

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Wayne Simpkins, a prisoner at HMP Lincoln, on 22 December 2020**

**A report by the Prisons and Probation Ombudsman**



## 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



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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.

Our 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 Wayne Simpkins died in hospital on 22 December 2020, after being found hanging in his cell at HMP Lincoln the previous day. He was 46 years old. I offer my condolences to Mr Simpkins' family and friends.

Mr Simpkins was sentenced to two years in prison on 4 November 2020. Two days later, staff started suicide and self-harm monitoring (known as ACCT) after Mr Simpkins told staff that he wanted to die because he felt guilty about his offence. On 11 November, Mr Simpkins tried to hang himself. Staff discovered him while he was still breathing and he recovered in hospital. Mr Simpkins returned to the prison a week later and staff continued ACCT monitoring until 27 November. Mr Simpkins was not being monitored when he died.

I am concerned that staff stopped ACCT monitoring prematurely on 27 November. Mr Simpkins was still showing high levels of anxiety at the time and continued to have panic attacks, which had led him to self-harm previously. His panic attacks worsened around a week before his death and yet no one considered restarting ACCT monitoring. This was a missed opportunity to put support in place.

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**

**August 2021**

## **Contents**

Summary .....	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	5
Findings .....	13

# Summary

## Events

1. On 1 May 2020, Mr Wayne Simpkins was remanded in prison custody charged with arson and possession of drugs, and sent to HMP Lincoln. This was his first time in prison.
2. On 22 May, staff started suicide prevention monitoring (known as ACCT) because they had concerns about Mr Simpkins' mental health due to his strange behaviour. He had been abusive to prisoners and staff and had acted inappropriately towards female nurses. Staff stopped ACCT monitoring on 23 May, but mental health staff continued to support Mr Simpkins.
3. Mr Simpkins' behaviour continued to be challenging for several weeks and included trying to drag an officer into his cell, flooding his cell and dirty protests. However, his behaviour improved from July, after he started taking antipsychotic medication, and he remained stable for the next few months.
4. Mr Simpkins was sentenced to two years imprisonment on 4 November. On 6 November, staff started ACCT monitoring after Mr Simpkins told them he wanted to die because of the guilt he felt. On 11 November, staff found Mr Simpkins hanging from his sink. He was unresponsive but breathing and was taken to hospital where he recovered. He returned to Lincoln a week later. Staff stopped ACCT monitoring on 27 November.
5. At around 1.45pm on 21 December, during welfare checks, an officer found Mr Simpkins hanging from the window bars in his cell. Staff immediately went into the cell and started cardiopulmonary resuscitation (CPR). Mr Simpkins was taken to hospital but died the next day.

## Findings

6. Mr Simpkins was acutely mentally unwell during May and June. The mental health team provided very good support and staff managed him well during that period.
7. We are concerned that staff stopped ACCT monitoring too soon on 27 November. Mr Simpkins continued to have panic attacks at the time, which had led him to self-harm previously. We consider that staff overlooked this significant risk factor and placed too much reliance on Mr Simpkins' own statements that he had no thoughts of suicide or self-harm. We also identified a couple of deficiencies in the way the ACCT monitoring was managed.
8. The clinical reviewer found that mental health staff failed to carry out a Generalised Anxiety Disorder (GAD7) assessment when Mr Simpkins reported frequent panic attacks.

## Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national policy, in particular staff should:
  - hold multidisciplinary case reviews wherever possible, to include healthcare staff where appropriate;
  - assess risk based on the prisoner's risk factors and behaviour, not what the prisoner tells them;
  - mark caremap actions as complete only once they have been fully actioned;
  - consider whether the prisoner needs the protective factor of a cellmate, including prisoners who have been assessed as high risk on their Cell Sharing Risk Assessment (CSRA).
- The Head of Healthcare should ensure GAD7 assessments are carried out when a prisoner is complaining or exhibiting anxiety and panic attacks.

