

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Jamie Simmons, a prisoner at HMP Swaleside, on 4 March 2022**

**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



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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.

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 Jamie Simmons died in hospital of a hypoxic brain injury on 4 March 2022, after he was found hanging in his cell at HMP Swaleside on 26 February. He was 41 years old. I offer my condolences to his family and friends.

Mr Simmons was taken to hospital on 25 February, after he was found on the floor of his cell in a confused state and with a black eye and swollen face. He claimed that he had fallen out of bed and hit his head. At hospital, he was found to have secreted a mobile phone inside his body. He discharged himself and was placed in the segregation unit on his return to Swaleside that night. He was found hanging around an hour later.

I am satisfied that Mr Simmons gave no indication to staff that he was at risk of suicide or self-harm on 25/26 February, or in the period leading up to that. I am also satisfied that the decision to place him in segregation was a reasonable one in the circumstances.

I am concerned, however, that there was a nine-minute delay between an officer calling a medical emergency code when they discovered Mr Simmons and control room staff calling an ambulance. It is important that control room staff call an ambulance immediately when a medical emergency code is called.

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

**Kimberley Bingham**  
**Acting Prisons and Probation Ombudsman**

**January 2023**

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# Summary

## Events

1. Mr Jamie Simmons was serving a life sentence for murder. He was moved to HMP Swaleside on 8 January 2019.
2. Initially, Mr Simmons settled at Swaleside but as time went on, his behaviour deteriorated. Staff found him with fermenting liquid (hooch), psychoactive substances (PS), medication not prescribed to him and a mobile phone. Mr Simmons also assaulted another prisoner, and on many occasions, officers found weapons in Mr Simmons' cell. They suspected he was involved in the prison's drug trade.
3. On 29 December 2021, Mr Simmons was found under the influence of an illicit substance. That day, he told his key worker that he was struggling with his mental health. A mental health nurse assessed him on 31 December. She found no evidence of psychotic illness but referred him to the primary mental health team for support. However, Mr Simmons refused to engage with them and said he was fine.
4. On 25 February 2022, officers found Mr Simmons lying on the floor of his cell, with a black eye and swollen face. He said he had fallen out of bed and hit his face on the pipes. Staff thought that he might be under the influence of an illicit substance. Mr Simmons initially refused to go to hospital but, later in the day, decided to go. While at the hospital, an x-ray showed that Mr Simmons had secreted a mobile phone inside his body.
5. Mr Simmons discharged himself from hospital, and at around 1.00am on 26 February, he returned to Swaleside. An x-ray scan at the prison showed that Mr Simmons still had the mobile phone inside him. Therefore, prison staff sent him to the Care and Separation Unit (CSU, the segregation unit).
6. At 1.53am, an officer in the CSU responded to a prisoner's cell bell. The prisoner shouted that Mr Simmons needed to be checked. The officer could not get a response from Mr Simmons so called a medical emergency code at 1.55am. Officers arrived at Mr Simmons' cell first; the nurse was delayed as he needed to pick up the appropriate emergency bag from the healthcare department.
7. Officers found Mr Simmons had tied a ligature around his neck. They cut Mr Simmons down and started cardiopulmonary resuscitation (CPR). Control room staff called an ambulance at 2.04am and paramedics arrived at 2.18am. Mr Simmons was taken to hospital and placed in an induced coma. He died on 4 March, after his life support machine was turned off.
8. A post-mortem examination found Mr Simmons' cause of death was due to hanging.

## Findings

9. We are satisfied that Mr Simmons gave no indication to prison staff that he was at risk of suicide or self-harm on 26 February or in the period leading up to that. We are also satisfied that it was appropriate to place him in the CSU on his return from hospital.
10. There was an unreasonable delay of nine minutes between the officer calling the medical emergency code and the control room calling an ambulance. Control room staff should have called for an ambulance immediately.
11. Mr Simmons' mother complained that officers were at Mr Simmons' bedside when his family visited him in hospital. The prison said this was for security reasons in case items were passed to Mr Simmons for him to smuggle back into prison. While we accept that officers needed to be with Mr Simmons at hospital, we consider that as he was in an induced coma, they could have observed him from a distance without being at his bedside.
12. We are concerned that Swaleside was unable to provide us with CCTV footage for 25 February. They said the footage had been lost due to a problem with the CCTV system.
13. Swaleside was also unable to provide PIN phone recordings. They said no one was trained to download the recordings though someone has since been trained.
14. The clinical reviewer found that the standard of care Mr Simmons received at Swaleside was equivalent to that which he could have expected to receive in the community. However, he had concerns about the availability of emergency response bags in the CSU.

