

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Jason Parkinson, a prisoner at HMP Stocken, on 31 December 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



© Crown copyright, 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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.

My 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 Parkinson died of a lack of oxygen/blood to the brain on 31 December 2020 while a prisoner at HMP Stocken. This was caused by a cardiac arrest, triggered by the combined effects of an antidepressant and a psychoactive substance (PS). He was 23 years old. I offer my condolences to his family and friends.

Mr Parkinson had a long history of substance misuse and frequently used PS in prison. Although prison staff observed him under the influence on several occasions, we are concerned that there is no evidence that they submitted security intelligence reports, in line with local and national policy. Stocken had a comprehensive drug strategy at the time of Mr Parkinson's death but we consider that more needs to be done to ensure its effective implementation.

I am concerned that the defibrillator brought to the emergency had to be changed due to a low battery. This did not affect the outcome for Mr Parkinson but in another emergency, this could be critical. We have raised concerns about defibrillators at Stocken before and urgent action is required. We are also concerned that not all officers had up to date training in first aid.

Prison staff appropriately initiated an investigation after Mr Parkinson reported drug-related debt. However, I am concerned that the initial referral was delayed, and the resulting action was not communicated to staff.

We also identified deficiencies in family contact which the prison will need to address.

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

Sue McAllister CB
Acting Prisons and Probation Ombudsman

April 2022

Contents

| | |
|--------------------------------|----|
| Summary | 1 |
| The Investigation Process..... | 3 |
| Background Information..... | 4 |
| Key Events..... | 6 |
| Findings | 10 |

Summary

Events

1. On 10 April 2020, Mr Jason Parkinson was sentenced to just over seven and a half years in prison for attempted robbery. He was transferred to HMP Stocken on 18 September. He had emotionally unstable personality disorder and a history of substance misuse.
2. Over the next two months, mental health staff assessed Mr Parkinson and concluded that his condition was stable. Substance misuse staff started a period of assessment and gave him in-cell workbooks to complete.
3. On 4 December, an officer conducted a keywork session and recorded that Mr Parkinson reported a PS debt of £200. Four days later, she completed a challenge support intervention plan (CSIP) referral. On 9 December, an officer conducted a CSIP assessment, and a Custodial Manager (CM) considered that no intervention was required but that staff should monitor the situation.
4. At 2.59pm on 31 December, while doing cell decency checks, prison staff saw Mr Parkinson put something in his boxer shorts. They conducted a search and removed smoking paraphernalia and a quantity of paper, which he claimed was soaked psychoactive substances (PS). At 5:33pm, a prisoner approached Mr Parkinson's cell, slid an item under the door and gave him a 'thumbs up'.
5. At 6.13pm, an officer looked through Mr Parkinson's cell observation panel and saw him slumped on his bed. She alerted a nearby officer who unlocked the door. They entered the cell, moved Mr Parkinson onto the floor and found that he did not have a pulse. At 6.14pm, an officer radioed a medical emergency code and started cardiopulmonary resuscitation (CPR).
6. At 6.16pm, healthcare staff arrived with medical equipment. At 6.24pm, a nurse collected another defibrillator as the device being used issued a low battery warning. Paramedics took over resuscitation efforts at 6:31pm. At 6.50pm, they confirmed that Mr Parkinson had a faint pulse and prepared him for transfer to hospital. The ambulance was ready to leave the prison at 7.37pm but did not depart until 7.48pm due to an issue with the main vehicle gate.
7. At 9.40pm, hospital doctors pronounced that Mr Parkinson had died.

Findings

8. Mr Parkinson engaged with the substance misuse team but continued to take PS despite knowing their health risks. We are concerned that although staff knew that Mr Parkinson was a PS user and had seen him under the influence on several occasions, there is no evidence that they submitted any security intelligence reports. Stocken had a comprehensive drug strategy at the time of Mr Parkinson's death but we consider that more needs to be done to ensure that it is implemented effectively.

