

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Parker, a prisoner at HMP Isle of Wight, on 16 December 2021

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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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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Thomas Parker died from respiratory failure caused by lung damage as a result of COVID-19 pneumonia in hospital on 16 December 2021 while a prisoner at HMP Isle of Wight. He was 67 years old. I offer my condolences to Mr Parker's family and friends.
4. Mr Parker was offered the COVID-19 vaccination in February, March and April 2021 but declined it each time. In September, he agreed to have the vaccination but due to a national shortage, he was placed on a waiting list. On 13 November, Mr Parker tested positive for COVID-19 and was admitted to hospital a week later. It appears that he caught COVID-19 in prison as he had not left the prison for several months.
5. The clinical reviewer concluded that the clinical care Mr Parker received at Isle of Wight was equivalent to that which he could have expected to receive in the community. Healthcare staff monitored him daily after he tested positive for COVID-19 and sent him to hospital promptly when his symptoms worsened.
6. We are concerned that on two occasions, there was a delay in providing Mr Parker's bedwatch officers with personal protective equipment (PPE).

Recommendations

- The Governor should ensure that personal protective equipment (PPE) is readily available for prison staff completing bedwatch duties.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Parker's clinical care at Isle of Wight.
8. The PPO investigator has investigated non-clinical issues, including aspects of the prison's response to COVID-19, Mr Parker's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
9. The PPO investigator interviewed three prisoners at Isle of Wight on 1 February 2022. The PPO investigator and the clinical reviewer interviewed prison staff and healthcare staff at Isle of Wight on 23 February and 21 March.
10. The PPO family liaison officer wrote to Mr Parker's next of kin, his wife, to explain the investigation. She asked questions about Mr Parker's asthma care which have been addressed in the clinical review report. She also raised some other issues which we have addressed in separate correspondence.
11. Mr Parker's wife received a copy of the draft report. She raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at HMP Isle of Wight

13. Mr Parker was the eighteenth prisoner to die at HMP Isle of Wight since December 2019. Of the previous deaths, 13 were from natural causes (two from COVID-19) and four were self-inflicted. There are no similarities between our findings in the investigation into Mr Parker's death and our investigation findings for the previous deaths.

COVID-19 (coronavirus)

14. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.
15. COVID-19 can make anyone seriously ill but some people are at higher risk of severe illness and developing complications from the infection. In response to the pandemic, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain outbreaks - to be implemented at local level, depending on the needs of individual prisons. (A key strategy was 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly arrived prisoners from the main population.)

16. In September 2021, the shielding programme ended in the community but HMPPS continued routinely to offer shielding to clinically high-risk prisoners. This has recently been replaced by a system of individual risk assessments by clinical staff, to determine the measures necessary to support such prisoners. The agreed adjustments are documented in a *Personal Management Plan*, which is then facilitated by operational staff.

Key Events

17. In January 2014, Mr Thomas Parker was sentenced to 20 years imprisonment for sexual offences. On 20 June 2014, he was moved to HMP Rye Hill.
18. Mr Parker had been diagnosed with asthma before he was sent to prison.
19. On 25 February 2021, a prison nurse offered Mr Parker a COVID-19 vaccination but he declined it. On 6 March, a healthcare assistant visited him to explain the clinical risks of COVID-19 in relation to his own health. Mr Parker said that he still did not want the vaccination.
20. On 28 April, Mr Parker was moved to HMP Isle of Wight. As part of the reception screening process, a nurse offered him a COVID-19 vaccination. He said he did not want it as he did not consider it safe.
21. On 17 May, the prison GP reviewed Mr Parker's record and assessed he was at moderate risk of developing complications from COVID-19. As a result, Mr Parker was not required to shield. (Shielding is when an individual isolates due to the risks posed to their health by COVID-19; it was offered only to those at high risk.)
22. On 15 September, a prison GP reviewed Mr Parker's medication as he reported several asthma attacks within the previous two weeks. He found that his prescription had run out early due to a prescribing error. The GP corrected this. He also discussed the COVID-19 vaccination with Mr Parker and reassured him about his concerns. Mr Parker agreed to have the vaccination and a nurse added him to the waiting list for the next vaccination cohort. (Mr Parker did not receive a COVID-19 vaccination before his death due to a national shortage in vaccine supplies.)
23. On 13 November, Mr Parker tested positive for COVID-19. He was isolated from other prisoners and nurses completed daily observations to monitor his condition.
24. On 20 November, a prison nurse completed observations on Mr Parker. She noted that his blood oxygen level was low, so escalated this to the prison GP. The GP arranged for Mr Parker to be taken to hospital and he went later that day. Mr Parker was taken to hospital using restraints, which is standard practice for his security level. The restraints were removed when his condition worsened.
25. On 23 November, Mr Parker was moved to the Critical Care Unit (CCU) in hospital as he had become short of breath.
26. On 26 November, Mr Parker was transferred to the Intensive Care Unit (ICU) in hospital as his condition continued to deteriorate.
27. The following day, Mr Parker was put in an induced coma to help control his breathing. Prison nurses contacted ICU for regular updates over the following days and were told his condition remained critical but stable. During this time, his sedation levels varied. Officers were located either inside or outside of the ward, depending on the level of his sedation.
28. On 3 December, the prison was unable to provide bedwatch officers with full personal protective equipment (PPE) at the start of their shift as there was no clean

