Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Rebecca Parkinson, a prisoner at HMP Styal, on 31 July 2022

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.

Ms Rebecca Parkinson died in hospital on 31 July 2022, two days after she was found unresponsive in her cell at HMP Styal. She was 43 years old. I offer my condolences to Ms Parkinson's family and friends.

Ms Parkinson had been at Styal for only around 24 hours when she was found unresponsive on the floor of her cell. She had suffered a cardiac arrest, but the post-mortem examination was unable to ascertain the cause.

My investigation identified some issues with the emergency response, though we cannot say whether they affected the outcome for Ms Parkinson.

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 **September 2024**

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Summary

Events

1. On 28 July 2022, Ms Rebecca Parkinson was remanded to HMP Styal charged with assaulting a police officer. It was her first time in prison.

2. Before she arrived at Styal, the community mental health team told the prison's mental health team that Ms Parkinson was at risk of harming herself (she self-harmed by punching herself or banging herself off objects with force). She had a history of mental health problems including anxiety, depression and psychosis. When she arrived at Styal, staff started suicide and self-harm prevention procedures (known as ACCT) and set observations at one an hour.

3. During her initial health screen, Ms Parkinson told the nurse that she was anxious about being in prison for the first time. She said that she had last self-harmed by banging her head on 25 July. Staff placed Ms Parkinson on the Valentina Unit (for women who need higher levels of care) due to her history of self-harm.

4. The next day, staff held an ACCT case review with Ms Parkinson. She said she was anxious about being in prison but had not self-harmed. She refused lunch but had hot water. She also had a call to her father to let him know where she was.

5. Shortly after 6.00pm, an officer saw Ms Parkinson climbing onto her bed and thought she was going to have a rest as she had not eaten much all day and had just taken her medication. When the officer returned at around 6.45pm, she saw Ms Parkinson lying face down on a quilt on the floor of her cell. She thought that she could see Ms Parkinson breathing, however, she got no response when she knocked on the door and shouted her name. She radioed for staff assistance.

6. A healthcare support worker, who was in a nearby cell, overheard and went to help. She looked through Ms Parkinson's cell door and thought that she was not breathing. She then went to the healthcare unit (attached to the Valentina Unit) to ask nursing colleagues for urgent assistance.

7. The healthcare support worker returned to the cell with two nurses. The officer and the nurses entered and started CPR. At 6.52pm, a second officer arrived at the cell and called a medical emergency code, which prompted the control room to call an ambulance.

8. Nurses attached a defibrillator which showed Ms Parkinson did not have a shockable heart rhythm. They then inserted an airway and gave her oxygen. A nurse also gave two injections of adrenaline.

9. At 7.09pm, the ambulance arrived at the Valentina Unit and paramedics took over Ms Parkinson's care. The paramedics continued CPR and gave Ms Parkinson more adrenaline. They attached their defibrillator to Ms Parkinson which showed pulseless electrical activity (PEA – a form of cardiac arrest where there is no pulse, but the heart's electrical activity is present). The paramedics continued CPR and moved her to the ambulance. She was taken to hospital at 7.39pm.

10. Ms Parkinson was admitted to intensive care where she remained in a coma. On 31 July, doctors confirmed that she was brain stem dead. They stopped all treatment and at 5.49pm, confirmed her death.

11. The post-mortem examination was unable to establish the cause of Ms Parkinson's death. The pathologist found no natural disease that could have caused Ms Parkinson to have a cardiac arrest but also found no compelling evidence that her death had been caused by a head injury.

Findings

12. There was a delay in calling the medical emergency code which resulted in a delay in calling an ambulance. We have previously made recommendations to Styal about ensuring staff follow the medical emergency procedures by promptly calling the appropriate code.

13. The clinical reviewer found that the nurse who administered adrenaline during the emergency response used the dose and method for a severe allergic reaction instead of a cardiac arrest. She concluded that Ms Parkinson's clinical care was partially equivalent to that which she could have expected to receive in the community.