9. While staff appropriately started the CSIP process after Mr Parkinson reported drug-related debt, we are concerned that the referral was delayed by four days and that an action resulting from the investigation was not communicated to staff.
10. Officers and healthcare staff responded promptly to the emergency. However, we are concerned that the defibrillator used by staff had a low battery. This did not affect the outcome for Mr Parkinson as another device was available but, in another emergency, this could be critical. This is not the first time that we have raised concerns about faulty defibrillators at Stocken and urgent action is needed to address the issue. We are also concerned that not all officers had up-to-date training in first aid.
11. We are concerned that the prison did not inform Mr Parkinson's next of kin that he was seriously ill, in line with Prison Service instructions.
12. The clinical reviewer considered that the clinical care that Mr Parkinson received at Stocken was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor should ensure that:
 - Stocken's drug supply and demand reduction strategies are properly implemented to help reduce the availability and abuse of illicit substances, including PS; and
 - staff are vigilant to signs of substance misuse and take appropriate action.
- The Governor should ensure that:
 - all operational staff are aware of when and how to submit a CSIP referral; and
 - requests to monitor prisoners outside of the CSIP process following a CSIP investigation are properly communicated to staff and include a requirement to make an entry in the wing observation book.
- The Governor should ensure that:
 - defibrillators are well-maintained so that fully charged and functioning devices are taken to medical emergencies; and
 - operational staff have up-to-date training to administer basic first aid.
- The Governor should review the functionality of the main vehicle gate to assure himself that it is fit for purpose and to ensure that any ongoing problems are identified and addressed at the earliest opportunity.
- The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Stocken informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
14. The investigator obtained copies of relevant extracts from Mr Parkinson's prison and medical records.
15. The investigator interviewed seven members of staff at Stocken between 16 and 17 September. He also interviewed one member of staff by phone on 21 September.
16. NHS England commissioned a clinical reviewer to review Mr Parkinson's clinical care at the prison.
17. We informed HM Coroner for Rutland and North Leicestershire area of the investigation. She gave us the results of the post-mortem examination and we have sent her a copy of this report.
18. The Ombudsman's family liaison officer contacted Mr Parkinson's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He wanted to know:
 - what caused Mr Parkinson's death;
 - whether he had COVID-19;
 - why was he not taken to a closer hospital; and
 - how long it took for him travel from prison to hospital.

We have addressed these concerns in this report and in separate correspondence.

19. Mr Parkinson's brother received a copy of the initial report. He did not raise any further issues or comment on the factual accuracy of the report.
20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out several factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Stocken

21. HMP Stocken is a medium security prison in Rutland which holds up to 1056 men. Practice Plus Group provides physical and mental healthcare services. Inclusion – Midlands Partnership NHS Foundation Trust are sub-contracted by Practice Plus Group to provide psychosocial substance misuse services. Clinical substance misuse interventions are delivered by the primary care team within Practice Plus Group. The healthcare service operates from Monday to Friday from 7.30am to 6.30pm and from 8.00am to 5.30pm at weekends. Two GPs provide ten GP sessions per week.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Stocken was carried out in February 2019. Inspectors reported that the use of illicit substances, particularly psychoactive substances (PS), remained a serious problem. They found that although the prison's approach to supply reduction was good, the strategy to provide a whole-prison approach to limiting illicit substance use and driving improvement was underdeveloped. The drug strategy was not based on an assessment of local issues and the drug reduction action plan failed to address the use of PS or the emerging increase in alcohol use.

Independent Monitoring Board

23. 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 April 2021, the IMB reported that the prison had seen a sharp drop in the availability of illicit substances, such as PS. They also noted that state of the art scanning equipment made it difficult for prisoners to conceal illicit items and that the most likely source of supply was by transfers of prisoners from other prisons.

Previous deaths at HMP Stocken

24. Mr Parkinson was the fourth prisoner to die at Stocken since December 2018. Of the previous deaths, two prisoners took their own lives and cause of death for one was unascertained. There have been three deaths since, two from natural causes and one self-inflicted. We have previously made a recommendation about faulty defibrillators and it is concerning that we have had to do so again.

Psychoactive substances (PS)

25. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition,

heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, it is possible that PS precipitate or exacerbate the deterioration of mental health and that it has links to suicide or self-harm.

26. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.
27. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drug testing arrangements.

Key Events

28. On 10 April 2020, Mr Jason Parkinson was sentenced to just over seven and a half years in prison for attempted robbery. He was sent to HMP Peterborough. It was not his first time in prison.
29. Mr Parkinson had a diagnosis of emotionally unstable personality disorder and a significant history of substance misuse problems. He was prescribed olanzapine (an antipsychotic) and amitriptyline (an antidepressant).

