Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Gemma Strand, on 23 December 2021, following her release from HMP/YOI New Hall

A report by the Prisons and Probation Ombudsman

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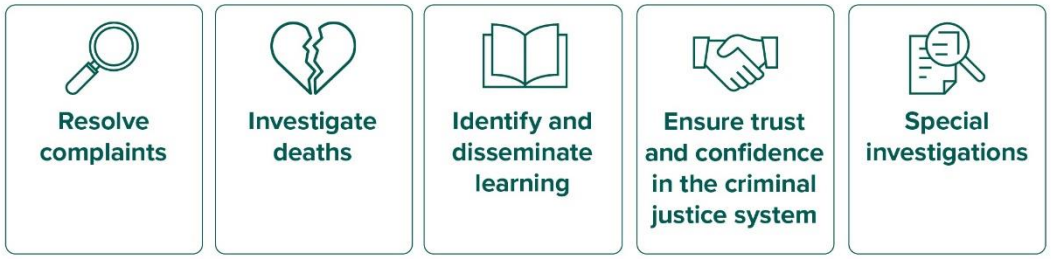
OUR VISION

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

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. If my office is to best assist His Majesty's 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.

3. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of a prisoner's release from custody.

4. Ms Gemma Strand died of morphine toxicity on 23 December 2021, following her release from HMP New Hall on 16 December. She was 39 years old. I offer my condolences to those who knew her.

5. Ms Strand was sentenced to seven days in prison on 10 December after she breached her licence conditions. She had a history of non-compliance with support services and so a number of agencies in the community had withdrawn their services. Ms Strand had a history of substance misuse but said she had abstained from drugs for two years. She was given substance misuse support due to her previous use and was advised of naloxone (which can reverse the effects of an opioid overdose).

6. Ms Strand was released on post-sentence supervision to her partner's address on 16 December 2021. She was not given naloxone on release because she had said she was drug-free, she was not on opiate substitution medication and was released with accommodation in place. However, following release, it transpired that the relationship had ended, and the property was no longer available to her. Ms Strand was given temporary accommodation in a hotel in the local area. A package of support was put in place for her in light of the changes in her circumstances and her increased level of motivation to engage with services.

7. Ms Strand attended probation appointments on 16 and 20 December. She was found dead in her hotel room on 23 December following a welfare check.

8. We did not find any issues of concern.

The Investigation Process

9. HMPPS notified us of Ms Strand's death on 6 April 2022. The PPO investigator obtained copies of relevant extracts from Ms Strand's prison and probation records.

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

11. The Ombudsman's family liaison officer contacted Ms Strand's next of kin to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.

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

Background Information

HMP New Hall

13. HMP New Hall is a local prison, holding up to 381 adult and young adult female prisoners who are on remand or have been sentenced. Healthcare is available 24 hours a day. Practice Plus Group provides healthcare services for all physical and mental health needs, and Inclusion, Midlands Partnership NHS Foundation Trust are the Health in Justice substance misuse treatment provider.

Probation Service

14. 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 supervise people throughout their licence period and post-sentence supervision.

Key Events

15. On 26 February 2021, Ms Strand was sentenced to 18 weeks custody for an offence of failing to surrender and absconding while she was previously subject to a Community Order. On 29 April 2021, Ms Strand was released from HMP New Hall, however, she was immediately detained in hospital under the Mental Health Act. She was discharged on 14 June 2021.

16. Ms Strand was appointed a Community Offender Manager (COM) from 1 March 2021. On 15 June, the COM completed an assessment of Ms Strand's risks and needs in the community following her release. At that point, Ms Strand had moved in with her partner at his address. The COM identified that Ms Strand led a chaotic lifestyle and had a history of substance misuse. She noted that Ms Strand was taking medication for her mental health and was abstinent from drugs at that time. However, she noted that Ms Strand had been a sporadic drug user and had previously injected "risky" amounts. She assessed that risk would increase if Ms Strand failed to engage with support services, returned to substance misuse or failed to comply with prescribed medications for her mental health. Instability in accommodation and her relationship were also identified as factors which may increase her level of risk. Ms Strand's risk management plan involved a package of support from CHART (a drug and alcohol support service specialising in mental health) and the Community Mental Health Team.

17. Ms Strand fell into breach shortly after discharge from hospital due to non-compliance and disengagement from probation and was subsequently returned to court. The breach was heard on 27 September 2021 and the order was allowed to continue.

