

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Neville Parker, a prisoner at HMP Garth, on 23 December 2024

A report by the Prisons and Probation Ombudsman

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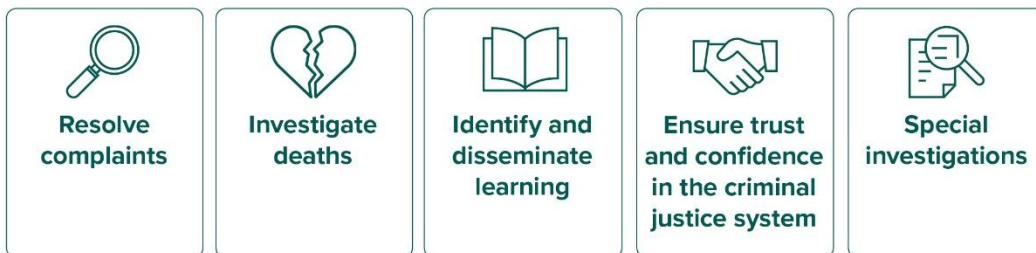
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OUR VISION

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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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. On 10 May 2023, Mr Neville Parker was sentenced to life imprisonment for sexual offences and received a minimum tariff of 11 years. Mr Parker died of metastatic lung carcinoma on 23 December 2024, at HMP Garth. He was 74 years old. We offer our condolences to Mr Parker's family and friends.
4. The Ombudsman's office wrote to Mr Parker's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.
5. NHS England commissioned an independent clinical reviewer to review Mr Parker's clinical care at HMP Garth.
6. The clinical reviewer concluded that the clinical care Mr Parker's received at Garth was of a reasonable standard and equivalent to what he could have expected to receive in the community. She identified areas good practice where the registered nurse sought information and clarity with the hospital about Mr Parker's ongoing care needs and supported him during his hospital visits. The clinical reviewer made recommendations not related to Mr Parker's death that the Head of Healthcare will wish to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Parker's care. We found no non-clinical issues of concern.
8. We make no recommendations.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS and Practice Plus Group did not find any factual inaccuracies.
10. At the inquest held on 12 February 2026, the coroner concluded that Mr Neville Parker died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

October 2025

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