Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Simon Parkinson, a prisoner at HMP Durham, on 7 July 2023

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

OUR VISION

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

WHAT WE DO

WHAT WE VALUE

Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. 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. Mr Simon Parkinson died in hospital on 7 July 2023 of aspiration pneumonia (an infection of the lungs caused by inhaling fluids or food) caused by a stroke, while a prisoner at HMP Durham. He was 60 years old. We offer our condolences to Mr Parkinson's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Parkinson received at HMP Durham was equivalent to that which he could have expected to receive in the community. The clinical reviewer made four recommendations which were not relevant to the death but which the Head of Healthcare will need to address.

5. When Mr Parkinson was taken to hospital on 2 July, he was restrained using an escort chain despite the nurse observing that Mr Parkinson had no coordination or movement in his right arm and leg. It was unclear if his medical condition was considered when this decision was made and given his health at the time, we do not consider that the decision to restrain him was justified.

6. The Head of Healthcare told the investigator that healthcare staff were not always asked to contribute to the risk assessment process, especially in emergency situations.

Recommendations

- The Governor should ensure that prison staff understand that medical information about a prisoner must be sought and properly considered when deciding whether to use restraints and in cases where a medical objection is disregarded or is not obtained the reason is documented.

The Investigation Process

7. HMPPS notified us of Mr Parkinson's death on 7 July 2023.

8. NHS England commissioned an independent clinical reviewer to review Mr Parkinson's clinical care at Durham.

9. The PPO investigator investigated the non-clinical issues relating to Mr Parkinson's care.

10. The investigator and clinical reviewer jointly interviewed Mr Parkinson's cellmate on 6 September and a member of staff on 5 October. The investigator also interviewed a further member of staff on 3 October and had telephone discussions with the Interim Deputy Head of Healthcare and Complex Care Lead on 3 and 5 October.

11. The PPO family liaison officer wrote to Mr Parkinson's friend to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Parkinson's friend asked about the administration of Mr Parkinson's medications while he was in prison, the timeliness of him being notified that Mr Parkinson had been admitted to hospital and Mr Parkinson being restrained in hospital.

12. Mr Parkinson's friend received a copy of the draft report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

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

14. NHS England received a copy of the report. They raised two issues and the report has been amended accordingly.

Previous deaths at HMP Durham

15. Mr Parkinson was the sixteenth prisoner to die at Durham since 7 July 2020. Of the previous deaths, eight were from natural causes, six were self-inflicted and one was drug-related. There are no similarities between the findings in our investigation into Mr Parkinson's death and the findings from our investigations into the previous deaths.

Key Events

16. On 17 April 2023, Mr Simon Parkinson was sentenced to 4 years and 5 months for sex offences and he was sent to HMP Durham.

17. Before arriving in prison, Mr Parkinson had been diagnosed with a number of health conditions for which he was prescribed medication.

18. On 24 May, a nurse went to see Mr Parkinson to find out why he was not attending the medications hatch to collect his lunchtime medication. Mr Parkinson told her that he was not aware that he had lunchtime medications.

19. On 22 June, a nurse made an entry in Mr Parkinson's medical records that he had failed to attend the medications hatch for his lunchtime medication. A task was raised for a nurse to find out why and to report back.

20. Prisoner A, who shared a cell with Mr Parkinson, told the investigator that Mr Parkinson had medications to take three times a day. He said that there were one or two occasions when Mr Parkinson had not been unlocked to take his medications. He later wrote to the investigator that he remembered several occasions when Mr Parkinson had missed his medications due to not being unlocked.

21. Prisoner A also told the investigator that Mr Parkinson did not always take the medications that he had collected.

22. The Interim Deputy Head of Healthcare told the investigator that Mr Parkinson had two medications that he had to take three times a day, with one dose being issued at lunchtime. She advised that Mr Parkinson never collected the lunchtime dose and he was reminded of this on 24 May and 23 June. She told us that Mr Parkinson was unlocked for lunch each day and it was his responsibility to make his own way to the medication clinic.

Events of 1 July

23. At approximately 8.30pm, Prisoner A activated the emergency call bell in his cell. He told the investigator that Mr Parkinson had asked him to help him back from the toilet and to get him some help.

