Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jeremie Simmons, a prisoner at HMP Wakefield, on 4 May 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.

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 Jeremie Simmons died of asphyxia after he was found hanged in his cell in the segregation unit on 4 May 2022 at HMP Wakefield. He was 21 years old. I offer my condolences to his family and friends.

We found evidence of systemic failures in the mental healthcare provided to Mr Simmons, including issues we have identified during previous investigations at the prison. Despite Mr Simmons's needs and risk factors being well documented and a comprehensive clinical handover from the sending prison, the mental health team at Wakefield did not consider them and therefore they did not inform initial risk assessments. The mental health team also failed to share the information with prison staff. As a result, mental healthcare effectively stopped and staff responsible for Mr Simmons's day-to-day care in the segregation unit were unaware of his risk factors and triggers. It is not possible to measure the impact of these failings on Mr Simmons's decision to take his own life. However, we consider that these were serious omissions, which limited the ability of prison staff to fully understand and appropriately respond to Mr Simmons's needs. Most importantly, we are concerned that this led to a decline in his wellbeing in the days before his death. Our findings are extremely concerning and should be addressed urgently.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **March 2023**

Contents

Summary

Events

1. On 5 August 2020, Mr Jeremie Simmons was remanded in prison custody for a range of offences. He spent time at HMP Isle of Wight and HMP Aylesbury before he was transferred to HMP Wakefield on 28 January 2022.

2. Mr Simmons's time in prison was very challenging for both him and for staff. His needs and behaviours were complex, and he found it difficult to regulate his emotions. Mr Simmons had a range of mental health issues, dating back to his childhood. He also had a long history of suicide attempts and self-harm and he was supported by Prison Service suicide and self-harm prevention procedures (known as ACCT) on at least ten occasions. He was not being monitored under ACCT procedures at the time of his death.

3. Mr Simmons assaulted two female staff members while in prison. He spent a significant period of his imprisonment in segregation as a result of the assaults and while awaiting the outcome of his referral to the Closed Supervision Centre (CSC), before which he could not be located on a main location, due to his age and vulnerability. At around 6.10am on 4 May, while completing a routine check, an officer found Mr Simmons hanged from his cell window. An officer radioed a medical emergency code and prison and healthcare staff responded. Paramedics attended and at 6.36am, confirmed Mr Simmons had died.

Findings

4. When the mental health team at Wakefield received Mr Simmons's handover information from Aylesbury, they did not undertake an assessment to identify his individual needs and how they could be met. This should have been a priority for a young person who was transitioning into segregation in a Category A adult prison and who presented significant and documented needs and risks.

5. We found fundamental issues with the referral process for mental health assessment, including a failure by the internal referral management system to identify that Mr Simmons had not been considered for one.

6. There was no information sharing protocol in place between the mental health team and other departments, which meant that staff involved in Mr Simmons's care could not access key information on his risk of suicide and self-harm.

7. Healthcare staff did not always comply with segregation protocols and policy, and clinical record keeping was often poor, lacked assessment or was absent.

Recommendations

- The Governor and Head of Healthcare should develop and implement a multidisciplinary information-sharing protocol, for the purposes of care planning and risk assessments, that ensures information is shared appropriately between disciplines inputting into an individual's care.

- The Head of Healthcare should conduct an urgent review of the following areas of mental healthcare delivery at Wakefield:
    - develop a protocol for disseminating transfer handover information, within a centralised email system, not to an individual staff member's email, to minimise the loss of critical clinical information;
    - ensure all staff within the mental health team understand the requirement to use medical records to inform clinical practice/assessment;
    - review the referral process and consider a centralised referral point, that is administratively managed, to ensure referrals are not missed;
    - ensure there is a clinical reason recorded for any referral task when it is closed;
    - review email processes to ensure there are clear standards for healthcare staff to check their emails;
    - complete a retrospective audit of closed tasks and referrals to identify if any have been closed before completion; and
    - review forensic psychologists' authority to access medical records.
- The NHS Commissioner for Northeast and Yorkshire Region should write to the Ombudsman setting out how they intend to improve mental health care at Wakefield, within twelve weeks of receiving our initial report.
- The Governor and Head of Healthcare should review healthcare staff attendance and input at daily segregation reviews to ensure safe and effective care.
- The Head of Healthcare should ensure daily clinical records for segregated prisoners capture and clearly reflect clinical thinking and assessment, in line with Nursing and Midwifery Council practice and communication standards.
- The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Wakefield informing them of the investigation and asking anyone with relevant information to contact her.

9. During her initial visit on 9 May 2022, the investigator went to the segregation unit and obtained copies of relevant extracts from Mr Simmons's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Simmons's clinical care at the prison. The investigator and clinical reviewer jointly interviewed 18 prison and healthcare staff in June and July. The investigator also interviewed a prison manager at HMP Aylesbury.

11. We informed HM Coroner for West Yorkshire Eastern District of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.

12. The Ombudsman's family liaison officer contacted Mr Simmons's next of kin, his father, to explain the purpose of our investigation and to ask if he had any matters he wanted us to consider. He did not have any specific questions.

