

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Parkinson on 15 August 2022, following his release from HMP Altcourse

A report by the Prisons and Probation Ombudsman

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

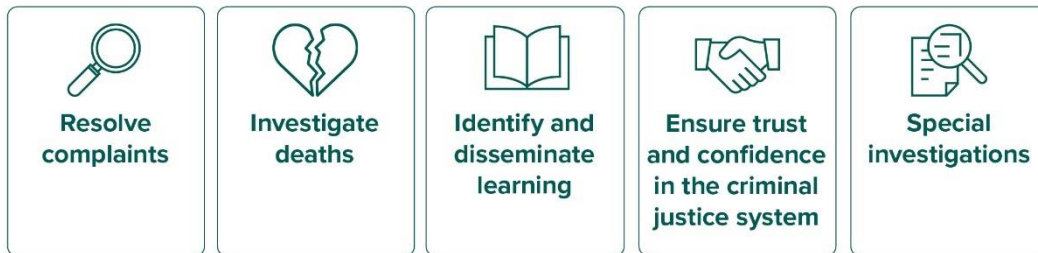
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 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



© Crown copyright, 2023

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.

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. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.
3. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
4. Mr Michael Parkinson died from the toxic effects of amitriptyline (an antidepressant) in combination with methadone and alcohol on 15 August 2022, following his release from HMP Altcourse on 4 August. He was 53 years old. I offer my condolences to those who knew him.
5. Potentially fatal levels of amitriptyline, a medication he was prescribed, were found in Mr Parkinson's blood, which indicates that he took an excessive amount before he died. There is no evidence to suggest that this was a deliberate overdose. Mr Parkinson had a history of substance misuse and engaged with prison and community substance misuse services. We are satisfied that he received appropriate support with his substance misuse issues.
6. Mr Parkinson had a history of not engaging with the Probation Service. We note that he was disabled, which may have impacted on his ability to attend the office. We consider that probation staff could have done more to explore the reasons for his non-compliance and to encourage him to engage.

Recommendations

- The Head of Knowsley and St Helens Probation Delivery Unit should seek assurances that probation staff explore all alternatives to encourage engagement with non-compliant people on probation, in line with assessed levels of risk.
- The Head of Knowsley and St Helens Probation Delivery Unit should ensure probation staff consider how a disability may impact a person's engagement with probation and whether reasonable adjustments are required.

The Investigation Process

7. The PPO investigator obtained copies of relevant extracts from Mr Parkinson's prison and probation records.
8. The investigator interviewed two probation practitioners on 9 and 18 November 2022.
9. We informed HM Coroner for Sefton, St Helens and Knowsley of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
10. The Ombudsman's family liaison officer contacted Mr Parkinson's next of kin, his mother, to explain the investigation and ask if she had any matters she wanted us to consider. She did not have any questions but asked for a copy of the report.
11. We shared our initial report with HM Prison and Probation Service (HMPPS). They asked for some amendments to the report and recommendations, to which we agreed.
12. We sent a copy of our initial report to Mr Parkinson's mother. She did not notify us of any factual inaccuracies.

Background Information

HMP Altcourse

13. HMP Altcourse is a local prison run by G4S which holds up to 1,164 men, including around 100 young adults. As a local prison, one of its primary functions is to serve the courts of Merseyside, Cheshire and North Wales and it has a very high turnover of prisoners. Healthcare is provided by G4S Health Services.

Probation Service

14. The Probation Service works with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

Key Events

2021

15. On 25 March 2021, Mr Michael Parkinson was given an 18-month suspended sentence for threat with intent to commit criminal damage. A requirement of this order was to have an electronic tag fitted.
16. Mr Parkinson failed to attend several initial probation appointments and appointments to fit his electronic tag. On 20 April, Mr Parkinson attended probation for a rescheduled appointment with a duty officer. The duty officer noted that Mr Parkinson was an amputee (his records note that his right leg had been amputated) and made details of his journey to the office, however there is no record that they asked Mr Parkinson whether his disability impacted on his ability to attend the office.
17. On 30 April, Mr Parkinson's probation practitioner sent a breach report to court as Mr Parkinson had failed to attend four out of five probation appointments and had failed to attend several appointments to fit his electronic tag.
18. On 4 May, the probation practitioner reviewed Mr Parkinson's risk assessment. She assessed that Mr Parkinson posed a high risk of harm to the public due to violent offending.
19. On 7 May, Mr Parkinson attended a scheduled probation appointment with a duty officer. He did not provide any evidence for his missed appointments. The duty officer told Mr Parkinson that he would be receiving a new probation practitioner, who would contact him with a next appointment.
20. The new probation practitioner continued to provide Mr Parkinson with new appointments and recorded his failures to attend, however as Mr Parkinson was already in breach of his order, there was no further enforcement action the probation practitioner could take. On 17 June, Mr Parkinson's breach order was heard in court. This was adjourned and he was remanded in custody.
21. On 9 July, Mr Parkinson's breach order was heard in court. As a result, the custodial element of his suspended sentence was activated, and the court ordered six months imprisonment. Mr Parkinson was sentenced to a further four weeks imprisonment on 5 August, for common assault and battery.
22. On 17 September, Mr Parkinson was released from prison. He failed to attend his initial probation appointment. The probation practitioner sent a new appointment for 20 September. Mr Parkinson attended that appointment. There is no record that the duty officer discussed with Mr Parkinson whether his disability would impact on his ability to attend the probation office.
23. On 15 October, the probation practitioner submitted paperwork to the Public Protection Casework Section (PPCS) to recall Mr Parkinson back to prison, after he failed to attend three further probation appointments. Mr Parkinson was arrested and sent to HMP Altcourse the following day.