Recommendations

- The Governor and Head of Healthcare should review how staff are trained on the use of medical emergency codes and satisfy themselves that all staff are aware of their responsibilities during medical emergencies.

- The Head of Healthcare should ensure that staff understand how and when to administer adrenaline in medical emergencies and that they have received the appropriate training to do so.

The Investigation Process

14. HMPPS notified us of Ms Parkinson's death on 31 July 2022.

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

16. The investigator obtained copies of relevant extracts from Ms Parkinson's prison and medical records.

17. NHS England commissioned an independent clinical reviewer to review Ms Parkinson's clinical care at the prison. The investigator and clinical reviewer interviewed four members of staff at Styal on 5 September 2022.

18. We informed HM Coroner for Cheshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. The Ombudsman's family liaison officer contacted Ms Parkinson's parents to explain the investigation and to ask if they had any matters they wanted us to consider. They wanted to know more about the circumstances leading up to Ms Parkinson's death, which we have covered in this report.

20. We shared our initial report with HMPPS. They pointed out a minor factual inaccuracy in this report and in one of the interview transcripts, which have been corrected. They provided an action plan which is annexed to this report.

21. We sent a copy of our initial report to Ms Parkinson's parents via their legal representative. They did not notify us of any factual inaccuracies.

Background Information

HMP Styal

22. HMP Styal is a prison and young offender institution (YOI) in Wilmslow, Cheshire, for women aged 18 and over. It holds up to 486 women. Spectrum community health CIC provides healthcare and substance misuse services. Mental health services are contracted from Greater Manchester Mental Health NHS Foundation Trust.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Styal was in October 2021. Inspectors found that outcomes for women at Styal were reasonably good across healthy prison outcomes (safety, respect, purposeful activity, rehabilitation and release planning). They found there was good oversight of medicines management, however some dispensing practices were unsafe and required immediate attention.

Independent Monitoring Board

24. 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 30 April 2022, the IMB reported despite operational difficulties, most women received primary care that was at least as good as that provided in the community. They were concerned that healthcare had not consistently provided a timely, safe process for administering medication.

Previous deaths at HMP Styal

25. Ms Parkinson was the fifth prisoner at Styal to die since July 2019. Of the previous deaths, two were from natural causes and two were self-inflicted.

26. We have previously made recommendations about ensuring staff use the appropriate code when they discover a medical emergency. In September 2021, we were told that staff were being provided with Emergency Response Information Cards (ERIC) to provide information on calling emergency response codes, along with further training at morning briefings.

Key Events

27. On 28 July 2022, Ms Rebecca Parkinson was remanded in prison, charged with assaulting a police officer, and sent to HMP Styal. It was her first time in prison.

28. Before Ms Parkinson arrived at Styal, a member of the community mental health team (CMHT) spoke to a member of the prison's mental health team to tell them that Ms Parkinson was at risk of self-harm (she self-harmed by punching herself or banging herself off objects with force). The CMHT also advised that staff should see Ms Parkinson in pairs as she posed a risk of assault. They said there was a working diagnosis of depression with psychosis and possible emotionally unstable personality disorder (EUPD). Ms Parkinson was also diagnosed with attention deficit hyperactivity disorder (ADHD). She was on a range of medication including antipsychotics and antidepressants.

29. Ms Parkinson arrived at Styal shortly after 5.00pm. Staff started suicide and self-harm prevention procedures (known as ACCT) and set observations at one an hour. During her initial health screening, Ms Parkinson told the nurse that she had last self-harmed by banging her head on 25 July. She said she had not lost consciousness and the nurse found no signs of injury. The nurse asked prison staff to place Ms Parkinson on the Valentina Unit (used for women who need higher levels of care) as she was concerned about her history of self-harm and her anxiety about being in prison.

30. Staff checked on Ms Parkinson hourly through the night. They noted that she was upset because she had been unable to contact her parents who did not know she was in prison.

29 July

31. The next day, staff noted that Ms Parkinson was feeling down but there were no signs of self-harm. They noted that Ms Parkinson had called her father that morning and that she was anxious and upset. She refused lunch but had hot water.

