Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kurt Broadbent, a resident at Burdett Lodge Approved Premises, on 15 June 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100

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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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.

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.

Mr Kurt Broadbent died from solvent abuse on 15 June 2024 at Burdett Lodge Approved Premises. He was 30 years old. I offer my condolences to Mr Broadbent's family and friends.

Mr Broadbent was released from prison after a 14-day recall for taking drugs. Mr Broadbent had a long history of substance misuse and was well known to substance misuse services both in prison and in the community. Mr Broadbent's community offender manager and substance misuse worker gave Mr Broadbent support to help him stop taking drugs. Despite that support, Mr Broadbent started using drugs again the day after he was released from prison.

I make no recommendations.

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

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

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Summary

Events

1. On 28 May 2024, Mr Kurt Broadbent was recalled to prison for 14 days for breaching his licence by taking drugs. He was sent to HMP Nottingham.

2. On 10 June, Mr Broadbent was released on licence to Burdett Lodge Approved Premises (AP) in Derby.

3. The next day, Mr Broadbent travelled to Nottingham to see his substance misuse worker and to collect his methadone prescription. When Mr Broadbent returned from Nottingham, residential workers at Burdett Lodge recorded that he was struggling to stand up and appeared to be under the influence.

4. On 15 June, at around 6.00am, a residential worker started his morning checks of all residents. When he got to Mr Broadbent's room, he called his name, but Mr Broadbent did not respond. He noticed that Mr Broadbent was lying in an odd position on the bed with his legs dangling over the side. He could not see any signs of movement or breathing, and Mr Broadbent's eyes appeared to be open.

5. The residential worker radioed his colleague for help and they both went to the office to fetch a defibrillator and a cordless phone to call an ambulance. They returned to Mr Broadbent's room and tried to call 999 but were unable to get an outside line on the cordless phone. One of them went back to the office to call for an ambulance and asked the Ambulance Service operator to call them back so they could answer on the cordless phone. The Ambulance Service operator asked them to move Mr Broadbent to the floor and start resuscitation attempts. However, the residential worker said they were still opening the defibrillator box when they saw an ambulance arriving.

6. When the paramedics arrived, they assessed that Mr Broadbent had been dead for some time so did not attempt resuscitation.

Findings

7. We found that Mr Broadbent was given appropriate support with his substance misuse issues prior to his release. He was warned about reduced tolerance and risk of overdose. He was also given naloxone (medicine that rapidly reverses an opioid overdose).

8. There was a slight delay in the emergency response. Staff did not know how to call an outside line on the cordless phone so had to leave Mr Broadbent's room to go back to the office to call an ambulance. We found that Burdett Lodge did not have any local guidance for residential workers on what they should do if they found a resident unresponsive. It made no difference to the outcome for Mr Broadbent as he was dead when found, but we bring this to the AP manager's attention.

The Investigation Process

9. HMPPS notified us of Mr Broadbent's death on 15 June 2024

10. The investigator issued notices to staff and residents at Burdett Lodge Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

11. The investigator visited Burdett Lodge on 19 June. She obtained copies of relevant extracts from Mr Broadbent's prison, probation and medical records.

12. The investigator interviewed four members of staff at Burdett Lodge on 20 August. She also interviewed Mr Broadbent's substance misuse worker and a member of probation staff.

13. We informed HM Coroner for Derby and Derbyshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

14. The Ombudsman's office contacted Mr Broadbent's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Broadbent's mother wanted to know why she was not told officially that Mr Broadbent had died and why she found out on social media several days later. Mr Broadbent's mother also wanted to know more information around the circumstances of his death. We have answered these questions in this report.

15. We shared our initial report with HMPPS. They found no factual inaccuracies.

16. We sent a copy of our initial report to Mr Harvey's next of kin. They did not notify us of any factual inaccuracies.

Background Information

Burdett Lodge Approved Premises

17. Approved Premises (formerly known as probation or 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.

18. The Probation Service manages Burdett Lodge Approved Premises (AP) in Derby. It has 29 bedrooms and there is a kitchen and dining area that the residents can use. A key worker is allocated to each resident to oversee their progress, wellbeing and adherence to licence conditions and the premises' rules. Probation Service employees are on duty 24 hours a day to monitor residents' behaviour and report to their offender manager.

Previous deaths at Burdett Lodge

19. The last death at Burdett Lodge was in July 2020. It was drug related. In June 2023, a resident at Burdett Lodge was murdered in an adjacent street. We did not investigate this death.

