

**Prisons &
Probation**

Ombudsman
Independent Investigations

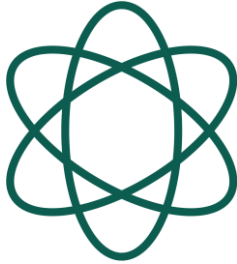
Independent investigation into the death of Mr Lee Carr on 27 May 2022, following his release from HMP Durham

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 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. 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 Carr died from the toxic effects of methadone (heroin substitute), pregabalin and another prescription drug on 27 May 2022, following his release from HMP Durham on 23 May. He was 31 years old. I offer my condolences to his family and friends.
5. Mr Carr had a history of substance misuse. We found that Mr Carr received appropriate support for his substance misuse issues while he was at Durham and was warned about the risks of continuing to take pregabalin alongside his methadone. We make no recommendations.

The Investigation Process

6. The PPO investigator obtained copies of relevant extracts from Mr Carr's prison and probation records.
7. We informed HM Coroner for Cumbria of the investigation. They gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
8. The Ombudsman's family liaison officer contacted Mr Carr's next of kin, his father, to explain the investigation and to ask if he had any matters he wanted us to consider. He had no questions but asked for a copy of our report.
9. We shared our initial report with HM Prison and Probation Service (HMPPS). They found one factual inaccuracy, which has been amended in the report.
10. We sent a copy of our initial report to Mr Carr's father. He did not notify us of any factual inaccuracies.

Background Information

HMP Durham

11. HMP Durham is a category B local prison which holds up to 980 male prisoners who have either been convicted or are on remand. It is managed by His Majesty's Prison and Probation Service (HMPPS).
12. Spectrum Community Health CIC is the prime provider of health care, including clinical substance misuse services. Psychosocial drug and alcohol services are subcontracted to Humankind and mental health care is subcontracted to Tees, Esk and Wear Valleys NHS Foundation Trust.

Probation Service

13. 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

14. On 26 April 2022, Mr Lee Carr was convicted of driving offences and was sentenced to eight weeks in prison. He was sent to HMP Durham.
15. On 27 April, Mr Carr told a prison GP that he had a history of drug use which included the abuse of prescription medication, specifically benzodiazepines (a type of sedative medication). Mr Carr also said that he was taking methadone (an opiate (heroin) substitute), pregabalin (used to treat anxiety and epilepsy but also widely abused as it increases the euphoric effects of opiates) and Epilim (used to treat seizures) before he entered prison. The GP told Mr Carr that he should no longer take pregabalin, due to its addictive nature and because of the potential dangers of mixing it with other drugs. The GP started Mr Carr on a pregabalin detox (slowly reducing his daily dose of pregabalin before stopping it completely).
16. On 28 April, the prison Drug and Alcohol Recovery Team (DART) accepted Mr Carr onto their caseload.
17. On 3 May, Mr Carr had a review with the DART team. The DART team advised Mr Carr not to use drugs in prison and warned him about how his tolerance levels would change if he did reduce his drug use. They explained that this would increase his risk of overdosing.
18. The next day, a DART nurse saw Mr Carr and completed a full substance misuse assessment. The nurse again warned Mr Carr of the risk of overdosing and about drug tolerance levels. The nurse referred Mr Carr to Recovery Steps Carlisle (the community DART team) ready for his release from prison.
19. On 12 May, a DART nurse visited Mr Carr after he requested a raise in his methadone dose due to experiencing withdrawal symptoms (shaky legs). The DART nurse again discussed tolerance and overdose levels with Mr Carr. The DART nurse did not agree to increase his methadone dose.
20. The same day, Mr Carr saw a prison GP after concerns were raised that he had stopped taking his seizure medication. The doctor told Mr Carr about the risks of not taking this medication. The GP also told him about the dangers of taking pregabalin and methadone together, which increased risks to the heart and could lead to sudden death. The GP strongly advised Mr Carr to continue his pregabalin detox after release from prison.
21. On 23 May, Mr Carr was released from Durham. The same day, the prison DART team sent a referral letter to the community DART team, informing them of Mr Carr's release.

Post-release

22. On 23 May, Mr Carr reported to Carlisle Probation Office for his initial supervision appointment. Mr Carr's allocated probation officer was on leave, so Mr Carr was seen by a colleague. During the appointment, Mr Carr signed his licence conditions and gave her a brief overview of his current circumstances. He told her that he had problems with substance misuse and that he was working with Recovery Steps. He

told her that he had an appointment with Recovery Steps that day and was going to attend after his probation appointment. She told Mr Carr to attend his next probation appointment with his allocated probation officer on 1 June at 10.00am.

23. On 1 June, Mr Carr did not attend his appointment at Carlisle Probation Office. The same day, his probation officer sent him a letter with a new appointment date for 7 June.

Circumstances of Mr Carr's death

24. On 7 June, Mr Carr's stepmother contacted the probation officer and told her that Mr Carr had died. Mr Carr's father had found him dead in his flat on the morning of 27 May.

Post-mortem report

25. The post-mortem report concluded that Mr Carr died of respiratory depression (a failure of the lungs) caused by a combination of methadone, pregabalin and bromazolam (a benzodiazepine).

Inquest

26. At the inquest held on the 6 April 2023, the Coroner concluded that Mr Carr's death was drug related.

Kimberley Bingham
Acting Prisons and Probation Ombudsman

April 2023

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