## The Investigation Process

9. The investigator, issued notices to staff and prisoners at HMP Lincoln informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Simpkins' prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Simpkins' clinical care at the prison. The investigator interviewed staff on 25, 27 and 28 January and 8 February. The investigator and the clinical reviewer jointly interviewed healthcare staff on 27 January. Due to coronavirus restrictions, all interviews were conducted by telephone and video.
12. We informed HM Coroner for Central Lincolnshire of the investigation. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Simpkins' family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked what Mr Simpkins did between his last telephone call to his mother on 21 December and his death, and whether we could say why he had taken his own life. We have addressed these questions in this report.
14. We shared our initial report with HM Prison and Probation Service (HMPPS). They pointed out two factual inaccuracies which have been amended in this report. They provided an action plan which is annexed to this report.
15. We provided Mr Simpkins' next of kin with a copy of our initial report. They did not raise any issues or comment on the factual accuracy of the report.

## Background Information

### HMP Lincoln

16. HMP Lincoln holds up to 729 remanded and convicted men. It serves the courts of Lincolnshire, Nottinghamshire and Humberside. It has four residential wings, including a Vulnerable Prisoners Unit. Nottingham Healthcare NHS Trust provides health services and there is 24-hour nursing cover.

### HM Inspectorate of Prisons

17. The most recent inspection of HMP Lincoln was in December 2019/January 2020. Inspectors reported that Lincoln was a much safer prison since their last inspection in 2017, though there had been two self-inflicted deaths since then. Inspectors said that the prison's approach to prisoners in crisis was good, and they had implemented previous PPO recommendations.
18. The inspectors found that prisoners and staff had a good relationship, which was a real strength.

### 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 the year to 31 January 2020, the IMB reported on a slight decrease in the level of self-harm, but it remained high. The Board praised the day-to-day management of the Care and Separation Unit (CSU) and said the care given to prisoners was of a high standard.

### Previous deaths at HMP Lincoln

20. Mr Simpkins was the seventh prisoner to die at Lincoln since December 2018. Of the previous deaths, three were self-inflicted, and three were from natural causes. We found no similarities between our findings from our investigation into Mr Simpkins' death and our findings from our investigations into the previous deaths.

### Assessment, Care in Custody and Teamwork

21. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses 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 at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap 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 until all the actions are completed.

## Key Events

22. Mr Simpkins was remanded in prison custody on 1 May 2020, charged with arson and possession of drugs, and sent to HMP Lincoln. He had a long history of anxiety and depression and was prescribed amitriptyline (an antidepressant).

### *First ACCT: 22 to 23 May*

23. On 22 May, staff started suicide and self-harm monitoring (known as ACCT) because of concerns about Mr Simpkins' mental state. He had been acting strangely, been abusive to staff and prisoners and had made sexually inappropriate comments to several nurses.
24. On 23 May, a supervising officer held an ACCT review with Mr Simpkins. Two prison officers and a mental health nurse, attended. Staff agreed that Mr Simpkins needed mental health support but that his risk of suicide and self-harm was low and that he did not need to be supported using ACCT. Staff closed the ACCT and scheduled a post-closure review for 30 May.
25. The mental health nurse put in place a mental health support plan which included daily checks by mental health staff.

