

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Burnard on 20 October 2022, following his release from HMP Guys Marsh

A report by the Prisons and Probation Ombudsman

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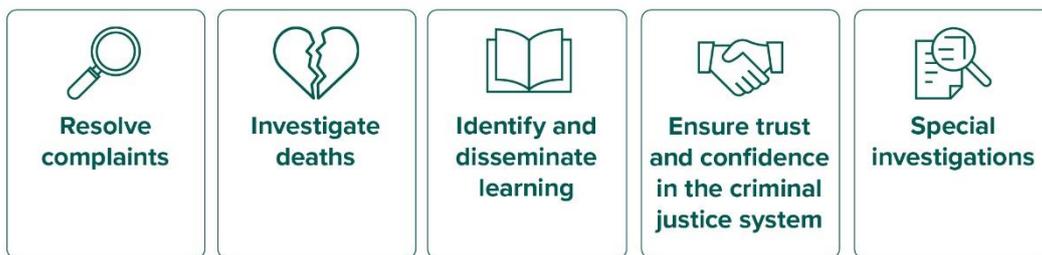
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OUR VISION

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



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Summary

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. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.
3. 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.
4. Mr Lee Burnard died of a heroin overdose on 20 October 2022, following his release from HMP Guys Marsh on 7 October. He was 38 years old. We offer our condolences to those who knew him.
5. We consider that Mr Burnard's community offender manager appropriately prepared for his release by assessing his risks and needs and finding him supported accommodation. She continued to give good support to Mr Burnard after his release.
6. We found evidence of good practice by a substance misuse recovery worker at Guys Marsh, who expended considerably greater effort than the minimum standard in order to put appropriate substance misuse support in place for Mr Burnard both in prison, and for his release.
7. We make no recommendations.

The Investigation Process

8. HMPPS notified us of Mr Burnard's death on 26 October 2022.
9. The PPO investigator obtained copies of relevant extracts from Mr Burnard's prison and probation records.
10. We informed HM Coroner for Plymouth of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
11. The Ombudsman's family liaison officer contacted Mr Burnard's ex-partner to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Guys Marsh

13. HMP Guys Marsh is a category C medium security prison that holds up to 491 men. Practice Plus Group provides primary and secondary mental healthcare and has commissioned another agency, Exeter Drugs Project (EDP), to provide integrated substance misuse services.

Probation Service

14. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervise people throughout their licence period and post-sentence supervision.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Guys Marsh was in July 2022. Inspectors reported that clinical caseloads were high, but joint prescribing reviews with the prisoner and psychosocial worker were frequent. Suitable harm minimisation advice was given to new arrivals, with comprehensive psychosocial assessments being completed within three days. Psychosocial workers had high caseloads and although care plans were in place, they did not always have mental health practitioner input. The substance misuse team had a community link worker, who was providing excellent links with the community for prisoners and was highly active and visible within the resettlement and release planning boards.
16. Inspectors reported that release planning arrangements were inconsistent, and prisoners reported that they felt unsupported and unprepared for their upcoming release. The prison was still waiting for two resettlement officers to be recruited by the Probation Service, despite the funding for these being granted over one year previously. The prison worked collaboratively to address this issue and had a small team of two prison-employed staff and two peer-led 'pathways ambassadors' who contacted prisoners 12 weeks ahead of release, to identify their resettlement needs and arrange appointments. Inspectors reported that on average, 16% of prisoners were released without knowing where they would be sleeping that night, or their accommodation status was unknown.

Key Events

17. On 22 April 2021, Mr Lee Burnard was convicted of grievous bodily harm and sentenced to 21 months in prison. He was sent to HMP Channings Wood.
18. On 22 November, Mr Burnard was released from Channings Wood on licence.
19. On 20 May 2022, Mr Lee Burnard was convicted of assault and was sentenced to 12 weeks in prison. He was sent to HMP Exeter.
20. On 30 May, Mr Burnard was moved to HMP Guys Marsh. As he had breached his licence conditions for the original offence, he remained in prison after the 12-week sentence had finished and completed his 21-month sentence for the original offence. He was released on post-sentence supervision.

