Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stewart Gerred on 17 October 2021, following his release from HMP High Down

A report by the Prisons and Probation Ombudsman

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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

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. From 6 September 2021, the PPO is investigating post-release deaths that occur within 14 days of the prisoner's release.

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 Stewart Gerred died from multiple injuries after he was hit by a train on 17 October 2021 following his release from HMP High Down two days earlier. He was 50 years old. We offer our condolences to his family and friends.

5. Mr Gerred completed alcohol detoxification at High Down but declined to engage with the substance misuse psychosocial team which limited his options for alcohol withdrawal support on release.

6. Although we note that Mr Gerred was not released homeless and was given emergency accommodation, we are concerned that it was so far from his home, family and support network. The provision of suitable accommodation for people leaving prison is an issue that extends beyond the remit of HMP High Down or local probation services, and the local authority may want to be aware of the issues raised in this case.

7. A senior probation officer arranged to meet Mr Gerred on 19 October to discuss sentence planning with him but he died two days earlier.

8. Support was not offered to Mr Gerred's resettlement officer or his community offender manager (COM) after his death.

Recommendations

- The Governor at HMP High Down and the Regional Probation Director for Kent, Surrey and Sussex should ensure that Probation Service Officers (PSOs) and COMs are offered support if a service user in their caseload dies.

The Investigation Process

9. The investigator obtained copies of relevant extracts from Mr Gerred's prison and probation records.

10. We informed HM Coroner for Berkshire of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.

11. The Ombudsman's family liaison officer wrote to Mr Gerred's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She had no specific questions.

12. We shared the initial report with the Prison Service and the Probation Service. There were no factual inaccuracies, and their action plan has been appended to this report.

13. We shared the initial report with Mr Gerred's sister. There was one factual inaccuracy, and this report has been amended accordingly.

Background Information

HMP High Down

14. HMP High Down is a local prison in Surrey which holds up to 1,150 men. Central and North-West London NHS Foundation Trust provides primary health services and in-reach mental healthcare. Anchor Health delivers GP services. The healthcare unit has inpatient facilities with 24-hour nursing cover.

HM Inspectorate of Prisons

15. The most recent inspection of HMP High Down was in June 2019. Inspectors reported that there were far too few offender supervisors in post and not enough probation officers. They noted that uniformed offender supervisors were often deployed elsewhere in the prison and caseloads were far too high. They found that too many prisoners did not have an up-to-date offender assessment system report (OASys) on their risks and needs. Inspectors reported that the Offender Management Unit (OMU) had introduced a good process for formalising contact between prison offender managers and community offender managers at an earlier stage in high-risk cases.

Probation Service

16. Probation services supervise individuals serving community orders, provide offenders with resettlement services while they are in prison (in anticipation of their release) and supervise all individuals sentenced for offences committed after the Offender Rehabilitation Act 2014, for a minimum of 12 months after they are released from prison. During 2021, probation services went through structural reforms. The private probation services (known as Community Rehabilitation Companies (CRCs)) were re-nationalised and merged with the public sector National Probation Service (NPS) to form the Probation Service. The merging of services was staggered across the regions of England and Wales starting in June 2021.

HM Inspectorate of Probation

17. The most recent inspection of the Kent, Surrey and Sussex Community Rehabilitation Company (now part of the National Probation Service) was in June 2019. Inspectors found that case supervision either required improvement or was inadequate. They found some good practice aimed at engaging individuals in their sentence but very limited intervention delivered to reduce reoffending and keep people safe. There was effective delivery of services to support desistance in only half of inspected cases. Resettlement plans were generally completed and sufficient but staff were struggling to deliver and coordinate activity to individuals to prepare them for release.

Assessment, Care in Custody and Teamwork (ACCT)

18. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

19. On 13 September 2021, Mr Stewart Gerred was convicted of a racially aggravated public order offence and was sentenced to ten weeks in custody at HMP High Down. He had a long history of offending.

20. A nurse was unable to complete Mr Gerred's initial health screen as he was intoxicated and agitated. She sent him to the inpatient unit for detoxification. A nurse noted that Mr Gerred had a history of alcohol dependence and usually drank all day. He had also had his right leg amputated in 1999.

21. On 15 September, a member of staff was allocated as Mr Gerred's Prison Offender Manager.

22. On 16 September, a prison GP sent Mr Gerred to hospital because he had alcohol dependence syndrome and his condition had deteriorated. On 21 September, Mr Gerred returned to High Down.

23. On 28 September, a Probation Service Officer (PSO) and Mr Gerred's resettlement officer emailed another PSO and Mr Gerred's allocated community PSO. The PSO completed Mr Gerred's basic custody screen (to identify the key issues to prioritise in Mr Gerred's resettlement plan). She noted that Mr Gerred told her that he would be released from prison without accommodation but that he had lived with many family members over the years. She noted that a wellbeing and mental health caseworker at the Hope Hub (a charity which provides homelessness prevention services to vulnerable people), had arranged a meeting for 12 October to consider housing options for Mr Gerred.