13. Mr Simmons's family received a copy of the initial report. They did not identify any factual inaccuracies.

14. The prison also received a copy of the report. They did not identify any factual inaccuracies.

Background Information

HMP Wakefield

15. HMP Wakefield is a high security prison and holds up to 750 men. There are four main residential wings, a healthcare centre, a segregation unit and a close supervision centre (CSC). The CSC is a small unit aiming to provide a supportive, safe, structured and consistent environment for the most challenging prisoners.

16. Practice Plus Group is commissioned by NHS England to provide the majority of healthcare services at Wakefield. Psychiatry, recovery and clinical psychology services are contracted to Midlands Partnership Foundation Trust. Forensic psychologists are employed by HMPPS.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Wakefield was in June 2018. Inspectors found that the majority of prisoners in the segregation unit at the time of the inspection had been transferred from other segregation units or following serious disruptive behaviour elsewhere. Their average length of stay in segregation was more than five months and nearly double the duration noted at the previous inspection. Exit plans took too long to implement and prisoners' physical and mental wellbeing was negatively affected, especially if they had pre-existing mental health problems.

18. Inspectors noted that Wakefield was working towards Autism Awareness accreditation and had developed a multidisciplinary approach to supporting prisoners with learning disabilities and those identified with autism spectrum disorders. A locally designed information-sharing scheme called 'This is Me' was an impressive initiative that had been introduced to provide additional support to these prisoners. As part of the scheme, prisoners were asked to provide staff with information about their needs, triggers that might cause distress or sudden changes in behaviour and how they could be supported. Several prisoners praised the support they had received through the scheme.

Independent Monitoring Board

19. 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 Wakefield for the year to April 2021, the IMB reported that the prison provided a relatively calm environment, despite its challenging prisoner mix and changing population profile.

20. The IMB remained concerned about the Governor's ability to influence healthcare service delivery in Wakefield which is significantly constrained by the outsourcing of healthcare provision to an external contractor. They reported that although prisoners are entitled to receive an equivalent level of care to that which might reasonably be expected in the community, they did not consider that this is always the case at Wakefield and observed situations where it appeared that the contract, rather than the individual needs of prisoners, determined service delivery.

21. The IMB noted their concern that Wakefield does not have access to a consultant forensic psychiatrist, possibly because the contract does not specify provision for one. They found this was not consistent with the provision at other Long Term High Security Estate (LTHSE) prisons and did not consider that the mental health needs of prisoners who require forensic psychiatry services are being met at Wakefield. They were also concerned about the impact on segregated prisoners' mental health due to the length of time for mental health issues and assessments to be processed which led to a deterioration in prisoner behaviour and wellbeing. When we visited Wakefield during the course of our investigation, we found that they had since employed a consultant psychiatrist.

22. The IMB noted that the segregation unit (F wing) continued to present its own unique challenges and would continue to monitor the long-term effects of prolonged stays on the unit. They noted urgent concerns about the time taken to address the mental health issues of certain individuals and those who have spent an extraordinary amount of time within segregation. However, they acknowledged the positive steps taken to progress such prisoners into the general population whenever possible, given the complexities and challenges they present.

Previous deaths at HMP Wakefield

23. Mr Simmons was the fifteenth prisoner to die at Wakefield since May 2020. Two of the previous deaths were self-inflicted. We have previously identified failings within the referral process to the mental health team, and in the recording of information on medical records by healthcare staff. We have identified similar issues during this investigation and described these within this report.

Assessment, Care in Custody and Teamwork

24. ACCT is the care planning system used by the Prison Service to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

25. Part of the ACCT process involves assessing immediate needs and drawing up support actions to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the support actions are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Segregation units

26. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable, under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving periods of cellular confinement after disciplinary hearings. Prisoners who are segregated are assessed by a member of healthcare staff. A senior operational manager must then be satisfied

that the prisoner is fit for segregation. The unit at Wakefield can hold up to 30 prisoners.

27. Segregation unit regimes are usually restricted, and prisoners are permitted to leave their cells only to collect meals, shower, make phone calls and to exercise in the open air. If prisoners are not out of bed or refuse to interact with staff, they forfeit the chance to make applications or to access the regime for that day.

28. Wakefield also has a Closed Supervision Centre (CSC), which operates under a 'national co-ordinated management strategy' to provide a secure isolated location for those prisoners who are assessed as consistently and violently disruptive. In addition, a small number of 'designated cells' are available in the segregation unit for prisoners who may be awaiting selection into the CSC system.

Key Events

Background

29. On 5 August 2020, Mr Jeremie Simmons was remanded in prison custody and taken to HMP Winchester. He had been to prison before. On 12 May 2021, when he was 20 years old, Mr Simmons received an extended sentence of 21 years and four months, consisting of a 13-year custodial period and eight-year licence period in the community for assault, kidnap, robbery, threats to kill and committing an offence, with the intention of committing a sexual offence. The earliest he could be considered for parole was 6 December 2028.

30. Mr Simmons experienced significant abuse as a child, and this had been assessed by professionals as having impacted on his social, emotional and cognitive development. He had experienced anxiety and depression since he was a child and had a long history of self-harm. Mr Simmons also had a mild learning disability, which meant he struggled to understand information and communicate his feelings. Both professional assessment and Mr Simmons's own reflection was that he found it difficult to engage with women, due to the childhood abuse he had experienced from a woman.