Pre-release planning

Substance misuse services

21. When Mr Burnard arrived at Guys Marsh, he was already on a buprenorphine detoxification programme (medication used to treat the symptoms of heroin withdrawal). He continued the programme at Guys Marsh.
22. On 31 May, a Substance Misuse Service (SMS) recovery worker saw Mr Burnard for an initial assessment. Mr Burnard said that he would like help with his substance misuse issues. He was allocated a recovery worker. She agreed to work with Mr Burnard on a 1:1 basis and they agreed on a care plan to address his substance misuse issues.
23. On several occasions during June, staff suspected that Mr Burnard was under the influence of psychoactive substances (PS). Although he denied using drugs on every occasion, the recovery worker went to see Mr Burnard and warned him about the risks associated with taking PS, which included heart attack and overdose. She gave Mr Burnard advice to minimise these risks which included not using drugs by himself and only using small amounts to test their strength.
24. On 5 July, the recovery worker saw Mr Burnard for a therapy appointment. She warned him that taking PS can lead to loss of consciousness and death. Mr Burnard signed a welfare form to say that he understood. Later that day, she sent Mr Burnard some additional information on minimising the risks of harm associated with taking drugs.
25. On 18 July, Mr Burnard told the recovery worker that he would like to complete the relapse prevention programme.
26. On 1 August, Mr Burnard attended his first session of the relapse prevention programme. He attended seven further sessions and completed the programme on 10 August.
27. On 29 September, the recovery worker sent a referral to Turning Point, the community SMS team in Burnham-on-Sea.

28. On 4 October, the recovery worker told Mr Burnard that he had a telephone appointment with Turning Point on 10 October, and a face-to-face appointment on 11 October at 2.30pm.
29. On 7 October, the recovery worker saw Mr Burnard for a pre-release appointment. She told him that he would be given a seven-day prescription for his buprenorphine which he could collect from a local pharmacy. As Mr Burnard was no longer being released to Burnham-on-Sea, she gave him a map and highlighted the route he needed to take from his accommodation to the pharmacy to collect his prescription. She told Mr Burnard that she had arranged three appointments with the Gloucester community substance misuse team and gave him details of these appointments.
30. The recovery worker trained Mr Burnard in the use of naloxone (a medication used to reverse the effects of opioid overdose) and told him that he would be given a naloxone kit on his release. She then gave Mr Burnard detailed advice around harm minimisation. This included safer injecting information, information on the dangers of polydrug use, information on needle exchange hubs in Gloucester, and information on tolerance levels and overdose awareness. She told Mr Burnard how to recognise the signs and symptoms of an overdose, and what to do in the event of one. Mr Burnard said that he had no intention to use drugs illicitly. However, she gave him advice on how to keep himself safe if he did decide to use drugs. She told Mr Burnard to try a small amount first to test its strength and told him to smoke heroin rather than inject it, as injecting increased the risks of overdose. She also warned him about using crack cocaine and heroin together and how this could also increase the risks of overdose.
31. The recovery worker asked Mr Burnard if he understood what they had discussed, and he said that he did. She gave Mr Burnard a list of Narcotics Anonymous meetings in the Gloucester area as well as a list of other services that he could call if he found himself in crisis.
32. Later that day, Mr Burnard was released from Guys Marsh with his seven-day prescription of buprenorphine and a naloxone kit.

Release from Guys Marsh

33. As Mr Burnard had no accommodation, prior to his release, his community offender manager (COM) submitted several housing referrals and a duty to refer application (DTR - where certain public authorities must notify local authorities that a person who has engaged with them might be homeless or at risk of homelessness) to Plymouth Council. The COM found Mr Burnard a room in supported accommodation with a local charity, Julian House, however the room was not available until two weeks after his release. As the COM considered that he would be a high risk of harm to himself and others if he was released homeless, she arranged for him to stay at Ryecroft Approved Premises (AP) in Gloucester until the room at Julian House was ready.
34. On 7 October, Mr Burnard was released from Guys Marsh. He went to Ryecroft AP, and an AP worker inducted him. He signed to say he understood the AP rules which included not being under the influence of drugs.