### *25 May to October*

26. On 25 May, staff restrained Mr Simpkins after he tried to pull a female member of staff into his cell. Staff moved Mr Simpkins to A Wing. His behaviour continued to be unsettled over the next few days. He flooded his cell, he was naked for much of the time and he threw urine at staff through his observation panel. Nurses and a prison psychiatrist visited Mr Simpkins but they noted it was difficult to have a meaningful conversation with him as he seemed paranoid with disordered thoughts. The psychiatrist wanted to prescribe antipsychotic medication but Mr Simpkins had to have a blood test first, which he had refused. On 27 May, Mr Simpkins continued to flood his cell and began a dirty protest. He was moved to the Care and Separation Unit (CSU – the segregation unit).
27. Staff held an ad hoc case review with Mr Simpkins. He agreed he needed mental health support but said he had no thoughts of suicide or self-harm. Staff agreed that the ACCT did not need to be reopened as Mr Simpkins would be checked frequently in the CSU and have mental health support.
28. On 28 May, after Mr Simpkins had consented to a blood test which was normal, the prison psychiatrist prescribed olanzapine (an antipsychotic). Mr Simpkins did not take the medication initially and continued to act strangely. A custodial manager met Mr Simpkins for an ACCT post-closure interview on 30 May. Mr Simpkins said he had no thoughts of suicide or self-harm and the ACCT remained closed.
29. The mental health team discussed Mr Simpkins at a meeting on 2 June. The team had differing views on prescribing Mr Simpkins antipsychotic medication, due to his fluctuating mental capacity. The prison psychiatrist said he would re-prescribe Mr Simpkins olanzapine, and it was the responsibility of the nursing staff administering this daily, whether Mr Simpkins had capacity to accept the medication or not. The psychiatrist agreed to refer Mr Simpkins for an assessment of his suitability to transfer to a secure psychiatric hospital.

30. On 10 June, Mr Simpkins was given olanzapine for the first time. Once Mr Simpkins was taking olanzapine regularly, his behaviour improved. On 26 June, he was moved back to A Wing.
31. A consultant psychiatrist interviewed Mr Simpkins on 1 July, to assess his suitability to transfer to a medium secure psychiatric hospital. His report concluded that Mr Simpkins had acute psychosis associated with substance misuse and that he did not require transfer to a hospital.
32. Throughout July, Mr Simpkins appeared much more settled. He remained on a nurse's caseload and continued to be monitored regularly. On 10 August, Mr Simpkins had improved so much that the mental health team agreed to discuss him every four weeks, rather than weekly. Mr Simpkins regularly took his antipsychotic medication and appeared much better.
33. Mr Simpkins was described as "doing well" and "stable" during a mental health team meeting on 5 October. During a meeting with the first nurse on 29 October, Mr Simpkins spoke of having daily contact with his daughter, a good relationship with both his son and daughter, and that he hoped to re-establish a relationship with his mother once he was sentenced (the arson offence was against his mother's property).

*Second ACCT: 6 – 27 November*

34. On 4 November, Mr Simpkins was sentenced to two years imprisonment. Two days later, on 6 November, Mr Simpkins told staff he wanted to die because he felt guilty about what he had done to his mother and was scared about what his family would do to him. He said he was having panic attacks, was not eating or sleeping and thought about suicide all the time. Staff set observations at one an hour.
35. A senior prison officer chaired the first case review on 7 November. Mr Simpkins, a nurse and a safer custody officer attended. Mr Simpkins said he could not forgive himself for what he had done to his mother, though his daughter had told him his mother had forgiven him. Mr Simpkins said he was happy on A Wing and had no issues, but he was not eating or drinking much, and his mind was racing while in his cell with nothing to do. Staff increased observations to two an hour. The senior prison officer noted on the caremap that staff would encourage Mr Simpkins to eat and drink, and provide in cell activity packs.
36. Later that day, Mr Simpkins said he had illicitly traded his vape for six mirtazapine (antidepressant) tablets which he had taken. Healthcare staff checked Mr Simpkins. The senior prison officer held an ad hoc ACCT case review. He increased Mr Simpkins' observations to three an hour and removed all medication and anything sharp from Mr Simpkins' cell. The nurse saw Mr Simpkins that evening. Mr Simpkins told him he had no further thoughts of suicide or self-harm but could not guarantee his own safety. Mr Simpkins said he still felt guilty about his offence. Shortly afterwards, wing staff asked another nurse to examine Mr Simpkins as he was shaking and his heart rate was high. The second nurse advised him on breathing techniques. Mr Simpkins asked whether she could give him anything to help him sleep, but this was not possible after taking six mirtazapine tablets.