31. Mr Simmons did not have any significant physical health issues, but he was clinically obese.

32. Mr Simmons had a history of violent and aggressive behaviour. He assaulted two female members of staff in prison, which led to extended periods in segregation. On 30 March 2021, while at HMP Winchester, he assaulted a female nurse. He was placed on report, the incident was referred to the police, and he was located in the segregation unit. On 7 April, Mr Simmons was transferred to HMP Isle of Wight, after it was agreed that he could not remain at Winchester following the assault. Mr Simmons was a young offender, so it was not appropriate for him to live on a standard adult residential wing. He was located in the segregation unit. An alert was added to Mr Simmons's prison record to say that he should not have lone contact with female staff.

33. On 10 May, Mr Simmons returned to Winchester and lived in the prison's healthcare unit. He was sentenced two days later, and ACCT procedures were started to give him additional support. ACCT monitoring was stopped on 28 May.

Aylesbury

34. On 2 June, Mr Simmons was transferred to HMP/YOI Aylesbury. He was immediately referred to the mental health team and the Safety Intervention Meeting (SIM – a multidisciplinary meeting to discuss managing risks to prisoners and the prison) due to his mental health issues and self-harm history.

35. The mental health team provided Mr Simmons with comprehensive, multidisciplinary support during his time at Aylesbury, and continuity of his medications for anxiety and depression. The prison psychiatrist and psychologist completed regular assessments and discussed Mr Simmons's care at Safety Intervention Meetings. Mr Simmons also completed an 'All About Me' document,

which provided him with an opportunity to highlight risks, triggers and protective factors to help manage his emotions and behaviours. A care plan and separate intervention and early warning/crisis plans were developed to monitor and manage Mr Simmons's symptoms of low mood and challenging behaviour.

36. Mr Simmons's behaviour was mixed. Staff described him as someone who was polite, engaged, and who complied with the wing regime. There was evidence he was being bullied by other prisoners, but also made threats to staff and other prisoners. Mr Simmons was placed on report for smashing property and flooding his cell, as well as misusing his emergency cell bell. Staff assessed that these actions were impulsive due to poor emotional control, and they supported Mr Simmons using a Challenge, Support and Intervention Plan (CSIP, used to manage violence and support victims of violence). He was also monitored under ACCT procedures after incidents of self-harm.

37. On 12 October, Mr Simmons self-harmed by cutting his arm and staff opened ACCT procedures. He was supported by prison staff and the mental health team, and he contacted Samaritans (a service that provides support to anyone in emotional distress, struggling to cope or at risk of suicide) when he felt low. Mr Simmons engaged well with the ACCT process and key worker sessions. His behaviour started to improve, and he achieved enhanced Incentives and Earned Privileges (IEP) status. He worked as a wing cleaner, which he enjoyed. The ACCT was closed on 4 November.

38. On 15 November Mr Simmons cut his arm again. He told staff that he did so out of frustration, after being told that a mandatory drug test was positive. His ACCT was reopened. He was also placed on report but on 20 November, the charge was dismissed when it was identified that the positive test was likely due to his prescribed medication. The ACCT was closed again on 11 December, but post-closure monitoring continued. (Additional monitoring continues for a minimum of seven days after an ACCT is closed to provide ongoing support and to ensure there has been no decline in the person's wellbeing.)

39. On 1 January 2022, there is an entry in Mr Simmons's prison record which states that at the end of December, he made a telephone call to his father. During the call, Mr Simmons told his father that a prisoner had arrived at Aylesbury who had bullied him at school, and he believed that he might do 'something' to him. The next day, Mr Simmons harmed himself by cutting his arm and the ACCT was reopened. On 3 January, during an ACCT review, Mr Simmons said his frustration had built up over a period of time after he had damaged some of his property and prisoners were being unkind to him when he went to the healthcare unit. The review assured Mr Simmons that they would monitor and challenge any inappropriate behaviour, and he said that he felt better now that staff were aware. Mr Simmons said he had managed thoughts of self-harm by speaking to Samaritans, wing staff and the mental health team. The review considered that Mr Simmons's risk had reduced and closed the ACCT, with a post-closure review scheduled for 10 January.

40. Mr Simmons experienced three bereavements during his time in prison, including the suicide of his sister. On 4 January, the prison chaplain was taking Mr Simmons to the chapel to light a candle for his friend, when he assaulted her. It is unclear why she was not accompanied, given the alert on Mr Simmons's' record. Mr Simmons was placed on report, the incident was referred to the police and he was

moved to the segregation unit. He later tied a ligature and said he could not live with what he had done. Staff reopened his ACCT and implemented observations five times an hour. They asked Mr Simmons to change into anti-ligature clothing, which he did.

41. The next day, a forensic psychologist, a forensic psychiatrist and a learning disability nurse assessed Mr Simmons's mental health. They noted that Mr Simmons was remorseful for his behaviour and showed no signs of acute mental illness. Mr Simmons said he wanted to end his life because he had 'messed up' but that he did not have any current thoughts of suicide or self-harm. Later that day, during an ACCT review, he expressed his remorse again. He said he felt angry because he was being bullied and he did not consider his strategies for coping with his emotions before the assault. The review agreed that Mr Simmons could have his clothes returned and observations were reduced to three an hour.

