7 January 2025.
8. The PPO investigator obtained copies of relevant extracts from Mr Jessop's prison and probation records.
9. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
10. The Ombudsman's office contacted Mr Jessop's family to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

## Background Information

### HMP Durham

11. HMP Durham is a category B prison which holds convicted and remanded male prisoners. It is managed by HMPPS. Spectrum Community Health CIC provides physical healthcare services and Tees Esk and Wear Valley (TEWV) provides mental healthcare services.

### Probation Service

12. 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 appropriate. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

### HM Inspectorate of Prisons

13. The most recent inspection of HMP Durham was in May 2024. Inspectors reported that they saw some improvement in preparation for release, where outcomes were now reasonably good. There were impressive opportunities for prisoners to maintain contact with their children and families, and resettlement services had improved overall. However, far too many prisoners were released homeless.

## Key Events

### Background

14. On 29 September 2024, Mr Paul Jessop was sentenced to 26 weeks imprisonment for theft. He was sent to HMP Leeds. On 8 October, Mr Jessop was transferred to HMP Wealstun.
15. On 5 December, Mr Jessop was released from prison, however on 14 December, he was recalled to prison after he breached his licence conditions and he was sent to HMP Durham.
16. That day, Mr Jessop had a reception health screen. He said that he had been using drugs intravenously and used cocaine. He said that he was prescribed methadone and levetiracetam for epilepsy. A nurse referred Mr Jessop to the substance misuse service. Mr Jessop was re-prescribed methadone with titration starting at 30mls, was booked on a five-day drug addiction maintenance therapy and was re-prescribed medication for his epilepsy.
17. On 16 December, Nurse A assessed Mr Jessop. Mr Jessop said that he smoked crack cocaine on a regular basis, used benzodiazepines (zopiclone), which he took in the morning and at night, and also used heroin. Later that day, Mr Jessop started the drug addiction maintenance therapy which was to be reviewed on 21 December. He was given harm reduction advice about the risks of illicit use of drugs while in prison and was advised not to share vapes.
18. Nurse B discussed naloxone (medication that reverses an opioid overdose) with Mr Jessop. He agreed to accept a naloxone kit on release. He said that he wanted to be issued with the nasal spray option and that he was aware of how to administer it as he had used it before. Nurse B referred Mr Jessop to the community drug and alcohol team. On 17 December, Mr Jessop was added to Waythrough, a community substance misuse service, caseload.

### Pre-release planning

19. On 18 December, Nurse C was informed that Mr Jessop was going to be released on 23 December. She referred him to community drug and alcohol services and requested an appointment.
20. Nurse C also referred Mr Jessop to the probation notification actioning programme (PNAP – these are emailed to probation, to notify the allocated community probation office of the date and time of the service user's community drug and alcohol appointment) and agreed to have his next pre-release session when the community appointment was received. Mr Jessop was encouraged to engage with the substance misuse service and he was given harm minimisation advice and information about the risk of overdose.
21. On 20 December, Ms A prepared Mr Jessop's medication as he was due to be released on 23 December. Due to him being released over a bank holiday, he was to be issued with two weeks' worth of medication. It was agreed that he would seek to have his epilepsy reviewed in the community.

22. Later that day, Nurse C saw Mr Jessop for a pre-release session. She gave him his PNAP community appointment which was scheduled for 24 December. Mr Jessop was concerned about not having accommodation upon release, as he was housed prior to coming back to prison and he was unsure if he still had his accommodation. Nurse C contacted the pre-release team to raise his concerns and they agreed to look into it and feed back to him later. It was confirmed that CAS3 accommodation (short term accommodation for up to 84 nights provided by HMPPS for prison leavers) had been secured for Mr Jessop, which was where he was living before he was recalled.
23. Nurse C offered to refer Mr Jessop to mental health services in the community but he declined the offer and said that he had no mental health issues.

### **Release from HMP Durham**

24. On 23 December, Mr Jessop was released from Durham. He was released with a 14 - day supply of medication which included amitriptyline, mirtazapine (an antidepressant) and levetiracetam, and he was given a naloxone kit. His post-sentence supervision conditions were explained to him and he signed the licence to confirm he understood them.
25. Mr Jessop reported to the local probation office for his initial appointment with the duty Community Offender Manager (COM). During this meeting, the duty COM went over his licence conditions and his induction pack.
26. The duty COM noted that Mr Jessop appeared to be under the influence of drugs and the meeting was terminated earlier than planned. Mr Jessop was advised that his licence was going to be amended to include drug testing. Before he left, the next meeting was scheduled and information of this was to be communicated to him by text and post.
27. The next day, Mr Jessop attended the continuity of care meeting with the community drug and alcohol service as planned.

### **Circumstances of Mr Jessop's death**

28. At 9.25pm on 29 December, Mr Jessop's flat mate found him unresponsive and started CPR. The flat mate called the police and ambulance service, who attended at 9.37pm. At 9.50pm, the ambulance crew pronounced life extinct.

### **Post-mortem report**

29. The post-mortem report concluded that Mr Jessop died from multi drug toxicity, due to the presence of cocaine, methadone, zopiclone and pregabalin, which were at levels associated with fatality.

## **Findings**

30. Mr Jessop had a history of substance misuse. While it is noted that he participated in the pre-release planning process and actively engaged with the substance misuse team in prison, the plan was that once released, he would continue to

engage with community services, which would have provided him with additional support. We are satisfied that both the prison and probation services did all they could to support Mr Jessop.

31. We make no recommendations.
32. The initial report was shared with HM Prison and Probation Services (HMPPS) and Healthcare. HMPPS and Spectrum CIC did not find any factual inaccuracies.
33. At the inquest held on 24 October 2025, the coroner concluded that Mr Paul Jessop's death was drug related.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**October 2025**

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