Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Gresham on 17 April 2023, following his release from HMP Hull

A report by the Prisons and Probation Ombudsman

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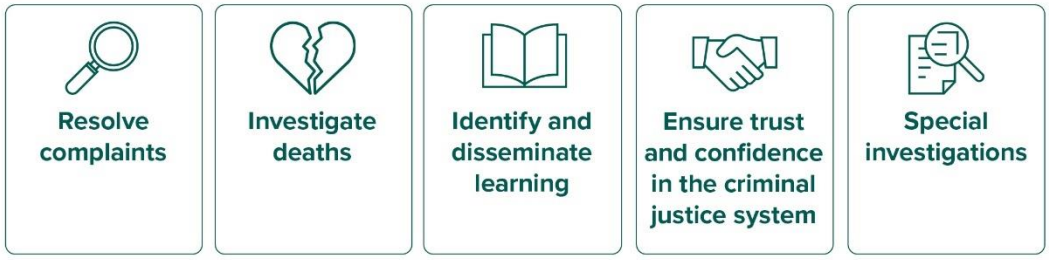
OUR VISION

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 detained people 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 been investigating post-release deaths that occur within 14 days of the person's release from prison.

4. Mr Lee Gresham died in hospital on 17 April 2023, from the effects of cocaine use, following his release from HMP Hull on 5 April. Mr Gresham was 40 years old. We offer our condolences to his family and friends.

5. We found no issues of concern and make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Gresham's death on 21 April 2023.

7. The PPO investigator obtained copies of relevant extracts from Mr Gresham's prison and probation records.

8. We informed HM Coroner for North East Lincolnshire and Grimsby of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

9. The Ombudsman's family liaison officer contacted Mr Gresham's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not have any questions for the investigation but asked for a copy of the report.

10. The initial report was shared with Mr Gresham's mother. She did not make any comments.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found some factual inaccuracies relating to the identification of the roles of individuals checking on Mr Gresham's accommodation. These have been corrected in this final report.

Background Information

HMP Hull

12. HMP Hull is a local inner-city prison with a complex population of remand and sentenced prisoners. It can hold about 1,000 men, mostly in double cells. About 130 prisoners are released each month.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Hull was in March 2022, which was a review of progress following concerns raised in the previous inspection in 2021. The inspectors found good progress in some areas, including in resettlement with better coordination by the prison with probation staff in the community. Inspectors were concerned that healthcare services were still failing in some critical areas. However, the healthcare provider has changed since the inspection.

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. Mr Lee Gresham had an extensive history of acquisitive offending linked to substance misuse. He had been in prison numerous times. He had a poor history of complying with licence conditions, for example, by failing to attend substance misuse service (SMS) or probation appointments. Before Mr Gresham's latest sentence, he was most recently admitted to HMP Hull in October 2022, and released under licence on 20 February 2023. He was supervised in the community by the Probation Service and the police as part of the Integrated Offender Management programme (IOM, a programme which identifies persistent and problematic offenders who are managed jointly by partner agencies working together).

16. On 7 March, the Probation Service decided to recall Mr Gresham to prison. This was due to several missed appointments and alleged further offending. The recall dossier said that a period of imprisonment would give Mr Gresham the opportunity to reengage with drug treatment in prison.

17. However, on 9 March, before he was recalled, Mr Gresham received a further sentence of 56 days imprisonment for theft. He was taken to Hull on 10 March. On arrival, Mr Gresham told healthcare staff that he did not have a problem with drugs and did not want to engage with the prison SMS. Therefore, he was not tested for drugs and had no input from the prison SMS while at Hull.

18. Mr Gresham was only at Hull for a short period and after receiving some medication for his asthma at the beginning of his sentence, he had no further contact with healthcare staff.

Pre-release planning

19. Prior to his imprisonment in March, Mr Gresham had not engaged with the community SMS. Although his recall dossier expressed the hope that he would have the opportunity to reengage with the prison SMS, he chose not to do so. This meant that there were no arrangements relating to substance misuse when he left prison. His lack of engagement also meant that on release from prison he was not issued with naloxone (a medicine that rapidly reverses an opioid overdose), or reminded of the increased risk of overdose because of reduced tolerance following abstinence in prison.

20. Despite his lack of engagement with the prison SMS, Mr Gresham's community offender manager (COM) added drug treatment and testing conditions to his licence. This meant that contact with a community SMS could be enforced if she had concerns.

21. Mr Gresham refused to attend a resettlement appointment in prison on 27 March. However, through multi-agency working, staff secured him CAS3 accommodation on release. (CAS3 is short term accommodation with low level support which can be made available to prisoners on release who would otherwise be at risk of being homeless). Prior to his release, the probation office contacted the prison to inform Mr Gresham of the details of the accommodation he would be going to.

Post-release planning

22. On 5 April, Mr Gresham was released from prison. Mr Gresham was late in getting to Grimsby because of transport issues. Therefore, he was unable to report to probation as, if he had done so, he would not have been able to pick up the keys to his accommodation in time. However, Mr Gresham telephoned the probation office and staff made him an appointment for 11 April.

23. The day after his release from prison, an IOM Police home visit was completed at Mr Gresham's accommodation, but he was not there.