42. On 10 January, during an ACCT review, Mr Simmons said that he was anxious about his father visiting because he had not told him about the assault and transfer to segregation. He explained that after he assaulted a nurse at Winchester, his father said he would disown him if it happened again. Mr Simmons told the review that if his father disowned him, 'the jail would lose me'. The review staff decided to keep observations at the same level and the next review was scheduled after the visit from Mr Simmons's father.

43. On 13 January, staff reviewed Mr Simmons's ACCT following his visit from his father. There were no concerns raised and Mr Simmons said that he had no thoughts of suicide or self-harm because he did not want to hurt his father. The review explained that Mr Simmons would be re-categorised as a result of the assault and would be transferred to another prison. Observations were reduced to hourly.

44. Over the next few weeks, Mr Simmons continued to engage with the segregation regime and ACCT reviews; he reflected that he liked the structure and routine of the unit. He showered and exercised each day and used his time to read books. The ACCT was closed on 20 January, but post-closure monitoring continued.

45. The Head of Residence referred Mr Simmons to the Close Supervision Centre (CSC) at Wakefield because of his assaults and threats to staff, and his risk to lone females. His 21st birthday was coming up and therefore he would be able to go to Wakefield, which was an adult prison.

46. On 27 January, the day of Mr Simmons's 21st birthday, a nurse in the mental health team telephoned a senior mental health nurse at Wakefield to prepare for the transfer. She provided a detailed mental health handover, including information about Mr Simmons's diagnosis and risks. At 12.26pm, the nurse emailed the senior mental health nurse with a summary of the verbal handover and attached Mr Simmons's psychosocial care plan, mental health assessment and risk assessment. She confirmed that Mr Simmons had a learning disability, post-traumatic stress disorder (PTSD) and depression and was prescribed an antidepressant (mirtazapine). This information was also recorded in Mr Simmons's medical record.

47. There is no record of the decision-making process for Mr Simmons's transfer to Wakefield, despite his age and the potential impact of a transition into the adult estate, or his individual needs such as the distance from home.

Wakefield

48. At 4.30pm on 28 January, Mr Simmons arrived at Wakefield. He was transferred to the segregation unit while awaiting the outcome of the CSC application. A segregation officer noted that Mr Simmons looked nervous. The officer explained the unit's regime and contacted Mr Simmons's father to tell him that he had arrived and was OK. At 4.50pm, the segregation unit manager completed the initial authorisation process for holding Mr Simmons in segregation. He also noted that Mr Simmons was in ACCT post-closure. He arranged for Mr Simmons's segregation to be reviewed three days later on 31 January.

49. At 4.55pm, Nurse A completed the segregation safety screen algorithm for Mr Simmons to assess if there were any clinical reasons to advise against the use of segregation. She assessed that Mr Simmons was medically fit to be held in segregation. Earlier that day, the senior mental health nurse had forwarded an email sent to her from Aylesbury on 27 January to some of her colleagues in the mental health team at Wakefield, but this did not include Nurse A. Nurse A did not have access to Mr Simmons's medical record, or the handover information provided by Aylesbury and recorded on the algorithm that he had no current self-harm or ACCT history.

50. At 5.44pm, a nurse completed Mr Simmons's initial health screen. She noted his history of suicidal thoughts and self-harm and that he was in ACCT post-closure. She sent a task to the mental health team, requesting a full assessment. Mr Simmons was prescribed his antidepressant. He had to have it dispensed by a nurse each day as he was not allowed to keep and administer it himself.

51. On 31 January, the segregation unit manager chaired Mr Simmons's first segregation review and gave authority for his continued segregation, pending the outcome of the CRC referral. He chaired all subsequent segregation reviews, attended by the mental health team, forensic psychologist and the IMB (on 2 and 16 February, 2, 16 and 30 March, and 13 and 27 April). On each occasion, Mr Simmons was described as compliant, raised no issues and made a daily application to have a shower, exercise and use the telephone.

52. Nurse A made a retrospective entry in Mr Simmons's medical record that she had completed his segregation safety screen when Mr Simmons arrived. She noted his history of suicidal ideation and self-harm, but this was not reflected on the original segregation safety algorithm. Later, a prison GP recorded that she had seen Mr Simmons in the segregation unit, and that he was fit to be held there. She noted that he raised no concerns about his physical or mental health. There was no reference made to the information recorded in Mr Simmons's medical record by the mental health team at Aylesbury.

53. On 2 February, a trainee forensic psychologist met Mr Simmons. She introduced herself, explained her role and that she would meet with him on 9 February to complete a psychological assessment in order to identify what support was necessary. Later, she shared Mr Simmons's 'About Me' document (completed at

Aylesbury) with the segregation manager and officers, prison offender manager and the mental health team to ensure they were aware of his needs. She said that this document was comprehensive, so there was no need to complete a separate version at Wakefield.

54. On 7 February, a nurse task for mental health to complete a full assessment was recorded as completed, but Mr Simmons was never assessed by the mental health team.

