Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Simmons, a prisoner at HMP Humber on 20 April 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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Thomas Simmons died in hospital on 20 April 2022, after he suffered a seizure in his cell at HMP Humber the previous day. He was 45 years old. I offer my condolences to Mr Simmons' family and friends.

Mr Simmons suffered a serious head injury in April 2021 while in the community and a post-mortem concluded that this injury likely contributed to his death a year later.

We had concerns about the way in which the emergency response was managed. The clinical reviewer concluded that this aspect of Mr Simmons' care was not equivalent to that which he could have expected to receive in the community.

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

Adrian Usher
Prisons and Probation Ombudsman **August 2023**

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Summary

Events

1. On 19 July 2021, Mr Thomas Simmons was sentenced to 11 months in prison for possession of a bladed article.

2. Mr Simmons was released on licence on 3 December but was recalled ten days later. He was moved to HMP Humber on 5 January 2022.

3. On 19 April, at around 3.30pm, staff found Mr Simmons collapsed on the floor of his cell. Staff called a medical emergency code. Shortly after healthcare staff arrived at the cell, Mr Simmons appeared to be recovering and staff thought he had been under the influence of an illicit substance. A nurse said that the ambulance was no longer required, and healthcare staff continued to care for Mr Simmons in his cell.

4. However, at around 4.15pm, Mr Simmons' condition began to deteriorate. Staff requested an ambulance again and continued to treat him, carrying out cardiopulmonary resuscitation (CPR) when he became unresponsive, until ambulance staff arrived and took over his care. Mr Simmons was transported to hospital but did not regain consciousness and died the following day.

5. The post-mortem examination found that Mr Simmons died from a presumed seizure arising from an old head injury.

Findings

6. Staff stood down the ambulance too early before they were satisfied that Mr Simmons had fully recovered.

7. An unqualified member of healthcare staff was left to manage the emergency situation, with a suction machine that did not work. This situation continued for around 15 minutes before another nurse arrived with a working suction machine and took charge of the situation. The clinical reviewer established that while the contents of the emergency bags are audited daily, the audit does not include a check that the equipment is in good working order.

8. We found some failings in the ongoing family liaison from the prison.

Recommendations

- The Head of Healthcare should ensure that, once an emergency code blue has been called and an ambulance is on the way, staff should only stand it down if they are confident that the patient has fully recovered.

- The Head of Healthcare should ensure that the daily audit of the emergency bags includes checking that the equipment is in good working order.

- The Governor should ensure that there are sufficient trained family liaison officers to contact and provide effective and consistent support for bereaved families.

The Investigation Process

9. HMPPS notified us of Mr Simmons' death on 20 April 2022.

10. The investigator issued notices to staff and prisoners at HMP Humber informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

11. The investigator obtained copies of relevant extracts from Mr Simmons' prison and medical records.

12. NHS England commissioned an independent clinical reviewer to review Mr Simmons' clinical care at the prison. The investigator and clinical reviewer jointly interviewed four members of staff.

13. We informed HM Coroner for Hull and the East Riding of Yorkshire of the investigation. The coroner shared Mr Simmons' post-mortem report with us. We have sent the coroner a copy of this report.

14. The Ombudsman's family liaison officer contacted Mr Simmons' father to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Simmons' father had no questions but asked for a copy of our report.

15. We shared our initial report with Mr Simmons' father. He did not raise any factual inaccuracies.

16. We shared our initial report with the Prison Service. The Prison service identified a factual inaccuracy which has been amended within our report.

Background Information

HMP Humber

17. HMP Humber is a category C prison that holds up to 1,062 men. Spectrum Community Health CIC provides primary healthcare services between the hours of 07:30 to 20:30. Tees Esk and Wear Valleys NHS Foundation Trust provides mental health services but during core hours only.

HM Inspectorate of Prisons

18. The last full inspection of HMP Humber was in November and December 2017. Inspectors found that access to healthcare services was adequate, with appropriate treatment provided for most prisoners and the care of prisoners with long-term health problems being reasonably good. They found some aspects of operational management to be weak, including that emergency equipment was not routinely checked and there was a significant backlog of unanswered health care complaints.

19. Inspectors carried out a Scrutiny Visit in October and November 2020 and found that healthcare provision had progressed since their last inspection. They noted that healthcare staff had maintained core functions during the COVID-19 restrictions, but some clinics still had not restarted. Inspectors found some errors with medicines management which compromised prisoner safety.

