PRISONS AND PROBATION
OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a resident of Dickson House Approved Premises, Fareham in May 2013.

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death, on 5 May 2013, of a man while he was a resident at Dickson House Approved Premises, Fareham. The cause of the man's death was abdominal sepsis (blood poisoning). He was 39 years old. I offer my condolences to the man's family and friends.

Staff at Dickson House and the Hampshire Probation Trust cooperated fully with the investigation.

On 8 May 2012, the man was released from HMP Camp Hill on licence to Dickson House. At a room check at 11.00pm on 11 August 2012, the man was in another resident's room, panting for breath. He told the night staff officer that he had been doing press-ups. Forty minutes later, the man went to the staff office and said he was having difficulty breathing. He was taken to hospital where he was found to have a ruptured spleen, which was removed in an emergency operation. It subsequently emerged that the man had been punched in the stomach while sparring or play-fighting with the other resident.

The man recovered from his operation but his health declined from that time onwards and over the following months he had frequent further hospital admissions until his death on 5 May 2013. Although the full facts of what happened on 11 August 2012 are not entirely clear, it would be difficult in the light of his other health problems, to say that the man's death was directly caused by the fight in August 2012. The police examined the matter and the Crown Prosecution Service decided not to take any action. I am satisfied that there is little that staff at Dickson House could have done to predict or prevent the man's death.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2014**

CONTENTS

Summary 5

The investigation process 5

Dickson House Approved Premises 5

Key events 6

Issues 8

SUMMARY

1. The man was a resident of Dickson House Approved Premises in Fareham. On 11 August 2012, he was punched in the stomach while sparring or play-fighting with another resident when three residents were together in one of their rooms, which was contrary to the rules. A little later, the man was taken to hospital where he underwent an emergency operation to remove a ruptured spleen. His health steadily deteriorated in the months that followed until his death on 5 May 2013 from abdominal sepsis (blood poisoning). The investigation found that, although there were times when residents did not comply with the rules, there was little staff at Dickson House could have done to prevent his death.

THE INVESTIGATION PROCESS

2. The Prisons and Probation Ombudsman is obliged by his terms of reference to investigate the deaths of all residents of approved premises. As part of the investigation into the man's death, the investigator visited Dickson House and spoke to the premises manager. One of our family liaison officers wrote to several members of the man's family, who had no questions for the investigation to consider.

DICKSON HOUSE APPROVED PREMISES, FAREHAM

3. Approved premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence, to be supervised in the community and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment.

4. Dickson House is an approved premises in Fareham, near Portsmouth, managed by the Hampshire Probation Trust. It provides accommodation for up to 19 adult males. The building has two small communal rooms in addition to a larger communal area where residents dine and play pool. Each resident is allocated a key worker, with whom the resident discusses their progress and well-being. The key worker also ensures that residents adhere to their individual licence conditions and the rules of the approved premises. Dickson House is staffed 24 hours a day by probation employees.

KEY EVENTS

5. The man was born on 8 May 1973. He had many criminal convictions and had served a number of prison sentences. He had misused drugs and alcohol for many years.

6. The man had been sentenced to three years imprisonment. On 8 May 2012, he was released from HMP Isle of Wight to Dickson House Approved Premises in Fareham. His licence period was due to end on 9 December 2013.

7. When he arrived at Dickson House, the man was told about the premises' rules. These included a rule that he was allowed to have one other resident in his room except during curfew hours, which were between 11.00pm to 6.00am. This rule also applied to one of the other two premises in the Hampshire Probation Trust.

8. A night supervisor at Dickson House, conducted a room check at 11.00pm on the evening of 12 August. She found the man and two other residents all together in room two: the room occupied by another resident. The man was sitting on a chair and panting for breath while one of the other residents was jigging up and down shadow boxing. The night supervisor asked the man if he was all right and he said he had been doing press-ups. The night supervisor told the three to keep quiet and that she would be checking rooms again in an hour. She then returned to the office.

9. Around 40 minutes later, the man went to the office and told the night supervisor that he needed an ambulance as he was finding it very difficult to breath. He said he had fallen on the corner of the bed. The night supervisor telephoned for an ambulance and the man was taken to Queen Alexandra Hospital in Portsmouth.