HMP Stocken

30. On 18 September, Mr Parkinson moved to HMP Stocken as part of his sentence progression. At 1.39pm, a nurse conducted an initial and secondary health screen and recorded that he had a history of mental health and substance misuse problems. (Secondary health screens normally take place separately but were undertaken at the same time as a response to the COVID-19 pandemic.) She referred Mr Parkinson to the mental health team, but he declined a substance misuse referral. At 2.49pm, a prison GP prescribed amitriptyline and olanzapine and noted that Mr Parkinson was not assessed as suitable to have his medication in his cell with him.
31. On 27 September, a mental health nurse reviewed Mr Parkinson's mental health referral and added him to the waiting list for a triage assessment.
32. On 16 October, a member of the keyworker team visited Mr Parkinson. He explained that due to the COVID-19 restrictions, he would not have a dedicated keyworker unless he was identified as being in one of five priority groups of prisoners. Mr Parkinson was not assessed as falling into any of these categories and therefore did not have regular contact with a keyworker.
33. On 2 November, a mental health nurse conducted a mental health triage assessment and recorded that Mr Parkinson had a history of substance misuse and reported having post-traumatic stress disorder (PTSD). She gave him a form to apply for counselling and referred him to the substance misuse team. She also recorded that she would add him to the waiting list for a medication review with a psychiatrist.
34. At 1.25pm on 9 November, a substance misuse worker conducted an initial substance misuse assessment. She noted that Mr Parkinson denied any thoughts of suicide or self-harm but said that he had overdosed on a mixture of his mother's prescription medication in March, following the death of his father. He said that he started taking psychoactive substances (PS) in prison but that he had not taken any at Stocken due to the high cost. She gave harm reduction advice and explained that there would be a period of assessment.
35. At 1.33pm, healthcare staff discussed Mr Parkinson at a multidisciplinary team meeting (MDT) and decided to add him to the caseload of a Healthcare Assistant (HCA), who worked in the mental health team, as he presented as stable.

36. On 16 November, an officer from the Safer Custody Department conducted a welfare check. He asked him how he was getting on in lockdown and he said: "It's very boring but what can you do about it". No other concerns were recorded.
37. On 19 November, a substance misuse worker conducted a follow-up substance misuse assessment. He noted that illicit drugs had been a part of Mr Parkinson's life for a long time and that he recognised that he needed to remain drug-free to achieve his long-term goals. Mr Parkinson said that he struggled to find productive things to do and agreed to complete some in-cell workbooks, which included one about PS use. The worker agreed a care plan and asked Mr Parkinson to return the completed workbooks by 31 December.
38. On 24 November, Mr Parkinson failed to attend a mental health appointment with the HCA. There is no reason recorded.
39. On 4 December, an officer introduced herself to Mr Parkinson and explained that she had come to see him for a keywork session. She recorded that he been working on in-cell courses and participating in the limited regime. However, she also noted that he had amassed a lot of debt for Spice (a PS). Mr Parkinson told her that he initially owed £300 but he had reduced it to £200 and arranged to pay the rest with prison shop orders.
40. On 8 December, an officer completed a challenge support intervention plan referral (CSIP – a national case management model for managing those who are violent or pose a raised risk of harming others through violent behaviours). A safer custody support officer screened the CSIP referral and agreed that it should progress to investigation.
41. On 9 December, an officer conducted a CSIP investigation. He recorded that Mr Parkinson was open about his PS use and said that his debt was not an issue as he had the means to pay it. He also said that he would speak to staff if his situation changed, and he needed support.
42. The officer asked Mr Parkinson how he got the PS, but he refused to say. At interview, he told us that he spoke to a substance misuse worker and updated a Supervising Officer (SO), who said he was aware of the situation and had submitted an intelligence report. However, the substance misuse worker told us that he could not recall the conversation and the intelligence was not recorded.
43. Later that day, a Custodial Manager (CM) reviewed the CSIP and recorded that Mr Parkinson did not want support in managing his debt. He concluded that no further intervention was needed, and that wing staff would monitor the situation. However, there is no record to indicate how staff would be made aware that they needed to monitor Mr Parkinson.
44. On 11 December, the HCA reviewed Mr Parkinson, who reported having a panic attack that morning, triggered by his cellmate speaking a foreign language. The HCA arranged to provide him with anxiety workbooks and said that he would explore trauma groupwork once COVID-19 restrictions allowed. Mr Parkinson's cellmate was moved to another wing on 15 December.

45. On 29 December, Mr Parkinson contacted his mother by phone, and they spoke about “getting him clear”. The next day, he phoned his mother again and told her that he planned on “getting some as soon as it gets in”.