Independent Monitoring Board

20. 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 31 December 2021, the IMB reported that the health and wellbeing of prisoners had been extremely well-managed during challenges and constraints of the COVID-19 pandemic.

Previous deaths at HMP Humber

21. Mr Simmons was the ninth prisoner to die at Humber since April 2019. Six of the previous deaths were from natural causes and two were self-inflicted. There are no similarities between the findings from our investigation into Mr Simmons' death and our findings from previous investigations.

Key Events

Background

22. On 19 July 2021, Mr Thomas Simmons was sentenced to 11 months in prison for possession of a bladed article. He was sent to HMP Hull and later transferred to HMP Humber.

23. Mr Simmons was released on licence on 3 December but was recalled ten days later. He initially returned to Hull before being transferred back to Humber on 5 January 2022.

24. Mr Simmons had been in prison many times before and had a history of substance misuse and mental health issues. Staff appropriately referred him to the relevant services to offer him treatment and support. In April 2021, a few months prior to starting his last prison sentence, he had suffered a major head injury after being assaulted in the community. Mr Simmons was not receiving any active treatment for the head injury by the time he was sent to Hull.

25. On arrival at Humber on 5 January, staff noted no significant concerns. Mr Simmons requested an increase in his antidepressant medication, and this was appropriately actioned by the mental health team.

26. Mr Simmons had unwarranted concerns about his physical health and told staff on numerous occasions that he was worried that he might have cancer. He did not at any time raise concerns about his previous head injury and there was no cause for staff to see him or assist him in attending any appointments about his head injury.

27. On 18 April, Mr Simmons made cuts to his arms with a razor blade and staff started suicide and self-harm monitoring (known as ACCT). He said he had done this because he was feeling unwell, and he continued to tell staff that he thought he had cancer and a sexually transmitted infection.

Events of 19 April 2022

28. At around 2.15pm on 19 April, staff tried to conduct an ACCT assessment with Mr Simmons, but he did not want to come out of his cell. Staff went to his cell and found that he and the cell appeared dirty and unkempt. He became angry when a mental health nurse pointed this out to him. He continued to say that staff were ignoring his health issues. Staff agreed to arrange appointments for him to see the sexual health nurse, the mental health nurse, and also his offender manager to discuss his concerns about his forthcoming release. Staff left the cell at 2.40pm and agreed to continue monitoring him on hourly observations.

29. At around 3.30pm, Officer A was returning another prisoner to his cell when he looked into Mr Simmons' cell and saw him lying on the floor. He said he was not entirely sure what was wrong with Mr Simmons, but he was aware he was subject to ACCT monitoring. Therefore, after returning the other prisoner to his cell, he went back to Mr Simmons' cell, opened the door and tried unsuccessfully to get a response from him. When he could not get a response, he radioed a code blue (a medical emergency code which tells the control room that a prisoner is

unresponsive or not breathing and an ambulance is required immediately). He said that the call did not immediately go through as there was a communications network test going on, so he had to call the code again. He thought this did not take more than 30 seconds to one minute.

30. Two other members of staff arrived and continued to try to rouse Mr Simmons while waiting for healthcare staff to arrive. Staff suspected that Mr Simmons was under the influence of an illicit substance and put him into the recovery position on the floor.

31. Nurse A, a senior nurse, arrived at the cell with the emergency bag, accompanied by assistant practitioner and a healthcare assistant. Healthcare staff took observations and found that Mr Simmons appeared to be recovering so they moved him onto the bed. Within eight minutes of the code blue being called, the nurse said the ambulance was no longer required.

32. At around 4.00pm, Nurse A administered naloxone (a drug that can reverse the effects of opioids) as staff suspected Mr Simmons may have taken illicit drugs. However, Mr Simmons' condition began to deteriorate and, shortly afterwards, he began to have a seizure and started to vomit. She requested an ambulance again at around 4.10pm, but left the cell as she was feeling unwell, leaving unqualified staff to take control of the situation. The assistant practitioner tried to remove vomit from Mr Simmons' mouth, but the suction machine in the emergency bag was not working properly, so she had to use her hands and a sheet. She requested support from Nurse B, who was working elsewhere in the prison. She asked him to attend and to bring a working suction machine.

33. Nurse B attended at approximately 4.30pm and took control of the emergency. By this time, Mr Simmons had been having a seizure for around 20 minutes. Nurse B used the suction machine to clear Mr Simmons' airway. He also instructed the assistant practitioner to administer rectal diazepam to help control the seizures and a further dose of naloxone. Staff moved Mr Simmons onto the floor in case emergency cardiopulmonary resuscitation (CPR) became necessary.