Recall

20. Recall refers to the process of returning to prison an individual who does not follow their licence conditions. It is the responsibility of the Probation Service to initiate recall of individuals on licensed supervision through the Public Protection Casework Section (PPCS).

21. The recall process is set out in the Recall, Review and Re-Release of Recalled Prisoners Policy Framework. In addition to breaching a licence condition, Probation practitioners must consider whether the recall threshold has been made based on an individual's behaviour or circumstances presented whilst on licence.

22. At the point of initiating recall, it is the responsibility of the police to attend a known address and arrest the individual.

Key Events

23. On 10 November 2023, Mr Kurt Broadbent was recalled to prison for assaulting an emergency worker and criminal damage. He was sent to HMP Dovegate. On 28 November, Mr Broadbent was moved to HMP Featherstone.

24. On 10 April 2024, Mr Broadbent was released on licence to Trent House Approved Premises (AP) in Nottingham. However, on 28 May, he was recalled to prison for breaching his licence by taking drugs. He was sent to HMP Nottingham to complete a 14-day recall.

25. On 30 May, Mr Broadbent's community offender manager (COM) told Mr Broadbent's prison offender manager (POM) that Mr Broadbent had been allocated a space at Burdett Lodge AP in Derby (there was no space available at Trent House AP). The COM sent Mr Broadbent a message on the prison portal to tell him where he needed to go when he was released.

26. On 6 June, a worker from the substance misuse (SMS) team saw Mr Broadbent. He recorded that Mr Broadbent was aware of overdose risks and opiate tolerance on release, and that he accepted naloxone (medication that rapidly reverses an opioid overdose). He also recorded that an appointment had been made at Clean Slate (a community substance misuse team in Nottingham) for 3.00pm on 10 June (Mr Broadbent's release date).

27. The same day, a worker from the substance misuse team recorded that he notified a pharmacy in Nottingham of Mr Broadbent's release and shared his methadone prescription. (The SMS team had not been told that Mr Broadbent was due to be released to an AP in Derby and assumed he was being released to an AP in Nottingham.)

Release on 10 June

28. On 10 June, Mr Broadbent was released on licence to live at Burdett Lodge AP. His licence conditions included requirements to attend appointments with his COM, to abstain from using drugs and to comply with drug testing. In addition, Mr Broadbent was required to report to AP staff at 11.00am and 3.00pm each day, and to be at Burdett Lodge between the hours of 8.00pm and 6.00am.

29. At around 3.30pm that day, Mr Broadbent arrived at Derby probation office to see his COM. She recorded that she discussed Mr Broadbent's licence conditions with him and completed his induction pack. She also recorded that she was concerned that Mr Broadbent's SMS worker was in Nottingham and the pharmacy that he needed to collect his methadone prescription from was also in Nottingham, around an hour away from Derby.

30. The COM gave Mr Broadbent a travel warrant for the following day so that he could travel to see his SMS worker and collect his medication. She emailed Clean Slate to request that Mr Broadbent be transferred to St Andrews, a substance misuse team in Derby, nearer to where he was living.

Burdett Lodge Approved Premises

31. At around 5.00pm on 10 June, Mr Broadbent arrived at Burdett Lodge. Staff members were busy serving the residents their evening meal, so the AP manager (who had recently taken over on 3 June) completed Mr Broadbent's induction and a Support and Safety Plan (SaSP). During the induction, she explained the rules of the AP. She recorded that Mr Broadbent did not raise any concerns.

32. The next morning, Mr Broadbent left the AP to go to Nottingham to collect his methadone and see his substance misuse worker. Mr Broadbent returned to the AP later that day. Staff recorded that he was struggling to stand up and appeared to be under the influence. Staff monitored Mr Broadbent hourly throughout the rest of the day and night.

33. On 12 June, Mr Broadbent attended an induction with his key worker. The key worker recorded that Mr Broadbent no longer appeared to be under the influence and that he was annoyed that staff had monitored him every hour throughout the night. He also recorded that Mr Broadbent did not want his SMS worker to change and that he said he was happy to travel to Nottingham.

34. On 13 June, a residential worker recorded that Mr Broadbent appeared to be under the influence again. He recorded that Mr Broadbent was swaying and slurring his words. When he challenged Mr Broadbent, he said that he had had 'a spliff' an hour ago.

