Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Simpson, a prisoner at HMP Wakefield, on 12 March 2019

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 I 020 7633 4100
F I 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

© Crown copyright 2018

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

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

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Simpson died on 12 March 2019 of a stroke while a prisoner at HMP Wakefield. He was 71 years old. I offer my condolences to Mr Simpson's family and friends.

I am satisfied that the care Mr Simpson received at Wakefield was equivalent to that which he could have expected to receive in the community. Mr Simpson sometimes chose not to attend his medical appointments or follow recommended advice, which made continuity of care difficult. Healthcare staff encouraged Mr Simpson to engage, while respecting his decisions.

However, I am concerned that shortly after the emergency code was called, control room staff were instructed by an officer at the scene that an ambulance was not needed, meaning there was an almost five-minute delay before an ambulance was called. While it is unlikely that the delay affected the outcome for Mr Simpson, it is important that staff follow the correct medical emergency procedures and an ambulance is called automatically unless a member of healthcare staff instructs the control room to stand the ambulance down.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **January 2020**

Contents

Summary 1

The Investigation Process 3

Background Information 4

Key Events 5

Findings 8

Summary

Events

1. Mr Anthony Simpson was serving a life sentence for the murder of his wife, with a minimum term of nine years imprisonment. He had been at HMP Wakefield since 5 July 2002. Mr Simpson had a history of depression, suicidal thoughts, asthma and arthritis.

2. During 2015, Mr Simpson reported coughing up blood and weight loss. A GP told Mr Simpson that these symptoms could mean he had cancer, but Mr Simpson refused any tests to explore this.

3. Mr Simpson continued to refuse any tests to confirm or rule out his suspected cancer. However, in March 2016, he accepted a spirometry test to measure his lung function and was diagnosed with advanced Chronic Obstructive Pulmonary Disease (COPD).

4. In September 2017, in response to his frailty, severe COPD and suspected lung cancer, Mr Simpson was placed on the Gold Standards care register. This is a way of assessing, tracking and planning care for people thought to have a life-limiting condition. Mr Simpson's health and care needs were discussed regularly at healthcare multi-disciplinary (MDT) meetings.

5. On 8 March 2019, Mr Simpson was taken to hospital by emergency ambulance because he had chest pains. A CT scan showed he had had a large stroke.

6. On 12 March at 7.55am, it was confirmed that Mr Simpson had died in hospital.

7. The coroner recorded Mr Simpson's cause of death as a stroke. There was no post-mortem examination.

Findings

Clinical care

8. We agree with the clinical reviewer that the care Mr Simpson received at Wakefield was equivalent to that which he could have expected to receive in the community.

9. At times, Mr Simpson chose not to attend healthcare appointments or follow recommended advice, which made continuity of care difficult. There is evidence that the healthcare staff continued to encourage him to engage, while respecting his decisions. His medical records contain evidence of an open-door policy, which meant that he could change his mind at any time, should he wish to take the recommended tests or management plans.

10. In the final year of his life, Mr Simpson refused to discuss his COPD and refused all tests recommended to confirm or rule out lung cancer.

Emergency response

11. We are satisfied that officers responded promptly when a prisoner told staff that Mr Simpson was unwell, and immediately triggered an emergency response.

12. We are however, concerned that an officer initially stood the ambulance down, and that, as a result, there was almost a five-minute delay in calling the emergency ambulance.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff understand the procedures for responding to a medical emergency code so that there is no delay in calling an ambulance.
- The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

The Investigation Process

13. 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. No one responded.

14. The investigator obtained copies of relevant extracts from Mr Simpson's prison and medical records.

15. NHS England commissioned a clinical reviewer to review Mr Simpson's clinical care at the prison.

16. We informed HM Coroner for Wakefield of the investigation. The coroner informed us of the cause of death. We have sent the coroner a copy of this report.

17. We contacted Mr Simpson's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Simpson's son responded with some questions. These have been addressed in separate correspondence.

18. We shared our initial report with HM Prison and Probation Service (HMPPS). They did not identify and factual inaccuracies.

Background Information

HMP Wakefield

19. 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 (a small unit aiming to provide a supportive, safe, structured and consistent environment for some of the most challenging offenders).

20. Care UK provides the healthcare provision at Wakefield. They provide primary healthcare services during normal working hours, and overnight, and weekend care in the inpatient unit for prisoners with physical health problems. There is a dedicated palliative care suite in the healthcare unit.

HM Inspectorate of Prisons

21. The last inspection at Wakefield was in June 2018. Inspectors noted that health services were good overall, but some parts of the healthcare environment needed improvement. Primary care services were very good and had an appropriate emphasis on the care of patients with long-term conditions.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to April 2018, the IMB reported that the prison offered a regime that was overall fair, just and safe.

