

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Jason Parker, a prisoner at HMP Durham, on 2 May 2020

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

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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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.

This 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 Jason Parker was found hanged in his cell at HMP Durham on 2 May 2020. He was 48 years old. I offer my condolences to his family and friends.

Mr Parker had been at Durham for just four days when he took his life. Although he arrived with a suicide and self-harm warning form in place and with several risk factors for suicide and self-harm, prison staff failed to monitor him under suicide and self-harm prevention procedures (known as ACCT).

The PPO's investigations and thematic reports have repeatedly found that staff too often focus on how prisoners present and overlook their risk factors for suicide and self-harm.

This is now the fourth time in two years that we have expressed our concerns about Durham's failure to identify those at risk of suicide or self-harm when they arrive. It is critical that the Governor addresses these repeated failings and ensures that improvements are made as a matter of urgency.

Although Mr Parker's clinical care was generally equivalent to that to which he could have expected to receive in the community, we are concerned that the reception nurse did not refer him urgently to the prison's mental health team for assessment.

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

**Elizabeth Moody**  
**Deputy Prisons and Probation Ombudsman**

**April 2021**

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# Summary

## Events

1. On 28 April 2020, Mr Jason Parker was remanded to HMP Durham, charged with threatening to kill a member of the public. It was his first time in prison, and he arrived with a suicide and self-harm warning form. He had recently self-harmed and had a significant history of mental health issues, including having spent time in secure psychiatric units.
2. An officer interviewed Mr Parker when he arrived, and a nurse assessed him at a reception health screen. The nurse referred him to the prison's mental health team. Neither the nurse nor the officer considered that Mr Parker was at risk of suicide or self-harm. Mr Parker spent his short time at Durham in the prison's first night centre.
3. At around 5.11am on 2 May, an officer found Mr Parker in his cell with a ligature tied around his neck. Staff and paramedics responded promptly and tried to resuscitate him. He was pronounced dead at 5.50am.

## Findings

4. Although Mr Parker had several risk factors for suicide and self-harm, and arrived with a warning form, staff did not monitor him under ACCT procedures. We are concerned that the staff who assessed him on arrival focussed on his presentation and what he said and did not give sufficient consideration to his risk factors, and did not record their reasons for not starting ACCT procedures, as they should have done.
5. The clinical reviewer concluded that the healthcare that Mr Parker received at Durham was of a reasonable standard and was at least equivalent to that which he could have expected to receive in the community.
6. However, although Mr Parker was referred to the prison's mental health team, this was a routine referral. We consider that an urgent referral should have been made given Mr Parker's significant history of mental health issues. This was a missed opportunity for mental health staff to identify his mental health needs promptly.

## Recommendations

- The Governor and Head of Healthcare should ensure that all reception staff:
  - know the risk factors and triggers for suicide and self-harm as set out in PSI 64/2011;
  - consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm;
  - understand that they must take risk factors into account when assessing risk and not rely solely on what a prisoner says or how he presents;
  - start ACCT procedures where appropriate; and

- record the information considered and the reasons for the decision about whether to start ACCT procedures.
- **The Prisons Group Director for Tees and Wear should write personally to the Ombudsman setting out what he is doing to ensure that staff at Durham have a better understanding of the principles of risk assessment for suicide and self-harm.**
- The Governor and Head of Healthcare should ensure that the information on self-harm and suicide warning forms and PERs is shared with healthcare staff who see prisoners as part of the reception process.
- The Head of Healthcare should ensure that:
  - reception nurses request an urgent mental health risk assessment if they identify that a newly arrived prisoner has significant mental health issues or has recently self-harmed; and
  - prisoners who meet the criteria for secondary mental healthcare receive a comprehensive assessment within 24 hours of arrival.
- The Governor and Head of Healthcare should ensure that a copy of this report is shared with SO A, Officer A and Nurse A and that a senior manager discusses the Ombudsman's findings with them.