Events on 31 December

46. At 2.59pm, a CM and an officer unlocked Mr Parkinson’s cell to conduct a cell decency check and saw him put something in his boxer shorts. They alerted a Supervising Officer (SO) and an officer, who entered the cell to conduct a full search of Mr Parkinson. At interview, the SO told us that Mr Parkinson willingly handed over the paper that he had tried to hide in his boxer shorts and said it was infused with PS.
47. At 3.06pm, the SO and an officer locked Mr Parkinson in a nearby classroom while they searched his cell. At 4.08pm, the SO recorded that Mr Parkinson had been placed on report for possessing smoking paraphernalia, a homemade pipe and a quantity of paper, which he claimed had PS on it.
48. CCTV footage at 5.15pm shows Mr Parkinson outside his cell, talking to two prisoners. One of the prisoners then left. He returned around a minute later and appeared to pass an item to Mr Parkinson. At 5.20pm, the officer locked Mr Parkinson in his cell for the evening.
49. The CCTV timeline shows that at 5.33pm, a prisoner spoke to Mr Parkinson through his cell door. He then proceeded to slide an item under the door and gave Mr Parkinson a ‘thumbs up’.
50. At 6.13pm, an officer looked through Mr Parkinson’s cell observation panel while checking that the cell door was locked and saw him slumped on his bed. She shouted to her colleague, who was conducting a roll count nearby, and he unlocked the door. They entered the cell, moved Mr Parkinson onto the floor and found that he did not have a pulse. At 6.14pm, the second officer radioed a medical emergency code blue (which indicates that a prisoner is unconscious or has breathing problems) and started CPR.
51. At 6.16pm, healthcare staff arrived with the emergency medical bags and Mr Parkinson was moved onto the wing landing for easier access. Prison staff alternated conducting CPR while healthcare staff established an airway and applied a defibrillator, which, after a few cycles, detected a shockable rhythm. However, within minutes, staff had to get another defibrillator as the one being used issued a low battery warning. At 6.24pm, an ambulance arrived at the prison and the first paramedic reached Mr Parkinson’s cell at 6.31pm. Paramedics provided emergency care and detected that Mr Parkinson had a faint pulse at 6.50pm.
52. At 7.26pm, paramedics and prison staff moved Mr Parkinson from the wing to an ambulance for transfer to Peterborough General Hospital. The control room log shows that although the ambulance was ready to leave the prison at 7.37pm, it did not depart until 7.48pm. The ambulance log noted that the delay was caused by a problem opening the main vehicle gate. Two officers escorted Mr Parkinson to hospital, without using restraints.

53. Mr Parkinson arrived at hospital at 8.22pm. At 9.40pm, after a period of CPR, a doctor pronounced that Mr Parkinson had died.

Contact with Mr Parkinson's family

54. At around 9.45pm on 31 December, a CM notified the police of Mr Parkinson's death and they tried unsuccessfully several times to contact his mother, whom he had named as his next of kin.
55. At 12.30pm on 1 January 2021, the prison appointed a SO and an officer as family liaison officers. The SO was subsequently told that the police had broken the bad news to Mr Parkinson's mother at 12.00pm and tried twice unsuccessfully to contact her by phone.
56. On 2 January, the officer recorded that he continued to have difficulty contacting Mr Parkinson's mother. He noted that he would keep trying over the weekend and would write to her if he still had difficulty getting through by phone.
57. On 5 January, the officer sent a letter to Mr Parkinson's mother containing his name and contact information. On 11 January, the officer spoke to Mr Parkinson's mother by phone and offered his support.
58. The officer provided ongoing support to Mr Parkinson's mother until his funeral, which took place on 15 February. The prison contributed towards the cost in line with national policy.

Support for prisoners and staff

59. After Mr Parkinson's death, the Head of Security debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. After Mr Parkinson died, a CM debriefed the staff present at the hospital.
60. The prison posted notices informing other prisoners of Mr Parkinson's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Parkinson's death.

Post-mortem report

61. The post-mortem report found that Mr Parkinson died from a hypoxic/ischaemic brain injury caused by a cardiac arrest which resulted from the combined effects of amitriptyline and a synthetic cannabinoid (a PS). Toxicology analysis of his blood found amitriptyline at therapeutic levels, abacavir (used to prevent and treat HIV) and 4F MBMB-BINACA (a type of PS). The report noted that that amitriptyline and PS can both cause an irregular heartbeat and that, in the absence of any underlying medical condition, the combined effect of these drugs was the most probable cause of death.