23. The IMB found that end of life care continued to be of a high standard, and that prison nursing staff had worked closely with A&E staff from the local NHS trust to improve healthcare services offered in the prison.

Previous deaths at HMP Wakefield

24. Mr Simpson was the twelfth prisoner to die at Wakefield since March 2017. One death was self-inflicted, the others were from natural causes. There have been six deaths since Mr Simpson’s death, four from natural causes, one self-inflicted and two awaiting classification. We have made recommendations in four previous investigations about staff’s failure to use the medical emergency codes.

Key Events

25. Mr Anthony Simpson was serving a life sentence for the murder of his wife and received a minimum tariff of nine years imprisonment. He had been at HMP Wakefield since 5 July 2002.

26. Mr Simpson had a history of depression, suicidal thoughts relating to his offence, asthma and arthritis.

27. Mr Simpson had a reception health screening when he arrived at Wakefield. His past medical history was noted and he declined to see a doctor. Mr Simpson declined screening using assessment tools for depression.

28. During 2015, Mr Simpson reported bringing up blood and weight loss. This resulted in a referral to a consultant respiratory physician. On 26 August 2015, the consultant respiratory physician told Mr Simpson (in detail) about his concerns about his symptoms and that they could be signs of cancer, but Mr Simpson refused further tests. He said that he would review Mr Simpson urgently if he changed his mind.

29. The nursing team also spoke with Mr Simpson about the consequences of refusing further tests. Mr Simpson was booked in for a bronchoscopy but he refused to attend the appointment and refused to sign the disclaimer paperwork.

30. On 7 September 2015, a prison GP reviewed Mr Simpson but again, he declined further tests. The prison GP recorded, 'I believe he has capacity at this point, and he understands if he has lung cancer and not dealt with, he will likely die.'

31. On 2 March 2016, the consultant respiratory physician reviewed Mr Simpson and told him that he needed a spirometry test to check for COPD. Mr Simpson refused the test.

32. On 11 January 2017, after having the spirometry test, Mr Simpson was diagnosed with very severe COPD. He was referred for regular vaccinations, a smoking cessation course and a pulmonary rehabilitation programme.

33. On 19 May, the consultant respiratory physician reviewed Mr Simpson who was slowly deteriorating and had become increasingly frail. Mr Simpson declined the advice to start using a nebulizer to inhale his medication and again refused chest x-rays.

34. On 15 September, in response to his frailty, severe COPD and suspected lung cancer, Mr Simpson was placed on the Gold Standards register. This is a way of assessing, tracking and planning care for people thought to have a life-limiting condition. Mr Simpson's health and care needs were discussed regularly at healthcare multi-disciplinary (MDT) meetings throughout 2017 and 2018.

35. Between March and May 2018, Mr Simpson was invited four times to a NHS health check, which would have included an assessment of his risk of developing heart disease, diabetes, kidney disease and stroke. Mr Simpson did not attend any of these appointments.

36. On 25 October, a prison GP reviewed Mr Simpson because he reported feeling lethargic and had lost weight. He recommended Mr Simpson have blood tests, but Mr Simpson became angry and refused any interventions suggested by the doctor. He told Mr Simpson he could come back when he was happy to accept the help offered.

37. On 4 January 2019, a nurse from the prison's healthcare unit tried to complete routine COPD monitoring. Mr Simpson refused to answer all questions or have any tests.

38. On 9 January, Mr Simpson's health was reviewed at an MDT meeting. Mr Simpson remained on the residential wing and no new concerns were noted.

39. On 5 February Mr Simpson refused a shingles vaccination.

Events of 8 March 2019

40. At approximately 2.40pm, a prisoner approached three officers, who were on the landing next to the wing gate and told them that Mr Simpson was experiencing chest pains.

41. An officer told the investigator that she went to see Mr Simpson, who was sitting outside his cell in a landing chair. An officer asked Mr Simpson if he was ok, he did not respond and started to lean forward. She tried to get him to sit up, and while she was doing this, an officer called an emergency code blue over the radio. The control room log shows that the emergency code was called at 2.46pm.

42. Two nurses responded immediately and were with Mr Simpson within minutes. A Custodial Manager (CM) also responded and arrived at the same time as the nurses.

43. The CM told the investigator that she asked the nurses present if an ambulance was still needed and that one of them said no, although she cannot remember who. An officer told the investigator the same.

44. The control room log shows that Oscar 1 (the orderly officer, who was the CM) said that an ambulance was not required at 2.47pm, and control room staff did not call an ambulance.

45. The CM said that shortly after this, one of the nurses told her an ambulance was required, so she called the control room. The control room log shows that the ambulance was called at 2.50pm, and ambulance services records show that they received the call at 14:50:57, almost five minutes after the code blue was called.

46. While waiting for the emergency ambulance to arrive, staff took Mr Simpson to the healthcare unit in a wheelchair to treat him. Mr Simpson became less responsive, vomited and his oxygen levels dropped.