32. Staff held an ACCT case review with Ms Parkinson. A member of the mental health team attended. Staff noted that she engaged well but was anxious about being in prison. She said that she self-harmed in the community, usually by banging her head, but had managed not to while she had been in prison.

33. A mental health nurse carried out a mental health assessment with Ms Parkinson. The nurse noted that Ms Parkinson was willing to engage but that it was hard to build a rapport with her as she was staring intently, spoke in a monotone voice and was facially flat. The nurse noted that Ms Parkinson was being supported using ACCT and would be referred to the Single Point of Contact in the mental health team to be placed on the caseload.

34. At approximately 5.30pm, an officer walked Ms Parkinson back to the Valentina Unit after collecting her medication. She noticed that Ms Parkinson was slightly unsteady on her feet and asked if she was okay. Ms Parkinson told the officer that she was not okay and needed to speak to her. The officer said she had some duties to do and would come back to her cell to speak to her.

35. The officer returned to Ms Parkinson's cell at approximately 6.05pm and saw Ms Parkinson climbing onto her bed. At interview, she said she thought Ms Parkinson was tired as she had not eaten much and had just taken her medication. She decided to leave Ms Parkinson to get some rest and go back later.

36. At approximately 6.45pm, the officer saw Ms Parkinson lying face down on a quilt on the floor of her cell. She looked through the observation panel in the cell door and thought that she could see Ms Parkinson breathing, but she did not respond when she knocked on the door and shouted her name. She radioed for officer assistance as she needed a second officer with her before unlocking the cell door as the prison was in patrol state (when fewer staff are on the units). A second officer responded and confirmed they were on their way. At interview, the officer said that she risk assessed in the moment that she would wait for a second officer to unlock the cell as she did not know Ms Parkinson and had seen from her record that she had a history of assault.

37. A healthcare support worker overheard the officer asking for assistance on the radio and went to the cell to help. She looked through the cell door and could not see any obvious signs of breathing from Ms Parkinson. She went to the healthcare unit (connected to the Valentina Unit) to ask for urgent assistance.

38. The healthcare support worker arrived back at the cell with two nurses. The officer opened the door and entered with the nurses. At 6.52pm, another officer arrived and radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts staff in the control room to call an ambulance).

39. The nurses found that Ms Parkinson was unresponsive and not breathing. They started CPR and then Nurse A returned to the healthcare unit to get the emergency bags and the defibrillator (shocks the heart to restore a normal heartbeat).

40. The nurses then attached the defibrillator which did not advise any shocks to be delivered. They then inserted an airway device and gave Ms Parkinson oxygen.

41. Nurse A gave Ms Parkinson two injections of adrenaline. However, the dose and route by which she gave the adrenaline was to treat anaphylaxis (injected into a muscle at a low dose), not cardiac arrest (injected into a vein at a high dose).

42. At 7.01pm, the ambulance arrived at Styal. The control room initially sent the ambulance to the Waite Wing where there was another code blue. Once staff realised, they redirected the ambulance to the Valentina Unit.

43. At 7.09pm, the ambulance arrived at the Valentina Unit and paramedics took over Ms Parkinson's care. The paramedics continued CPR and gave Ms Parkinson more adrenaline (using the correct dose and route). They attached their defibrillator which showed pulseless electrical activity (PEA – a form of cardiac arrest where there is no pulse, but the heart's electrical activity is present). The paramedics continued chest compressions and moved her to the ambulance. She was taken to hospital at 7.39pm.

44. While in hospital, Ms Parkinson remained in a coma. She had a CT scan which showed that she had a hypoxic brain injury (when the brain does not get enough oxygen and the brain cells die).

45. Ms Parkinson did not regain consciousness and on 31 July, doctors confirmed that she was brain stem dead. All treatment was stopped, and at 5.49pm, doctors confirmed her death. Her family were present.