## Recommendations

- The Governor should ensure that control room staff call for an ambulance immediately when a medical emergency code is called.
- The Governor and the Head of Healthcare should ensure that there are emergency response bags located in the CSU.
- The Governor should ensure that if appropriate, and subject to security risk assessments, consideration should be given to supervise prisoners who are in an induced coma from a distance during family visits.
- The Governor should ensure that all CCTV systems are fully functional, regularly checked and in the event of an error, every effort is made to identify and retain any data that is at risk of being lost.
- The Governor should ensure that all evidence requested by the PPO is provided, in line with PSI 58/2010.

## The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
16. The investigator visited Swaleside on 17 March 2022, and again on 4 May. He obtained copies of relevant extracts from Mr Simmons' prison and medical records.
17. The investigator interviewed 12 members of staff and two prisoners. The investigator conducted some of these interviews in person while at Swaleside on 17 March and 4 May. The remaining interviews took place over telephone and video call on 27 April, 12 May, 27 May and 8 August.
18. NHS England commissioned an independent clinical reviewer to review Mr Simmons's clinical care at the prison.
19. We informed HM Coroner for Mid Kent and Medway of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent her a copy of this report.
20. The Ombudsman's family liaison officer contacted Mr Simmons' mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Simmons' mother was concerned that Mr Simmons had a head injury but was not monitored by staff when he returned from hospital. She was also distressed that officers were at Mr Simmons' bedside when she visited him in hospital.

## Background Information

### HMP Swaleside

21. HMP Swaleside, on the Isle of Sheppey, is part of the Long-Term and High Security estate. It houses up to 1,090 men serving sentences of four years or more. Integrated Care 24 Ltd provides primary healthcare. There is 24-hour nursing cover and a 17-bed inpatient unit. GPs work in the prison Monday to Friday, and Medway on Call Care provides an out of hours GP service. Oxleas NHS Foundation Trust provides mental health services. Forward Trust provides substance misuse treatment.

### HM Inspectorate of Prisons

22. The most recent inspection of HMP Swaleside was in October 2021. Inspectors reported that the living conditions in the segregation unit had not improved since their last inspection when they found that cells were grubby, the toilets had no seats, and the exercise yard was stark. The daily regime for segregated prisoners was too limited, with around 40 minutes in the fresh air each day and access to showers every other day.
23. Inspectors commented that their independent review of progress in 2019 found that good progress was being made towards reducing the supply of illicit drugs and embedding the prison's drug strategy. However, some of the work (for example, suspicion drug testing) had stopped during COVID-19 restrictions. In HMIP's survey, 37% of respondents said that it was easy to get illicit drugs, and 41% alcohol, in the prison. Drugs and hooch were the most frequent finds over the previous 12 months, with over 2,800 litres of alcohol found. A three-day lockdown search of the prison, carried out just before the inspection, indicated the level of concern about the availability of illicit items and their impact on the prison.
24. The drug strategy was up to date and there was good attendance at drug strategy meetings, which provided oversight of local issues. Mandatory drug testing was reintroduced in July 2021 but was sometimes dropped if staff were needed elsewhere in the prison. Prisoners who were suspected of having used illicit substances were referred to the Forward Trust for support.

### Independent Monitoring Board

25. 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 30 April 2021, the IMB found the prison had had a difficult year coping with the COVID-19 pandemic; at one point 150 staff were off work. Although they considered that Swaleside had still managed to forge ahead and make some improvements in terms of physical repairs and collaborative working, they remarked on the lack of meaningful activity/work available for prisoners which had been necessary to keep staff and prisoners safe.

## **Previous deaths at HMP Swaleside**

26. Mr Simmons was the fifteenth prisoner to die at Swaleside since August 2020. Seven of the other deaths were from natural causes, one is currently awaiting classification, one was drug-related and five were self-inflicted. There are no similarities between the recommendations made in this investigation, and those made in the investigations into the previous deaths.