55. On 9 February, the trainee forensic psychologist recorded that she thought Mr Simmons displayed some traits of autism, but that he had not received a formal diagnosis. She noted that he had a low IQ and might appear to understand more than he did. After their meeting, she spoke to the clinical lead for the Mulberry Unit at Wakefield (a small unit that accommodates up to 12 prisoners who have a diagnosis of autism) and suggested they explore if Mr Simmons met the criteria. She suggested this was a possible pathway out of the segregation unit.

56. On 1 March, a member of the Case Management Group for the High Security Estate confirmed that Mr Simmons was considered unsuitable for the CSC. The Group felt that other options were available and better suited to manage his risks.

57. On 8 March, the trainee forensic psychologist met Mr Simmons and completed several assessments to help identify if he was on the autism spectrum. Mr Simmons was able to complete the assessments without breaks and fully engaged with the process. A few days later, she and the clinical lead scored Mr Simmons's assessments, which were inconclusive and did not produce a definitive diagnosis.

58. During the segregation review on 30 March, the Board shared concerns about Mr Simmons returning to a standard residential wing. They noted his vulnerability due to his age and the risks associated with him mixing with other older prisoners. The next day, the trainee forensic psychologist completed a referral to the Mulberry Unit, which was sent to the clinical lead. They discussed Mr Simmons's' medical history and made a request for information from the healthcare team about a previous autism assessment. They wanted to review the assessment before deciding whether or not he was suitable for the unit. The forensic psychologist team did not have access to Mr Simmons's medical record, which meant that the process for assessing the most suitable place for his pathway out of segregation was delayed.

59. Over the next few weeks, Mr Simmons continued to comply with the segregation regime and staff recorded no issues. On 5 April, West Yorkshire Police interviewed Mr Simmons about the assault of a staff member at Aylesbury. The force was assisting their colleagues in Thames Valley Police, who were leading the investigation. (The criminal investigations into both prison assaults were not concluded before Mr Simmons died).

60. During a segregation review on 13 April, the segregation unit manager recorded that the delays in Mr Simmons's assessment for the Mulberry Unit could be stressful for him, but staff were aware and providing regular reassurance. Mr Simmons gave permission for his previous Child and Adolescent Mental Health Services (CAMHS) assessment to be shared with staff to assist the assessment process.

61. Mr Simmons told the review that he was worried about his father and that he had let him down by making bad choices. He also said that he had broken his television and it had not been replaced. The segregation unit manager authorised some phone credit so that Mr Simmons could contact his father and noted that he would arrange for him to have a new television. An officer noted in Mr Simmons's prison record that he had asked for a new television and the cleaners reported that this was his fourth television in as many weeks.

62. On 27 April, the segregation unit manager chaired another segregation review for Mr Simmons. He recorded that Mr Simmons was very settled, polite and complied with the regime. He authorised continued segregation and noted that the forensic psychology team were trying to contact the author of Mr Simmons's CAMHS assessment to assist with their ongoing autism assessment. It was noted that the Mulberry Unit was full at the time but that a further referral had been made to the Supporting Transition, Enabling Progress (STEP) specialist unit at HMP Full Sutton. (The STEP unit was designed for men who had spent 30 days or more in segregated conditions. Long-term segregation does not work as a deterrent for poor behaviour, and for some, it can increase the risk of future violent behaviour, and also worsen anxiety, depression and self-harm.)

63. Mr Simmons told the review that he continued to worry about his father and letting him down. The segregation unit manager reassured Mr Simmons that he could talk to staff and asked if Mr Simmons would like to see the mental health team. Mr Simmons said that he would like to speak to them and the mental health nurse in attendance at the review said she would take it forward. There is no evidence that the mental health team made any further contact. Mr Simmons said he would also like to speak to the chaplain who visited the segregation unit each day. The visiting chaplain recorded that they had had contact with Mr Simmons.

64. On 29 April, an advanced nurse practitioner recorded he had seen Mr Simmons as part of his routine segregation visit and that he was lying on his bed, reading.

65. On 30 April, Mr Simmons met the chaplain during their daily visit. The chaplain recorded that Mr Simmons was polite and well. An officer recorded that Mr Simmons had accessed the wing regime and did not raise any issues.

66. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. Between 30 April and 3 May, no further records were made about Mr Simmons. During the period, he continued to speak to his father regularly by phone. The investigator listened to the calls and there was nothing that appeared unusual or suggested he was in crisis.

67. At 4.17am on 3 May, an officer recorded that another prisoner in the segregation unit was on a 'dirty protest' (where a prisoner has chosen to either defecate or urinate in a cell or room without using the facilities provided). He noted that the prisoner was singing very loudly and that it was not unusual.

68. At 8.15am, Mr Simmons used the wing telephone to call his father. Mr Simmons told his father that the speakers had blown on his television and that staff had removed it, but not yet replaced it. He said he hoped he would get a replacement television by the weekend as he was worried that he would not be able to watch

Formula One racing. (When Mr Simmons was discovered, there was a television in his cell.)

69. Mr Simmons said he was completing word searches and listening to the radio to keep himself occupied. He said that the previous night, he had heard banging and asked an officer if he could turn up the volume on his radio so that he could block out the noise. He said the officer had given him permission to do so, as long as the radio was not too loud. Mr Simmons chatted to his father and said, 'Life's a bitch until you die'. He then reflected on someone who had said the same and had died and that had he [Mr Simmons] not been in prison, he could have got him help. Mr Simmons's father reassured him and said the person did not want help. The call ended with Mr Simmons telling his father he loved him and that they would speak in the morning. There was nothing unusual about this call, although Mr Simmons sounded a little more subdued than in previous calls.

