Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Chignell, on 12 August 2025, following his release from HMP Peterborough

A report by the Prisons and Probation Ombudsman

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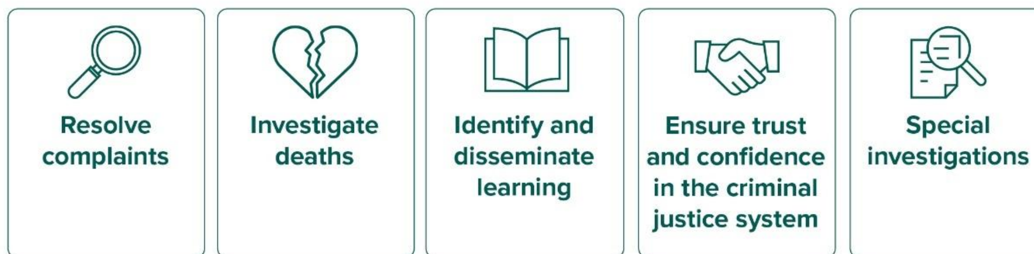
OUR VISION

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 investigated 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 Chignell died from combined cocaine, methadone, olanzapine, morphine, and clonazepam toxicity on 12 August 2025 following his release from HMP Peterborough on 6 August 2025. He was 34 years old. We offer our condolences to those who knew him.

5. HMP Peterborough failed to ensure that Mr Chignell was released with the correct licence, despite his community offender manager providing this information to the prison in advance. Peterborough also did not respond to any emails from his community offender manager, and this made the release planning for Mr Chignell difficult. We make the following recommendations:

Recommendations

- The Director and Head of Healthcare should review the processes for sharing relevant pre-release information between relevant departments, and with the community offender manager, in a timely manner so that release planning is effective.

The Investigation Process

6. HMPPS notified us of Mr Chignell’s death on 20 August 2025.

7. The PPO investigator obtained copies of relevant extracts from Mr Chignell’s prison and probation records.

8. As part of the investigation, the investigator spoke to Mr Chignell’s community offender manager.

9. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. They gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Peterborough

11. HMP Peterborough is a category B private prison which holds both male and female prisoners in separate sides of the prison. It is managed by Sodexo Justice Services. Northamptonshire Healthcare NHS Foundation Trust provide physical and mental healthcare, as well as substance misuse services.

Probation Service

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

Key Events

Background

13. Mr Lee Chignell had served a number of sentences in prison, most recently for the possession of offensive weapons, for which he was released from HMP Peterborough on 7 July 2025. Four days later on 11 July 2025, he was recalled to Peterborough for a fixed term of 28-days for not complying with his licence conditions.

14. During his initial health screen on 11 July, Mr Chignell tested positive for buprenorphine (an opiate substitution medication), methadone (another opiate substitution medication), opiates and benzodiazepine. He told the healthcare nurse that he had a history of crack cocaine use and had used heroin when he was released from Peterborough. He was referred to substance misuse services and was prescribed methadone.

15. On 14 July, a recovery worker for the substance misuse team, saw Mr Chignell. He told her that he wanted to be released to Norwich. She provided him with naloxone (a medication that reverses the effects of opioids) training and harm reduction information. He declined to engage with the substance misuse service but agreed to a referral to Change Grow Live (CGL, a community substance misuse service) in Norwich. The referral was later made. She did not share this information with Mr Chignell's prison offender manager (POM) or community offender manager (COM). The Healthcare Operations Manager told the investigator that it is not part of the healthcare pathway to share information with staff unless it is requested or a risk is identified. The Head of Offender Management Delivery told us that recovery workers should liaise with POMs and can email COMs directly.

16. Despite Mr Chignell declining substance misuse treatment, a recovery worker continued to see Mr Chignell throughout his time at Peterborough, but there were no concerns raised.

17. On 31 July, following a video-link appointment with Mr Chignell's COM, submitted an application for housing to Harlow council under the statutory duty to refer those at risk of homelessness. She told the investigator that she completed the referral there because Mr Chignell had connections to Harlow. The COM told the investigator that neither Mr Chignell nor the prison had told her that he intended to live in Norwich on release, and had she known, she would not have supported this wish.

18. On 1 August, the COM completed a housing application to Chelmsford council under the duty to refer. That day, she also emailed the Offender Management Unit (OMU) at Peterborough with details of Mr Chignell's release probation appointment on 6 August at the Harlow probation office and additional licence conditions. She also asked if Mr Chignell had been referred to the community substance misuse team. She did not receive a response to this email.

19. That day, the COM also referred Mr Chignell to Emerging Futures (a community service which provides housing to those at risk of homelessness) in Hertfordshire.