## **Assessment, Care in Custody and Teamwork (ACCT)**

27. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

## Key Events

28. On 11 November 2017, Mr Jamie Simmons was remanded in prison custody, charged with murder. On 11 May 2018, he received a life sentence, with a minimum term to serve of 25 years.
29. On 8 January 2019, Mr Simmons was moved to HMP Swaleside. Initially, he got on well, was helpful to staff and was upgraded to the enhanced incentive level (the highest level of the scheme, which gave him extra privileges).
30. However, from June 2019 onwards, Mr Simmons' behaviour deteriorated. In June, staff found illegally brewed alcohol (hooch) in his cell; in September, they found an improvised weapon in his cell; and in October, they found a mobile phone in his cell. In October 2020, staff again found illegally brewed alcohol in his cell.
31. On 25 January 2021, Mr Simmons assaulted another prisoner with a bladed weapon. Staff moved him to the Care and Separation Unit (CSU, the segregation unit) and opened a Challenge, Support and Intervention Plan (CSIP, a process used to manage prisoners who are violent or pose a heightened risk of being violent). After this incident, Mr Simmons was found with weapons on several occasions. He said he held weapons for his own protection, and that he was under threat. A member of Swaleside's security department said they thought Mr Simmons was an 'enforcer' for the drug dealers in the prison. (An 'enforcer' uses violence, or the threat of violence, to ensure drug debts are paid and punish those prisoners who do not pay.)
32. On 12 March, staff found that Mr Simmons had 'spice paper' (paper that has been sprayed with psychoactive substance (PS), also known as 'spice').
33. On 19 September, staff recorded that Mr Simmons was behaving oddly. He had forgotten that he had already had his association time and believed his cell walls were covered in water, which they were not.
34. On 29 December, healthcare staff withheld Mr Simmons' medication for 24 hours as he appeared to be under the influence of an illicit substance. They noted that Mr Simmons' speech was slurred, his pupils were dilated, and he was holding onto another prisoner for support when talking to staff.
35. That day, Mr Simmons told his key worker that he was struggling with his mental health as he was worried about his mother's health, the length of his sentence and his cousin who was on the same wing as him. Mr Simmons said he had no intention of harming himself. His key worker said she would arrange for the mental health outreach team to visit Mr Simmons.
36. On 31 December, a mental health nurse visited Mr Simmons and assessed him. She found no evidence of psychotic illness. She referred him to the primary mental health team who could offer coping techniques to help him deal with his long sentence.
37. On 5 January 2022, a mental health nurse from the primary mental health team visited Mr Simmons. He said he was not interested in engaging with her or the

primary mental health team and that he was alright. The nurse reminded him how to contact the mental health team if needed in future.

38. On 27 January, an officer noted that Mr Simmons was in an unfit state, and appeared to be under the influence of PS.

## **Events of 25 and 26 February 2022**

39. On the morning of 25 February, Mr Simmons was found lying on the floor of his cell. He was conscious and talking but appeared very confused. He had a black eye and swollen face and claimed that he had fallen out of bed in the night and hit his head on the pipes. Healthcare staff assessed him and thought he should go to hospital. They thought he could be under the influence of an illicit substance.
40. Mr Simmons initially refused to go to hospital but later in the day, decided to go. There were concerns from prison staff that he was going to hospital to pick up a "package".
41. Mr Simmons was taken to hospital at 4.00pm. While at hospital, Mr Simmons had an X-ray, which showed he had an item secreted inside his body. This item was later discovered to be a mobile phone.
42. Mr Simmons was not happy with the suggestion of having surgery to remove the mobile phone and discharged himself from hospital.
43. When Mr Simmons returned to Swaleside at approximately 1.00am on 26 February, the x-ray body scanner showed that he still had the mobile phone inside his body. He refused to hand over the mobile phone, and so officers took Mr Simmons to the CSU. Officers told Mr Simmons he could return to a standard wing when he no longer had the mobile phone.
44. At 1.13am, Mr Simmons arrived at the CSU. The CSU officer on duty, spoke to him. Mr Simmons asked for a television and said he had not eaten anything as he had been in hospital (this was not correct as Mr Simmons had eaten an evening meal in hospital and then later a sandwich). The CSU officer told Mr Simmons that at that time, there were no televisions available, and the prison's kitchen was not open so he could not be given food. The CSU officer said he told Mr Simmons to get some sleep and that he would get him some food in the morning.
45. At 1.52am, a prisoner in the CSU, pressed his cell bell. The CSU officer responded a minute later and heard the prisoner shouting that Mr Simmons needed to be checked. (The prisoner that he had not been given any food and heard him say, 'This is it, I've got a line around my neck'.)
46. The CSU officer said that when he got to Mr Simmons' cell, he could see Mr Simmons' feet and part of his head, and that Mr Simmons' back must have been against the door. The CSU officer got no response from Mr Simmons, so at 1.55am, he called a medical emergency code blue.
47. A custodial manager (CM) and two officers, and a nurse were dealing with another incident at the time, but when they heard the code blue, they immediately stopped