70. At 4.21pm, Mr Simmons was given his mirtazapine medication. He also submitted his applications to access the regime and the canteen the following day, which were normal aspects of his routine. At around 7.10pm, an officer completed the evening roll check (a count of prisoners). Officer A arrived on the segregation shortly afterwards to start his night shift. CCTV footage shows that he completed checks throughout the night on those prisoners subject to special monitoring arrangements. Mr Simmons was not included in those arrangements.

Events on 4 May

71. CCTV footage shows that Officer A started the early morning roll check. He arrived at Mr Simmons's cell first at 4.52am. He looked through the observation panel and five seconds later, he moved on to the next cell. There was nothing in the officer's body language to suggest there was a problem and he continued to check the remaining cells in a similar way. The officer said he saw Mr Simmons and believed that he was standing near his sink.

72. At 6.10am, while conducting another roll check, Officer B arrived at Mr Simmons's cell and looked through the observation panel. He saw Mr Simmons hanging and shouted for staff assistance. Another officer radioed a medical emergency code blue (used when a prisoner has difficulty breathing or is unconscious). An officer responded to the call. Officer B found Mr Simmons with a ligature made of a towel and blanket around his neck, tied to his window. He tried to cut the ligature, but as well as being very thick material, Mr Simmons had placed something inside it, thought to be his TV aerial. They lowered Mr Simmons to the floor and removed the ligature. Other prison staff also responded to the medical emergency, and they tried to start cardiopulmonary resuscitation (CPR). At 6.21am, a nurse arrived at the cell and told staff to stop CPR in line with National Resuscitation Council guidance as there were clear signs Mr Simmons was dead.

73. When the code blue was radioed, the control room immediately contacted Yorkshire Ambulance Service. Ambulance Service records show an ambulance was requested at 6.14am. Paramedics arrived at Mr Simmons's cell at 6.33am. They assessed him and at 6.36am confirmed he had died.

74. Mr Simmons left a note in his cell, addressed to his father, indicating that he meant to take his own life.

Contact with Mr Simmons's family

75. The prison appointed a family liaison officer (FLO) and a deputy. Due to the distance between Wakefield and Mr Simmons's father's address, arrangements were made for HMP Ford staff to visit his home and share the news of his death. The FLO contacted Mr Simmons's father later that day and offered her condolences and ongoing support. The prison contributed towards the costs of Mr Simmons's funeral, in line with national policy.

Support for prisoners and staff

76. After Mr Simmons's death, prison managers debriefed all prison staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff support team and the trauma risk management manager also contacted prison staff.

77. The prison posted notices informing other prisoners of Mr Simmons'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 Simmons's death.

Post-mortem report

78. The pathologist concluded that the cause of Mr Simmons's death was asphyxia (a lack of oxygen), due to hanging. The pathologist concluded that the cause of Mr Simmons's death was asphyxia (a lack of oxygen), due to hanging.

Findings

Assessment of risk of suicide and self-harm

79. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)* contains the mandatory requirements staff must comply with when they identify that a prisoner is at risk of suicide and self-harm. It lists risk factors and potential triggers that might indicate or increase the risk of suicide and self-harm. Mr Simmons presented a number of these risk factors: he was serving a lengthy sentence; he had a history of mental health issues; he had previously tried to take his own life; he had experienced childhood adversity; there was a family history of suicide; and he had had recent contact with psychiatric and psychological services.

80. Mr Simmons had a well-documented history of self-harm and ligaturing while in prison. Before he arrived at Wakefield, he had been monitored under ACCT procedures at HMP Winchester, HMP Isle of Wight and HMP Aylesbury on at least ten separate occasions. We found that overall, the use and management of Mr Simmons's ACCTs were appropriate in these prisons. Assessments were thorough and multidisciplinary, supportive action plans were put in place that reflected his needs, and case reviews were comprehensive and completed when there was a change in his circumstances.

81. Mr Simmons arrived at Wakefield in ACCT post-closure. He was reviewed regularly, and staff reported that he appeared to be settling, with no need for additional monitoring. ACCT post-closure monitoring stopped on 20 February and no further concerns were identified. This approach seems appropriate, based on the information available to staff at the time and what Mr Simmons was saying to them. However, prison staff were not aware of the detailed risk information contained in Mr Simmons's medical record, including his childhood trauma, his family history of suicide and the nature and extent of his mental health difficulties and previous self-harm.

82. We have identified systemic failures within the mental health team that prevented the sharing of this information and limited the ability of prison staff to make an informed assessment of Mr Simmons's risk. Specifically, these were inadequate systems for information sharing within the mental health team, and outside of it with prison staff, and the use of such information to inform risk assessment and management processes, including the safety algorithm for segregation and ACCT procedures. We therefore make the following recommendation:

    The Governor of Wakefield and Head of Healthcare should develop and implement a multidisciplinary information-sharing protocol, for the purposes of care planning and risk assessments, that ensures information is shared appropriately between disciplines inputting into an individual's care.