10. At the hospital, the man was found to have a ruptured spleen with associated internal bleeding. His spleen was removed successfully and he gradually began to recover from the operation.

11. The day after the man was admitted to hospital, Dickson House staff reported the matter to police and informed them that he had had an emergency operation. Police officers visited the man in hospital and he explained that his injury occurred when he was punched in the abdomen during a play-fight with the other resident. Police officers interviewed the other resident and the third resident, who both said that the man had been hurt during a play-fight and there had been no intention to harm him.

12. On 21 August, the man was told that his injuries were life-changing and two days later, he told police officers that he wished to make a complaint against the other resident. He then said that on the evening of 11 August, the other resident had been shadow boxing when he suddenly punched him three times in the abdomen and he did not have the chance to defend himself.

13. Police officers re-interviewed the other resident, who maintained that he and the man had been play-fighting and it had not been his intention to harm the man. The Crown Prosecution Service (CPS) was asked to consider

prosecuting the other resident for grievous bodily harm but decided not to pursue the matter.

14. Shortly after the incident, Dickson House imposed a ban on residents entering each others' rooms at any time.

15. The man was discharged from hospital on 23 August and moved to a new room at Dickson House, an adapted room on the ground floor. Over the following months, he returned to hospital many times. Some of these attendances were elective admissions for treatment and others were emergency admissions. His final hospital admission was on 22 January 2013, for abdominal pain and distension. He remained in hospital for over three months, until his death on 5 May 2013.

16. A post-mortem examination discovered that the man's primary cause of death was abdominal sepsis (blood poisoning) from leakage of a feeding tube. The pathologist described how the man's ruptured spleen, combined with his background of severe liver disease (caused by alcohol and intravenous drug abuse), would probably have contributed to various other complications, such as abdominal adhesions (where areas of the stomach lining become stuck to one another) and progressive scarring of the stomach lining. The pathologist described other clinical processes that could have caused the scarring but wrote that whatever the cause, the condition worsened inexorably causing intermittent obstructions of the bowel. The pathologist explained that during the man's final illness he became agitated a number of times and pulled various medical tubes from his body. It seemed probable that at some stage he dislodged his feeding tube into his small bowel causing death through sepsis of the abdominal cavity. He added that the man's liver disease had caused his spleen to become enlarged and that an enlarged spleen is more fragile than normal and prone to rupture on impact.

17. After the man's death, the police resubmitted the case to the CPS. Having considered all the factors, including the man's existing poor clinical health at the time of the alleged play-fight with the other resident and the inconsistencies in the man's evidence, the CPS concluded that there was insufficient evidence to afford a realistic prospect of conviction and that proceedings should not be taken against the other resident.

18. The man's partner lived in Portsmouth and she was in contact with him during his time at Dickson House and in hospital. The man had little contact with his father and two sisters who lived in Cheltenham and Dickson House did not have their contact details. The police offered to trace them to break the news.

19. One of the man's sisters took charge of the funeral arrangements. She went to the premises with the man's partner to collect his belongings. Hampshire Probation Trust contributed to the funeral expenses and three members of staff from Dickson House attended the funeral.

ISSUES

Visitors in other residents' rooms

20. When the man arrived at Dickson House, the premises' rules allowed residents to have one other resident in their rooms other than during curfew hours. There were occasions when this rule was not followed or enforced, including the night of 11 August 2012 when the man and a third resident were in the other resident's room. After the events of 11 August, the rules at Dickson House were changed and residents are no longer permitted any visitors in their rooms. We note the action taken but observe that the incident could also have occurred in a communal area of the premises.

The incident involving the man and the other resident

21. The man and the other resident were apparently involved in some form of horseplay or play-fighting on the evening of 11 August 2012, after which the man suffered a ruptured spleen. The CPS twice considered whether there were grounds for a prosecution against the other resident: the first time was soon after the incident and they reconsidered after the man's death. They concluded on both occasions that there was insufficient evidence to consider pursuing a prosecution. We are satisfied that there was little staff at Dickson House could have done to prevent his death. It is not apparent, given the man's other health problems, that the incident was a direct cause of his death.