

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Gardner, on 12 August 2022, following his release from HMP Portland

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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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 detained people in immigration centres.
2. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of a person's release from prison.
3. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
4. Mr Lee Gardner died from cocaine toxicity on 12 August 2022, following his release from HMP Portland on 9 August. He was 40 years old. We offer our condolences to his family and friends.
5. Mr Gardner had a long history of substance misuse but claimed he was drug-free during his last period in prison (from August 2021). We found that there was good pre-release planning for Mr Gardner, which included arranging appropriate accommodation for him on release. Despite this, the day after his release, Mr Gardner was found unconscious in the street after taking heroin and cocaine. He died in hospital two days later.
6. We make no recommendations.

The Investigation Process

7. The PPO investigator obtained copies of relevant extracts from Mr Gardner's prison and probation records.
8. We informed HM Coroner for Avon of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
9. The Ombudsman's family liaison officer contacted Mr Gardner's next of kin, his father, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not have any questions but asked for a copy of the report.
10. The initial report was shared with Mr Gardner's father. He did not make any comments.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies.

Background Information

HMP Portland

12. HMP/YOI Portland is a category C prison holding up to 530 adult and young adult male prisoners. GP and primary care health services are delivered by Practice Plus Group. Substance misuse services are provided by Exeter Drugs Project.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Portland was in July and August 2022. Inspectors found that there had overall been significant improvements in the prison since their previous inspection in 2019. However, they reported that changes in resettlement provision had created uncertainties in both staff and prisoners. They said that although they saw some good quality resettlement plans with follow up actions, there were now only two resettlement workers with one administrator for support. However, they said these staff were working hard to address shortfalls, including that not all prisoners had their resettlement plans in place in time before their release.

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. They have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

Key Events

15. On 11 August 2021, Mr Lee Gardner was convicted of assault and threatening behaviour. He was released on bail pending sentencing. However, on 24 August, he was remanded in prison custody, following further charges, and sent to HMP Bristol. He was sentenced to 23 months imprisonment on 14 September. On 14 February 2022, he was sent to HMP Portland.
16. Mr Gardner had a history of substance misuse, including heroin, crack cocaine and buprenorphine (an opioid). Although Mr Gardner had been prescribed methadone (a synthetic opioid) during some of his previous sentences, he refused to see a GP or engage with substance misuse services when he arrived at Bristol. However, Mr Gardner agreed to have naloxone (a medication to be used in an emergency to reverse the effects of opioids) stored with his belongings to be available for him on release.
17. Mr Gardner claimed that he was drug-free during his latest sentence, and there were no confirmed positive drug tests while he was at Bristol or Portland. However, at both prisons, officers found hooch (illicitly brewed alcohol) in cells that Mr Gardner occupied. The last time this happened was on 29 July, just before he was released from prison.

Pre-release planning

18. On 16 February, Mr Gardner's Prison Offender Manager (POM) introduced herself to him. He told her that he did not like probation workers and would not be working with them either in prison or on release.
19. Mr Gardner's prison resettlement officer met him on 19 May. She went through a 12-week resettlement plan with him, and he said he would be homeless on release. She sent the 12-week resettlement plan to the POM, and the assigned Community Offender Manager (COM). She also noted that although Mr Gardner said he was not using drugs, she was aware of his history of substance misuse and had already liaised with the prison's substance misuse services.
20. The prison resettlement officer carried out a further housing assessment with Mr Gardner on 30 June and noted that he was very worried about becoming homeless on release from prison.
21. On 13 July, a multidisciplinary team discussed Mr Gardner's issues at a pre-release meeting.
22. After Mr Gardner's father contacted a resettlement officer from Bristol who had previously worked with Mr Gardner, he contacted the prison resettlement officer. She co-ordinated phone calls between Mr Gardner and the resettlement officer from Bristol and also with his COM. In the week before his release, Mr Gardner's accommodation with the Junction Project was confirmed. This is supported housing in Bristol, tailored for people with substance misuse problems.
23. The resettlement team at Portland also booked Mr Gardner an appointment at a Jobcentre and went through all the steps with him to address issues such as

claiming benefit and his referrals to other support agencies. The day before his release, the prison resettlement officer met Mr Gardner to make sure he was clear about everything, including his appointments with his COM the next day.

Post-release

24. Mr Gardner was released from prison on 9 August and reported to the probation office at 2.00pm as planned. Mr Gardner's COM went through his licence conditions with him. Although Mr Gardner said he was not happy with the conditions, he indicated that he was willing to comply. His COM also completed a referral for Mr Gardner to the Interventions Alliance Activity Hub, an organisation offering a safe space to develop employability and life skills, and told him that his next appointment at the probation office was on 16 August.
25. The resettlement officer from Bristol picked up Mr Gardner following his appointment with his COM and took him to his accommodation. The following day, Mr Gardner attended his appointment with the Jobcentre, and he phoned the resettlement officer for his help to sort out an issue he had with filling in his forms.

Circumstances of Mr Gardner's death

26. Following his Jobcentre appointment on 10 August, Mr Gardner's movements are unknown until someone found him unwell in a street and called an ambulance at around 1.40pm.
27. When the paramedics arrived a few minutes later, Mr Gardner was lying unconscious in the road with an extremely high temperature (42.1C) and extremely high heart rate (over 160 beats a minute and as high as 177). His breathing rate was also elevated, and his blood oxygen level was low, as was his blood pressure. The paramedics gave Mr Gardner oxygen, paracetamol and precautionary naloxone (a drug that rapidly reverses an opioid overdose).
28. The ambulance crew took Mr Gardner to hospital, where he was treated in the intensive care unit (ICU). However, Mr Gardner did not recover, and died in hospital on 12 August.

Post-mortem report

29. The post-mortem report concluded that although Mr Gardner had taken heroin before he died, it was not at a level that alone would have caused death. There was also a significant amount of cocaine present. The pathologist concluded that this had probably caused a sudden cardiac event which had led to a cardiac arrest (when the heart stops pumping blood around the body). The pathologist gave the cause of death as global cerebral hypoxia (a lack of oxygen to the brain) and multi organ failure, caused by acute toxicity of cocaine.

Findings

30. Mr Gardner had used drugs and alcohol over a very long period of time. When he went to Bristol on remand, he tested positive for several illegal drugs. However, he refused to see a GP or engage with substance misuse services despite experiencing the effects of withdrawal. His engagement with healthcare at Portland was also minimal, and he refused to engage with his healthcare discharge planning. However, he had accepted a naloxone kit at Bristol which had been placed in his stored possession in prison for him to have on release.
31. We found that there was very good engagement and planning for Mr Gardner's release by the resettlement officers at both Portland and Bristol, who coordinated well with Mr Gardner's COM, as well as his family. Mr Gardner was released into appropriate housing for someone with his substance misuse issues. However, Mr Gardner relapsed quickly and the day after he was released from prison, he was found in a serious condition from the effects of substance misuse, from which he died in hospital two days later.
32. We make no recommendations.

Kimberley Bingham
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