24. An Officer Support Grade (OSG) told the investigator that she responded to the call bell. She said that Mr Parkinson told her that he felt dizzy. She told him to drink some water and rest.

25. The OSG said that she phoned healthcare and told them what had happened. She said she was told that the advice she had given Mr Parkinson was correct. She said that she did not record this incident in the wing logbook and there was no record of the conversation in Mr Parkinson's medical notes. She was unable to recall whom she spoke to.

26. The Deputy Head of Healthcare told the investigator that nursing staff on duty at that time could not recall a telephone call from an officer about Mr Parkinson.

27. Prisoner A told the investigator that at approximately 10.00pm, Mr Parkinson had asked him to help him to the toilet and that he was sitting up in bed but could not move one side of his body. He said that Mr Parkinson was not able to make it to the toilet, wet himself and laid down on his bed. He said that he pressed the call bell and told the officer what had happened. The officer told him that she had not been able to contact the nurse.

28. The OSG told the investigator that the call bell had only been activated once that evening at 8.30pm. (The prison told us that there was no facility for recording cell bell usage on that wing.)

Events of 2 July

29. Prisoner A told the investigator that at approximately 4.00am, he activated the call bell to find out what was happening. He said that Mr Parkinson had wet himself again.

30. The OSG said that she went to the cell, and she could see that Mr Parkinson looked unwell and was unable to speak.

31. At approximately 4.16am, the OSG called a medical emergency code blue (which triggers the control room to call an emergency ambulance and for healthcare and prison officers to attend as an emergency).

32. A Custodial Manager (CM), who was the officer in charge overnight, responded to the code blue and arrived at Mr Parkinson's cell with two officers. She told the investigator that she arrived at the same time as the nurse and opened the cell.

33. The CM told the investigator that it was obvious Mr Parkinson was unwell and needed to go to hospital. She said that they removed Prisoner A from the cell, and she left the other officers and the nurse to attend to Mr Parkinson while she completed the necessary escort paperwork.

34. A nurse said that she examined Mr Parkinson and found that he was very pale, he had a clear droop to the side of his face, and he was cold to touch. She said that he was soaked in urine and was unable to speak in clear full sentences. She carried out clinical observations and calculated a NEWS2 score of eight. (NEWS2 is a tool to detect and respond to clinical deterioration. A score above seven indicates the need for an emergency response.) However, the temperature was not recorded, as Mr Parkinson was unable to keep the probe under his tongue, so the score of eight was based on an incomplete set of observations.

35. The CM told the investigator that when she completed the Prisoner Escort Record and risk assessment, she did not have access to Mr Parkinson's security information and risk level. She said that only certain computers could facilitate access to the system and these were located in a different part of the prison.

36. The CM said that she decided that Mr Parkinson should be escorted to hospital by two officers, restrained using a single cuff and escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). She said that due to the fact that the escort was an emergency, she did not

ask healthcare staff to complete the medical risk assessment. She could not recall if she discussed restraints with them.

37. The risk assessment document provided by the CM was wrongly dated 12 April and indicated that a double cuff and escort chain was to be used. (A double cuff is when the prisoner's hands are handcuffed in front of them and one wrist is attached to a prison officer by an additional set of handcuffs.) The form also indicated a medical objection to the use of restraints.

38. In an email to the investigator, the CM said that she had reviewed the risk assessment document and noticed that she had ticked yes to medical objection, so she may have spoken to the nurse. She also said that the form indicated that a double cuff was used. She said that this was not correct and believes that this was a formatting issue caused by completing the form on a computer.

39. At approximately 4.38am, the ambulance arrived and the paramedics assessed Mr Parkinson. They concluded that he should be taken to hospital.

40. The nurse said that she and a colleague dressed Mr Parkinson in clean clothes and helped him onto the stretcher chair. She made an entry in the medical notes which said that Mr Parkinson had no co-ordination or movement in his right arm and leg and when he was in the stretcher chair, he was leaning to the right side.