## The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Durham informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. The investigator obtained copies of relevant extracts from Mr Parker's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Parker's clinical care at the prison.
10. The investigator interviewed 14 members of staff at Durham in June 2020, some jointly with the clinical reviewer. All the interviews were conducted remotely, either by Microsoft Teams or by telephone, because of the restrictions imposed as a result of the Covid-19 pandemic.
11. We informed HM Coroner for County Durham and Darlington of the investigation. He provided us with a copy of the post-mortem report. We have sent him a copy of this report.
12. We contacted Mr Parker's next of kin, his mother, to explain the investigation and to ask if she had any matters that she wanted us to consider. Mr Parker's mother asked whether her son was on a suicide watch and if prison staff realised he was a danger to himself.
13. M Parker's next of kin received a copy of the initial report. They did not make any comments.

# Background Information

## HMP Durham

14. HMP Durham, which holds around 990 men, is a local prison serving the courts of Durham, Tyneside and Cumbria. Spectrum Healthcare provides GP and pharmacy services and Tees, Esk and Wear Valley NHS Trust provide mental health services.

## HM Inspectorate of Prisons (HMIP)

15. HM Inspectorate of Prisons carried out an unannounced inspection of Durham in September and October 2018. They concluded that the outcomes for prisoners in relation to safety were poor.
16. Inspectors reported that the number of self-harm incidents was very high, and higher than would normally be seen in a local prison. Inspectors reported that the prison did not focus sufficiently on identifying prisoners' vulnerabilities, needs or risks during the reception and first night process. Inspectors reported their disappointment that the PPO's previous recommendations had not been addressed with sufficient vigour or urgency and that the prison had not paid sufficient attention to their implementation.
17. Inspectors reported that although there was a significant demand for mental health care, the integrated mental health team delivered an appropriate range of accessible and responsive services that focused on keeping prisoners safe.
18. HMIP carried out an Independent Review of Progress in July 2019 to review the progress made in achieving the key recommendations from the 2018 inspection.
19. They found that weaknesses in the suicide and self-harm prevention measures remained a significant concern and required urgent attention. Inspectors also reported that implementation of PPO recommendations from previous reports was still insufficient and that despite efforts to improve the quality of ACCT procedures, not enough had been done to provide effective care.

## Independent Monitoring Board

20. 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 October 2019, the IMB reported their concern about the increase of incidents of self-harm at the prison.

## Previous deaths at HMP Durham

21. Mr Parker was the sixth prisoner to take his life at Durham since January 2019. Since his death, there have been a further two self-inflicted deaths at the prison which are currently being investigated.
22. In three of the previous self-inflicted deaths (two in February 2019 and one in January 2020), we made recommendations about the need for staff to be aware of and consider prisoners' risk factors when assessing their risk of suicide and

self-harm, not to rely solely on their presentation or what they said, and to record the reasons for not starting ACCT procedures.

### **Assessment, Care in Custody and Teamwork (ACCT)**

23. 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. As part of the process, a risk reduction plan, also known as a caremap (a plan of care, support and intervention) should be put in place. The ACCT plan should not be closed until all the actions of the risk reduction plan have been completed. After closure, a follow-up interview should take place within seven days.
24. 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. Prison Service Instruction (PSI) 64/2011 on safer custody sets out how staff should operate ACCT procedures.

