

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Tracey Simpson, a prisoner at HMP Leeds, on 1 August 2021

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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

OGI

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Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Tracey Simpson died of ischaemic heart disease (heart problems caused by narrowed heart arteries) on 1 August 2021 while a prisoner at HMP Leeds. This was caused by coronary artery atheroma (a build-up of fatty deposits in the heart arteries). He was 58 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Simpson received at HMP Leeds was equivalent to that which he could have expected to receive in the community.
5. We did not identify any non-clinical issues of concern.

The Investigation Process

1. NHS England commissioned a clinical reviewer to review Mr Simpson's clinical care at HMP Leeds.
2. The PPO investigator has investigated non-clinical issues, including Mr Simpson's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
3. The PPO family liaison officer wrote to Mr Simpson's son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not reply.
4. We shared the initial report with the Prison Service. There were no reported factual inaccuracies.

Previous deaths at HMP Leeds

6. Twenty-two prisoners died at HMP Leeds in the two years before Mr Simpson's death. 14 of whom died from natural causes, seven were self-inflicted and one was drug-related. There have been four deaths from natural causes, one self-inflicted death and a death awaiting classification since Mr Simpson's death. There are no similarities between our findings in this investigation and those of the other deaths we have investigated.

Key Events

7. On 7 June 2017, Mr Tracey Simpson was sentenced to 20 years in prison for sex offences and was sent to prison. On 21 May 2021, he was transferred to HMP Leeds.
8. Mr Simpson lived in the complex care unit (a healthcare unit for prisoners with 24-hour social care needs) at Leeds. He had a significant medical history, including insulin-dependent diabetes, strokes, high blood pressure and reduced mobility. He used a walking frame and a wheelchair. Healthcare staff created a number of care plans for him, including for diabetes, catheter care, showers, falls, weight management, hypertension, and pressure sore management.

Events of 1 August

5. At about 5.45am on 1 August, a nurse saw Mr Simpson in his cell to check his welfare. She noted that he was comfortable, and she had no concerns.
6. A nurse said that she took Mr Simpson's medication to him and administered his insulin during the morning rounds.
7. A short while later, a Healthcare Assistant (HCA) saw Mr Simpson to support his personal and social care needs and take him his breakfast.
8. Shortly before midday, an officer took Mr Simpson his lunch. He appeared fine and began eating. She then completed a roll count of the unit. She had no concerns about Mr Simpson.
9. At about 3.27pm, a nurse went to Mr Simpson's cell with an officer and a Health Care Support Worker (HCSW) to administer his afternoon medication. The officer looked through the cell door observation panel and said that Mr Simpson looked like he had died. The officer radioed a medical emergency code blue (which indicates that a prisoner is unconscious or having difficulty breathing).
10. The nurse, officer and HCSW went into the cell. The nurse checked Mr Simpson for signs of life but found none. He was pale and cold to the touch, with signs of vomit on and around him. She said that she did not start cardiopulmonary resuscitation (CPR) because it was obvious that Mr Simpson had died.
11. At 3.40pm, ambulance paramedics were at his side and at 3.50pm, pronounced that he had died.

Post-mortem report

12. A post-mortem examination established that Mr Simpson died from ischaemic heart disease caused by coronary artery atheroma.

Sue McAllister, CB
Prisons and Probation Ombudsman

March 2022

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