

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

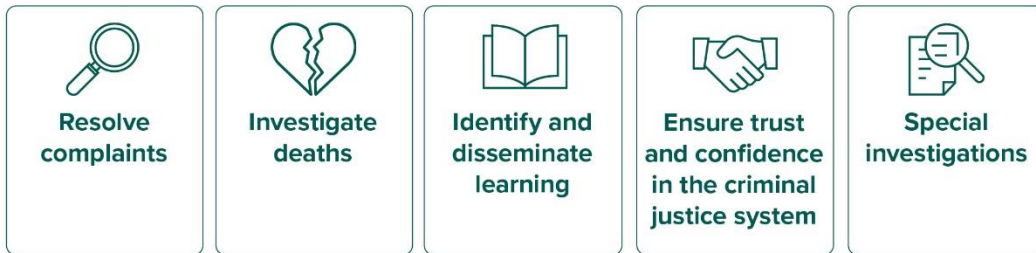
# **Independent investigation into the death of Mr Robert Simmons, a prisoner at HMP Cardiff, on 20 July 2021**

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

## 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, 2024

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](https://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. 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 Robert Simmons died in hospital on 20 July 2021, of septic shock while a prisoner at HMP Cardiff. He was 37 years old. I offer my condolences to Mr Simmons' family and friends.
4. The clinical reviewer concluded that the clinical care Mr Simmons received at HMP Cardiff was equivalent to that which he could have expected to receive in the community. He made two recommendations about recording physical observations and discharging prisoners from the prison's healthcare unit.
5. The clinical reviewer concluded that even if Mr Simmons physical observations had been completed and the discharging process from the healthcare unit had been more robust, it was unlikely to have or would not have changed the outcome for Mr Simmons.
6. We found no non-clinical issues of concern.

## Recommendations

- The Head of Healthcare should ensure that healthcare staff undertake and record a full set of physical observations to guide them in the management of prisoners who present with an illness.
- The Head of Healthcare should review the process of discharging prisoners from the healthcare unit onto the prison wings.

## **The Investigation Process**

7. Healthcare Inspectorate Wales commissioned an independent clinical reviewer to review Mr Simmons' clinical care at HMP Cardiff.
8. The PPO investigator has investigated the non-clinical issues, including, Mr Simmons' location, the security arrangements for his hospital escorts, liaison with his family, and whether compassionate release was considered.
9. The PPO family liaison officer wrote to Mr Simmons' next of kin, his aunt, to explain the investigation. She asked for a copy of our report.
10. Mr Simmons' family received a copy of the initial report. They raised several issues and questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
11. The initial report was shared with the Prison Service and the prison healthcare service. They did not find any factual inaccuracies.

## **Previous deaths at HMP Cardiff**

12. Mr Simmons was the seventh prisoner to die at HMP Cardiff since July 2019. Of the previous deaths, three were from natural causes and three were self-inflicted. There are no similarities between our findings in the investigation into Mr Simmons' death and our investigation findings for the previous deaths.

## Key Events

13. On 26 June 2020, Mr Robert Simmons was remanded to HMP Cardiff, charged with assault and theft. In July, he was sentenced at Cardiff Magistrates Court to 12 months imprisonment.
14. Mr Simmons had a history of substance misuse, including heroin, cannabis and amphetamines. He was under the care of Dyfodol, a community drug service, and had a prescription for methadone. On 24 December, Mr Simmons was released from prison, on licence.

### 2021

15. Mr Simmons was recalled to Cardiff on two occasions, on 3 June and 10 July 2021, for breaching the conditions of his licence and for shoplifting.
16. On 17 June, he was sentenced to six weeks imprisonment for handling stolen goods.
17. On 5 July, Mr Simmons saw his drug worker for a pre-release meeting. She gave him his appointment with community drug services and discussed relapse prevention. On 7 July, Mr Simmons was released on probation licence.
18. Following his recall to Cardiff on 10 July, a nurse saw Mr Simmons for his initial health screening. Mr Simmons told her that he had been taking benzodiazepines (psychoactive medications used to treat conditions including anxiety, depression and seizures) since his release, and that he was on a methadone prescription.
19. He told the nurse that he had not injected drugs for around a year. He also said that he had hurt his left leg running from the police. He was walking with a limp, but there was no sign of any swelling. A prison GP prescribed Mr Simmons pain relief. Later that day, a substance misuse nurse saw Mr Simmons and prescribed him methadone.
20. On 11 July, Mr Simmons had his second health screening. He also saw a mental health nurse. Mr Simmons told the nurse that he did not need the support of the prison's mental health service but said that he had pain in his left leg from intravenous drug use. She referred Mr Simmons to the nursing team.
21. That day, a nurse saw Mr Simmons. He told the nurse that he had hurt his leg running from the police. The nurse examined Mr Simmons' leg. There was no swelling, bruising or redness and the area was not hot to the touch. Mr Simmons had a full range of movement in his knee, and could bear weight on his leg, although it was painful. Mr Simmons said that the pain relief medication was not helping. The nurse advised him to rest and come back to nursing staff if it did not improve.
22. The next day, Mr Simmons saw his drug worker. He told her that the injury in his groin was from intravenous drug use. She noted that he had told nurses that the injury happened when he ran from the police. She shared this information with the healthcare team. She also referred Mr Simmons to Dyfodol.