# Key Events

## HMP Durham

25. On 28 April 2020, Mr Jason Parker was remanded to HMP Durham, charged with threatening to kill a member of the public. It was his first time in prison.
26. Mr Parker had a long history of self-harm. He had epilepsy, an extensive history of mental health issues, including anxiety, depression, psychosis, borderline personality disorder and paranoid schizophrenia, and had been admitted to psychiatric hospitals on several occasions.
27. Mr Parker arrived at Durham with a suicide and self-harm (SASH) warning form. His person escort record (PER) noted his history of self-harm, that he had last self-harmed on 19 April when he had held a knife to his throat, and that he had made outlandish claims about police, and noted his deteriorating mental health.
28. Supervising Officer (SO) A assessed Mr Parker's vulnerabilities in reception. He had access to the PER and SASH forms. He recorded (incorrectly) that Mr Parker had not recently self-harmed and that he denied any thoughts of doing so. He also recorded (incorrectly) that it was not Mr Parker's first time in prison and that his offence was not serious.
29. SO A told the investigator that, shortly after completing the assessment, he realised that Mr Parker had arrived with a suicide and self-harm warning form, and asked Mr Parker again if he had any thoughts of self-harm. Mr Parker said that he did not.
30. The vulnerabilities form that SO A completed says that if the prisoner has recently self-harmed, an ACCT should be opened. The investigator asked why he did not open ACCT procedures when he saw the SASH form saying that Mr Parker had a history of self-harm and had last self-harmed on 19 April. The SO said that it was his job to make a judgement and that at the time Mr Parker "presented no risk to himself or expressed any risk or desire to hurt himself". He said:

"I know for a fact that when I did speak to [Mr Parker], that he presented no risk, what I thought didn't warrant him to be on an ACCT, because he stated to me that he had no thoughts of self-harm or suicide. Otherwise, if he did, I would have opened an ACCT."
31. At Mr Parker's initial health screen, Nurse A, a mental health nurse, noted that Mr Parker had a history of poor mental health and had been diagnosed with a personality disorder and depression. She recorded that Mr Parker said that he "spontaneously" cut himself from time to time, most recently on 19 April, but that he "strongly" denied any thoughts of self-harm and said he felt okay. She referred Mr Parker to the mental health team. She told the investigator that Mr Parker was in good spirits, jovial and chatty. Although the SO had initially assessed Mr Parker's risk to others as standard, which meant that he could share a cell, she reassessed his risk as high because of his "unpredictable behaviour" and deteriorating mental health.

32. Mr Parker told Nurse A that he had not taken the medication (prescribed by his community GP) for a couple of days. He said he was prescribed clonazepam and gabapentin for epilepsy. Nurse A told an advanced nurse practitioner, who made immediate arrangements to request Mr Parker's GP records and to ask the prison GP to prescribe his medication. The advanced nurse practitioner said that Mr Parker was well kempt, polite, quiet and respectful, and did not appear unwell. She had no immediate concerns about his welfare but did not know that he had arrived with a suicide and self-harm warning form.
33. At around 4.30pm, Mr Parker was taken to the prison's first night centre, where Officer A provided a prison induction, explaining the prison's regime and available support. Mr Parker declined the offer of a telephone call or a PIN number to contact family or friends. (Mr Parker made no telephone calls at Durham.)
34. Although Officer A told the investigator that he could not recall seeing the suicide and self-harm warning form, he noted on the vulnerability assessment that Mr Parker had a history of self-harm. In the light of that, he said he asked Mr Parker if he wanted him to take the razor out of the washing kit, and Mr Parker said that he did. He said that he asked Mr Parker if he had any thoughts of suicide or self-harm and that Mr Parker expressed no thoughts of suicide or self-harm and gave no indication that he needed ACCT monitoring. He said newly arrived prisoners were "probably asked maybe five to seven times ... before they actually make it into the cells on the wing whether they do have any thoughts [of suicide or self-harm], because the nurses will ask, the reception staff, the SO in reception asks".
35. A prison GP, who was working remotely because of the Covid-19 pandemic, read Mr Parker's notes. He said at interview that he was suspicious about whether Mr Parker had actually been prescribed clonazepam and gabapentin in the community. He said although these drugs could be prescribed for epilepsy, there were better medications available and both drugs are widely misused in the community and in prison and could be dangerous if taken in combination with illicit drugs. He, therefore, decided not to prescribe the drugs until their prescription had been confirmed by Mr Parker's community GP.
36. That evening, a prison GP assessed Mr Parker in person. He said that he did not see Nurse A's earlier entry in Mr Parker's medical record and did not know that he had a history of self-harm or that he had arrived with a SASH warning form. He noted that his epilepsy medication had not been prescribed. He decided not to prescribe Mr Parker's medication until he received confirmation from his community GP the next day. Mr Parker denied thoughts of suicide and self-harm and the GP noted that he looked well.
37. In line with Durham's first night centre procedures, Mr Parker was checked regularly throughout the night.
38. On the morning of 29 April, a worker from the prison's substance misuse team assessed Mr Parker. She told him about the risks of taking illicit substances in prison, reduced drug tolerance levels and the risks of overdose. Mr Parker said that he did not want to engage with the team.

