Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jamie Reay, on 21 April 2022, following his release from HMP Wealstun

A report by the Prisons and Probation Ombudsman

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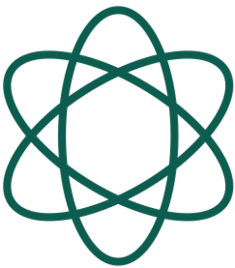
Our vision

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

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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 a 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 Jamie Reay died on 21 April 2022 of ventricular hypertrophy (thickening of the wall of the heart) and the effects of both prescribed and illicit substances following his release from HMP Wealstun on 14 April 2022. He was 34 years old. I offer my condolences to those who knew him.

5. We did not find any issues of concern.

The Investigation Process

6. The PPO investigator obtained copies of relevant extracts from Mr Reay’s prison and probation records.

7. We informed HM Coroner for Gateshead 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 Reay’s mother to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but asked for a copy of the report.

9. Mr Reay’s family received a copy of our report. They pointed out a factual inaccuracy that we have addressed in this final version.

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

Background Information

HMP Wealstun

11. HMP Wealstun is a category C adult prison which holds up to 820 male prisoners. Healthcare services are provided by Care UK and Midlands Partnership NHS Foundation Trust. Substance misuse treatment services are provided by Care UK.

Probation Service

12. 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 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

Pre-release

13. On 2 February 2022, Mr Jamie Reay was convicted of possession of an offensive weapon and sentenced to eight months in prison.

14. On 10 February, Mr Reay transferred to HMP Wealstun. At his initial reception health screening, healthcare recorded prescriptions for medications to treat depression, heartburn, an underactive thyroid and epilepsy. They also noted that Mr Reay had a history of substance misuse issues, including pregabalin (used to treat anxiety and epilepsy) and benzodiazepines (a sedative medication used to treat a range of issues) and referred him to the prison substance misuse service. Mr Reay's methadone prescription (an opiate replacement drug) and other medications were continued. His community pregabalin prescription for epilepsy was stopped and replaced with levetiracetam.

15. Healthcare recorded prescriptions for medications to treat depression, heartburn, an underactive thyroid and epilepsy, which were continued in prison. At the second health screening, healthcare staff recorded that Mr Reay had no family history of heart disease.

16. On 9 February, an offender manager was allocated as Mr Reay's Community Offender Manager (COM) with responsibility for his risk management following release.

17. On 14 February, a substance misuse worker met with Mr Reay and provided information on the risk of overdose for those whose tolerance for opiates has reduced. The substance misuse worker also told Mr Reay about naloxone (a drug used to reverse an opiate overdose) in preparation for his release.

18. On 16 March, the COM applied for Mr Reay to be housed in an approved premises (accommodation for people on probation with a high risk of reoffending) in the North East region on his release.

19. On 4 April, the COM completed an assessment of Mr Reay's risks and needs in the community, in preparation for his release. She assessed that Mr Reay was at risk of causing harm to others in shared accommodation and the risk would increase if he misused drugs. She noted that a bed in an approved premises would help ensure the risks were managed.

20. On 4 April, Mr Reay attended an appointment with the substance misuse service for relapse prevention work. They discussed his triggers for relapse, the risks of relapse, the signs of overdose and use of naloxone again.

21. On 4 April, Mr Reay's approved premises application was rejected because of a lack of availability of rooms. On 12 April, the COM applied for accommodation in the North West region, which was rejected later the same day because of a lack of availability.

22. The COM was able to secure accommodation for Mr Reay through Gateshead Local Authority. The accommodation was near a police station, had an on-site warden and included contact with a support worker.

23. On 12 April, the substance misuse team told Mr Reay they had organised an appointment with the Gateshead Community Partnership, a community-based drug and alcohol support service, on 19 April. They gave Mr Reay naloxone training and provided a kit for him to pick up at reception on the day of his release. They also reinforced the risks of relapse and signs of overdose.

24. On 14 April, Mr Reay was released from HMP Wealstun. Gate staff gave Mr Reay a copy of his licence with the conditions of his release and instructed him to attend Gateshead Probation for his first supervision appointment. Mr Reay picked up his naloxone kit and medications for opioid detoxification and epilepsy.

Post-release

25. Mr Reay reported to Gateshead Probation for his first supervision appointment. The COM recorded that Mr Reay was aggressive towards staff and did not sign his licence conditions. He said he did not plan on following them. A senior probation officer spoke to Mr Reay about his barriers to engagement with Probation. Mr Reay said that his mental health and difficulties with staff were stopping him from engaging with the COM.

26. Later that day, Mr Reay attended his housing appointment with Gateshead Local Authority. Staff reported that Mr Reay was aggressive towards them but signed a tenancy agreement and behaviour agreement. Local authority and probation staff agreed to share information.

27. On 19 April, Mr Reay did not attend his scheduled probation appointment.

Circumstances of Mr Reay's death

28. Between 20 and 21 April, Mr Reay was socialising with friends. We understand that they drank alcohol and took some unidentified tablets. At around 6.00am on 21 April, Mr Reay went to sleep.

29. At around 10.00am a support worker at Gateshead Local Authority contacted the COM to say that he had not heard from Mr Reay in a while and would visit his home to check on him. The COM contacted the Gateshead Recovery Partnership, who shared that Mr Reay had attended his appointment on 19 April.

30. At around 11.00am, an acquaintance of Mr Reay's woke up and found him unresponsive so called an ambulance. Paramedics attended the address and started cardiopulmonary resuscitation (CPR), but Mr Reay did not respond and his death was confirmed at 11.29am.

Post-mortem

31. The post-mortem examination concluded that Mr Reay had died of ventricular hypertrophy (thickening of the wall of the heart) and the effects of pregabalin (a

drug used for epilepsy and pain relief), methadone (an opiate replacement drug), cocaine, bromazolam (a benzodiazepine drug), diazepam (a drug used to treat anxiety) and mirtazapine (a drug used to treat depression).

32. Mr Reay had been prescribed methadone and mirtazapine but had not been prescribed pregabalin, bromazolam or diazepam.

Inquest

33. The inquest into Mr Reay's death concluded on 17 April 2023, and found that he died of misadventure.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **August 2023**

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