what they were doing and went to the CSU. Prison staff went straight to the CSU, while the nurse collected a code blue emergency bag.

48. At 1.59am, prison staff arrived at the CSU and pushed their way into Mr Simmons' cell. They found that Mr Simmons had connected a ligature to the emergency cell bell unit, and then around his neck. The officers cut him down and started cardiopulmonary resuscitation (CPR). The nurse arrived at 2.01am.
49. Initially, Mr Simmons had no pulse, but staff managed to restore Mr Simmons' heartbeat. Control room staff called for an ambulance at 2.04am, and the first of three ambulances arrived at 2.18am. Ambulance paramedics took over resuscitation attempts.
50. At 3.15am, an ambulance took Mr Simmons to hospital and admitted him to the Intensive Care Unit. Two officers accompanied him and stayed with him at the hospital. Prison staff did not apply restraints at any point and Mr Simmons' family was allowed to visit him.

### **Events of 27 February to 4 March**

51. On 27 February, hospital staff tried to remove the tube helping Mr Simmons to breathe but were unsuccessful as Mr Simmons began having seizure-like symptoms. Hospital staff placed him in an induced coma.
52. On 2 March, hospital staff confirmed that Mr Simmons had brain damage.
53. On 4 March, hospital staff turned off Mr Simmons' life support machine and at 7.23pm, he died.

### **Contact with Mr Simmons' family**

54. On 26 May, the prison appointed an officer as the family liaison officer (FLO). She telephoned Mr Simmons' family on the morning of 26 May. She maintained contact with the family until she went on leave, when another officer took over as the family liaison officer. Both family liaison officers attended the hospital to support Mr Simmons' family.
55. The prison contributed to the costs of Mr Simmons' funeral in line with national policy.

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

56. After the incident involving Mr Simmons on 26 February, the CM 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.
57. The prison posted notices informing other prisoners of Mr Simmons' death, and offered support.

## **Post-mortem report**

58. The post-mortem report concluded that the cause of Mr Simmons' death was hypoxic brain injury due to suspension (hanging).

# Findings

## Management of Mr Simmons' risk of suicide and self-harm

59. Prison Service Instruction (PSI) 64/2011 on safer custody sets out the procedures (known as ACCT) that should be followed when a prisoner is identified as being at risk of suicide and self-harm.
60. Staff monitored Mr Simmons using ACCT on three occasions early on in his sentence in 2018. He was not monitored using ACCT during his time at Swaleside. We are satisfied that he gave staff no indication that he was at risk of suicide or self-harm. We note that in December 2021, Mr Simmons said he was struggling with his mental health. However, he said that he had no thoughts of self-harm and when he was offered support by the primary mental health team, he said he was alright and did not want to engage.
61. A prisoner who was also in the CSU on 25 and 26 February 2022, told the investigator that Mr Simmons had said to, the CSU officer that he was going to take his own life because he would not give him any food. At interview, the CSU officer said that Mr Simmons had not said that. There is insufficient evidence to say that Mr Simmons gave staff any indication that he planned to take his life. We are satisfied that staff could not have known that Mr Simmons was at imminent risk of suicide.