39. A chaplain told Mr Parker about the available chaplaincy support. He said that Mr Parker did not say much but was very polite and raised no concerns.
40. The advanced nurse practitioner spoke to a prison GP to clarify his rationale for not prescribing Mr Parker's medication when he arrived at the prison as she was concerned that he may suffer ill effects if he missed further doses. The GP told her that he wanted to confirm Mr Parker's mental health history before prescribing and asked her to speak to the community mental health services for further information.
41. The prison GP also said that he would prescribe the medication in anticipation of the information so that there would be no delay in Mr Parker receiving it once the need had been confirmed. He asked the prison's pharmacy not to dispense it until further information had been received from the community mental health team. The advanced nurse practitioner asked the duty mental health nurse to access Mr Parker's community mental health records.
42. A mental health nurse reviewed and triaged Mr Parker's referral to the mental health team. She concluded that Mr Parker should continue to receive his clonazepam until the mental health team or prison psychiatrist had assessed him. She did not indicate the urgency of the referral. (The target for a routine appointment is within 4 working days. There is no record of a booked appointment within that timeframe, or of an urgent referral.)
43. Mr Parker subsequently tested negative for drugs and a prison GP instructed the prison's pharmacy to dispense Mr Parker's medication. Although the GP remained sceptical about the need for the medication, he said he thought that on balance it was better to prescribe it than to leave Mr Parker without it for too long.
44. On the evening of 30 April, a mental health nurse gave Mr Parker his medication. She recalled that he was polite and courteous.
45. At around 4.30pm on 1 May, Mr Parker asked an officer for a replacement kettle as his was broken. The officer gave him a new one and said that Mr Parker was happy and that he had never seen anyone smile as much when given a kettle.
46. That evening, a nurse gave Mr Parker his medication. He asked her if he was allowed sleeping tablets. She told him that he could not obtain any as they had not been prescribed, and she said that he accepted this.
47. At 8.22pm an officer carried out a roll check and said that he recalled seeing Mr Parker because he was making a hot drink with the kettle that he had given him earlier.
48. At around 5.11am, Officer B carried out the early morning roll check. He looked through the cell door observation panel and saw Mr Parker in a seated position next to his bed, hanging from a ligature made of bedsheets which had been tied to the top bunk of his bed. He immediately radioed a medical emergency code blue. (A code blue is used when a prisoner is unresponsive or has breathing difficulties and triggers an automatic request for an ambulance and for healthcare staff to attend.) Officer C, who was nearby, responded and arrived at the cell within 30 seconds as Officer B unlocked the cell door.

49. The officers went into the cell and Officer C cut the ligature from Mr Parker's neck. They said there were no signs of life and they could not find a pulse. Officer C started cardiopulmonary resuscitation (CPR). Officer B said that Mr Parker looked pale and was cold to touch but that rigor mortis had not set in.
50. A nurse arrived within a minute of the officers entering the cell, followed by a colleague, who brought the emergency response bag and defibrillator. The officers continued their resuscitation attempts and the nurse attached a defibrillator, which advised no shock and to continue chest compressions. Staff continued in their efforts to resuscitate Mr Parker until paramedics arrived at around 5.29am and took over. They confirmed Mr Parker's death at 5.50am.