37. The first nurse saw Mr Simpkins the next day, 8 November. Mr Simpkins reported feelings of anxiety and panic. Although he said he had no thoughts of harming himself, he said he did not want to be left alone, though he accepted that he would be. The first nurse reassured him that staff would check him three times an hour, and he could talk to them. That afternoon, A Wing staff asked healthcare staff to see Mr Simpkins, as he was having a panic attack. The second nurse saw Mr Simpkins on the wing. She noted that he kept his head down, gave minimal eye contact and said his “head has gone”. She reminded him how to use breathing techniques and told him to focus on positive factors. She noted that Mr Simpkins needed to see a doctor or psychiatrist for a medication review.
38. On 9 November, staff saw Mr Simpkins in his cell with a lanyard loosely tied around his neck. He was not physically hurt. The senior officer held another ad hoc case review with a safer custody officer and Mr Simpkins’ key worker present. The nursing matron noted in Mr Simpkins’ medical record that nobody had asked a member of healthcare staff to attend this case review. Mr Simpkins said he had been having a panic attack and putting pressure around his neck helped to calm him down. The senior officer agreed that Mr Simpkins could help the wing cleaners for the day to keep him busy, which would distract him. Mr Simpkins said he had no current thoughts of suicide or self-harm. Staff kept observations at three an hour and scheduled the next ACCT review for 11 November. Mr Simpkins kept his lanyard.
39. Later that afternoon, Mr Simpkins told staff he had “nibbled on a bleach tablet” (chlorine tablet). Mr Simpkins told healthcare staff he was sick of having panic attacks.
40. On 11 November, an officer noted the ACCT on-going record to say that Mr Simpkins had seemed in a happy mood and had been helping with the cleaning on the wing. He returned to his cell at 11.09 am, and tried to telephone his daughter but was unable to. He said he thought his daughter had blocked him. (This was the case as his daughter had asked for her number to be removed from his PIN.) At 12.15pm, an officer checked Mr Simpkins and found him with a lanyard tied around his neck and tied to the sink in his cell. Staff called an emergency code blue (indicating a prisoner is not breathing or is having difficulty breathing) and went into the cell. They cut the ligature which had made a mark on his neck and laid him in the recovery position. Mr Simpkins was breathing but unresponsive. He had left a letter in his cell for his mother.
41. Mr Simpkins was taken to hospital where he was put into an induced coma. Hospital doctors were concerned that Mr Simpkins might have been under the influence of illicit substances when he was admitted, but this could not be established. Mr Simpkins improved and was well enough to return to Lincoln on 16 November.
42. A nurse saw Mr Simpkins in reception when he returned. He said he felt well, but anxious. He was located in the Reverse Cohorting Unit (RCU – all newly arrived prisoners, and those returning from hospital, must stay in the RCU for 14 days to try to limit the spread of COVID-19).
43. a custody manager chaired an enhanced ACCT review later the same day. (The enhanced process is used for more complex cases and involves more senior staff.) Mr Simpkins and a nurse attended. Mr Simpkins appeared very tearful and staff

assessed his risk as raised. Mr Simpkins said he felt 'okay' and that having been in hospital he realised he did not want to die and was now in a much better place. Mr Simpkins understood that he must remain on the RCU for 14 days but asked if he could return to A Wing afterwards and have a cleaning job. The custody manager said they would discuss this when he had completed his time in the RCU. Mr Simpkins said he wanted to rebuild his relationship with his mother and it was agreed that he would apply to the Offender Management Unit to see if he could have the restriction on contact lifted. Staff increased observations to four an hour.

