

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man while resident  
at Burdett Lodge Approved Premises, Derbyshire  
Probation Trust on 1 November 2012**

## ***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 report of an investigation into the death of a man who died on 1 November 2012. The man was a resident at Burdett Lodge Approved Premises in Derby where he had lived for just over a week after his release from prison. He was 35 years old. I offer my sincere condolences to his family and friends.

The man had been treated in prison with pregablin and fentanyl for chronic pain arising from a road traffic accident. He continued to be prescribed this medication when he was released. He had also misused drugs before and during his imprisonment and had tested positively for amphetamines at Burdett Lodge on 26 October. On the evening of 31 October, he left Burdett Lodge at 10.10pm but failed to return before the 11.00pm curfew. Staff began procedures to recall him to prison but, in the early hours of the following morning, the police reported that he had been found unconscious in a street nearby and had subsequently died.

A post-mortem examination was unable to determine the cause of his death, although toxicology results indicate that it might have been due to the effects of a combination of drugs. I am satisfied that staff at Burdett Lodge managed him appropriately and that there is nothing they could reasonably have been expected to do which would have prevented his death.

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

**July 2013**

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## SUMMARY

1. The man was released on licence from HMP Ranby on 23 October 2012, to live at Burdett Lodge Approved Premises. He was 35 years old.
2. In prison, he had received treatment for pain caused by a road traffic accident. He was on strong pain medication and on the day of his release was prescribed two weeks supply. He had previously taken methadone as well as illicit drugs.
3. When he arrived at Burdett Lodge, the rules and routines were explained to him. His medication was locked securely in the office and he collected it daily. A drug test conducted on his arrival was negative, but a further test three days later on, 26 October, showed a positive result for amphetamine which he was not prescribed. Staff sent the test away for independent screening, with the intention to take further action if a positive result was confirmed. Staff noticed that he sometimes seemed confused and so carried out additional checks on his wellbeing during the day.
4. On 31 October, the man left Burdett Lodge at 10.10pm, to go to the local shop. As he had not returned before the curfew of 11.00pm, staff initiated procedures to recall him to prison and notified the local police. At 2.30am, on 1 November, the police informed staff that someone matching the man's description had been found unconscious in the street. He had been taken to hospital but pronounced dead on arrival. The police notified his family of his death. The manager of Burdett Lodge did not contact them until a month later.
5. A clinical review of the man's medication concluded that the medication he was prescribed was appropriate. The post-mortem examination did not find a definitive cause of death, but it is possible that it could have been due to a combination of drugs.
6. We are satisfied that staff at Burdett Lodge managed him appropriately and could not have predicted or prevented his death. However, it would have been preferable for staff to have visited his family sooner to offer condolences and support.

## **THE INVESTIGATION PROCESS**

7. The investigator, visited Burdett Lodge on 7 November 2012, where he met several of the staff, including the manager. The investigator obtained all relevant documents.
8. Notices about the investigation were displayed at Burdett Lodge, inviting staff and residents to contact the investigator if they had relevant information. No one came forward.
9. The investigator obtained the man's medical record and information about his contact with drug treatment services from HMP Ranby while he was in custody there. As he died only a short time after his release from prison, this office commissioned, NHS Doncaster, to carry out a review of his medical treatment and medication in custody.
10. HM Coroner for Derbyshire was informed of the investigation and provided a copy of the post-mortem report. A copy of this report has been sent to the Coroner.
11. One of the Ombudsman's family liaison officers, spoke to the man's father on 3 December and explained the investigation process. His father said that he was aware that his son had been receiving medication in prison and wanted to know if this had continued after his release.
12. The family were sent a copy of the draft report and following the consultation process highlighted no factual inaccuracies.

## **BURDETT LODGE APPROVED PREMISES**

13. Approved premises (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.
14. Burdett Lodge, in Derby, is managed by a Senior Probation Officer. Each resident is allocated a key worker soon after their arrival, who acts as their primary point of contact and support to help residents comply with their licence conditions. Relevant information is shared with field probation officers who act as case managers.
15. All residents are required to register with a local general practitioner (GP), to pay rent and abide by the rules and regulations. There is a general curfew between 11.00pm and 6.00am, when all residents are expected to be in the building.
16. This death was the first at Burdett Lodge since the Ombudsman started investigating deaths in custody in April 2004.