24. The PSO said that when a prisoner posed a high risk of serious harm, a community offender manager would complete a housing referral to try to secure accommodation after release from prison. She said that a resettlement officer would complete a local authority application for prisoners who posed a low or medium risk of serious harm. The PSO said that she liaised with councils, housing agencies, St Mungo's (a charity which aims to end homelessness) and Interventions Alliance (an organisation which offers support to offenders) to try to secure emergency or longer-term accommodation for prisoners approaching release.

25. The PSO noted that she had read a previous Offender Assessment System (OASys) risk and needs report for Mr Gerred which said that he had struggled to manage his finances. She felt that Mr Gerred would benefit from support from the wellbeing and mental health caseworker. The PSO said that she had sent Mr Gerred an in-cell-pack, including useful telephone numbers to help him set up a benefit claim on release.

26. The PSO noted that Mr Gerred had told her that he had brain damage, epilepsy and had had many fits. She said that alcohol had always been at the forefront of Mr Gerred's offending. She noted that previous encounters with substance misuse services had had a positive effect and lowered Mr Gerred's alcohol consumption. However, she noted that as soon as he stopped engaging, his consumption increased and he was in denial about the huge amounts of alcohol that he drank.

27. The PSO noted that Mr Gerred mixed with his peers in the community and that this led him to drink more alcohol and commit further offences. She felt that more frequent visits to the Hope Hub would enable Mr Gerred to meet new people, not feel bored and encourage him to learn new skills.

28. On 5 October, a nurse said that Mr Gerred completed his alcohol detoxification treatment with the substance misuse clinical team in the inpatient unit. He was prescribed thiamine (a vitamin commonly deficient in patients with alcohol dependency). The nurse said that Mr Gerred declined to engage with the substance misuse psychosocial team which would have triggered a referral to community alcohol services for aftercare psychosocial support on release.

29. On 12 October, staff at Surrey Adults Matters (part of the national organisation, Making Every Adult Matter which aims to improve the lives of those facing disadvantages and to reduce reoffending) discussed Mr Gerred's release. The wellbeing and mental health caseworker emailed the PSO to share details of Surrey Heath Housing, ask for Mr Gerred's release date and asked if he would have post-release reporting requirements.

30. On 15 October, a housing solutions case officer at Surrey Heath Borough Council, emailed a PSO and told her that she had arranged a room for Mr Gerred at a bed and breakfast guest house in Datchet.

31. On 15 October, Mr Gerred was released on licence from High Down. His licence conditions required him to report to the Guildford probation office at 12.00pm that day. Prison staff gave him the cash remaining in his prison account and a travel warrant.

32. Before he left High Down, healthcare staff gave Mr Gerred his medication, including levetiracetam and zonisamide for epilepsy, co-codamol for pain relief and mirtazapine for depression. He had not been monitored under ACCT procedures during his time at High Down.

33. Mr Gerred reported to the Guildford probation office, where he had a supervision appointment with a senior probation officer. She noted that Mr Gerred had travelled from the prison with another prisoner released at the same time. Mr Gerred told her that he was annoyed that he had to use £10.00 from his discharge grant to pay for his train fare. She offered to refund this sum but Mr Gerred did not have the receipt. She noted that it was difficult to engage with Mr Gerred, explain his licence conditions or complete his induction paperwork as he was focused on where he wanted to go after the meeting. She noted, however, that Mr Gerred understood his licence conditions.

34. The senior probation officer planned to meet Mr Gerred on 19 October to discuss accommodation, plan his support, manage his substance misuse and health issues and carry out offence-focussed work with him. She said that a full community sentence plan had not been completed because Mr Gerred had just been released.

35. The senior probation officer noted that she had given Mr Gerred details of the bed and breakfast housing booked for him. He told her that he had to go to his mother's house to collect some belongings. She telephoned the housing manager at his arranged accommodation and told her that Mr Gerred was on his way and would

arrive by 4.30pm. She gave Mr Gerred a travel warrant to get to Datchet. She booked an appointment to see Mr Gerred at 10.00am on 19 October and gave him a travel warrant for this.

36. At about 4.30pm, the Head of Operations at Hope Hub, saw Mr Gerred in Camberley town centre by chance. He noted that Mr Gerred was intoxicated. He added £10.00 to Mr Gerred's mobile telephone credit and had a lengthy conversation with him. Mr Gerred told him that he did not want to go to the bed and breakfast guest house in Datchet. The Head of Operations advised him to spend the night at his mother's house and then go to the guest house at the weekend. Mr Gerred told him that 'he did not want to be here anymore'. He reassured Mr Gerred and told him to come to the Hope Hub on Tuesday 21 October. Mr Gerred asked him to tell the wellbeing and mental health caseworker that he really appreciated everything that she had done to help him.

37. The wellbeing and mental health caseworker said that Mr Gerred's friend told her that Mr Gerred stayed at his mother's house that night and the following day, he collected Mr Gerred with some of his belongings from his mother's house and drove him to the bed and breakfast accommodation.

Circumstances of Mr Gerred's death

38. At 2.00pm on 17 October 2021, a member of the public and a train driver saw Mr Gerred on the platform of Datchet railway station. He appeared intoxicated and unsteady on his feet. He walked towards a moving train as it travelled at slow speed into the station. The police report about the incident referenced CCTV footage at the station which indicated that Mr Gerred stumbled and fell into the gap between the platform edge and the train.