equipment available. Approximately one hour later, a prison officer delivered all missing equipment to the bedwatch officers at the hospital.

29. On 11 December, the prison was again unable to provide bedwatch officers with full PPE at the start of their shift as it was not delivered on time. Approximately one hour later, a prison officer delivered all missing equipment to the bedwatch officers at the hospital.
30. Mr Parker's condition continued to deteriorate while in ICU. On 16 December, a hospital consultant contacted Mr Parker's wife and told her that the hospital planned to withdraw treatment.
31. Mr Parker died at 5.24pm on 16 December.

Post-mortem report

32. The post-mortem report concluded that Mr Parker died of respiratory failure, caused by diffuse alveolar damage (lung damage) which had been caused by COVID-19 pneumonia.

Findings

Clinical Findings

33. The clinical reviewer concluded that the care that Mr Parker received was equivalent to that which he could have expected to receive in the community. She made several recommendations about Mr Parker's asthma care which we have not included in this report but which the Head of Healthcare will need to address.

Management of Mr Parker's risk of infection from COVID-19

34. Mr Parker had not left the prison in the weeks before he became ill and it appears, therefore, that he caught COVID-19 in prison. We have therefore looked at whether the prison took adequate steps to protect him.
35. Mr Parker was assessed as at moderate risk from COVID-19 and was therefore not in a category that was advised to shield.
36. Healthcare staff asked Mr Parker on several occasions whether he wished to have the COVID-19 vaccination, but he declined due to his concerns about the safety of the vaccine. On 15 September 2021, following a discussion with the prison GP, Mr Parker agreed to have the vaccination and a nurse added him to a waiting list for the next cohort of vaccinations. Mr Parker tested positive for COVID-19 before the next vaccination cohort and therefore did not receive a COVID-19 vaccination before he contracted the virus.
37. The clinical reviewer noted that while there was a national shortage of COVID-19 vaccine in the autumn of 2021, there had also been a change in the vaccine ordering system, which had impacted more on prisons than the community (due to the software requiring a degree of internet connectivity and stability plus types of verification that were not at that time available at HMP Isle of Wight). The clinical reviewer was satisfied that these issues had now been rectified.

Monitoring Mr Parker after he contracted COVID-19

38. As Mr Parker had been assessed as at moderate risk of complications from COVID-19, healthcare staff carried out daily welfare checks on him after he tested positive for COVID-19 on 13 November. This ensured daily monitoring of his health and early identification of any deterioration in his condition. On the morning of 20 November, the prison nurse and GP took prompt and appropriate action when they identified that Mr Parker's blood oxygen was low and sent him to hospital.

Personal protective equipment (PPE)

39. We are concerned that on two occasions while Mr Parker was in hospital, the prison was unable to provide bedwatch officers with full PPE at the start of their shifts. As a result, they were unable to enter the ward.

40. Had an incident involving Mr Parker arisen at the hospital that had required bedwatch officers to enter the ward, they would not have been able to do so safely. We consider that the lack of PPE put officers at unnecessary risk. We recommend:

The Governor should ensure that personal protective equipment (PPE) is readily available for prison staff completing bedwatch duties.

Kimberley Bingham

Acting Prisons and Probation Ombudsman

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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