### **Contact with Mr Parker's family**

51. The Managing Chaplain was appointed as the family liaison officer. Mr Parker had not provided the prison with any details of his next of kin, but they established contact details for Mr Parker's brother. At 11.50am, the Managing Chaplain telephoned him to break the news of Mr Parker's death. Durham contributed to funeral expenses in line with national instructions.

### **Support for prisoners and staff**

52. A custodial manager debriefed operational 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.
53. The prison posted notices informing other prisoners of Mr Parker's death and offered support. We understand that staff reviewed prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Parker's death.

### **Post-mortem report**

54. A post-mortem examination found that Mr Parker died from pressure on the neck caused by hanging.
55. The post-mortem toxicological examination revealed the presence of gabapentin and clonazepam, both of which had been prescribed to Mr Parker. No alcohol or other illicit drugs were detected.

# Findings

## Assessment of Mr Parker's risk of suicide and self-harm

56. Prison Service Instruction (PSI) 64/2011 on safer custody requires staff who have contact with prisoners to be aware of the risk factors and triggers for suicide and self-harm and to manage prisoners identified as at risk under ACCT procedures.
57. Mr Parker arrived with a number of risk factors: it was his first time in prison, he had a history of significant mental health concerns, his alleged offences were odd in nature, he had a history of self-harm and he had recently harmed himself.
58. Despite Mr Parker's risk factors, SO A considered that he did not need to be monitored under ACCT procedures. He failed to record his decision-making process to explain why not. Nurse A was aware that Mr Parker had recently self-harmed and had significant mental health issues and referred him for a mental health assessment because of his unpredictable behaviour and deteriorating mental health, but also did not consider that he needed to be monitored under ACCT procedures. Officer A was also aware that Mr Parker had a history of self-harm but, although Mr Parker asked for the razor in his induction pack to be removed, the officer did not consider that Mr Parker was at an increased risk of suicide or self-harm.
59. In our thematic report about risk factors in self-inflicted deaths, published in April 2014, we identified that too often, staff place too much weight on how a prisoner 'presented', rather than indications of risk, even where there had been very recent acts of self-harm. We reinforced these messages in a learning lessons bulletin about early days and weeks in custody, issued in February 2016. We have continued to reinforce these messages repeatedly in individual investigation reports and annual reports. It is very disappointing to see such a basic failing repeated yet again in this case.
60. Staff judgement is fundamental to the ACCT system. Prisoners intent on suicide rarely say so and will often withhold the extent of their distress from staff. In addition, a prisoner may feel fine when he is talking to other people but may feel quite different alone in his cell or at night. While a prisoner's presentation and what they say is important and reveals something of their level of risk, it is only a reflection of their state of mind at the time and should be considered as a single piece of evidence when judging risk. Staff should make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm.
61. The SO and officer both emphasised that they did not consider Mr Parker to be at risk because when they asked him if he had any thoughts of suicide, he said he did not. We are concerned that staff based their assessments of Mr Parker's risk largely on what he told them, and that they accepted his denials of suicidal thoughts at face value and relied too heavily on his presentation, without sufficiently considering his risk factors. As a result, they under-estimated his risk of suicide and self-harm.
62. We also note that SO A did not record Mr Parker's risk factors in his 'first night in prison vulnerabilities' assessment' or his prison record. These are important

tools in communicating identified risk to colleagues responsible for a prisoner's ongoing care.

63. Staff at Durham did not effectively identify Mr Parker's risk and in doing so, may have missed an opportunity to consider if more could have been done to ensure that he received more appropriate support. While we cannot know whether this might have changed the outcome for Mr Parker, we consider that based on his risk factors, staff should have started ACCT procedures, which would have led to a further assessment and evaluation of his risks.
64. In the three self-inflicted deaths at Durham before Mr Parker's, two in February 2019 and one in January 2020, we identified failings in staff identifying prisoners' risk during reception and made recommendations about this. Following the first of these deaths, Durham told us that they had identified that refresher training on risk identification was needed and over 100 staff received further training. However, we identified similar failings in our investigation into the death of a prisoner in January 2020, in particular that staff had not recorded risk factors or the reasons for their decisions not to start ACCT procedures. Durham agreed to implement our recommendation by November 2020.
65. We are extremely concerned that Mr Parker's death is the fourth in two years to have identified failings in assessing prisoner risk at Durham. We therefore make a further recommendation that:

