

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kevin Hassan, on 18 December 2024, following his release from HMP Chelmsford

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



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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. 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 the person's release from prison.
4. Mr Kevin Hassan died from cardio-respiratory failure and polysubstance toxicity on 18 December 2024 following his release from HMP Chelmsford on 11 December 2024. He was 40 years old. We offer our condolences to those who knew him.
5. We did not identify any significant learning relating to the pre-release planning or post-release supervision of Mr Hassan.
6. We make no recommendations.

The Investigation Process

7. HMPPS notified us of Mr Hassan's death on 27 February 2025.
8. The PPO investigator obtained copies of relevant extracts from Mr Hassan's prison and probation records.
9. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
10. The Ombudsman's office contacted Mr Hassan's family to explain the investigation and to ask if they had any matters, they wanted us to consider. Mr Hassan's family wanted to know about the treatment Mr Hassan received for his mental health during his time in prison. They also asked a for a copy of our report. We have answered Mr Hassan's family's question in this report.

Background Information

HMP Chelmsford

11. HMP Chelmsford is a category B local reception and resettlement prison holding adult men and a small number of young adults. It is managed by HMPPS. HCRG provides primary care, secondary mental health, pharmacy, and other services. The Forward Trust provides substance misuse services and Time For Teeth provides dental services.

Probation Service

12. 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, prepare reports to advise the Parole Board and have links with local partnerships to which they refer people for resettlement services, where appropriate. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Chelmsford was in February 2024. Inspectors reported that staff had worked hard to reduce contraband getting into the prison. Subsequently, violence had reduced, the positive MDT rate was lower than at comparable prisons at 15% and higher levels of prisoner attendance at education, training and work had been achieved, but self-harm had increased and poor coordination between the two providers of therapeutic support and long waiting lists prevented the delivery of much needed support for prisoners struggling with their mental health.

Key Events

Background

14. On 28 August 2024, Mr Kevin Hassan was remanded to HMP Chelmsford, charged with burglary. He had been in prison several times before.
15. Mr Hassan had a history of substance misuse (cocaine), depression and had a mental health disorder. During his reception screen, Mr Hassan said that he had been struggling with his drug addiction and wanted help. Mr Hassan was referred to the substance misuse use team and the mental health team.
16. On 29 August, the substance misuse team saw Mr Hassan after he was showing signs of withdrawal. A nurse took his clinical opiate withdrawal scale which measured nine and indicated that he needed treatment. That day, Mr Hassan started a methadone detoxification programme and was prescribed 10mls of methadone. Mr Hassan said that he was prescribed 30mg of mirtazapine for depression and 40mls of methadone in the community. Over the following weeks, Mr Hassan's methadone dosage gradually reduced by 5ml. As Mr Hassan was known to suffer from anxiety and depression, this was managed under IAPT (improving access to psychological therapies) and he was added to the waiting list for counselling.
17. The reduction of the methadone went well and Mr Hassan did not experience any withdrawal symptoms. The substance misuse team continued to offer support and advice.
18. Over the following months, Mr Hassan did not report any physical or mental health difficulties.

Release from HMP Chelmsford

19. On 11 December, Mr Hassan was preparing to attend court for sentencing. As he was still on remand, he did not undergo any pre-release planning. A nurse and staff from the substance misuse service saw Mr Hassan in case he did not return from court. He was given his methadone dose of 15mls, issued with a naloxone kit, and he was advised how to administer it and was told about the risks of drug overdose. Mr Hassan was encouraged to engage with his local community drug team if he was released, and was advised that if he encountered any problems, he should inform the local drug team so that they could contact the integrated drug treatment service at the prison, to which he agreed.
20. Later that day, Mr Hassan attended court. He was sentenced to four months imprisonment for burglary, however as he had been held on remand for that period, and he was released directly from court.
21. Mr Hassan reported to his local probation office for his initial appointment with the duty community offender manager (COM). The duty COM went over his licence conditions and his induction pack. Because Mr Hassan did not have any secured accommodation, the duty COM told him to go to the local housing office. Mr Hassan's next probation appointment was scheduled for 19 December.

Circumstances of Mr Hassan's death

22. At 6.23am on 18 December, Redbridge council cleaners found Mr Hassan in public toilets. They notified the police and the ambulance service, and he was confirmed deceased on their arrival.

Post-mortem report

23. The post-mortem report concluded that Mr Hassan died from cardio-respiratory failure and polysubstance toxicity (cocaine, street heroin and nitazene – a synthetic opioid).

Findings

24. Mr Hassan had a history of substance misuse. While it is noted that he actively engaged with the substance misuse service in prison, the plan was that once he was back in the community, he would continue to engage with the local drug support service, which would have provided him with additional support.
25. Mr Hassan was cared for and supported with his mental health at Chelmsford, was prescribed appropriate medication, and he was referred for counselling. Mr Hassan did not raise any concerns about his mental health during his time at Chelmsford and no referrals were made to community services.
26. Mr Hassan was on remand awaiting sentencing, therefore there was no pre-release provision available to him. Suitable accommodation had not been secured for Mr Hassan because he was released directly from court. During his initial probation appointment, the duty COM advised Mr Hassan to attend the local housing office. We do not know whether he attended as advised.
27. We are satisfied that both the prison and probation services did all they could to support Mr Hassan.
28. We make no recommendations.
29. The initial report was shared with HM Prison and Probation Service (HMPPS) and Healthcare. HMPPS and HCRG care group did not find any factual inaccuracies.
30. At the inquest held on 16 January 2026, the coroner concluded that Mr Kevin Hassan's death was drug related.

Adrian Usher
Prisons and Probation Ombudsman

October 2025

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