18. Ms Strand fell into breach a second time but failed to attend court on 6 December as directed. She was arrested and appeared in court on 10 December where she was sentenced to seven days in prison to mark the breach.

19. Ms Strand was returned to HMP New Hall on 10 December. She presented with COVID-19 symptoms so was placed in isolation.

20. An initial health assessment took place on 10 December with a nurse, where Ms Strand reported she was fit and well. She disclosed her previous psychiatric hospital admission and said she had a psychiatric case worker in the community and a diagnosis of schizophrenia. Ms Strand denied any issues with drugs or alcohol and denied any self-harm or suicidal ideations. A referral was made to the mental health team and the GP.

21. That day, a prison GP noted that Ms Strand had a history of drug use but reported no current drug or alcohol use. She prescribed olanzapine and rivaroxaban. She noted Ms Strand was previously prescribed clonazepam but felt the indication for this was unclear so requested clarity from the pharmacy before prescribing it.

22. A second reception health screening took place on 12 December and a task was sent to the Mental Health team for a triage appointment. Ms Strand was given advice on a number of issues, including drugs, alcohol and a healthy lifestyle.

23. The mental health in-reach team tried to triage Ms Strand on 13 December, but she was asleep, and they did not feel it was appropriate to wake her. They spoke with wing staff who raised no concerns and said that Ms Strand was isolating in line with COVID-19 regulations. A further triage appointment was scheduled for seven days later following the completion of the isolation period, with guidance for staff to contact the team if needed. They noted Ms Strand had recently been detained under section 3 of the Mental Health Act and had since been discharged from the community team due to lack of engagement. The follow-up appointment did not take place as Ms Strand only remained in custody for seven days.

Pre-release planning

24. On 13 December, New Hall contacted Ms Strand's COM with her proposed release address which was her partner's privately owned property. The COM instructed Ms Strand to attend probation and meet staff on the day of release in her absence. Ms Strand was due to be released on post-sentence supervision with standard conditions.

25. On 14 December, the COM contacted an Integrated Offender Management (IOM) officer to request her attendance at an appointment with Ms Strand. The COM raised her concerns about Ms Strand's lack of engagement with other agencies and previous non-compliance with probation and was keen to engage her with assistance from IOM. IOM includes support from a local police team for hard-to-reach offenders. The IOM officer said she would discuss the matter with her sergeant as Ms Strand had been removed from the cohort due to lack of engagement.

26. On 14 December Ms Strand was allocated a substance misuse worker in New Hall for support due to her previous substance misuse.

27. A Probation Service Officer completed a Basic Custody Screening with Ms Strand on 15 December. Accommodation was not considered a concern as Ms Strand said she would be returning to live with her partner at his property upon release. She denied any issues with drugs or alcohol and said she was taking medication daily for schizophrenia. She said she had moved and needed to get a new GP. No other issues were raised.

28. A worker carried out a structured psychosocial intervention with Ms Strand by telephone on 15 December. Ms Strand stated she had no drug or alcohol problems and had been drug-free for two years. She was given details of support services in her local area and advice about lifestyle, harm minimisation and the risk of overdose. The worker discussed naloxone with Ms Strand.

29. On 15 December, New Hall's IOM officer contacted the community IOM team and asked them to collect Ms Strand from the gate and take her to her initial appointment. This was agreed and communicated to the COM.

30. A substance misuse worker made an entry on 16 December that she was unable to see Ms Strand in reception in New Hall as she was not there. She said harm minimisation advice was given the day before, as well as information about naloxone. (Ms Strand was not released with naloxone as she had denied any recent substance misuse and was not receiving any opiate substitute medication, and she

did not meet the criteria for naloxone under the local pathway.) The worker said Ms Strand knew how to access services in the community if she required support.

31. A nurse met Ms Strand in reception at the point of her release and gave her a discharge letter and a supply of olanzapine and rivaroxaban.

Post-release

32. On 16 December, Ms Strand was released from prison and collected from the prison gate by an IOM officer. She reported to probation as directed and engaged in an induction supervision appointment with a probation worker in her COM's absence. Ms Strand was on post-sentence supervision and subject to standard conditions. She said she would be going back to live with her partner and denied any issues in the relationship. She expressed motivation to engage with appointments and avoid getting into trouble. She requested support with her financial affairs and asked that her appointments take place in Dewsbury in future as this was more convenient for her.

33. Following the probation appointment, the IOM officer made three attempts to take Ms Strand to her partner's address, but he was not at home. They then collected a food parcel for Ms Strand and the officer dropped her at the local authority housing centre at her request to obtain temporary housing. The local authority provided Ms Strand temporary accommodation in a hotel in the local area.