**The Governor and Head of Healthcare should ensure that all reception staff:**

- **know the risk factors and triggers for suicide and self-harm as set out in PSI 64/2011;**
- **consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm;**
- **understand that they must take risk factors into account when assessing risk and not rely solely on what a prisoner says or how he presents;**
- **start ACCT procedures where appropriate: and**
- **record the information considered and the reasons for the decision about whether to start ACCT procedures.**

66. We also recommend:

**The Prisons Group Director for Tees and Wear should write personally to the Ombudsman setting out what he is doing to ensure that staff at Durham have a better understanding of the principles of risk assessment for suicide and self-harm.**

We are also concerned that two of the healthcare staff who saw Mr Parker when he arrived at Durham – the advanced nurse practitioner and a prison GP – told us that that they did not know Mr Parker had arrived with a suicide and self-harm warning form. It would have been difficult to have assessed Mr Parker's risk to himself appropriately without this key piece of information. We recommend:

**The Governor and Head of Healthcare should ensure that the information on self-harm and suicide warning forms and PERs is shared with healthcare staff who see prisoners as part of the reception process.**

### **Impact of Covid-19**

67. Following the national lockdown of 23 March 2020 in response to the Covid-19 pandemic, HMPPS issued operational guidance to prisons on 27 March which significantly restricted prisoners' activities and time out of cell. As a result, prison visits were suspended, education and non-essential work was cancelled, and healthcare delivery was also affected. This meant that prisoners spent up to 23 hours a day locked behind their cell doors.
68. It is difficult to establish what effect the Covid-19 restrictions had on Mr Parker, but they may have contributed negatively to his wellbeing and already poor mental health. Officers continued to check on the welfare of prisoners but there is no evidence that any member of staff had a meaningful conversation with Mr Parker during his four days at Durham. In normal times, it is likely that staff would have had more interaction with him, and this might have enabled them to be more aware of his increased risk.

### **Clinical care**

69. The clinical reviewer concluded that the physical and mental healthcare that Mr Parker received at Durham was of a reasonable standard and was at least equivalent to that which he could have expected to receive in the community. She made some recommendations which the Head of Healthcare will need to address.

### **Mental health referral**

70. Although Nurse A was aware that Mr Parker had recently self-harmed, had significant mental health issues and had arrived with a suicide and self-harm warning form, she considered that he did not need to be monitored under ACCT procedures. However, because of his mental health history, his "unpredictable" behaviour and his deteriorating mental health, she made a routine referral for him to be assessed by the prison's mental health team. This had not taken place or been booked before he died.
71. Although obtaining Mr Parker's mental health records was considered urgent and was completed promptly, we consider that in the circumstances the reception nurse should have made an urgent referral to the mental health team for an assessment. If this had happened, it is likely that the duty mental health nurse would likely have assessed him that afternoon or evening.
72. We are concerned that this was a missed opportunity for mental health staff to identify and assess Mr Parker's mental health needs promptly and identify any risk of suicide or self-harm. We make the following recommendation:

**The Head of Healthcare should ensure that:**

- **reception nurses request an urgent mental health risk assessment if they identify that a newly arrived prisoner has significant mental health issues or has recently self-harmed, and**
- **prisoners who meet the criteria for secondary mental healthcare receive a comprehensive assessment within 24 hours of arrival.**

### **Learning lessons**

73. We have identified a number of concerns in this report and consider that it is important that staff learn from our findings. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that a copy of this report is shared with SO A, Officer A and Nurse A, and that a senior manager discusses the Ombudsman's findings with them.**



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