## Use of segregation

62. Prison staff took Mr Simmons to the CSU when he returned from hospital on 26 February, as Mr Simmons had a mobile phone secreted inside his body. Mobile phones represent a significant threat to the safety and security of a prison, as drug dealers use them to support their operations inside and outside prison.
63. The nurse said that he met Mr Simmons at reception. He said that Mr Simmons seemed okay and was not distressed or aggressive. The nurse said Mr Simmons' hospital discharge notes said he had second degree burns to his face, but that he was fit to be discharged from hospital.
64. Mr Simmons' mother was concerned that her son had received a head injury on 25 February, and that prison staff should have monitored him when he returned to Swaleside from hospital. The nurse said that there was no mention of a head injury in Mr Simmons' discharge notes. In the absence of reference to a head injury in the discharge notes and as Mr Simmons was considered fit to be discharged, staff would not reasonably have been expected to put special monitoring procedures in place for Mr Simmons.
65. The nurse carried out Mr Simmons' initial segregation health screen and assessed that he was fit to be segregated.
66. We consider the use of segregation in Mr Simmons' case was appropriate.

## Substance misuse

67. In their latest inspection report, HMIP said that prison staff were concerned about the availability of illicit items, including drugs at Swaleside, and were taking measures to tackle this problem. They said the prison's local drug strategy was up to date and there was good attendance at drug strategy meetings.
68. Evidence collected in this investigation, including intelligence reports, suggests that Mr Simmons was involved in the prison's drug culture. It appears that he was not only taking illicit substances, but also holding and trafficking these substances. Mr Simmons was also involved with violent acts relating to drugs, and some prison staff believed he was acting as a drug 'enforcer'.
69. Staff at Swaleside were regularly recording instances when Mr Simmons was engaging in behaviour linked to the prison's drug culture. Prison staff were also appropriately challenging and managing Mr Simmons through the Incentives Policy and CSIP. Mr Simmons was on drug addiction maintenance therapy, where healthcare staff administered his methadone. We are satisfied that staff were responsive to Mr Simmons's issues surrounding drugs.

## Emergency response

70. PSI 03/2013, *Medical Emergency Response Codes*, requires all prisons to have a medical emergency response code protocol in place, the purpose of which is to ensure a timely, appropriate, and effective response to medical emergencies. When a medical emergency is discovered, staff should call the appropriate medical emergency code straightaway so that relevant staff, including healthcare staff, are alerted, the correct equipment is brought, and an ambulance is called immediately.
71. The control room log shows that the code blue was called at 1.55am. However, an ambulance was not called until 2.04am, a delay of nine minutes. An officer, who was working in the control room at the time, said that the CSU officer radioed to ask the CM to attend the segregation unit as a prisoner [Mr Simmons] was not responding. The officer said she tried to clarify with the CSU officer who the prisoner was, but there were communication problems due to a separate incident. The officer said that about four minutes later, the CSU officer said over the radio that the prisoner [Mr Simmons] was not responsive, and so the officer called an ambulance. The officer said she did not hear the code blue being called. The radio call recordings confirm that, the CSU officer called a code blue.
72. The officer said that there had not been a nine-minute delay in calling an ambulance. She said she had not completed the control room log straightaway and that it was more likely that the code blue was called at 1.58am. The CCTV footage of the segregation unit is dark, grainy and there is no time stamp. It is possible that the code blue was called at 1.58am. However, this still does not explain why the ambulance was not called until 2.04am. We are concerned that an ambulance was not called immediately, in line with PSI 03/2013. We recommend:

**The Governor should ensure that control room staff call for an ambulance immediately when a medical emergency code is called.**

73. The CSU officer did not enter the cell immediately after calling the emergency code, waiting first for other prison staff to attend the scene. The CSU officer said the reason he did not go into the cell was because of Mr Simmons' history of violence, and that Mr Simmons had a crutch [which could be used as a weapon]. The CSU officer said that he was not sure if Mr Simmons "was faking or what was going on". In these circumstances, we accept, for reasons of personal safety, that it was reasonable for the CSU officer to wait for other prison staff to attend before entering Mr Simmons' cell.
74. When the CSU officer called the emergency code, other officers and the nurse were dealing with a prisoner on another wing who had a cut. They immediately left that incident and arrived at Mr Simmons' cell within four minutes of the emergency code being called. Considering the location of staff when the emergency code was called, the time it took them to reach Mr Simmons' cell was not unreasonable.
75. However, as the nurse had been dealing with a prisoner who had a cut, he only had a 'code red' response bag, which did not have the appropriate medical equipment to deal with Mr Simmons' code blue situation. The nurse needed to return to the healthcare unit to pick up a code blue response bag. This caused a delay in him reaching the CSU, and he arrived approximately two minutes after the officers. One of the officers was a trained paramedic technician, and so the delay in the nurse attending to Mr Simmons did not have a negative impact.
76. The nurse told the investigator that there are two medical emergency response bags (one 'code blue' and one 'code red') located in the medical room of each wing but there are no medical emergency response bags available on the CSU. Although in this case it did not impact on the treatment Mr Simmons received, emergency bags on the CSU would be of benefit, particularly as the CSU houses many prisoners with complex needs, where their risk of suicide and self-harm may be increased. We recommend:

**The Governor and the Head of Healthcare should ensure that there are emergency response bags located in the CSU.**

### **Presence of officers at Mr Simmons' bedside when family visited**

77. Mr Simmons' mother said that when she visited Mr Simmons in hospital [on 27 & 28 February, and 1 March], officers stood by Mr Simmons' bedside. Mr Simmons' mother said that this was degrading and made the situation worse.
78. The investigator spoke to the initial family liaison officer (FLO), who said that hospital staff had not confirmed that Mr Simmons would not wake up, and so there was a possibility that Mr Simmons would go back to Swaleside. As Mr Simmons had been found with a mobile phone, there was a concern he may be passed illicit items by someone to traffic into prison, and that staff also needed to ensure Mr Simmons' safety. An officer said that after Mr Simmons' brain scan confirmed he would not wake up, staff no longer stayed at his bedside when he had visitors, which was the case when his mother visited on 3 March.
79. We understand that for prison staff, it is often a difficult task to balance risk with the rights and dignity of individuals. However, Mr Simmons was in an induced coma from 27 February and therefore on every occasion his family visited him so he

would not have been able to receive an illicit item. Had someone concealed an item on his person, this would have been discovered by nurses who administered personal care to Mr Simmons, such as bathing and changing his clothes. Therefore, the likelihood of Mr Simmons being passed an illicit item, successfully concealing it, and then trafficking it into prison was extremely low. Furthermore, Mr Simmons' parents were both cleared to visit him in prison, and there is no evidence that they were a risk to him.

80. We consider that officers being at Mr Simmons' bedside when his family visited him was unnecessary as it caused the family undue distress. We recommend:

**The Governor should ensure that if appropriate, and subject to security risk assessments, consideration should be given to supervise prisoners who are in an induced coma from a distance during family visits.**

## **Provision of evidence to the PPO**

81. Swaleside was unable to provide CCTV footage for 25 February. The prison told us that the footage had been lost due to a problem with the CCTV system. We are currently investigating another death at Swaleside that occurred in June 22, also on A Wing. The prison has been unable to provide the CCTV for this case too.

82. In Mr Simmons' case, we were told that staff had watched the requested CCTV footage of A Wing, but the footage had subsequently been lost due to an error with the system. In the other case, Swaleside said that they had been experiencing issues with A Wing CCTV cameras for some time, where the CCTV system kept 'dropping out' resulting in no footage for those periods. They said the company who maintains Swaleside's CCTV system had been to the prison multiple times to try to fix the issue.

83. CCTV provides important evidence to support investigations and is vital for the safety and security of a prison environment. The issues surrounding Swaleside's CCTV system are of concern. We recommend:

**The Governor should ensure that all CCTV systems are fully functional, regularly checked and in the event of an error, every effort is made to identify and retain any data that is at risk of being lost.**

84. The PIN phone recordings were never provided to the PPO. Swaleside said that at the time, no one was trained to download PIN phone recordings. They have since trained a member of staff, but they are only able to retrieve recordings within three months of the request date. It is unclear why the prison did not seek assistance from the organisation that supports the PIN phone software to obtain guidance on how to download the recordings, or even contact another prison's security department for guidance.

85. PSI 58/2010 says that the PPO should have unfettered access to Prison Service data and information. It is disappointing that we were never provided with the PIN phone recordings for Mr Simmons. We recommend:

**The Governor should ensure that all evidence requested by the PPO is provided, in line with PSI 58/2010.**

## **Clinical care**

86. The clinical reviewer was satisfied that the physical and mental health care Mr Simmons received at Swaleside was equivalent to that which he could have expected to receive in the community.

## **Inquest**

87. The inquest concluded on 27 January 2023 with a conclusion of misadventure.

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