44. The psychiatrist and a nurse saw Mr Simpkins the next day, 17 November. Mr Simpkins told them he felt a lot better. He said that he had been doing okay until he had started to become increasingly anxious about the outcome of his court case. He had been having negative thoughts, difficulty sleeping and panic attacks. Mr Simpkins said he could not remember clearly what he had done when he committed his offence and thought he had been having a nervous breakdown at the time. The court case had brought back memories. Mr Simpkins said he was now sleeping better as he had been prescribed zopiclone (a sleeping pill) in hospital, which helped with his anxiety. Mr Simpkins was concerned that he was no longer in contact with his daughter but pleased that he had re-established contact with his mother. He said he was looking forward to completing his sentence and found regular mental health reviews helpful. The psychiatrist noted that Mr Simpkins seemed in a good mood, with no evidence of thought disorder or delusions.
45. The custody officer held an enhanced case review on 17 November, with Mr Simpkins and with a nurse. The custody manager noted that Mr Simpkins looked well and happy and said he had had a good night's sleep. He had kept himself busy speaking with chaplaincy, healthcare and wing staff. He said he felt well supported and was happy that he had been permitted to contact his mother. He said C Wing seemed a lot calmer than A Wing and asked if he could stay on C Wing. The custody manager said this could be considered at the end of his time on RCU. Mr Simpkins said he would like a cellmate to chat to. He said he was high risk (in terms of cell sharing) but he did not know why. The custody manager advised him to apply to safer custody for them to explore why he was high risk and whether he could share a cell in the future. He added this as a caremap action. (As Mr Simpkins' offence was arson, he had been assessed as high risk to share a cell.) Staff assessed Mr Simpkins' risk of suicide or self-harm as low, and reduced observations to two an hour.
46. The second nurse met Mr Simpkins the next day. The second nurse noted that Mr Simpkins appeared engaged and relaxed and said that he was glad he had not died. He said he harmed himself in response to continual panic attacks and being unable to relax and sleep. He said the zopiclone had had a good effect on his mood and he was now sleeping, and his panic attacks had subsided. Mr Simpkins told the second nurse he had no thoughts of suicide or self-harm.
47. The custodial manager chaired an ACCT review with Mr Simpkins on 20 November. The second nurse attended. They discussed an issue with Mr Simpkins' medication, as he had not been given it the night before and had to put on his cell bell to remind staff, which had made him anxious. The second nurse said this should not have happened and it had now been resolved. Mr Simpkins said he had felt quite well over the past few days. He said his daughter was now in contact with him, as well as his mother. The custodial manager noted that family support was

Mr Simpkins' protective factor. Staff assessed Mr Simpkins' risk as low, and reduced observations to three irregular observations throughout the night, and a conversation every morning, afternoon and evening. Staff also decided that Mr Simpkins no longer needed to be managed under the enhanced ACCT process and that a super would take over as case manager.

48. On 24 November, Mr Simpkins mentioned to a third nurse that he had experienced "flutters" in his chest earlier that day due to anxiety. The third nurse noted that Mr Simpkins seemed positive and discussed future events. She checked his pulse, oxygen level and blood pressure, which were all normal.
49. On 26 November, Mr Simpkins told Nurse Pattinson that his zopiclone had been stopped and his anxiety was increasing. A fourth nurse sent a message to the pharmacy. The first nurse assessed Mr Simpkins later that day. Mr Simpkins repeated that he felt anxious about his medication being stopped, and reported that his sleep was deteriorating, while his anxiety was rising. The first nurse advised him that zopiclone had been requested for him. This was resolved later that day.
50. A senior prison officer chaired another ACCT review on 27 November. A custodial manager provided a verbal report and a nurse attended. Mr Simpkins said he was doing well, although he still had panic attacks. He said he did not know why he got them, as he was not worrying about anything in particular. The third nurse explained some grounding techniques and Mr Simpkins agreed to try them. Mr Simpkins said he spoke to his mother twice a day, had built a good support network with his family and had absolutely no thoughts of suicide or self-harm. Everyone agreed that Mr Simpkins had improved significantly and they closed the ACCT. The senior officer scheduled a post-closure review for 4 December.

