Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Hatch, on 6 December 2022 following his release from HMP Cardiff

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. 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. 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.

4. Mr Steven Hatch died of mixed drug toxicity on 6 December 2022 following his release from HMP Cardiff on 28 November. He was 46 years old. We offer our condolences to those who knew him.

5. We did not find any issues of concern in the pre or post-release planning. We make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Hatch's death on 8 March 2023.

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

8. We informed HM Coroner for South Wales 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 office contacted Mr Hatch'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.

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

Background Information

HMP Cardiff

11. HMP Cardiff is a category B local prison which holds male prisoners who have either been convicted or are on remand. It is managed by HMPPS.

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

Key Events

13. On 26 September 2022, Mr Steven Hatch was convicted of burglary and was sentenced to eight months in prison. He was sent to HMP Cardiff.

14. That day, a nurse completed Mr Hatch's initial health screen. Mr Hatch said he was not currently using drugs. He also declined a urine dip test because he said he was unable to provide a sample at that time.

15. On 27 September, a nurse from the substance misuse team saw Mr Hatch on the wing. She took a urine sample which tested positive for buprenorphine and benzodiazepine. Mr Hatch said he had been using illicit subutex in the community. When he was unable to get buprenorphine, he would use his friends opiate based prescribed medication. Mr Hatch said he had issues with heroin and crack cocaine in the past and tried to not use them in the community but substituted alcohol for them instead.

16. A nurse started Mr Hatch on 10mls of methadone (used to treat opioid dependence), increasing to 30ml at his request. He was also prescribed thiamine (a vitamin medication that keeps the nervous system healthy) due to his alcohol misuse. However, the nurse noted he was out of the risk stage for severe alcohol withdrawal and that he did not need to start an alcohol detoxification programme.

17. On 7 October, Mr Hatch asked a nurse to reduce his methadone to 25ml, because he did not want to get addicted to it. The nurse told Mr Hatch he would be reviewed by a substance misuse nurse before his methadone would be reduced.

Pre-release planning

18. Also on 7 October, Mr Hatch's community offender manager (COM) visited him in prison with a Police Constable from the integrated offender management (IOM) team (a national framework for managing persistent and problematic offenders). They discussed Mr Hatch's substance misuse, but he did not tell his COM that he was on a methadone detoxification programme. She encouraged Mr Hatch to be honest with them so they could support him on release.

19. The COM also discussed the potential of Mr Hatch being released on Home Detention Curfew (HDC – a scheme which allows some people to be released early if they have a suitable address to go to). Mr Hatch said that he would like to be considered for this and the COM said that she was waiting to hear back from Mr Hatch's landlord to make sure the property was still available before any checks could be completed.

20. On 11 October, a nurse saw Mr Hatch. Mr Hatch said he wanted to be considered for buvidal injections (to treat dependence on opioid drugs). He said he struggled with anxiety, and this was the reason he did not collect his methadone prescription at Dyfodol (the local community substance misuse service). The nurse advised Mr Hatch that he needed to work on his triggers and past experiences, and that it was important he engaged in preparation work before his release. A plan was agreed for the nurse to email Dyfodol for preparation and motivational work to be completed before he could be considered for buvidal.

21. On 19 October, Mr Hatch's landlord confirmed that his flat was still available to him on release, and Mr Hatch was approved for HDC.

22. On 25 October, a nurse saw Mr Hatch on the wing to discuss his treatment plan. Mr Hatch said he was happy to stay on his current dose of 30ml of methadone and would reduce this in the community.

23. On 28 November, Mr Hatch was released from Cardiff on HDC. He had two drug-related licence conditions:

    - Attend Dyfodol as directed, to address his dependency on drugs;
    - Attend Bridgend Dyfodol/Probation as required, to undertake drug tests and to ensure that he was complying with his licence conditions.

Post-release management

24. On 28 November, Mr Hatch attended his initial appointment at the probation office with his new COM. Mr Hatch said he understood his licence conditions and signed his licence.

25. On 29 November, Mr Hatch attended his release appointment with a keyworker from the community Dyfodol team. Mr Hatch said he was not happy he was prescribed methadone in prison and said he wanted to switch to buvidal. She gave Mr Hatch overdose and tolerance information, he was also offered a naloxone kit, but he declined. Mr Hatch was given an appointment to see the Dyfodol GP at 3.00pm on 1 December so he could discuss buvidal further with the GP.

26. That day, Mr Hatch attended his second appointment with probation and engaged well. Mr Hatch admitted to drinking four cans of alcohol the previous night but had no spirits and wanted to keep it that way. No concerns with his substance misuse were raised during the appointment.

27. On 30 November, Mr Hatch attended his planned probation appointment with his COM. Mr Hatch appeared to be intoxicated. Mr Hatch admitted to drinking a bottle of rum the previous night, and after discussing this further, he realised he should not have done. She reminded Mr Hatch to attend his appointment the following day with the Dyfodol GP.

28. On 1 December, Mr Hatch did not attend his appointment with the Dyfodol GP. The COM contacted his keyworker who said that they had seen Mr Hatch the previous day. Because Mr Hatch did not collect his methadone on 1 and 2 December, he was no longer able to receive the prescription due to his lowered tolerance and risk of overdose.

29. On 5 December, Mr Hatch did not attend his planned probation appointment, and the COM sent him a warning letter for his non-attendance. That day, she called Dyfodol to find out if they had seen Mr Hatch. Mr Hatch's keyworker told her that he had not collected his methadone, and they had not seen him since 30 November, so he was now out of treatment.

30. The COM was concerned for Mr Hatch's welfare as no one had seen or heard from him for a few days. She decided to visit Mr Hatch the following day.

Circumstances of Mr Hatch's death

31. On 6 December, the COM and a PC went to Mr Hatch's home, but he did not answer the door. They noticed the TV and light were on and were concerned for his welfare. The COM called the letting agency, who agreed to meet them at the property with a spare key. When they entered the flat, they found Mr Hatch dead on the kitchen floor. There were clear signs that he had been dead for some time. The PC radioed for a response team and for an ambulance to attend the property and they confirmed that Mr Hatch had died.

Post-mortem report

32. The post-mortem report concluded that Mr Hatch died of mixed drug toxicity (heroin, methadone, pregabalin and bromazolam).

Findings

Substance misuse services

33. Mr Hatch had a history of substance misuse. While he was in prison, the substance misuse team saw him and warned him about the risks and dangers of taking drugs, he was also involved with his treatment plan. He was maintained on a dose of methadone and his wish to be prescribed buvidal instead was discussed with him. He was appropriately referred to the community drug and alcohol service for continued support after his release. He was also trained in the use of naloxone and offered a naloxone kit in the community, but he declined.

34. We are satisfied that both the prison and probation services did what they could to manage the risks associated with his substance misuse.

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

At the inquest held on the 17 January 2024, the coroner concluded that Mr Hatch died of drug related causes.

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