41. The ambulance left the prison at 5.36am.

42. At approximately 12.50pm, a stroke consultant at the hospital contacted the healthcare team to ask for Mr Parkinson's medical history. He told a prison nurse that Mr Parkinson had had a stroke and they would conduct an MRI scan (a scan which produces detailed images of the inside of the body).

43. On 3 July, the Complex Care Clinical Lead Nurse called the hospital for an update on Mr Parkinson's condition. She was told Mr Parkinson was being nursed in bed and was struggling with his speech and to communicate his needs.

44. At approximately 1.50pm on 4 July, an officer phoned a prison manager to report that doctors were concerned that Mr Parkinson could have a cardiac arrest and because he was unable to communicate, they did not have consent to carry out lifesaving treatment. The manager told him that he would instruct prison healthcare staff to contact the hospital and they would ask a family liaison officer to contact the next of kin. The officer was told to remove Mr Parkinson's restraints.

45. Later that day hospital staff confirmed that Mr Parkinson had had multiple strokes, his right side was paralysed and he was unable to speak or swallow. The doctor said that as Mr Parkinson was unable to confirm his wishes, they needed direction from a next of kin.

46. At 2.30pm, the family liaison officer contacted Mr Parkinson's next of kin, who arrived at the hospital a short while later.

47. On 7 July at 6.59pm, prison escort officers at the hospital with Mr Parkinson contacted the control room to tell them that Mr Parkinson had died. His death was verified by a hospital doctor at 8.22pm.

Post-mortem report

48. The doctor gave Mr Parkinson's cause of death as aspiration pneumonia (an infection of the lungs caused by inhaling fluids or food) caused by a multifocal ischaemic posterior circulation stroke. Mr Parkinson was also diagnosed with Clostridium difficile (a bacteria that causes a bowel infection) but this was not thought to have contributed to his death. The Coroner accepted this cause of death, and no post-mortem was carried out.

Inquest into Mr Parkinson's Death

49. The inquest into Mr Parkinson's death was concluded on 5 September 2024 and a verdict of natural causes was recorded. The coroner concluded that Mr Parkinson's death was due to aspiration pneumonia, multifocal ischaemic posterior circulation stroke and clostridium difficile.

Non-Clinical Findings

Restraints, security and escorts

50. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

51. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

52. During the early hours of 2 July, Mr Parkinson became unwell and was taken to hospital.

53. A nurse recorded that at the time that Mr Parkinson had a clear droop to the side of his face and had no co-ordination or movement in his right arm and leg. She said that they had to help him onto a stretcher chair and he was leaning to the right side.

54. The CM said that due to the emergency nature of the escort, and where she was located, she was unable to check Mr Parkinson's security file and his risk level. She was unable to recall for certain if she had spoken to healthcare staff about Mr Parkinson's condition. The risk assessment form provided by her indicated that there was a medical objection to the use of restraints.

55. We cannot be certain that Mr Parkinson's health was fully considered when the decision was made about the use of restraints. While the form indicates a medical objection, the CM was unable to recall if a conversation took place. Furthermore, she did not have his security and risk information. Given his presenting health at the time, the decision to restrain Mr Parkinson was not justified. We are also concerned that Mr Parkinson remained restrained in hospital until 4 July.

56. Healthcare staff told the investigator that they were not routinely asked to contribute to the escort risk assessment process. The Deputy Head of Healthcare said that historically they would contribute to planned escorts but were never asked to contribute to an emergency escort risk assessment. We therefore make the following recommendation:

    The Governor should ensure that prison staff understand that medical information about a prisoner must be sought and properly considered when deciding whether to use restraints and in cases where a medical objection is disregarded or is not obtained, the reason is documented.

Governor to note

57. During the interview, the OSG told the investigator that she had not received any training before being allocated to carry out a night shift and that while she had access to colleagues, she was essentially working on her own. This meant she was not aware that she should have recorded her interactions with Prisoner A and Mr Parkinson in the wing book or make a note of her conversation with healthcare staff.

58. We were told that there was no hot debrief but the staff on bedwatch at the time of Mr Parkinson's death were offered support. However, this offer was not extended to those involved in the medical emergency.

Adrian Usher
Prisons and Probation Ombudsman **February 2023**

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