Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Wayne Simmonds, a prisoner at HMP Leyhill, on 22 September 2023

A report by the Prisons and Probation Ombudsman

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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

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 Wayne Simmonds died on 22 September 2023, in a care home, while a prisoner at HMP Leyhill. His cause of death was a pulmonary embolism (a blockage in the pulmonary arteries, the blood vessels that send blood to the lungs) caused by a deep venous thrombosis (a blood clot in a deep vein), which was caused by cancer of the oesophagus (the tube that connects the mouth to the stomach) and which had spread to other parts of his body. Mr Simmonds was 50 years old. We offer our condolences to his family and friends.

4. The PPO family liaison officer wrote to Mr Simmonds' sister to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Simmonds's sister asked some questions about the care he received in the care home, which is outside the remit of our investigation. She also raised some points about her communication with Leyhill, which we have addressed in separate correspondence.

5. NHS England commissioned an independent clinical reviewer to review Mr Simmonds' clinical care at Leyhill.

6. The clinical reviewer concluded that the clinical care Mr Simmons received at Leyhill was of a good standard and was at least equivalent to that which he could have expected to receive in the community. The clinical reviewer found many examples of good healthcare practice, including prompt referral under the two-week rule for suspected cancer, promptly arranging GP appointments when necessary, and giving Mr Simmonds a named nurse who saw him regularly and demonstrated a thorough approach to Mr Simmonds' care.

7. The PPO investigator investigated the non-clinical issues relating to Mr Simmonds' care.

8. Staff at Leyhill arranged for Mr Simmonds to attend hospital on release on temporary licence. This meant that he could attend his appointments by himself without the security requirement of officers in uniform accompanying him. We consider this to have been good practice. We make no recommendations.

9. We shared the initial report with the Prison Service. There were no factual inaccuracies.

10. We shared the initial report with Mr Simmonds' sister. She did not respond.

Adrian Usher **April 2024**
Prisons and Probation Ombudsman

Inquest

The inquest, held on 13 November 2023 concluded that Mr Wayne Simmonds died from natural causes

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