Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Addy McAllister, a prisoner at Burdett Lodge Approved Premises, on 6 July 2020

A report by the Prisons and Probation Ombudsman

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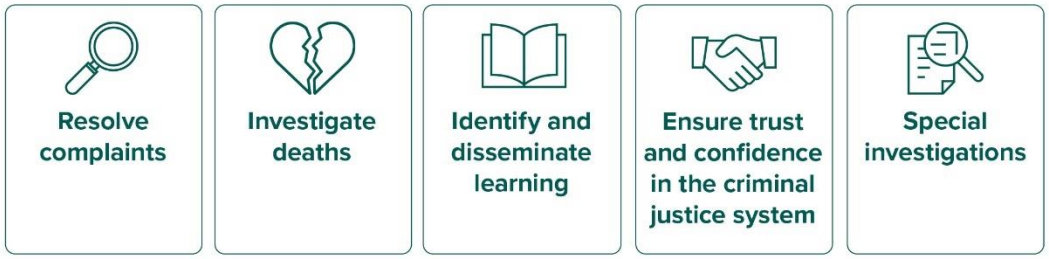
OUR VISION

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

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 HM 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 Addy McAllister died at Burdett Lodge Approved Premises on 6 July 2020 of combined drug toxicity. He was 38 years old. I offer my condolences to Mr McAllister's family and friends.

While in prison, Mr McAllister had successfully stopped taking drugs, and there was no evidence to indicate that he had recently used drugs in prison. I am satisfied that staff at Burdett Lodge had no reason to suspect that Mr McAllister was taking illicit drugs.

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

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

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Summary

Events

1. In 2017, Mr Addy McAllister was convicted of manslaughter and sentenced eight years in prison. He had no significant health issues, was not prescribed any medication and had no history of self-harm. He had a history of substance misuse but he had successfully stopped taking drugs while in prison at HMP Lindholme and there is no evidence that he had used drugs in prison in the eleven months before his release.

2. On 11 May 2020, Mr McAllister was released on licence from Lindholme to Burdett Lodge Approved Premises (AP). A residential support worker completed Mr McAllister's induction and made him aware of a reduced tolerance to drugs and an increased risk of overdose after release from prison.

3. Mr McAllister had regular contact with his probation practitioner who noted that he was feeling stronger and intended to remain drug-free. Mr McAllister complied with his curfew and AP staff did not suspect that he was under the influence of illicit substances.

4. At 6.00am on 6 July, a night support worker carried out a welfare check of residents and reported that Mr McAllister was asleep in bed. At 9.40am a resident alerted staff that Mr McAllister was unresponsive in his room. Staff immediately attended and a residential worker used her mobile phone to call an ambulance. The AP manager started cardiopulmonary resuscitation (CPR). At 9.51am, paramedics arrived and took over Mr McAllister's care. At 10.41am, a paramedic confirmed that Mr McAllister had died.

5. A post-mortem examination found that Mr McAllister died of mixed drug toxicity and bronchopneumonia.

Findings

6. Mr McAllister appeared to have been determined to change his lifestyle, including abstaining from drug use, on his release from Lindholme. AP staff told him about his likely reduced tolerance to drugs and his increased risk of overdose when he arrived.

7. Drug testing at Burdett Lodge had been suspended at the time of Mr McAllister's death due to COVID-19. AP staff said that Mr McAllister did not present as being under the influence of drugs at any time while he was resident at Burdett Lodge. In the hours before his death, staff did not have any concerns about his behaviour. We are satisfied that staff had no reason to suspect that he might be using illicit drugs.

The Investigation Process

8. HMPPS notified us of Mr McAllister's death on 7 July 2020.

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

10. The investigator obtained copies of relevant extracts from Mr McAllister's prison and medical records. She spoke to the AP manager and Mr McAllister's AP key worker several times by videoconferencing.

11. The case was suspended while we waited for the cause of death.

12. We informed HM Coroner for Derby and South 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.

13. We wrote to Mr McAllister's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr McAllister's mother asked if Mr McAllister was routinely drug tested and about the events leading up to his death. We have answered her questions in the report.

14. Mr McAllister's mother received a copy of the initial report. She pointed out a factual inaccuracy. This report has been amended accordingly, and also addressed in separate correspondence.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

Burdett Lodge

16. 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.

17. The National 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

18. Mr McAllister was the second resident to die at Burdett Lodge since July 2017. There were no similarities with the previous investigation.