Contact with Ms Parkinson's family

46. The Deputy Governor contacted Ms Parkinson's parents on 29 July to tell them that she was being taken to hospital. The next day, the prison appointed the duty governor as the interim family liaison officer. The duty governor spoke to Ms Parkinson's family the same day to introduce herself, explain her role, and offer support.

47. The prison offered to pay towards Ms Parkinson's funeral, but the family declined.

Support for prisoners and staff

48. After Ms Parkinson's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.

49. The Head of Healthcare attended Styal the next day, which was her non-working day, to support the nursing staff who were involved in the emergency response.

Post-mortem report

50. The post-mortem report concluded that Ms Parkinson died following a cardiorespiratory arrest but the cause of that was unascertained. There was no evidence of natural disease and toxicology tests showed that Ms Parkinson had taken only her prescribed medication. The pathologist also found no compelling evidence suggestive of a traumatic head injury including of brain injury being implicated in the cause of death. The pathologist concluded that the cause of death was unascertained.

Findings

Managing Ms Parkinson's risk of suicide and self-harm

51. The cause of Ms Parkinson's death is unclear. There is no evidence that she self-harmed while she was at Styal and on the evidence available, it does not appear that her death was self-inflicted. Nevertheless, we have considered the care she received at Styal with regard to her history of self-harm.

52. Staff correctly started ACCT procedures for Ms Parkinson when she arrived at Styal. They placed her on Valentina Unit for extra support and checked on her hourly. The day after she arrived, Ms Parkinson had an ACCT case review and a mental health assessment. We consider that she received appropriate support.

Clinical care

53. The clinical reviewer found that the clinical care Ms Parkinson received at Styal was partially equivalent to that which she could have expected to receive in the community. She found that Ms Parkinson received a thorough initial health screen to assess her needs and received a prompt mental health assessment. However, there were issues with the emergency response.

Emergency response

54. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, says that staff discover a prisoner who is unresponsive must call the appropriate code (code blue for unconsciousness or code red for severe blood loss) without delay. The code alerts healthcare staff to the nature of the emergency and tells the control room to call an ambulance immediately.

55. There was a delay of approximately seven minutes between Ms Parkinson being found unresponsive on her cell floor and the code blue being called. This meant that initially the nurses who responded did not bring the correct equipment with them (because the healthcare support worker simply asked for urgent assistance, which did not make clear the nature of the emergency) and there was also a delay in calling the ambulance. We cannot say whether this affected the outcome.

56. We have previously made several recommendations to Styal about ensuring staff efficiently communicate the nature of a medical emergency using the appropriate code to avoid delays.

57. In September 2021, the prison told us that all staff would be issued with Emergency Response Information Cards (ERIC) which provide information on calling the appropriate medical codes in an emergency. Monthly integrity tests were also to be introduced, along with training delivered at morning briefings. However, this same issue has arisen again. We recommend:

    The Governor and Head of Healthcare should review how staff are trained on the use of medical emergency codes and satisfy themselves that all staff are aware of their responsibilities during medical emergencies.

Use of adrenaline

58. The clinical reviewer found that adrenaline was not administered correctly to Ms Parkinson during the emergency response. She found that Nurse A administered a lower dose of adrenaline used for a severe allergic reaction, not a cardiac arrest, and that she gave the adrenaline by an injection into the muscle instead of into a vein, which was not in line with the Resuscitation Council UK guidance.

59. The clinical reviewer also noted that Nurse A was not trained in advanced life support. Resuscitation Council UK guidance says that adrenaline should only be given by clinicians who have undergone advanced life support training.

60. We recommend:

    The Head of Healthcare should ensure that staff understand how and when to administer adrenaline in medical emergencies and that they have received the appropriate training to do so.

Inquest

61. The inquest, held on 17 March 2025, reached a narrative verdict as follows:

    Rebecca Parkinson died as a result of hypoxic brain injury, caused by cardiac arrest. The cause of the cardiac arrest was hyponatraemia which was most likely caused by drinking excess water. The amount of water or the timing of the ingestion cannot be determined.

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