35. The temporary AP manager (who had remained in post for a one-month handover to the new AP manager) spoke to Mr Broadbent and told him that taking drugs was not acceptable. Mr Broadbent became upset and denied being under the influence. She told Mr Broadbent that if he continued to use drugs he may be recalled back to prison.

36. Staff at the AP reported Mr Broadbent's drug use to the COM, and she emailed Mr Broadbent's SMS worker and asked if Mr Broadbent's drug testing frequency could be increased.

37. On 14 June, Mr Broadbent returned to the AP and was seen talking to other residents and playing pool all evening.

Events of 15 June

38. At around 2.00am on 15 June, a residential worker at Burdett Lodge started his resident checks, which included making sure that all residents were in their rooms. He noted that Mr Broadbent was in his room asleep.

39. At around 6.00am, the residential worker carried out a routine morning check of all residents. (During the morning check, residential workers are expected to get a response which indicates the person is awake, though it does not necessarily need to be verbal.) He opened Mr Broadbent's bedroom door and called him, but Mr Broadbent did not respond. He saw Mr Broadbent lying towards the end of the bed at an odd angle, with his legs dangling over the edge. He raised his voice and called Mr Broadbent's name loudly to try to rouse him, but Mr Broadbent still did not

respond. In interview, he said he saw no signs of movement or breathing, and Mr Broadbent's eyes appeared to be open.

40. The residential worker radioed his colleague and asked him to come to Mr Broadbent's room. In interview, he said that he then realised they would need to call for an ambulance and collect a defibrillator, so he made the decision to go to the office.

41. The residential worker met his colleague in the corridor outside Mr Broadbent's room and both residential workers went to the office to get the cordless phone and a defibrillator and returned to Mr Broadbent's room. He tried to call for an ambulance on the cordless phone, but he did not know the code for an outside line, so he went back to the office and called an ambulance. He asked the operator to call back so they could answer on the cordless phone, and he returned to Mr Broadbent's room. His colleague was by then on the phone to the ambulance operator, who advised moving Mr Broadbent to the floor and starting resuscitation. He said they were still opening the defibrillator box when they heard the ambulance arriving.

42. At 6.14am, an ambulance arrived. Paramedics noted that rigor mortis had set in, so they did not start CPR. Paramedics pronounced that Mr Broadbent had died.

Contact with Mr Broadbent's family

43. The normal practice when a resident dies in an AP, is for the police to inform the next of kin (NOK). However, when Mr Broadbent had his initial induction at the AP he refused to give any NOK details, so AP staff were not able to tell the police who to contact.

44. Mr Broadbent's partner was listed on police records as Mr Broadbent's NOK, so police visited her to break the news of Mr Broadbent's death. Mr Broadbent's mother found out that Mr Broadbent had died on social media. She contacted the AP and told them that from then on, she would be Mr Broadbent's NOK.

45. The Probation Service contributed to the funeral expenses in line with national instructions.

Support for residents and staff

46. After Mr Broadbent's death, the temporary AP manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.

47. The temporary manager held a meeting and told all the residents that Mr Broadbent had died. She also spoke to all the residents individually and arranged for a counsellor to visit the AP for additional support.

Post-mortem report

48. The post-mortem report gave Mr Broadbent's cause of death as consistent with the effects of solvent use.

Findings

Substance misuse support

49. We found that Mr Broadbent received appropriate support with his substance misuse issues prior to his release from Nottingham. A prison substance misuse worker warned him about reduced tolerance and risk of overdose and gave him naloxone.

50. The substance misuse worker also arranged an appointment for Mr Broadbent to see his community SMS worker and for his methadone prescription to be sent to a community pharmacy. However, both were in Nottingham, around an hour away from Burdett Lodge in Derby. The SMS team had not been told that Mr Broadbent was going to Burdett Lodge and assumed that he was going back to Trent House in Nottingham.

51. The substance misuse worker said at interview that he would welcome regular meetings with the POM and would welcome a system where information could be shared. He said that would stop the issue of prescriptions being sent to a pharmacy that was a long distance away. We bring this to the attention of the Governor at HMP Nottingham and the Probation Service.

Emergency response

52. There was a slight delay in calling for an ambulance. We found that there was no local guidance to tell staff what to do in a medical emergency. While it made no difference in this case as Mr Broadbent was dead when found, we bring this issue to the AP manager's attention.

Inquest

53. The inquest, held on 10 January 2025, concluded that Mr Broadbent's death was drug related.

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