Parole Board

19. The Parole Board for England and Wales is an independent public body. Its role is to make risk assessments about prisoners to decide whether they can safely be released into the community once they have served the minimum term of imprisonment imposed by the courts.

Key Events

20. On 24 September 2015, Mr Addy McAllister was sentenced to life in prison for murder and sent to HMP Woodhill. On 25 September 2017, Mr McAllister was sentenced to 8 years in prison for manslaughter after he appealed against his original conviction. He spent time in several prisons before moving to HMP Ranby on 23 August 2018.

21. On 25 March 2019, Mr McAllister was released on licence to an Approved Premises (AP) but was recalled to HMP Lincoln on 9 April after he received a warning for taking psychoactive substances.

22. Mr McAllister had a history of substance misuse but completed a methadone detoxification programme in prison.

HMP Lindholme

23. On 25 April 2019, Mr McAllister was transferred to HMP Lindholme. There is no evidence that Mr McAllister used drugs at Lindholme in the eleven months before his release. Prison staff noted that Mr McAllister showed a willingness to address his offending behaviour and comply with future licence conditions.

24. On 9 March 2020, the Parole Board directed Mr McAllister's release from prison. A recommendation was made for Mr McAllister to live at an AP so he could receive closer supervision and community substance misuse support.

25. A nurse at Lindholme saw Mr McAllister before his release. The nurse raised no concerns about his fitness to be released, noted that he was not taking any medication, and that he reported no mental health issues and had no thoughts of self-harm. The nurse also offered Mr McAllister naloxone and explained how the medication should be used in the event of an opiate overdose. Mr McAllister declined to take the medication with him because he did not intend to use drugs. (Naloxone is a medication used as an emergency antidote for overdoses caused by heroin and other opiates. It is used to counter the life-threatening effects of depressed breathing in an opioid overdose and is administered to provide a window of time in which to seek further emergency assistance. It does not need to be administered by a medical professional.)

26. On 11 May, Mr McAllister was released on licence from Lindholme to live at Burdett Lodge AP. His licence conditions included requirements to attend appointments with his community offender manager (COM), to abstain from using drugs and to comply with drug testing. Mr McAllister was required to attend the Derbyshire Recovery Programme to address his issues with drugs and to address his violent offending behaviour problems at the Resolve Programme. He was required to report to AP staff at 11.00am and 3.00pm and to be at Burdett Lodge AP between the hours of 7.00pm and 6.00am.

Burdett Lodge Approved Premises

27. At 2.30pm on 11 May, Mr McAllister arrived at Burdett Lodge. A residential worker completed Mr McAllister's induction. He gave him information about the AP, including the AP's rules, and the additional rules during the COVID-19 lockdown (about social distancing and only leaving the AP for specific reasons, such as shopping and medical appointments). The induction also included a discussion with him about a reduced tolerance to drugs and an increased risk of overdose after release from prison. The residential worker noted that Mr McAllister intended to register with a GP practice. He also needed to be tested for drugs twice a week and alcohol three times a week when COVID-19 restrictions were changed.

28. That day, Mr McAllister spoke to his probation practitioner on the telephone. She noted that as Mr McAllister had not been assessed as being in crisis, he was unable to attend the drug and alcohol recovery service while COVID-19 restrictions remained in place. Mr McAllister said that he had been drug and alcohol free for eleven months. He was assessed as a low risk of suicide and self-harm and he was not prescribed any medication. She spoke to Mr McAllister once a week. She noted that he was feeling stronger, intended to engage with the drug and alcohol recovery service and was not using illicit substances.

29. Probation records show that a residential worker was allocated as Mr McAllister's AP keyworker. A keyworker works with the resident and their probation offender manager to address any issues that the resident might have. The key worker spoke to Mr McAllister regularly on the telephone and did not have any concerns.

30. During the seven weeks that Mr McAllister was at Burdett Lodge until his death, AP staff did not note any concerns about Mr McAllister's behaviour and he was fully compliant with his licence conditions. As drug testing at all APs had been suspended at the time due to COVID-19 restrictions, and AP staff only completed visual observations of residents. there was no evidence to suggest that Mr McAllister was under the influence of illicit substances.