Findings

Illicit substances

62. Following an inspection in February 2019, HM Chief Inspector of Prisons was concerned about Stocken's underdeveloped substance misuse strategy and ongoing problem with the use of illicit substances, particularly PS. However, for the year to April 2021, the IMB noted that the availability of illicit substances at Stocken had dropped considerably. The general consensus from interviews was that the use of illicit substances, mainly PS and prison-brewed alcohol, remained an issue. Staff told us that incidents of PS use appeared to come in waves and that when PS was not available, levels of illicit alcohol misuse increased.
63. The post-mortem report gave Mr Parkinson's cause of death as PS intoxication and noted that abacavir was also present in his blood. Mr Parkinson was not prescribed abacavir, so he must have obtained it illicitly.
64. Mr Parkinson had a long history of substance misuse for which he received support in prison. A SO and an officer told us that Mr Parkinson was a known PS user and that they had seen him under the influence of illicit substances on several occasions. The SO also said that he suspected that other prisoners used Mr Parkinson as a "guinea pig", to test new batches of PS. However, we are concerned that despite these reports, there is no record that staff submitted an intelligence report for Mr Parkinson before his death.
65. The Head of Security told us that there was an expectation that staff submit intelligence reports if they suspect that a prisoner has taken illicit drugs. However, an officer told us that staff did not always do so. He said that PS tended to arrive on the wing in batches and that staff often had to manage numbers of intoxicated prisoners at the same time, which meant that they had other priorities.
66. HMPPS's Drug Strategy, published in April 2019, highlights the importance of building a picture of the security risks to enable prisons to better target their resources to tackle them. The Head of Security told us that the availability of PS on M Wing, where Mr Parkinson was located, had previously been an issue and that security staff had asked the custodial managers on the wing to encourage officers to submit intelligence reports. It is troubling that this intervention does not appear to have been effective and suggests that more work need to be done to address the issue. We are also concerned that although an officer said that prison staff notified healthcare staff after seeing a prisoner under the influence, there is no record that Mr Parkinson was seen in such circumstances.
67. At the time of Mr Parkinson's death, Stocken had a drug and alcohol policy that was issued in January 2020. The policy acknowledged that the use of PS had substantial implications for prisoners' health and sets out measures to target PS trafficking, including the use of intelligence, photocopying prisoners' mail and scanning their property. The Head of Security told us that most of the PS entering Stocken came in with prisoners transferring from other prisons. The policy highlights this, but states that due to the large amount of property that prisoners had, only 5-10% of items were scanned, unless intelligence suggested otherwise.

68. We are concerned that despite a comprehensive drug strategy and measures to encourage the submission of intelligence reports, Mr Parkinson was seemingly able to easily obtain illicit drugs. We therefore consider that more needs to be done to address the issue of drugs at Stocken.

69. We make the following recommendation:

The Governor should ensure that:

- **Stocken’s drug supply and demand reduction strategies are properly implemented to help reduce the availability and abuse of illicit substances, including PS; and**
- **staff are vigilant to signs of substance misuse and take appropriate action.**

Violence reduction

70. A PPO publication on *violence reduction, bullying and safety*, issued in October 2011, noted the links between bullying, violence and the self-inflicted deaths of prisoners. In our PPO thematic report into self-inflicted deaths from 2013 to 2014, we found that reports or suspicions that a prisoner is being threatened or bullied need to be recorded, investigated and robustly addressed. HMP Stocken use the CSIP case management model to address bullying and violent behaviour.

71. When Mr Parkinson reported debt to an officer on 4 December, it took four days for her to make a CSIP referral. She told us that she was new at the time and was not aware that she needed to make a CSIP referral until a more experienced member of staff advised her to do so. She also said that she had not had CSIP training. Although we appreciate that she made a referral, we are concerned that she was not aware of the process and that this caused an unnecessary delay.