35. At approximately 2.45pm on 12 October, an AP worker found Mr Burnard unresponsive on the dining room floor. The AP worker managed to wake Mr Burnard, but he became abusive and aggressive towards her. The AP worker suspected that Mr Burnard had taken drugs as he was slurring his words and was unsteady on his feet. When questioned, Mr Burnard said that he had drunk alcohol but denied taking drugs. The AP manager told Mr Burnard that she would withdraw his bedspace if he continued to break AP rules.
36. At 3.50pm, Mr Burnard left the AP without telling staff where he was going.
37. At around 4.00am the next morning, Mr Burnard returned to Ryecroft AP. AP staff suspected that Mr Burnard was still under the influence of drugs, and he continued to be abusive towards the staff. Later that morning, the AP manager withdrew Mr Burnard's bed space. As Mr Burnard was now homeless, his COM told him to present himself to Plymouth Council as they had a duty to house him. The COM told Mr Burnard that he must not go to his parents' address as he was considered a risk to them.
38. Later that day, Mr Burnard left the AP and went to his parents address in Highbridge, Somerset. (Under the terms of Mr Burnard's post-sentence supervision, his COM could not force him to stay away from his parents.)
39. On 14 October, after being notified of Mr Burnard's threatening and abusive behaviour at the AP, Julian House withdrew Mr Burnard's bedspace.
40. Over the next few days, Mr Burnard's COM made daily welfare checks on him and ensured that he had arranged to pick up his buprenorphine script. He remained at his parents' address while they looked for alternative accommodation.
41. On 18 October, Mr Burnard's COM told him that he must go to Plymouth Council and present himself as homeless. She arranged for him to pick up a travel warrant from Bridgewater Probation.
42. Later that day, Mr Burnard collected the travel warrant and went to Plymouth by train.

Circumstances of Mr Burnard's death

43. On 19 October 2022, Mr Burnard travelled to his ex-partner's address in Plymouth after she had offered him somewhere to stay. They drank alcohol and fell asleep at around 5.00am. The next day at approximately 1.00pm, Mr Burnard's ex-partner woke up to find Mr Burnard unresponsive on the floor, so she phoned the emergency services. Approximately 30 minutes later, paramedics arrived and confirmed that Mr Burnard was dead. Paramedics found an empty syringe and a needle in Mr Burnard's trouser pocket.
44. On 21 October, the police informed HMPPS that Mr Burnard had died.

Post-mortem report

45. The post-mortem report concluded that Mr Burnard died from drug misuse. The pathologist found high levels of morphine in Mr Burnard's blood which he said was likely to be from illicit heroin use.

Findings

46. We consider that Mr Burnard's COM appropriately prepared for his release. She liaised with external support agencies, arranged emergency accommodation for him in an AP, and secured him a room in supported housing through a local charity.

Good practice

47. We would like to highlight the good practice of the recovery worker, who worked tirelessly from Mr Burnard's initial reception into Guys Marsh to his final release to ensure that he had appropriate support in place to address his substance misuse issues. She created a detailed recovery care plan for Mr Burnard, saw him for regular 1:1 therapy sessions, and promptly secured him a space on a relapse prevention course at his request. On each occasion he was suspected of being under the influence of drugs in prison, she personally went to see Mr Burnard to check on his welfare and to warn him of the dangers associated with drug use.
48. The recovery worker also ensured that substance misuse support was put in place for Mr Burnard's release from prison by making the relevant referrals to community substance misuse services and arranging release appointments. When his release area changed unexpectedly, she promptly rearranged these appointments with the relevant substance misuse service in that area.
49. On the day of his release, the recovery worker gave Mr Burnard details instructions of how and where to collect his buprenorphine prescription, gave him extensive advice on harm minimisation, and gave him the contact details of additional support agencies available to him in the community, should he find himself in crisis.

Adrian Usher
Prisons and Probation Ombudsman

November 2023

Inquest

The inquest, held on 6 August 2024, concluded that Mr Burnard's death was drug related.

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