

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

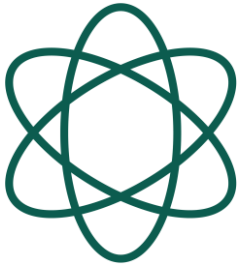
# **Independent investigation into the death of Mr Gregory Bracey on 21 April 2022, following his release from HMP High Down**

**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

**OGI**

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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 Gregory Bracey died of the combined toxic effects of cocaine and sertraline (an antidepressant) on 21 April 2022, following his release from HMP High Down on 19 April. He was 42 years old. We offer our condolences to those who knew him.
5. Mr Bracey had a history of substance misuse and mental health issues. He was prescribed a range of medication including sertraline.
6. We found that Mr Bracey received good support at High Down and his pre-release planning with regards to his substance misuse and mental health needs was good.
7. We make no recommendations.

## The Investigation Process

8. The PPO investigator obtained copies of relevant extracts from Mr Bracey's prison and probation records.
9. We informed HM Coroner for Reading of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
10. The Ombudsman's family liaison officer contacted Mr Bracey's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She raised no issues but asked for a copy of our report.
11. We shared our initial report with HM Prison and Probation Service (HMPPS). They pointed out one minor factual inaccuracy which has been amended in this report.
12. We sent a copy of our initial report to Mr Bracey's mother. She did not notify us of any factual inaccuracies.

## **Background Information**

### **HMP High Down**

13. HMP High Down is a local category C prison and young offender institution which holds up to 1,203 male prisoners who have either been convicted or are on remand. Central and North-West London (CNWL) NHS Foundation Trust provides primary health services and in-reach mental health care.

### **Probation Service**

14. 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, as well as prepare reports to advise the Parole Board and 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 3 December 2021, Mr Gregory Bracey was recalled to prison after he failed to report to his designated probation approved premises upon release. He was also arrested on the same day for alleged theft and being drunk and disorderly. He was moved to HMP High Down on 6 December.

### Pre-release planning

16. Mr Bracey had a history of drug and alcohol misuse and mental health issues. He engaged with substance misuse services at High Down and was under the care of the mental health team.
17. On 9 December, one of Mr Bracey's Community Offender Managers (COM) assessed Mr Bracey's risks and needs in the community upon release. He noted that Mr Bracey had no accommodation and was due to be released homeless. He assessed that homelessness increased Mr Bracey's risk of reoffending.
18. On 8 March 2022, Mr Bracey's other COM made a referral under the duty to refer scheme (used to refer people for accommodation if they are homeless) to Slough Council. They did not respond.
19. On 19 April, the day of Mr Bracey's release, healthcare staff gave Mr Bracey a 28-day supply of his prescribed medication, which included sertraline (an antidepressant). They also offered him a naloxone kit (medication that can rapidly reverse opioid overdose), which he accepted.

### Post-release planning

20. On 19 April, Mr Bracey reported to Bracknell Probation Office, where he had a supervision appointment with one of his COMs who went through his licence conditions with him. One of his conditions was to engage with Turning Point, a drug and alcohol recovery service. However, the COM had not yet arranged an appointment as it had not been confirmed where Mr Bracey would be living until the day of his release.
21. The COM told Mr Bracey that she had arranged for him to stay at a hotel while she waited for the council to respond to the request for accommodation. She explained the conditions of his stay at the hotel and accompanied him to the hotel in Slough to check him in.

### Circumstances of Mr Bracey's death

22. On 21 April, at around 2.00am, Mr Bracey left his hotel room. He shouted that he thought he was having a heart attack and then collapsed. Another guest at the hotel saw him and called the emergency services. Paramedics attended and attempted CPR but this was unsuccessful.
23. The police told a Senior Probation Officer that Mr Bracey had died from a suspected heart attack. She then informed both COMs and offered them support.

## **Post-mortem report**

24. The post-mortem report concluded that Mr Bracey died of the combined toxic effects of cocaine and sertraline. It also listed bilateral patchy bronchopneumonia (a lung infection), alcoholic fatty liver disease and cardiomyopathy (disease of the heart muscle) as contributory factors.

## Findings

25. We found that Mr Bracey received good support with his substance misuse and mental health issues while he was at High Down. Before his release, staff warned him of his reduced tolerance to drugs and increased risk of overdose and gave him a naloxone kit.
26. Probation staff recognised that releasing Mr Bracey to homelessness increased his risk of relapsing into substance misuse and increased his risk of reoffending. They made the relevant referral for council accommodation but had received no response by the time of Mr Bracey's release. They did however arrange hotel accommodation for him, so he was not released homeless.
27. We make no recommendations.

**Kimberley Bingham**  
**Acting Prisons and Probation Ombudsman**

**May 2023**

## Inquest

The inquest, held on 9 August 2023, concluded that Mr Bracey's death was drug related.

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