20. On 5 August, a recovery worker gave Mr Chignell the details of his appointment with CGL Norwich on release. She gave him harm reduction information and trained him again on how to use nasal naloxone.

Release from HMP Peterborough

21. On 6 August, Mr Chignell was released from Peterborough. He declined to take a nasal naloxone kit, against a recovery worker's advice. Mr Chignell was incorrectly advised that his release probation appointment was on 7 August. Mr Chignell's licence had also not been updated with the additional conditions the COM had set out in her email on 1 August. the Head of Offender Management Delivery told the investigator that the custody team would usually action emails from COMs but not necessarily respond to the email. However, on this occasion, it had not been actioned.

22. Mr Chignell's licence conditions included a condition which required Mr Chignell to address his drug dependency and be tested for drugs.

23. Mr Chignell did not attend his probation appointment on the day of release. The COM told the investigator that this was a common occurrence with him, and other than the video-link appointment on 31 July, Mr Chignell had failed to engage in all appointments since she took over his case in November 2024.

24. On 7 August, Mr Chignell attended the Peterborough probation office and was seen by the duty officer. He told the duty officer that he did not wish to attend the Harlow office. The COM joined the meeting via Teams and informed him of his housing assessment appointment on 12 August with Emerging Futures. He disclosed that he had been released with diazepam and had given them out to others and was street homeless in Peterborough. The COM's referrals for accommodation remained outstanding.

25. That day, the COM contacted the OMU at Peterborough via Microsoft Teams. They sent the COM the licence conditions, and she discovered that the wrong licence was issued to Mr Chignell on his release.

Circumstances of Mr Chignell's death

26. On 12 August, Mr Chignell was found collapsed in a supermarket car park in Peterborough. Despite the warm temperature, Mr Chignell was wearing several layers of clothing and was hyperthermic (when the body overheats) and hypotensive (low blood pressure). Paramedics were called at 4.13pm, and they arrived minutes later. Mr Chignell was admitted to Peterborough City Hospital, where he had a cardiac arrest. Hospital staff tried to resuscitate Mr Chignell but he died at 6.30pm.

Post-mortem report

27. The post-mortem report concluded that Mr Chignell died of combined cocaine, methadone, olanzapine, mirtazapine, morphine and clonazepam toxicity. Mr Chignell was prescribed mirtazapine, clonazepam, methadone and olanzapine. The post-mortem toxicology results found therapeutic levels of methadone, olanzapine

and mirtazapine, and low levels of morphine and clonazepam. However, we do not know whether Mr Chignell collected his methadone prescription in the community.

Inquest

28. At an inquest held on 15 April 2026, the Coroner concluded that Mr Chignell's death was drug related.

Findings

Accommodation

29. Homelessness on release from prison is a significant and complex challenge. While prison and probation staff can submit referrals to local authorities and charities, there are occasions when beds are not available or the individual does not meet the eligibility criteria for housing. If an individual is homeless, it can increase the likelihood that he will commit further offences or seek shelter and support in harmful places.

30. Mr Chignell was released from Peterborough without accommodation. Although Mr Chignell had told his recovery worker that he intended to live in Norwich on release, The COM was not made aware of this and completed housing referrals for areas where she knew Mr Chignell had connections. She had not been able to secure any accommodation for him before his release. We consider that the COM's made reasonable attempts to find accommodation for Mr Chignell during his short time in prison.

Communication between healthcare, prison and probation staff

31. Mr Chignell told his recovery worker on 14 July that he intended to live in Norwich following his release. Healthcare staff referred Mr Chignell to Norwich CGL for substance misuse support. This information was not shared with Mr Chignell's POM or the COM. The Healthcare Operations Manager and the Head of Offender Management Delivery told the investigator differing information about staff's responsibilities to share information, and there was no agreed practice in place to enable effective information sharing between healthcare staff and prison offender managers - who could then share that information with COMs.

32. Peterborough informed the COM of Mr Chignell's referral to Norwich CGL, she could have discussed this with Mr Chignell and explored the likelihood of obtaining accommodation for him there. Communication between prisons and probation as a prisoner is released from custody is important to ensure that community practitioners are given the information they need to manage individuals in the community.

33. Even though the COM gave the prison the relevant information in sufficient time for his release, the licence that Peterborough gave Mr Chignell on release contained inaccurate information, including the wrong date for his probation appointment. We found that the failures in communication affected the quality of pre-release planning and post-release supervision Mr Chignell received and we make the following recommendation:

    The Director and Head of Healthcare should review the processes for sharing relevant pre-release information between relevant departments, and with the community offender manager, in a timely manner so that release planning is effective.

Adrian Usher
Prisons and Probation Ombudsman **May 2026**

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Annexes

1. Action plan

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