#### *29 November to 20 December*

51. On 29 November, Mr Simpkins reported to the third nurse that he had been having panic attacks and was unable to distract himself. This nurse discussed grounding techniques again and wrote them down for him. The second nurse met Mr Simpkins in his cell on 1 December. Mr Simpkins appeared relaxed and was doing a word search. Mr Simpkins spoke of daily contact with his mother and communicating with his daughter through her. He said zopiclone had been prescribed again and his anxiety had lessened. Mr Simpkins said he had no thoughts of suicide or self-harm.
52. The senior officer carried out an ACCT post-closure interview with Mr Simpkins on 4 December. Mr Simpkins said he had no issues, had support and spoke to his mother daily. Mr Simpkins said he would approach staff if he needed additional support. Mr Simpkins had not been allocated any work or activities due to the restricted COVID-19 regime, but said he kept himself occupied reading and doing puzzles. It was agreed that the ACCT would remain closed.
53. On 7 December, Mr Simpkins took a COVID-19 test, and on 9 December, the result came back as positive, although Mr Simpkins did not feel unwell. Staff created a COVID-19 care plan, which included a seven-day period of isolation and daily welfare checks in the Protective Isolation Unit (PIU). It was noted on 11 December, that Mr Simpkins felt fit and well, with no COVID-19 symptoms. Healthcare staff checked Mr Simpkins daily. Mr Simpkins returned to a single cell on C Wing, following his period of isolation.

54. A fifth nurse was asked to see Mr Simpkins on 17 December, because he was having a panic attack. On his arrival Mr Simpkins had stopped panicking but was crying. He explained he was panicking about his mother's health as she had lung disease. The fifth nurse suggested Mr Simpkins telephone his mother to see how she was. Mr Simpkins agreed and appeared to calm down.
55. The second nurse met Mr Simpkins the next day. He noted in Mr Simpkins' medical record that he was anxious and having frequent panic attacks about his mother's health, especially when she sounded breathless on the telephone. They discussed relaxation techniques and Mr Simpkins asked for a medication review. He said he had no thoughts of suicide or self-harm.
56. A sixth nurse was asked to check Mr Simpkins during the early hours of 19 December, because he had been seen clutching his chest in his cell. The sixth nurse examined Mr Simpkins, whose blood pressure was raised, and he appeared shaky. The sixth nurse told him he was having a panic attack, and this was not a cardiac event. A few hours later, wing staff called the sixth nurse to see Mr Simpkins again because he was complaining about back pain. Mr Simpkins said he felt breathless but did not seem to be struggling to breathe. The sixth nurse gave Mr Simpkins paracetamol for back pain.
57. Later, on 19 December, Mr Simpkins saw the sixth nurse. He told her he had been having panic attacks, but this felt different. He complained of chest and back pain, and a pain radiating down his left arm. Although he looked grey, he had no shortness of breath or difficulty in moving. The sixth nurse said she would request an electrocardiogram (ECG). All his vital signs were normal. The sixth nurse checked on Mr Simpkins throughout the day and Mr Simpkins was escorted to Lincoln County Hospital for an ECG that evening. He also had a chest X-ray and blood tests, all of which were clear. He returned to prison that night and said he felt relieved about his results.
58. The sixth nurse checked Mr Simpkins the next morning, 20 December. He said he still felt unwell but could not describe in what way. The sixth nurse noted that Mr Simpkins was due for a medication review and to discuss his anxiety in four days' time. She encouraged him to do some colouring or word searches to try to distract himself, and that he should ask for a member of healthcare if he began to feel worse.
59. Mr Simpkins telephoned his mother at 10.42am, on 20 December. He said he had been taken to hospital the night before due to his panicking and was going to see a doctor on Thursday (24 December) for a medication review and to talk about his anxiety. Mr Simpkins' mother said he needed to learn to control his anxiety. Mr Simpkins replied that it was hard, and he needed medication. Mr Simpkins said he was missing his daughter and felt upset.
60. Mr Simpkins telephoned his mother again later that evening. They chatted generally, and Mr Simpkins told her he had been panicking again and was waiting for the medication to help him sleep (zopiclone). His mother said she would send him something to cheer him up and Mr Simpkins said, "Don't worry, I'll cheer up."