Clinical care

83. The clinical reviewer concluded that Mr Simmons's mental healthcare was not equivalent to that which he could have expected to have received in the community. Physical healthcare was found to be partially equivalent, but there were omissions

in the reception healthscreen when he arrived at Wakefield. Substance misuse support was found to be equivalent.

84. The clinical reviewer has identified a number of learning points which the Head of Healthcare will need to address.

Assessment and management of Mr Simmons's mental health

85. During Mr Simmons's time in other prisons, notably Aylesbury, the mental health team adopted a multidisciplinary approach to his care. This was in response to his complex needs and risk factors, which impacted on many areas of his daily life and engagement with the prison regime. Mr Simmons was actively encouraged to contribute to his care planning and regularly saw a prison psychiatrist and psychologist. He also had regular contact with the mental health in-reach team. The day before Mr Simmons was transferred to Wakefield, the mental health team at Aylesbury contacted a senior mental health nurse at Wakefield to provide a detailed verbal handover about Mr Simmons's history. The nurse followed up this discussion with an email to the senior mental health nurse, summarising the information that she had shared, and attaching a number of care plans which set out Mr Simmons's risks, triggers and details about his medication and PTSD diagnosis, and that he had a learning disability.

86. A few hours before Mr Simmons arrived at Wakefield, the senior mental health nurse forwarded the email and his medical record to some of the mental health team staff. No assessment was taken to identify his needs and how these could be met, and the information was not shared further. Reception staff made a referral for a full mental health screen following Mr Simmons's initial screen on arrival, offering another opportunity for the mental health team to identify his needs. However, the referral for assessment was not processed and was then closed inaccurately, which the internal referral management system failed to identify. Mr Simmons's mental health care effectively stopped when he arrived at Wakefield.

Access to medical records

87. The trainee forensic psychologist working at Wakefield, was actively involved in Mr Simmons's care and was aware of his vulnerabilities which she had identified from the psychological records shared by Aylesbury. She shared information she had, including Mr Simmons's 'All about me' document, with all relevant disciplines within the prison, including healthcare colleagues, which was good practice.

88. The trainee forensic psychologist observed Mr Simmons's characteristics and presentation and discussed whether autism was a factor with one of her managers. The psychology team agreed it would be helpful to explore and undertook an assessment, during which they consulted professionals who had worked with Mr Simmons's earlier in his life. She identified that the Mulberry Unit might meet Mr Simmons's needs and provide a pathway from segregation. However, mental healthcare staff did not share key information in Mr Simmons's medical record with her. She was therefore unaware of his significant mental health history and how this might have affected his presentation. At interview, we were told that this was due to her not having access to medical records because she is employed directly by HMPPS and not Practice Plus Group (PPG), who are commissioned to provide healthcare. We do not consider that this should be a barrier to information sharing,

where staff are directly inputting into the care of individuals. We found that other external staff did have access to medical records, for example, substance misuse services.

89. A combination of poor communication, poor clinical records and the absence of any consideration of Mr Simmons's mental health history resulted in Mr Simmons receiving no specific, individual mental healthcare support while at Wakefield, beyond basic clinical observations. This was despite his extensive and documented healthcare history. It is not possible to measure the impact of this on his wellbeing and safety during his time at Wakefield, or his death, but it is unacceptable that information necessary to properly safeguard Mr Simmons was not accessed by mental health staff or made accessible to other staff responsible for inputting into his care. We therefore make the following recommendation:

The Head of Healthcare should conduct an urgent review of the following areas of mental healthcare delivery at Wakefield:

- **develop a protocol for disseminating transfer handover information, within a centralised email system, not to an individual staff member's email, to minimise the loss of critical clinical information;**
- **ensure all staff within the mental health team understand the requirement to use medical records to inform clinical practice/assessment;**
- **review the referral process and consider a centralised referral point, that is administratively managed, to ensure referrals are not missed;**
- **ensure there is a clinical reason recorded for any referral task when it is closed;**
- **review email processes to ensure there are clear standards for healthcare staff to check their emails;**
- **complete a retrospective audit of closed tasks and referrals to identify if any have been closed before completion; and**
- **review forensic psychologists' authority to access medical records.**

90. Given the significant and systemic issues identified with the mental health provision at Wakefield, we make the following recommendation:

The NHS Commissioner for Northeast and Yorkshire Region should write to the Ombudsman, setting out how they intend to improve mental health care at Wakefield, within twelve weeks of receiving our initial report.

Compliance with segregation processes

91. Prison Service Order (PSO) 1700 *Segregation* sets out the expectations of staff when managing prisoners held in segregation. Our investigation highlighted a number of unsatisfactory segregation processes.

92. PSO 1700 states that the prison doctor must visit each prisoner in segregation as often as their individual health needs dictate and at least every three days. A registered nurse or healthcare officer must make the assessment on all other days, so that a member of healthcare staff visits the prisoner on a daily basis. Healthcare staff must assess the physical, emotional and mental wellbeing of the prisoner and whether there are any apparent clinical reasons to advise against the continuation of segregation.

93. Nurse A completed the segregation safety screen algorithm when Mr Simmons first arrived at Wakefield. She did not access his medical record and did not review available and relevant risk information. She incorrectly noted there was no current self-harm or ACCT history.