23. On 13 July, a nurse and a prison GP saw Mr Simmons. Mr Simmons told them that he had injected heroin on 8 July and had pain in his leg and thigh. They were concerned that Mr Simmons might have deep vein thrombosis (DVT – a blood clot in the vein). They arranged for him to go to hospital for assessment at 12.30pm. At 12.40pm, Mr Simmons was taken to University Hospital Wales (UHW). He was escorted by two prison officers and was handcuffed using an escort chain.
24. In hospital, Mr Simmons had an ultrasound scan of his leg and blood tests were taken. At 7.15pm, a hospital doctor advised Mr Simmons that they wanted to keep him in overnight, but Mr Simmons declined. He was discharged from hospital with prescribed medication. He returned to the prison and was located on the prison's healthcare unit overnight.
25. On 14 July, a nurse saw Mr Simmons. Mr Simmons said that he was feeling much better and asked to return to his wing. That morning, Mr Simmons was discharged from the healthcare unit. However, the nurse did not complete or document any physical observations.
26. In the morning of 15 July, a nurse saw Mr Simmons in his cell. Mr Simmons told the nurse that his leg was swollen and causing him pain. He said that he had injected drugs on 8 July. The nurse examined the swollen area and noted it was mildly discoloured. Mr Simmons said that he was struggling to walk properly. The nurse sent a task for advice to the GP service.
27. Later that morning, a prison GP reviewed Mr Simmons' notes. She noted that the tests in hospital had found no evidence of DVT. She noted that he was on medication prescribed by the hospital, and that Mr Simmons needed to give the antibiotics at least 48 hours to be effective. In the meantime, he should rest. If there were any concerns, nursing staff should take observations and discuss this with a doctor.
28. On 16 July, a nurse saw Mr Simmons. She took his physical observations, and the results were normal. She did not document any physical examination of Mr Simmons' leg.

### **Events of 19 July**

29. At around 10.45am, on 19 July, a nurse went to see Mr Simmons in his cell. Mr Simmons had told prison officers that he had pain in his leg. The nurse assessed the wound in his groin and asked a prison GP to review him.
30. That afternoon, a prison GP saw Mr Simmons. She noted that his lower left leg was very swollen, and he was pale and confused. She was concerned he might have DVT. She arranged a hospital appointment for him at 4.00pm.
31. At around 3.30pm, a nurse went to see Mr Simmons. Mr Simmons' condition had worsened. He was pale and was lying in the recovery position to help his breathing. Prison officers said that Mr Simmons was unable to get out of bed.
32. At 3.37pm, the prison called for an ambulance, but it was not immediately available. Staff decided to send Mr Simmons out to hospital by taxi. At 4.10pm, Mr Simmons

was taken to hospital, escorted by two prison officers, and restrained using an escort chain.

33. Mr Simmons arrived at hospital at around 4.35pm and was admitted to the resuscitation unit. At 5.00pm, doctors requested that the restraints be removed, and this was authorised by a prison manager. Around 5.30pm, Mr Simmons became agitated and began to struggle with staff. Prison officers, assisted by hospital security staff, had to hold him to his hospital bed so that clinical staff could sedate him.
34. At around 6.40pm, doctors asked for Mr Simmons' next of kin, as they considered that he was seriously ill.
35. Around 7.30pm, the duty governor rang Mr Simmons' next of kin, his aunt. She told his aunt that Mr Simmons was in hospital and was unconscious. His aunt was happy for the prison to pass her contact details to the hospital. His aunt asked that when Mr Simmons became conscious, he should be told that she knew he was in hospital. This information was passed to the prison officers with Mr Simmons.
36. At around 8.00pm, Mr Simmons was taken by hospital staff to an operating theatre. Around 9.30pm, the prison healthcare rang the hospital. Hospital doctors advised that Mr Simmons had been diagnosed with necrotising fasciitis (a serious bacterial infection with a high mortality rate), was currently having surgery, and that it was likely he would lose a significant proportion of his left leg.
37. Following surgery at around 10.50pm, Mr Simmons was moved into the Intensive Therapy Unit.
38. At around 5.45am on 20 July, the escorting officers asked for an update on Mr Simmons' health. Hospital staff advised that he remained in an induced coma and was due a surgical review. Officers were told that it was likely that Mr Simmons' left leg would be amputated.
39. At 8.55am, hospital staff informed the escorting officers that at 8.50am, Mr Simmons had died during surgery.
40. At 9.55am, the prison appointed a family liaison officer (FLO). At 10.30am, the FLO rang Mr Simmons' aunt to tell her that Mr Simmons had died. Mr Simmons' aunt was shocked. The FLO felt that Mr Simmons' aunt had been expecting a call from the surgeon to advise on the outcome of the operation. The FLO then spoke to the hospital, who advised that the surgeon had not been able to contact the family as they had been called back into the operating theatre.
41. Over the following days, the FLO provided support and information to Mr Simmons' family. In line with national policy, the prison made a financial contribution to the cost of the funeral.

## **Cause of death**

42. The cause of death was provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Simmons' cause of death as septic shock (dangerously low blood pressure caused by sepsis) caused by gas

gangrene (a bacterial infection that releases gas causing gangrene) of the left leg extending to retroperitoneal space (part of the abdomen).

**Sue McAllister CB**  
**Prisons and Probation Ombudsman**

**June 2022**

## **Inquest**

The inquest, held on 7 July 2023, concluded that Mr Simmons died from natural causes.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

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

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100