Post-mortem report

39. A post-mortem examination established that Mr Gerred died of multiple injuries. Toxicology tests detected a high level of alcohol in Mr Gerred's blood. Toxicology tests also detected a low therapeutic level of codeine (used for pain relief) and diazepam (used to treat alcohol withdrawal) and a therapeutic level of mirtazapine (for depression).

Staff support

40. The PSO said that after Mr Gerred's death, she did not receive any support and did not follow this up as she did not feel that it was necessary. The investigator found no evidence that either the senior probation officer or PSO was offered support after Mr Gerred died.

Contact with Mr Gerred's family

41. Police officers broke the news of Mr Gerred's death to his sister.

Findings

Pre-release planning

42. We are satisfied that the PSO appropriately prepared for Mr Gerred's release by completing a basic custody screen, providing his COM with up-to-date information before his release, arranging emergency accommodation through the local authority and advising the wellbeing and mental health caseworker of his release date and licence conditions.

Substance misuse

43. Mr Gerred had a history of alcohol dependence and during his time at High Down, he completed an alcohol detoxification programme. Unfortunately, he declined to engage with the substance misuse psychosocial team which limited his options for support when he was released from High Down.

44. The PSO noted in his basic custody screen that more frequent visits to the Hope Hub would help to reduce Mr Gerred's alcohol consumption and gave this information to his COM and the senior probation officer. who planned to meet Mr Gerred on 19 October, to discuss sentence planning with him.

45. Despite completing his alcohol detoxification treatment in High Down, Mr Gerred was intoxicated by the afternoon of his release, and there was a high level of alcohol in his blood at the time of his death.

46. The PSO said that under certain circumstances, prisoners could be released to a rehabilitation facility but this could not have happened for Mr Gerred because he declined to engage with the substance misuse psychosocial team which meant that he could not be referred to similar community services.

Accommodation

47. Homelessness on release from prison is a significant and complex challenge. The PSO said that she tried to find accommodation for all prisoners who were to be released from custody with no fixed abode. She said that unfortunately, she did not find accommodation in all cases and sometimes, prisoners were released homeless or were expected to report to the local authority on the day of their release in the hope of receiving emergency housing. She said that unfortunately, it was often the case that local authorities did not prioritise released prisoners and did not deem them suitable individuals to assist.

48. The wellbeing and mental health caseworker said that before Mr Gerred's release from High Down, she spoke to the PSO about his housing situation. She told the investigator that Mr Gerred was regularly placed in emergency accommodation away from his home area, away from his family, friends and support network and that when he was evicted from accommodation, Mr Gerred spent months living homeless.

49. While we note that Mr Gerred was not released homeless, the emergency accommodation with which he was provided was not in the area where he lived and did not meet his needs as it was so far from his home area, his family and support network. The provision of suitable accommodation for people leaving prison is an issue that extends beyond the remit of HMP High Down or local probation services, and the local authority may want to be aware of the issues raised in this case.

Risk of suicide and self-harm

50. There is no evidence that Mr Gerred was at risk of suicide or self-harm while he was at High Down and he was not monitored under ACCT procedures in prison. However, an entry in the Police National Computer states that rail staff stopped Mr Gerred jumping in front of a train in June 2018. Although Mr Gerred told the Head of Operations that 'he did not want to be here anymore' when he saw him by chance on the afternoon of his release, there is no further evidence to confirm that Mr Gerred intended to take his life when he was hit by a train.

51. There is, however, some evidence to suggest that Mr Gerred fell by accident. The train driver and a member of the public both saw that Mr Gerred was unsteady on his feet on the platform at the railway station. The police report also referenced CCTV footage at the train station and noted that Mr Gerred lost his balance on the platform as a train arrived at the station. It also noted that he put his hand out to steady himself but as the train was still moving, he fell in the gap between the platform edge and the train.

Staff support

52. The PSO said that after Mr Gerred's death, she was not offered any support but she also said that she did not need it. The investigator found no evidence that either a senior probation officer or a PSO was offered support after Mr Gerred's death. Prison Service Instruction (PSI) 02/2018 on post incident care reminds Governors that staff affected by a death may require support at any time and on more than one occasion, including during police and PPO investigations and during and after the completion of an inquest. Probation Instruction (PI) 01/2014 on reviewing and reporting deaths of offenders under probation supervision in the community says that COMs should be made aware of support services available to them, such as counselling, after a death. COMs should be told that they can access these services at a later date if required. We appreciate that the COMs in Mr Gerred's case had little or no contact with him and that the PSO said that she had not needed support but despite this, support should have been offered in line with national instructions. We make the following recommendation.

The Governor at HMP High Down and the Regional Probation Director for Kent, Surrey and Sussex should ensure that PSOs and COMs are offered support if a service user in their caseload dies.

Sue McAllister CB
Prisons and Probation Ombudsman **September 2022**

Annex

1. Prison Service and Probation Service action plan

Prisons & Probation Ombudsman
Independent Investigations

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