Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Simon Fell, a prisoner at HMP Wymott, on 29 January 2023

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

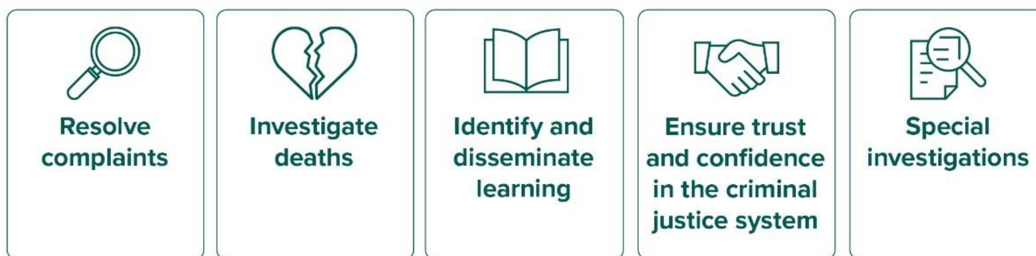
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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

© Crown copyright, 2023

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

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

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. 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.

3. Mr Simon Fell died on 29 January 2023, of heart disease at HMP Wymott. He was 60 years old. We offer our condolences to Mr Fell's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Fell received at Wymott was equivalent to what he could have expected to receive in the community. She made no recommendations.

5. We found no non-clinical issues of concern.

The Investigation Process

6. HMPPS notified us of Mr Fell's death on 30 January 2023. The PPO investigator issued notices to staff and prisoners at HMP Wymott informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded with information about his limited contact with Mr Fell.

7. The investigator obtained copies of relevant extracts from Mr Fell's prison and medical records and investigated the non-clinical issues relating to Mr Fell's care.

8. NHS England commissioned an independent clinical reviewer to review Mr Fell's clinical care at the prison. The clinical reviewer's report is annexed.

9. We informed HM Coroner for Lancashire and Blackburn with Darwen of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

10. The Ombudsman's family liaison officer contacted Mr Fell's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She said that she was concerned that her father had not received his blood pressure medication and wanted to know what had happened to him, because when he collapsed he had a head injury. We have addressed these issues in this report and the clinical review.

11. Mr Fell's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Previous deaths at HMP Wymott

13. Mr Fell was the 22nd prisoner to die at Wymott since January 2020. Of the previous deaths, 20 were from natural causes, one was self-inflicted and one was drug-related. There have been five natural causes death since. There are no significant similarities between Mr Fell's death and the other deaths at the prison.

Key Events

14. On 1 March 1996, Mr Simon Fell was sentenced to life imprisonment for murder and received a 15 year tariff. Mr Fell spent time in several prisons and on 4 April 2019, he was transferred to HMP Wymott.

15. When Mr Fell arrived at Wymott, he already had several health problems. These included hypertension (high blood pressure diagnosed from 2011), high cholesterol and asthma. For several years, Mr Fell believed he had a degenerative eye condition and always wore dark glasses and a cap as he believed exposure to light could cause complete blindness (there was no medical evidence to support his concerns so this was treated as a mental health issue).

16. Prison staff allocated Mr Fell a single occupancy cell.

17. Healthcare staff saw him frequently to manage his longstanding blood pressure and asthma problems. The clinical reviewer found that healthcare staff at Wymott created appropriate care plans and made appropriate hospital referrals.

18. The clinical reviewer noted that Mr Fell was not formally diagnosed with a mental illness or prescribed any medication for his mental health. However, he needed significant support and had several assessments of his mental state.

19. In his written statement, Operational Support Grade (OSG) said that at approximately 9.00pm on 28 January 2023, he saw Mr Fell in his cell and they greeted each other. The OSG noted that the rest of the night was peaceful.

Events of 29 January 2023

20. At approximately 5.00am and 6.20am, the OSG completed a routine check and did not notice anything of concern. At 8:30am, Officer A also completed a routine and welfare check and did not notice anything untoward.

21. At 8.45am, Officer B started unlocking the cell doors. When he arrived outside Mr Fell's door he opened the observation panel and looked inside, but he could not see Mr Fell on the bed. He shouted into the cell, opened the door and put the cell light on. He saw Mr Fell wedged between the side of his bed and the table next to it. He checked for a pulse, could not find one and noted Mr Fell was cold to touch. He radioed an emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties), then tried to move Mr Fell, but was unable to do so because of the position he was in.

22. Officers, managers and prison nurses arrived at the cell. The custodial manager moved the table so the staff could move Mr Fell to the centre of the cell. The nurse arrived and noted that there were no signs of life. Paramedics attended and, at 9.16am confirmed that Mr Fell had died.

23. Police and a Crime Scene Investigation Team conducted an investigation into the circumstances of Mr Fell's death. They interviewed staff and viewed the CCTV. The police were satisfied that all routine and welfare checks that were conducted during the night until Mr Fell was found were completed correctly.

Post-mortem report

24. A post-mortem examination gave Mr Fell's cause of death as a cardiac incident due to atheromatous coronary vascular disease (thickening or hardening of the arteries) and left ventricular hypertrophy (thickening of the wall of the heart's main pumping chamber), which was caused by hypertension (high blood pressure).

25. The post-mortem report noted that Mr Fell was found lying between the cell bed and a table and there was blood on the right side of Mr Fell's face, on the bed and the floor. The police confirmed that there was no evidence that Mr Fell had been assaulted which caused or contributed to his death. The post-mortem report concluded that there was no trauma related to Mr Fell's death.

26. At the inquest held on 20 October 2023, the coroner concluded that Mr Fell died of natural causes.

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

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T l 020 7633 4100