## KEY EVENTS

17. The man was released on licence from HMP Ranby on 23 October 2012. He had been at Ranby since 23 May 2012, after transferring from HMP Nottingham. Due to victim issues and the need for further assessment, his supervising probation officer arranged for him to reside at Burdett Lodge Approved Premises. He was 35 years old.
18. The man had a history of back pain caused by a road traffic accident. Prison healthcare staff had prescribed fentanyl transdermal patches and pregablin, to manage the pain. On the day of his release, they gave him a two-week prescription of both medications, as well as duloxetine, an antidepressant and advised him to follow up his pain management with his community GP. He had also used illicit drugs in prison and had misused amphetamines in the past. While he was in prison he had been prescribed methadone because of substance misuse related to pain relief but had stopped taking methadone before he was released.
19. At Ranby, the man attended appointments with the mental health team, who had been investigating a possible diagnosis of Attention Deficit Hyperactivity Disorder. They advised him to take this forward with his community psychiatric nurse.
20. When he arrived at Burdett Lodge on 23 October, one of the duty officers gave him a full induction. He gave his prescribed medications to premises staff to be held securely in the office. The man and the staff signed a medication sheet when it was dispensed. The investigator reviewed a copy of his medication sheet, which shows that he collected his prescribed dose of pregablin daily and his fentanyl twice. (The patches were collected as required.)
21. As part of the normal arrival procedures, the man was given an oral drug test to indicate whether he had used cocaine, opiates, amphetamines, cannabis or benzodiazepines. He tested negative for all substances.
22. The premises manager told the investigator that it was clear from conversations between staff that the man did not want to be at Burdett Lodge. He said that he had become emotional at times about being there, but staff had tried to support him.
23. The man registered with the local GP surgery on 25 October and returned there on 30 October to update his medication. He was referred to the Mental Health Service in Derby, but died before an appointment was received.
24. All residents have to be in their rooms by the evening curfew at 11.00pm and the man was also required as part of his licence conditions to report to staff in the office at 12.00pm and 5.00pm daily. Staff said that he became confused about this and they often had to remind him of his sign-in and curfew times. They said that he had problems with his memory and sometimes became disorientated. On one occasion, he got lost in the area near the hostel. Staff

therefore checked him at intervals during the day as well as the night-time wellbeing checks which all residents have.

25. On 26 October, he had a positive drug test for amphetamines. He was told that it would be sent away to an independent laboratory for verification and if it was confirmed as positive, further action might be taken which could affect his licence. Ultimately, when a person breaches their licence conditions they can be recalled to prison. The verification of the drug test which confirmed that he had taken amphetamines was not received until after his death.
26. On 31 October, the man left the premises at 10.15am and returned at 5.00pm. The signing in/out sheet for that day indicates that he had visited the local Citizens Advice Bureau (CAB.) He left the premises again at 10.10pm, to go to a local shop. He had not returned by 11.00pm and staff contacted the manager. At 11.40pm, probation staff decided to revoke his licence and recall him to prison. They contacted the local police to inform them that the man was absent without permission and that he had experienced problems with his memory and mobility in the past.
27. At 2.30am, on 1 November, the police attended Burdett Lodge and asked to see a photograph of the man. They explained that some members of the public had found someone unconscious in the street. An ambulance had taken him to hospital but, sadly, he was pronounced dead on arrival. The police said that they would inform his father, who was his next of kin and arrange for a formal identification of his body.

### **Actions following the man's death**

28. The residents of Burdett Lodge were told of the death on the morning of 1 November, during a residents' meeting.
29. The manager spoke to the man's father over the telephone but did not visit him in person until 30 November, when the police informed him that they had completed their enquiries.
30. Derbyshire Probation Trust offered financial assistance to the family towards funeral expenses in line with national guidance.
31. A post-mortem examination was inconclusive but cited the possibility that the man's death was due to the effects of a combination of drugs, including fentanyl and possibly amphetamines. The pathologist also considers that other factors, such as hypothermia, might have contributed to the death. The post-mortem report mentions that the toxicology results suggested the man may not have been taken "his carbamazepine for epilepsy" and that therefore his death could have been related to epilepsy.

## ISSUES

### Medication

32. As the man was released from custody not long before his death and was in receipt of potent medication which might have been a factor in his death, we commissioned a review of his medical care at HMP Ranby.
33. The clinical review noted a reference in the post-mortem report to carbamazepine (an anti-convulsant that can also be used to treat some types of nerve pain) and a question about whether the man's death was epilepsy related. He had reported a seizure in June 2012 which staff at Ranby considered had been a faint. The clinical review found no evidence that he had been diagnosed with epilepsy or prescribed carbamazepine at any time.
34. The clinical review is satisfied that the medication prescribed was appropriate and followed national guidelines. Two recommendations to HMP Ranby have been made but they do not directly relate to the man's death and we have therefore not repeated them in this report.
35. We also conclude that the staff at Burdett Lodge managed the man's medication appropriately, and monitored his drug use with appropriate testing.

### Family liaison

36. The police notified the family of the man's death. Staff from the approved premises visited his family around a month later. Probation Service guidance says:

All residents must be asked on their arrival to nominate two persons who are willing and able to act as their next-of-kin ... and a record of their names (with addresses and phone numbers) should be kept in each resident's case file. These will be the people whom staff should initially contact in the event of a resident's death ...'

As he was found in the street, the police initially treated his death as an unexplained death in the community and, appropriately, informed the family of his death. Staff had contacted his father by telephone on 7 November, but the manager and another senior member of staff did not visit until over four weeks later, on 30 November. The manager said they did not go sooner as he understood that the police were investigating the death and were the lead agency. He believed it was more respectful for one organisation to deal with the family. We consider it would have been preferable for someone from the Burdett Lodge or the Probation Trust to have visited his family earlier to offer condolences and provide immediate information and support in person, but otherwise the family liaison was appropriate.