*21 December*

61. Mr Simpkins telephoned his mother at 11.00am, on 21 December. They talked generally, and his mother asked if he was okay. Mr Simpkins replied, “not really” but did not elaborate, and said he would call her again later.
62. A prison officer spoke to Mr Simpkins that morning. Mr Simpkins had returned to the wing from the exercise yard, because he said it was too cold. They laughed together and Mr Simpkins went into his cell.
63. Later that morning, A second prison officer saw Mr Simpkins when he collected his lunch from the servery. This second prison officer said “hello” and Mr Simpkins smiled and replied “alright”. He then took his lunch back to his cell.
64. Mr Simpkins rang his cell bell at 11.58am. Staff could not remember who responded to the bell but said they would have remembered if Mr Simpkins had had an issue. Staff carried out a roll check on all prisoners at approximately 12.30pm and raised no issues. There is no CCTV on the wing so we were unable to confirm that Mr Simpkins’ cell was included in the roll check or who carried it out.
65. At approximately 1.30pm, a third prison officer had started a late shift and began carrying out welfare checks on C Wing, checking that all prisoners were safe and well by getting a response from them. This third prison officer arrived at Mr Simpkins’ cell at approximately 1.45pm, and saw he was hanging from the window frame, by a bedsheet, facing the cell door. She was not carrying a radio, so she shouted for staff assistance.
66. The second prison officer and a fourth prison officer heard the third prison officer’s shout for assistance and ran to Mr Simpkins’ cell. As soon as the officers arrived the third prison officer opened the cell door. A fifth prison officer radioed a code blue emergency call. Once inside, the second prison officer lifted Mr Simpkins to try to support his weight, while the third officer used her anti-ligature knife to cut the ligature. They then laid Mr Simpkins on the ground. The third prison officer recalled Mr Simpkins felt limp and looked grey. The second prison officer felt for a pulse in Mr Simpkins neck but did not find one. The fourth prison officer began cardiopulmonary resuscitation (CPR) by starting chest compressions. The second prison officer used his face mask to give rescue breaths. The second prison officer took over chest compressions from the fourth prison officer.
67. Two paramedics, working at Lincoln, had heard the emergency code blue call and arrived at the cell at 1.50pm, and took over CPR. They attached a defibrillator, which indicated no shock was required. Paramedics arrived at the cell at 1.59pm, and checked Mr Simpkins observations while CPR was ongoing. At 2.05pm, more paramedics arrived with a HEMMS (Helicopter) doctor. They moved Mr Simpkins onto the landing for more space, and paramedics attached their automatic defibrillator and ventilator. They also administered adrenaline. At 2.16pm, paramedics confirmed Mr Simpkins had a pulse. He was moved to the waiting ambulance at 2.38pm and taken to Lincoln County Hospital eight minutes later.
68. On 22 December, officers who were with Mr Simpkins at hospital telephoned the prison to tell them that Mr Simpkins had died at 8.40am.

### **Contact with Mr Simpkins' family**

69. A senior officer was appointed as family liaison officer. She had already spoken to Mr Simpkins' mother, following his self-harm on 11 November. On 21 December, the senior officer telephoned Mr Simpkins mother and explained that he was in hospital. The senior officer offered to arrange for her to visit the hospital, but she said she could not attend because she was in poor health. The senior officer rang other family members to see if they could sit with Mr Simpkins mother, as she was on her own, and remained in frequent contact with her.
70. The prison contributed to the cost of Mr Simpkins' funeral, in line with national guidelines.

### **Support for prisoners and staff**

71. After Mr Simpkins' death, a senior prison officer debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
72. The prison posted notices informing other prisoners of Mr Simpkins' 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 Simpkins' death.

### **Post-mortem report**

73. The coroner had not provided us with Mr Simpkins' full post-mortem and toxicology reports at the time of issuing this report, but a preliminary post-mortem report dated 5 January, noted Mr Simpkins' death was due to hypoxic brain injury, cardiorespiratory arrest and ligature suspension.