94. The mental health team are responsible for dispensing medication in the segregation unit, so Mr Simmons would have seen someone daily when they gave him his antidepressant medication. In addition, there were daily segregation review meetings which staff attend on a rota basis (some days it may be a primary care nurse, and at other times, it may be a mental health nurse or prison GP). The conversations and reviews of Mr Simmons were held at the cell door, with prison staff in attendance. When reviewing the daily segregation history sheets, there are numerous blank entries by healthcare staff. Overall, they attended fewer than 50% of the daily segregation reviews for Mr Simmons. Mr Simmons was seen on 1 May, three days before he died, but there was no clinical entry. There was no evidence that healthcare staff saw Mr Simmons for a segregation review on 2 or 3 May.

95. Segregation visits by the prison GP were not undertaken in accordance with PSO 1700. A GP said PPG had directed that an advanced nurse practitioner could undertake the role during the Covid-19 pandemic, in response to staff shortages. However, we found that since the peak of the pandemic, the Acting Head of Healthcare had directed the advanced nurse practitioner to complete clinics instead of the segregation round because it was viewed that the waiting list posed a greater risk. We make the following recommendation:

The Governor and Head of Healthcare should review healthcare staff attendance and input at daily segregation reviews, to ensure safe and effective care.

Record keeping

96. The clinical reviewer found that record keeping by the mental health team and the wider healthcare team at Wakefield was scant and included gaps. Entries gave little insight or understanding to Mr Simmons's thoughts and feelings and therefore use of these records was limited in some cases, despite them being a key source of information for care planning and risk assessments purposes. The medical records for Mr Simmons also do not detail a clinical entry for all daily segregation reviews. We therefore make the following recommendation:

The Head of Healthcare should ensure daily clinical records for segregated prisoners capture and clearly reflect clinical thinking and assessment, in line with Nursing and Midwifery Council practice and communication standards.

Decision to continue Mr Simmons's segregation

97. PSO 1700 states that segregation should be used only as a last resort. The reasons for initial and continuing segregation decisions are regularly monitored so that prisoners do not spend longer in segregation than is necessary. In a Learning Lessons Bulletin we issued in June 2015, we examined learning from investigations into the self-inflicted deaths of prisoners who were segregated at the time of their deaths. We noted that segregation reduces some protective factors against suicide and should be used only in exceptional circumstances for those at risk of taking their own life. HMIP inspectors noted in June 2018 that exit plans to move prisoners out of segregation at Wakefield took too long to implement.

98. Mr Simmons was considered too vulnerable to be moved to a standard residential unit because of his age and vulnerability. Prison staff and the forensic psychologist felt that he could be exploited by more sophisticated, dangerous prisoners. Staff made referrals to other units that they felt could meet his needs and offer a pathway out of segregation. These processes took time, and the custodial manager recognised the stress this might have caused for Mr Simmons and took steps to ensure regular dialogue on progress as a way of providing reassurance. Because Mr Simmons did not have a confirmed autism diagnosis, he could not immediately move to the Mulberry Unit. The difficulties obtaining historical medical information to support the assessment process and the departure of the clinical lead shortly after his referral meant that Mr Simmons's assessment was never fully completed.

99. Throughout the time Mr Simmons was segregated at Wakefield, another prisoner was located on the landing below him and was acutely mentally unwell. They were noisy, took up a lot of staff resources and frequently participated in 'dirty protests'. At interview, staff acknowledged that all prisoners in the segregation unit would have been aware of his actions. Mr Simmons never spoke to staff about this prisoner but in his last telephone call to his father, he mentioned a prisoner making a lot of noise and that he had used his radio to block it out.

100. Although the mental health team had information about Mr Simmons's childhood trauma, which included similar incidents, there is no evidence that they considered this information when contributing to his care, or shared it with other staff outside of healthcare, who were contributing to his care and managing the behaviour and potential impact of the other prisoner's actions on Mr Simmons. While we are unable to say if the actions of the other prisoner contributed to Mr Simmons's decision to take his own life, it is possible that these issues will impact on the care of other prisoners in future.

101. Until he was interviewed by the PPO, the manager responsible for the running of the segregation unit was unaware of the information known to the mental health team. He said, 'without a doubt', if the segregation staff had known about Mr Simmons's history, he would have been managed differently, specifically in terms of prioritising seeking the mental health team's input.

102. The segregation unit manager chaired most of the segregation reviews, which provided consistency and demonstrated the review considered Mr Simmons's individual needs. We found that the decision to keep Mr Simmons segregated, given the information that was known at the time of the review boards and the concerns about potential exploitation by other prisoners, was reasonable, based on

an assessment of both the security risks posed by Mr Simmons and the ability of staff to safeguard him appropriately.

Learning lessons

103. We have identified a number of concerns in this report, and we consider it important that staff have the opportunity to learn from our findings. We recommend:

The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

Inquest

104. The inquest into Mr Simmons' death concluded in November 2024, and that he died by suicide (asphyxia due to hanging). The inquest found that after considering the evidence provided by healthcare and prison staff, the jury believe that Mr Simmons would have been placed on a mental health caseload if a mental health assessment had taken place at HMP Wakefield. The jury identified missed opportunities that may have changed the outcome for Mr Simmons.

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