Events of 5 and 6 July

31. Probation records show that on 5 July, Mr McAllister left Burdett Lodge at 11.00am and returned at 3.00pm. He left again shortly after and returned at 7.00pm in accordance with his licence conditions. AP staff completed welfare checks at 11.00pm. Mr McAllister was in his room and did not express any concerns.

32. At 6.00am on 6 July, a night resident support worker completed a welfare check. He noted that Mr McAllister was asleep in his bed. He completed a handover with the AP manager and confirmed that the 6.00am welfare checks had been completed and that no concerns about Mr McAllister were raised.

33. At approximately 9.40am, an AP resident told staff that he was concerned that Mr McAllister had taken an overdose. Staff immediately responded and went into Mr McAllister's room. The AP manager told us that there was no evidence to suggest that the resident was taking drugs with Mr McAllister.

34. Mr McAllister was lying in his bed and was unresponsive. A residential worker used her mobile phone to call an ambulance and her colleague left the room to get a defibrillator. A resident helped the AP manager and a residential worker, and moved Mr McAllister to the floor to enable staff to start CPR and attached a defibrillator in accordance with ambulance service instructions.

35. At 9.51am, paramedics arrived at Mr McAllister's room and took over resuscitation efforts. At 10.41am, a paramedic pronounced that Mr McAllister had died. No evidence of drug use was found in Mr McAllister's room.

Contact with Mr McAllister's family

36. The normal practice when a resident dies in an AP is for the police to inform the next of kin. The AP manager gave the police Mr McAllister's mother's details as he had named her as his next of kin. The next day, he telephoned Mr McAllister's mother to offer his condolences and support.

37. The Probation Service did not contribute towards the cost of Mr McAllister's funeral, in line with national policy. During the initial report consultation stage, the Approved Premises Area Manager asked Mr McAllister's family to contact him to discuss the funeral contribution.

Support for residents and staff

38. After Mr McAllister's death, the AP manager offered immediate support to the staff on duty. Support was offered to all the staff who worked at the AP the next day.

39. Staff held a meeting and told all the residents that Mr McAllister had died and offered support. Notices were posted.

Post-mortem report

40. The post-mortem report gave Mr McAllister's cause of death as combined drug toxicity. Mr McAllister also had bronchopneumonia which did not cause but contributed to his death. The post-mortem report found that Mr McAllister had a level of tramadol, buprenorphine and pregabalin in his blood above the level that is usually associated with therapeutic use. Mr McAllister also had an underlying chest infection that compromised the use of his lungs.

Findings

Substance misuse

41. Mr McAllister had a history of substance misuse and was referred to the community drug and alcohol service on his release from prison. There was no evidence or intelligence to indicate that Mr McAllister had used drugs at Lindholme and he said he wanted to remain drug-free.

42. AP staff gave Mr McAllister information about the risk of drug overdose and his lowered drug tolerance. Mr McAllister told his probation practitioner that he had been drug free for eleven months and he displayed a positive attitude towards engaging with drug recovery services. Mr McAllister was referred to substance misuse services to help prevent the possibility of relapse, but he died before he had contact with them.

43. Once the induction process was completed, Mr McAllister was free to leave the AP. Staff had no reason to consider that he was leaving the AP to buy drugs and could not have prevented him from doing so. The AP staff who had contact with Mr McAllister said he appeared normal and did not present as being under the influence of drugs. In May 2020, the Probation Service issued standard operating procedure advice to all APs which said that drug testing would remain suspended due to the COVID-19 pandemic. We are satisfied that staff had no reason to suspect Mr McAllister had returned to drug use or take any specific action to manage this.

44. Prison records show that before his release from Lindholme Mr McAllister had displayed a positive attitude towards change and there was no evidence of drug use. Although staff contact with Mr McAllister at Burdett Lodge was more limited than would normally have been the case due to the COVID19 pandemic, none of the staff who had contact with him in the hours leading to his death considered that he was under the influence of any substances and he raised no concerns with staff.

45. The supply of naloxone (used to reverse an opioid overdose) is part of a harm-reduction approach in reducing drug-related deaths. In November 2021, HMPPS completed the roll-out of naloxone to all APs. We cannot say whether the outcome would have been different in Mr McAllister's death if staff had access to naloxone. However, we are satisfied that staff at Burdett Lodge are trained to recognise the signs of an opioid overdose and how to administer naloxone.

Inquest

46. At the inquest, which took place on 23 April 2021, the Coroner concluded that Mr McAllister's death was drug related.

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