34. At around 4.49pm, Mr Simmons suffered a cardiac arrest and staff started CPR while waiting for the ambulance to arrive. The ambulance arrived shortly before 5.00pm and paramedics took over Mr Simmons' care. They were able to resuscitate Mr Simmons and transfer him to hospital. However, Mr Simmons did not regain consciousness, and died around 1.40am the following morning.

Contact with Mr Simmons' family

35. When Mr Simmons was taken to hospital, records show that the prison tried to contact his stepfather, who was listed as his next of kin. However, they were unable to get in touch with him by telephone. Staff located a number for Mr Simmons' sister and told her that he had been taken to hospital. After Mr Simmons' death, hospital staff informed his sister by telephone that he had died. Mr Simmons' brother was a prisoner at another prison and prison staff also informed him.

36. At around midday on 20 April, the prison's family liaison officer (FLO) and a prison manager visited the home of Mr Simmons' stepfather to let him know that his

stepson had died. Mr Simmons' stepfather said that he had already heard about his stepson's death.

37. The FLO resigned from the role on 29 April, and we found that no-one else from the prison contacted Mr Simmons' stepfather until the start of August, when he was trying to make arrangements for the funeral.

38. The prison paid a contribution to Mr Simmons' funeral expenses in line with national policy.

Support for prisoners and staff

39. After Mr Simmons' death, a prison manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

40. The prison posted notices informing other prisoners of Mr Simmons' death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Simmons' death.

Post-mortem report

41. The post-mortem report found that Mr Simmons died due to complications of an out of hospital cardiac arrest and presumed seizure arising in the context of an old head injury. Post-mortem toxicology results did not identify any illicit substances in Mr Simmons' system.

Findings

Clinical care

42. The clinical reviewer concluded that Mr Simmons' mental health and substance misuse care was of a good standard and equivalent to that which he could have received in the community. However, the clinical reviewer considered that the level of care given during the emergency response was inadequate.

Emergency response

43. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, requires prisons to have a two-code medical emergency response system. Humber's local policy instructs staff to use a code blue where a prisoner is unconscious or otherwise shows signs of breathing difficulties. Calling an emergency medical code should automatically trigger the control room to call an ambulance and for healthcare staff to attend with the appropriate medical equipment.

44. When Officer A called the code blue, an ambulance was called immediately, and healthcare staff arrived at Mr Simmons' cell within a few minutes. However, Nurse A made the decision that an ambulance was no longer required before Mr Simmons' condition had been fully assessed.

45. Due to feeling unwell, Nurse A left the cell after Mr Simmons' health deteriorated, meaning that there was no fully qualified member of healthcare staff managing the situation for around 15 minutes.

46. The suction machine in the emergency bag was not working and the assistant practitioner had to remove vomit from Mr Simmons' mouth using her hand and a sheet until Nurse B arrived with a working suction machine. We agree with the clinical reviewer's opinion that the assistant practitioner coped well in what was a challenging situation until Nurse B arrived and took charge. While we understand that the situation was unavoidable due to Nurse A's sudden illness, we consider that the pressure on the assistant practitioner during that time would have been eased if she had access to proper working equipment.

47. At their last inspection of Humber, HM Inspectorate of Prisons noted that emergency equipment was not always checked. The clinical reviewer established that the contents of the emergency bags are audited daily. However, the audit does not include a check that the equipment is in good working order. We make the following recommendations:

    The Head of Healthcare should ensure that, once an emergency code blue has been called and an ambulance is on the way, staff should only stand it down if they are confident that the patient has fully recovered.

    The Head of Healthcare should ensure that the daily audit of the emergency bags includes checking that the equipment is in good working order.

Family liaison

48. No FLO support was made available from the prison to Mr Simmons' family between the end of April and the start of August 2022. During this time, Mr Simmons' stepfather was trying to get information about arrangements for his stepson's funeral. There was also a delay of some five months before Mr Simmons' property was returned to his stepfather. However, we acknowledge that when a new FLO was appointed on 1 August, she worked well with the family, offering support and resolving their outstanding queries. We make the following recommendation:

    The Governor should ensure that there are sufficient trained family liaison officers to contact and provide effective and consistent support for bereaved families.

Inquest

49. The inquest, held on 19 November 2024, concluded that Mr Simmons died from hypoxic brain injury caused by a seizure. The delay in administering the medication during his seizure contributed to his death.

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