47. The ambulance arrived at the prison at 2.56pm and were with Mr Simpson a few minutes later. Mr Simpson was taken to hospital by emergency ambulance. He was not restrained.

48. A CT scan showed Mr Simpson had had a large stroke, thought to be due to high blood pressure. Mr Simpson's prognosis was poor and the hospital advised end of life care.

49. The prison staff maintained regular contact with hospital staff. Plans were underway to move Mr Simpson back to the palliative care suite at the prison, but before he could be transferred, Mr Simpson died at 7.55am on 12 March.

Contact with Mr Simpson's family

50. On 8 March, an officer was appointed as the Family Liaison Officer (FLO). As Mr Simpson was very unwell, and Mr Simpson's next of kin, his son, lived almost 300 miles away and because the situation was time critical, the FLO informed Mr Simpson's son of his condition by phone. There were some difficulties in getting hold of Mr Simpson's son, however the FLO made every effort to contact him and other family members.

51. The FLO eventually spoke to Mr Simpson's son at 9.15pm on 8 March. The FLO, along with an officer waited at the hospital until 3.30am on 9 March, for Mr Simpson's son and other family members to arrive.

52. The FLO returned to the hospital on 10 March, gave the family support, and explained what would happen if Mr Simpson died and they were not there. The FLO said that they would phone Mr Simpson's son as soon as anything significant happened. Mr Simpson's family left later that day to return home.

53. On 12 March, at 8.03am, the FLO phoned Mr Simpson's son to inform him that Mr Simpson had died. The FLO maintained contact with Mr Simpson's son and provided support.

54. Mr Simpson's funeral was held on 26 April. The FLO and the Governor attended. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

55. After Mr Simpson's death, a Supervising Officer debriefed the staff involved to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

56. The prison posted notices informing other prisoners of Mr Simpson's death, and offering support.

Post-mortem report

57. The coroner recorded Mr Simpson's cause of death as a brainstem haemorrhagic stroke (bleeding at the base of the brain), due to hypertension (high blood pressure). There was no post-mortem examination.

Findings

Clinical care

58. The clinical reviewer is satisfied that the care Mr Simpson received at Wakefield was equivalent to that which he could have expected to receive in the community. At times, Mr Simpson chose not at attend healthcare appointments or follow recommended advice, which made continuity of care difficult. There is evidence that healthcare staff continued to encourage Mr Simpson to engage, while respecting his decisions.

59. Mr Simpson had severe COPD and was suspected to have lung cancer, which the healthcare team attempted to assess and review in a timely manner. His attendance at reviews was sporadic, and in the final year of his life, Mr Simpson refused to even discuss his COPD and refused all recommended tests to rule out lung cancer. Mr Simpson's choice not to engage was the only thing that impaired the application of NICE guidelines.

Emergency response

60. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called immediately when a medical emergency is called. Its provisions are mirrored in local policies at Wakefield. Wakefield's Medical Emergency Response Code Protocol specifically states that 'if a healthcare professional attends the scene and deems an ambulance is not required they must call the control room via the UHF radio and inform them to cancel the ambulance'.

61. We are satisfied that two officers responded promptly when a prisoner raised the alarm, and immediately called a code blue emergency. We are also satisfied that healthcare staff attended quickly.

62. The control room should have called an ambulance automatically as soon as the code blue was called, without waiting for anyone to clarify whether an ambulance was needed. However, this did not happen and a minute after the code blue was called, a CM told the control room that an ambulance was not required. This resulted in an almost five-minute delay before the control room finally called for an emergency ambulance.

63. The CM told the investigator that when she arrived at the scene, she asked one of the nurses if an ambulance was needed and was told 'no'. An officer also told the investigator that the CM asked one of the nurses if an ambulance was needed and was told 'no'. It has not been possible to verify this with the nurses who responded to the code blue.

64. Wakefield's Medical Emergency Response Code Protocol says that an ambulance should be called unless stood down by a healthcare professional, who should contact the control room themselves. Although the CM said she was acting on the advice of one of the nurse's present, she should not have been the one to stand down the ambulance.

65. Mr Simpson's had had a stroke, which, even without his pre-existing conditions, would have been very serious. He had an 18-month history of frailty, severe COPD and suspected lung cancer. The hospital concluded that Mr Simpson was not a candidate for surgery to treat the stroke, and the clinical reviewer considers that it is unlikely that the five-minute delay in calling an ambulance would have made a difference for Mr Simpson, and that the stroke was his 'final life event'.

66. Although the delay was unlikely to have changed the outcome for Mr Simpson, in future cases, it could be crucial. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff understand the procedures for responding to a medical emergency code so that there is no delay in calling an ambulance.

Sharing PPO findings

67. We consider it important that the findings of our investigations are shared with the staff involved. We, therefore, recommend:

The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141