24. On 14 December, Mr Parkinson was taken to hospital with COVID-19. He was released from prison on 17 December but remained in hospital until 20 December.

2022

25. On 2 February 2022, the probation practitioner breached Mr Parkinson for failing to attend three further probation appointments and not being in contact since his release. He did not consider whether a welfare check was required or whether an unannounced home visit may have helped engage Mr Parkinson.
26. On 25 February, Mr Parkinson was sentenced to eight weeks imprisonment for breaching his sexual offending registration requirements.
27. On 24 March, Mr Parkinson was released from prison. He failed to attend his initial probation appointment with the probation practitioner. The following day, the probation practitioner spoke with a senior probation officer (SPO) about Mr Parkinson's compliance. The SPO said she saw no option but to continue enforcing Mr Parkinson's order, in the hope he would re-engage.
28. The probation practitioner provided Mr Parkinson with two further appointments, which he failed to attend. On 7 April, he submitted recall paperwork and the following day, Mr Parkinson was sent to HMP Liverpool.
29. On 21 April, Mr Parkinson was released from prison. He failed to attend his initial probation appointment with his new probation practitioner.
30. On 4 May, the new probation practitioner submitted a breach application to court as Mr Parkinson failed to attend several appointments, and she had not seen him since his release.
31. Between May and July, the probation practitioner provided Mr Parkinson with several further appointments, all of which he did not attend. She recorded she could not take any further enforcement action as Mr Parkinson was already in breach of his order. She did not explore alternatives to engage Mr Parkinson, such as an unannounced home visit.
32. On 22 July, Mr Parkinson's breach was heard in court. He was sentenced to two weeks imprisonment and sent to HMP Altcourse.

Release from HMP Altcourse

33. On 4 August, Mr Parkinson was released from Altcourse to his local authority supplied flat. He failed to attend his initial probation appointment. The probation practitioner rescheduled the appointment for 11 August, but Mr Parkinson did not attend.
34. On 16 August, a police officer responsible for managing Mr Parkinson's sexual offences registration requirements contacted the probation practitioner, asking if Mr Parkinson was still being supervised by probation. She provided information about Mr Parkinson's poor compliance and asked whether it was possible to carry out a home visit, in the hope of improving his engagement.

35. Unbeknown to the police officer and the probation practitioner, the previous day, one of Mr Parkinson's neighbours had contacted police and said he could see flies on the inside of Mr Parkinson's flat window and there was a bad smell coming from the property. He said neighbours had not seen Mr Parkinson since 12 August.
36. When police attended and entered the property, they found Mr Parkinson's body. He was pronounced dead at 9.45pm on 15 August.

Post-mortem report

37. Toxicology tests found potentially fatal levels of amitriptyline (an antidepressant) in Mr Parkinson's blood, alongside methadone and alcohol. The post-mortem report concluded that Mr Parkinson died from the toxic effects of amitriptyline in combination with methadone and alcohol.

Findings

Substance misuse

38. Mr Parkinson died after taking an excessive amount of amitriptyline, a medication he was prescribed. There is no evidence to suggest that this was a deliberate overdose.
39. Mr Parkinson had a history of substance misuse. He was on a methadone (heroin substitute) programme and engaged with both prison and community substance misuse services. He was released from prison with a methadone prescription and with a naloxone kit (medication that can rapidly reverse an opioid overdose). We are satisfied that he received appropriate support with his substance misuse issues.

Exploring alternatives to engage Mr Parkinson

40. From March 2021 onwards, probation practitioners offered Mr Parkinson 31 appointments. Of those appointments, Mr Parkinson attended three and had two absences considered acceptable.
41. We found that more consideration could have been given to options available to try to engage Mr Parkinson before taking enforcement action. It was not until 16 August that a probation practitioner considered a home visit, by which point Mr Parkinson had died.
42. Both probation practitioners and SPOs should have considered whether an unannounced home visit could have helped engage Mr Parkinson. This may have led to an improved working relationship and a better understanding of Mr Parkinson's personal circumstances. During interview, both probation practitioners said that they were dealing with demanding caseloads and at the time, given he was not complying with his order, Mr Parkinson's engagement did not take priority over other high-risk cases.
43. Given Mr Parkinson's risk level, encouraging his engagement should have been of higher priority to probation practitioners and SPOs, to better manage the risk he posed to the public. We accept that the significant staff shortages that were being

experienced throughout the time Mr Parkinson was under supervision, along with the COVID restrictions in place up to August 2021, impacted on probation practitioners' ability to conduct home visits but nevertheless, we consider that more could have been done. We recommend:

The Head of Knowsley and St Helens Probation Delivery Unit should seek assurances that probation staff explore all alternatives to encourage engagement with non-compliant people on probation, in line with assessed levels of risk.

44. Probation staff were aware that Mr Parkinson was disabled, however there is no record that they considered whether this impacted on his ability to attend the office and his overall compliance. We recommend:

The Head of Knowsley and St Helens Probation Delivery Unit should ensure probation staff consider how a disability may impact a person's engagement with probation and whether reasonable adjustments are required.

Inquest

45. The inquest, held on 25 November 2022, concluded that Mr Parkinson's death was drug related.

**Kimberley Bingham
Acting Prisons and Probation Ombudsman**

November 2023

**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