

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Adam Simons, a resident at Nelson House Approved Premises, on 2 October 2021**

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



## Our vision

To carry out independent investigations to make custody and community supervision safer and fairer



## Our values

We are:

**Impartial:** we do not take sides

**Respectful:** we are considerate and courteous

**Inclusive:** we value diversity

**Dedicated:** we are determined and focused

**Fair:** we are honest and act with integrity



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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 Adam Simons died from heart disease on 2 October 2021, while a resident at Nelson House Approved Premises. He was 41 years old. I offer my condolences to Mr Simons' family and friends.

Mr Simons was released from HMP Holme House on 1 October 2021 and briefly visited Nelson House to drop off his belongings. He said he was going out for a family meal and would return later that afternoon to complete his induction. However, he did not return and was found dead in hospital grounds in the early hours of 2 October.

The clinical reviewer found that Mr Simons received a good standard of healthcare at Holme House. There was no evidence that Mr Simons had any heart problems.

I am satisfied that neither prison nor probation staff could have foreseen or prevented Mr Simons' death.

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

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

**July 2022**

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# Summary

## Events

1. On 1 October 2021, Mr Adam Simons was released on licence from HMP Holme House. He was required to live at Nelson House Approved Premises in Middlesbrough.
2. Mr Simons briefly attended Nelson House to drop off his belongings. He told staff that he could not stay as he was going out for a family meal and would return later to complete his induction.
3. Later that afternoon, after drinking alcohol and taking drugs, Mr Simons asked a taxi driver to take him to hospital because he felt unwell. While at the hospital, Mr Simons had an altercation with a security guard, and he was told he had to leave the hospital. In the early hours of 2 October, Mr Simons was found dead in the hospital grounds.

## Findings

4. The clinical reviewer found that Mr Simons received a good standard of healthcare at Holme House that was equivalent to that he could have expected to receive in the community. There was no evidence that Mr Simons had any heart problems.
5. Mr Simons had a history of substance misuse, but he engaged well with substance misuse services while he was in prison and had been drug free for some years when he was released.
6. We are satisfied that neither prison nor probation staff could have foreseen or prevented Mr Simons' death.
7. We make no recommendations.

## The Investigation Process

8. The PPO investigator issued notices to staff and residents at Nelson House Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Simons' prison and probation record.
10. NHS England commissioned an independent clinical reviewer to review Mr Simons' clinical care at HMP Holme House.
11. We informed HM Coroner for Teesside of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. The Ombudsman's family liaison officer contacted Mr Simons' partner to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She said that she would like a copy of our report and also asked why Mr Simons was released from prison without his betablockers (medication prescribed to slow down the heart). This has been addressed in our report.
13. We shared our initial report with HM Prison and Probation Service (HMPPS). They pointed out one factual inaccuracy, which has been amended in this report.
14. We sent a copy of our initial report to Mr Simons' partner. She did not notify us of any factual inaccuracies.

# Background Information

## Nelson House Approved Premises

15. Approved Premises (or APs, formerly known as probation and bail hostels) accommodate offenders released from prison on licence 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. Residents are responsible for their own healthcare and are expected to register with a GP.
16. Nelson House, in Middlesbrough, is managed by the National Probation Service. It can accommodate up to 23 residents. Nelson House is staffed by Probation Service employees who are on duty 24 hours a day. Sodexo provides security staff and cleaners. Staff on reception keep each resident's medication locked away and administer it as required. Nelson House staff are not clinically trained other than to distribute medication.
17. Residents are subject to AP rules on top of any licence conditions they have been given. They are not permitted to leave the building between 11.00pm and 6.00am.

## Previous deaths at Nelson House

18. Mr Simons' death was the second death at Nelson House since October 2019. The previous death was drug-related.

## Key Events

19. On 1 October 2021, Mr Adam Simons was released on licence from HMP Holme House. Mr Simons' licence conditions required him to live at Nelson House Approved Premises (AP) in Middlesbrough.
20. Mr Simons went straight to Nelson House to drop off his belongings. He arrived at around 10.30am. He told the staff there that he could not stay for his induction because he was going out for a family meal. Nelson House staff agreed that Mr Simons could complete his induction later on that afternoon.
21. Mr Simons met his stepmother and partner and went out for a family lunch. After lunch he went back to his partner's house, where he consumed alcohol and drugs.
22. At around 5.30pm, Mr Simons left his partner's house and got in a taxi to go to Nelson House for his induction. While he was in the taxi, he began to feel unwell. He asked the taxi driver to take him to the Accident and Emergency Department (A&E) of James Cook Hospital.
23. While waiting in A&E, Mr Simons had an altercation with a security guard and was told to leave the hospital.
24. On 2 October at 1.47am, hospital security guards found Mr Simons dead in the grounds of the hospital.

## Post-mortem report

25. The post-mortem report concluded that Mr Simons died from ischemic heart disease caused by coronary artery atheroma (build-up of fatty deposits in the arteries that supply the heart). Multi drug toxicity was listed as a contributing factor.

## Contact with Mr Simons' next of kin

26. Mr Simons' next of kin was his partner. The police notified her that Mr Simons' had died shortly after he had been found. The Probation Service kept in contact with Mr Simons' partner and paid for the funeral costs in line with national guidance.
27. Mr Simons' funeral was held on 27 October.

## Support for residents and staff

28. As Mr Simons had not resided at Nelson House none of the other residents knew him, therefore the offer of support was not necessary.

# Findings

## Clinical care

29. The clinical reviewer concluded that the clinical care Mr Simons received at HMP Home House was of a good standard and equivalent to that which he could have expected to receive in the community.
30. Mr Simons' family asked why Mr Simons was released from prison without his betablockers (medication prescribed to slow down the heart). However, the clinical reviewer found no evidence in Mr Simons' medical record to suggest that he had any heart issues. Mr Simons was prescribed antidepressant medication but was not on any medication for any physical health conditions.

## Substance misuse

31. Mr Simons had a history of substance misuse, but while in prison he engaged well with the substance misuse team and had been drug-free for some years by the time of his release. When Mr Simons arrived at Nelson House, staff had no reason to believe that he would take drugs.
32. We are satisfied that there was nothing that prison or probation staff could have done to prevent Mr Simons' death.
33. We make no recommendations.

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