72. While we are satisfied that there was no evidence to indicate that Mr Parkinson was at risk of violence and that the CSIP investigation’s conclusion for staff to monitor the situation was appropriate, we are concerned that the observation book action in the CSIP was marked ‘no’. A CM told us that he did not feel an observation book entry was required, as one would have been made in response to the SO’s intelligence report. However, even if his report had been submitted, it would not necessarily have recommended monitoring. We therefore consider that when staff decide to monitor a prisoner outside the CSIP process, they should ensure this information is recorded in the wing observation book, regardless of whether a related intelligence report has been submitted. We make the following recommendation:

The Governor should ensure that:

- **all operational staff are aware of when and how to submit a CSIP referral; and**
- **requests to monitor prisoners outside of the CSIP process following a CSIP investigation are properly communicated to staff and include a requirement to make an entry in the wing observation book.**

Emergency response

73. In line with PSI 03/2013 on medical response codes, Stocken's local policy instructs staff to use a code blue to indicate when a prisoner is unconscious or having breathing difficulties. Calling an emergency code should automatically trigger the control room to call an ambulance, and for healthcare staff to attend with the appropriate emergency equipment.
74. An officer promptly alerted her colleague when she found Mr Parkinson unresponsive and he immediately unlocked the cell, called the correct medical code and started CPR. The control room indicates that a code blue was radioed at 6.17pm but the ambulance log states that they received the call at 6.14pm. The CCTV timeline indicates that the second officer used his radio at 6.13pm, shortly after opening the cell door. We therefore consider that the difference was likely to have been a result of the information being taken from different sources.
75. Although we are satisfied that staff acted appropriately and that there was no delay calling an ambulance, we have some concerns about other aspects of the emergency response.

Emergency medical equipment

76. We are concerned that staff had to replace the first defibrillator that was applied to Mr Parkinson due to a low battery warning. While we are satisfied that staff retrieved a replacement device quickly, defibrillators are critical pieces of medical emergency equipment and it is essential that that they are properly maintained. In an investigation into the death of prisoner who died at Stocken in March 2020, we made a recommendation about faulty defibrillators and it is worrying that we have once again identified concerns about the maintenance of defibrillators. We are also concerned that not all staff involved in the emergency response had up-to-date training in first aid.
77. We do not consider that the lack of first aid training and change of defibrillator affected the outcome for Mr Parkinson but in future cases, the ability of prison staff to administer first aid and to have access to fully charged and functioning equipment could be crucial.

Delay leaving the prison

78. When the ambulance was ready to leave the prison with Mr Parkinson, a problem with the main vehicle gates meant it was delayed by 11 minutes. An Operational Support Grade (OSG) told us that the first response vehicle went through the first gate into the sterile area before it had fully opened, tripping the safety sensor and preventing the gate from closing. He said that this was usually resolved by re-setting the control panel, but this did not work, and he had to close the gate manually.
79. The OSG told us that at that point, the front gate failed to open and that it took staff some time to establish that the first response vehicle was too close to the gate's sensor and had again caused it to trip. He said that yellow lines have since been painted on the floor to stop vehicles from tripping the sensors but that despite some improvement, staff continued to experience occasional issues with the gates.

80. While we appreciate that the prison has taken measures to address the issue, we are concerned that it does not appear to have been fully resolved. We cannot know whether the delay had an impact on the outcome for Mr Parkinson, but he would have got to hospital sooner if the ambulance had left without hindrance. We make the following recommendations:

The Governor should ensure that:

- **defibrillators are well-maintained so that fully charged and functioning devices are taken to medical emergencies; and**
- **operational staff have up-to-date training to administer basic first aid.**

The Governor should review the functionality of the main vehicle gate to assure himself that it is fit for purpose and to ensure that any ongoing problems are identified and addressed at the earliest opportunity.

Informing Mr Parkinson's next of kin

81. Mr Parkinson was taken to hospital by ambulance at 7.48pm on 31 December. He was critically ill, and staff had resuscitated him. However, no one from the prison informed Mr Parkinson's next of kin of his admission to hospital.
82. Prison Rule 22 requires that when a prisoner is seriously ill, the Governor should tell the prisoner's spouse or next of kin "at once". A CM told us that when he took over at 8.00pm, he did not have an update about Mr Parkinson and that it was not common practice to notify the family. While this may be the case at Stocken, it is not in line with national instructions. We therefore consider that staff should have tried to contact Mr Parkinson's next of kin as soon as he went to hospital. We make the following recommendation:

The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible.

Clinical care

83. The clinical reviewer considered that the care that Mr Parkinson received at Stocken was equivalent to that which he could have expected in the community. Mental health staff completed appropriate assessments and reviews, and substance misuse staff assessed him and offered support. However, she made a recommendation about record keeping which we do not repeat in this report but which the Head of Healthcare will need to address. We are satisfied that the clinical care that Mr Parkinson received was of a good standard.

**Prisons &
Probation**

Ombudsman
Independent Investigations

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

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

T | 020 7633 4100