24. On 11 April, Mr Gresham attended his appointment with the COM. She noted that he appeared to be intoxicated and she asked about his substance misuse. Mr Gresham said that he had been drinking alcohol but was concerned that he would relapse into opioid misuse. His COM asked him to go to the Community SMS. Mr Gresham agreed to do so. However, he does not appear to have gone there.

25. On 13 April, Mr Gresham's accommodation key worker made a visit to his accommodation but Mr Gresham was not there. However, there was evidence of drug paraphernalia in a communal area, although it could not be definitively linked to Mr Gresham. The key worker passed on their concerns to the COM. The COM discussed follow up actions with her manager and they decided to test Mr Gresham for drugs at his next appointment the following week. If he tested positive, she would have issued a warning and then, as part of his licence conditions, directed him to attend the community SMS.

Circumstances of Mr Gresham's death

26. On 14 April shortly after 11.00am, paramedics attended another property after Mr Gresham had been found unconscious. Paramedics reported that they were told that Mr Gresham had taken a variety of drugs and he was surrounded by drug paraphernalia. They also said that there was evidence that someone had made use of a naloxone kit before they arrived.

27. The paramedics carried out cardiopulmonary resuscitation (CPR) and attached a defibrillator (a device that can shock a heart back into normal rhythm in some circumstances) to Mr Gresham. They succeeded in restoring his blood circulation but he had to be artificially ventilated as he could not breathe unaided.

28. Paramedics took Mr Gresham to hospital. Hospital scans showed that Mr Gresham had critical damage to his brain. He died in hospital on 17 April.

Post-mortem report

29. The post-mortem report concluded that Mr Gresham died from a haemorrhagic stroke (bleeding in or around the brain, which causes brain cells to die), caused by cocaine abuse. The report said it was likely that cocaine had severely increased his blood pressure, leading to the damage to his brain. Post-mortem testing also showed that Mr Gresham had taken diazepam and morphine (both prescription-only medications which are also used recreationally) although these were not considered causal to his death. These were found to be at therapeutic levels consistent with

prescription doses. However, neither of these drugs were prescribed to Mr Gresham in prison or in the community immediately prior to going to prison, so it is likely that he was using them recreationally.

Findings

30. Mr Gresham inconsistently engaged with services such as probation, IOM police staff, and SMS providers. Mr Gresham's recall documents said that he had told staff that his main drug use recently had been cocaine. Although Mr Gresham said he used it weekly, staff noted it was more frequent than this and included intravenous heroin use. Because of his lack of engagement with services, it was unclear exactly what Mr Gresham's levels of substance misuse were in March 2023. However, previously on entering prison in October 2022, he said he was spending at least £100 a day on crack cocaine, and was also using heroin several times a day. At that time he tested positive for drugs including cocaine.

31. When Mr Gresham returned to prison on 10 March 2023, he chose not to engage with SMS services. He said that he did not use drugs and therefore did not undergo a urine drug screen. Hull confirmed that this is only offered to prisoners who declare a drug problem in order to help tailor a drug treatment programme. So, although the recall dossier expressed the hope that Mr Gresham would have an opportunity in prison to reengage with SMS, engagement was voluntary and Mr Gresham did not wish to address his drugs use.

32. The SMS team leader at Hull told the investigator that when a prisoner engages with their services, they ask for their consent to speak to their COM and prison offender manager (POM). This is to provide a more collaborative approach particularly around support in the community with housing and to improve prisoners' continuity of care.

33. Although Mr Gresham had been issued with naloxone when previously released (most recently on 20 February 2023), his lack of engagement with the prison SMS meant that he was not considered for it on this occasion, and he was not reminded of the risks of overdosing after a period of abstinence. Mr Gresham was a long-term user of opioids and for people with histories like his, there is an elevated overdose risk on leaving prison. The post-mortem report did not show that opioids were a factor in Mr Gresham's death, so the possession of naloxone is not relevant to this death, but his case does illustrate a gap in provision.

34. Mr Gresham's COM said there had been a recent change in local practice and COMs now automatically check with the community SMS providers prior to release to confirm if a case is open to them and to determine if a new referral is needed. She said that the local SMS try to accommodate COMs sending people to them immediately, instead of waiting for forms to be processed. She said this is why she directed Mr Gresham to go to the SMS on the day she met him after his release from prison. He did not go. Following the feedback from the accommodation key worker on 13 April, the COM intended to follow this up with a drugs test at Mr Gresham's next visit to the probation office. This opportunity did not arise because Mr Gresham died before his appointment.

35. Mr Gresham was resistant to compliance as well as to the help that was available to him. We found no deficits in the prison or probation services provisions for Mr Gresham, and make no recommendations.

Good practice

36. We are encouraged by two areas of good practice we encountered in this investigation.

37. The first is the local probation practice to coordinate with community SMS providers prior to prisoner release as discussed above.

38. The second is the SMS teams in Hull and HMP Humber encouraging released prisoners to wear wrist bands that identify them as potentially needing treatment with naloxone in their possession in the event of a suspected opioid overdose. Mr Gresham was issued with one of these the previous October and the SMS team leader told the investigator that there was a high take up of the wrist bands.

Inquest

39. The inquest into Mr Gresham's death concluded on 11 December 2024. It found that Mr Gresham's death was drug related.

Adrian Usher
Prisons and Probation Ombudsman **December 2023**

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