# Findings

## Mr Simpkins' risk of suicide or self-harm

74. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that staff should follow when they identify that a prisoner is at risk of suicide and self-harm.
75. Mr Simpkins was monitored under ACCT twice while at Lincoln: in May 2020, when staff became concerned about his strange behaviour, and in November 2020, after he was sentenced and said he wanted to die.
76. We consider that the ACCT procedures in May were well managed. However, we are concerned that the second ACCT was closed prematurely on 27 November. Mr Simpkins was still having panic attacks at the time and this was a clear trigger for self-harm for him. After Mr Simpkins was found with a lanyard tied around his neck on 9 November, he told staff that he had done it because he was having a panic attack and putting pressure around his neck helped to calm him down. He also told the second nurse that the incident on 11 November, when he tied a ligature around his neck, was found unresponsive and taken to hospital, was due to him having continual panic attacks and not being able to relax and sleep.
77. Mr Simpkins' panic attacks became markedly worse from 17 December onwards. We are concerned that no one considered starting ACCT procedures again at this point, given the previous link between Mr Simpkins' panic attacks and his self-harm. We consider that staff placed too much reliance on Mr Simpkins' own statements that he had no thoughts of suicide and self-harm, rather than his risk factors and past behaviour.
78. We also have some concerns about aspects of the ACCT management. On 17 November at an ACCT review, Mr Simpkins said that he would like a cellmate to chat to. He said that he had been assessed as high risk in terms of cell sharing but did not know why. The custody manager told Mr Simpkins to apply to safer custody for them to explore why he was high risk and whether he could share a cell in the future. The custody manager added it as a caremap action and it was signed off as completed on 20 November. However, we have seen no evidence that Mr Simpkins submitted an application.
79. PSI 20/2015, The cell sharing risk assessment, says:

'Where a prisoner is assessed as CSRA [Cell Sharing Risk Assessment] high risk but is also self-harming, and it is felt appropriate for the prisoner to share a cell to provide a measure of peer support, it will be for managers responsible for the prisoner's care to balance the safety of both prisoners.'
80. We consider that staff should have looked into the possibility of Mr Simpkins sharing a cell and not put the onus solely on him to apply to safer custody for a review of his CSRA. It is recognised that having a cellmate is a protective factor against suicide and self-harm. Not only that, but Mr Simpkins had previously told his mental health nurse that he did not like being on his own, so the ACCT review on 17 November was not the first time he had raised this. We accept that Mr

Simpkins had been assessed as high risk for a cell share due to his offence but as PSI 20/2015 makes clear, this is not an automatic bar to a cell share where it is deemed necessary for support purposes and where it can be managed safely. Staff should at the very least have considered whether a cell share would be possible and if not, this could have been communicated to Mr Simpkins so he knew it had been considered.

81. We also note that no healthcare staff were invited to attend Mr Simpkins' ad hoc ACCT review on 9 November. PSI 64/2011 says that ACCT case reviews should be multidisciplinary wherever possible and we consider it would have been very important to have healthcare input at that stage.

82. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national policy, in particular staff should:

- hold multidisciplinary case reviews wherever possible, to include healthcare staff where appropriate;
- assess risk based on the prisoner's risk factors and behaviour, not what the prisoner tells them;
- mark caremap actions as complete only once they have been fully actioned;
- consider whether the prisoner needs the protective factor of a cellmate, including prisoners who have been assessed as high risk on their Cell Sharing Risk Assessment (CSRA).

### **Mental health care**

83. We consider Mr Simpkins' mental health was well managed, particularly surrounding his capacity to make decisions and understand his treatment. This was in line with the Mental Capacity Act 2005 and should be commended.

84. However, on several occasions Mr Simpkins expressed concern about feeling anxious and having panic attacks, particularly in the week before he died. There is no evidence that healthcare staff completed a GAD 7 (Generalised Anxiety Disorder Assessment) for Mr Simpkins to measure the severity of anxiety, nor did anyone consider opening an ACCT. The clinical reviewer concluded this was a deficiency of care. We make the following recommendation:

The Head of Healthcare should ensure GAD7 assessments are carried out when a prisoner is complaining of, or exhibiting, anxiety and panic attacks.

**Prisons &  
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