34. On 20 December, Ms Strand attended a probation appointment with her COM. Ms Strand appeared upset and erratic and disclosed the breakdown of her 20-year relationship. They discussed the importance of engagement with support. The COM called Ms Strand's mental health worker during the session, who advised that Ms Strand had been discharged due to her previous non-engagement, but she would look into re-opening the case without the need for a re-referral. Ms Strand also seemed motivated to work with IOM. A specialist support worker from Together Women (a support service commissioned by the Ministry of Justice to support women subject to community orders) was also bought into the session. She discussed the support they could offer and arranged for a parcel of food, toiletries, towels, and clothing to be given to Ms Strand from their women's centre, The Mission, that afternoon.

35. Ms Strand denied any drug or alcohol use and said she did not want support from CHART, the local drug and alcohol service. She said she needed to sort her medication as she had been discharged by her previous pharmacy. Ms Strand said she would call 111 later that day and her COM agreed to flag this with the mental health worker. The absence of stable factors and Ms Strand's loneliness was noted. Ms Strand was given contact details of those supporting her and encouraged to go to The Mission and see what was on over the Christmas period. The COM shared a summary of the session by email with the IOM officer, the Together Women worker, and the mental health worker.

36. On 21 December, the COM had a telephone call with a Housing Solutions Officer. She confirmed there were no issues to date at the current, temporary housing and that the Rough Sleepers team would check in on Ms Strand over the Christmas period. The officer agreed to put Ms Strand on the waiting list for another property. An alternative address was discussed but further exploration was needed about

suitability due to the complexity of Ms Strand's needs. A referral was also made to Kirklees Better Outcomes Partnership who support adults at risk of homelessness. The COM again shared a summary of this discussion with professionals involved in Ms Strand's case.

Circumstances of Ms Strand's death

37. At 9.00am on 21 December, a support worker conducted a check on Ms Strand and found her to be fit and well. At 11.00am that day, Ms Strand overdosed on drugs and was taken to Huddersfield Royal Infirmary, where she was discharged a short while later.

38. CCTV at the hotel where Ms Strand was staying showed her leave her room a number of times on 22 December, going into the room of another resident before returning to her room. She was last seen leaving her room at 6.00pm on 22 December, collecting a cup of coffee before returning to her room. Her support worker attended her room on 23 December and found Ms Strand dead.

39. An ambulance was called, and paramedics pronounced her death at 10.06am. There was clear evidence of drug paraphernalia at the scene. A needle was found in Ms Strand's groin area.

40. The police concluded that there were no suspicious circumstances or third-party involvement.

41. On 24 December, an IOM police officer informed probation that Ms Strand had died the previous night of a suspected overdose.

42. A message was passed to the COM, who was on annual leave, to inform her of Ms Strand's death.

Post-mortem report

43. The post-mortem report concluded that Ms Strand died of morphine toxicity. The toxicology examination showed morphine within the range associated with toxicity. This led to central nervous system depression and death.

Inquest into Ms Strand's death

44. The inquest into Ms Strand's death was held on 13 January 2023 and a verdict of drug related death was recorded. The coroner concluded that Ms Strand's death was due to morphine toxicity.

Support for staff

45. The COM said she felt very supported by her senior probation officer following Ms Strand's death.

Contact with Ms Strand's family

46. It has not been possible to establish who informed Ms Strand's next of kin of her death. However, it is believed that this was the police.

Good practice

47. Ms Strand received a seven day prison sentence to mark the breach for previous non-compliance with probation. As such, there was only a very short window to plan for her release. Before her short return to custody, Ms Strand had been referred to a number of support services and had an allocated IOM officer, a specialist mental health drug key worker and a community mental health worker. She was subsequently discharged from several services due to lack of engagement and assertions that she was abstinent from drugs.

48. Following her return to custody, Ms Strand was appropriately assessed by healthcare and a substance misuse worker. She was provided medication and offered support and guidance on substance misuse and naloxone.

49. Ms Strand was released after her seven day sentence on post-sentence supervision as opposed to licence, with standard conditions. She was collected and escorted to her appointment by IOM in a collaborative approach to encourage engagement.

50. Following release, it became apparent that Ms Strand had had some destabilising changes and her COM worked at pace to respond to these to build a package of support around her. Suitable temporary accommodation was secured when it transpired that Ms Strand's accommodation was no longer available. I am satisfied Ms Strand received appropriate support.

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

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