Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Hague, on 15 October 2023, following his release from HMP Wealstun

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 investigated 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 Andrew Hague died of acute heroin, flualprazolam and pregabalin toxicity on 15 October 2023, following his release from HMP Wealstun on 12 October 2023. He was 33 years old. I offer my condolences to those who knew him.

5. HMPPS has a legal duty to refer prisoners to the local authority if they are at risk of homelessness on release from prison. However, Mr Hague's Community Offender Manager did not refer him under this duty, and there were too few attempts to engage with Mr Hague to plan for his release.

6. The current criteria for offering prison leavers naloxone on release from prison relies too heavily on them having engaged with the prison's substance misuse team.

The Investigation Process

7. HMPPS notified us of Mr Hague's death on 15 October 2023.

8. The PPO investigator obtained copies of relevant extracts from HMP Wealstun's prison and probation records.

9. We informed HM Coroner for Wakefield of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

10. We contacted Mr Hague'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 but asked for a copy of the report.

11. The initial report was shared with HM Prison and Probation Service (HMPPS) and Practice Plus Group. HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

12. Mr Hague's mother received a copy of the draft report. She did not make any comments.

Background Information

HMP Wealstun

13. HMP Wealstun is a category C training and resettlement prison for men. Practice Plus Group provides healthcare, including mental health services, at the prison. Midlands Partnership NHS Foundation Trust provides substance misuse services.

Probation Service

14. 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, as well as prepare reports to advise the Parole Board. They 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 (where applicable).

Key Events

15. On 27 April 2021, Mr Andrew Hague was convicted of unlawful wounding and possession of an offensive weapon. He was sentenced to 30 months in prison. Mr Hague was released on licence a number of times. His last recall to prison was on 8 February 2023 and he was sent to HMP Leeds.

16. On 19 January 2023, prison Probation Service Officer made a housing referral for him because it was known that he would be homeless on release.

17. On 9 February 2023, Mr Hague saw a member of the resettlement team at HMP Leeds. He refused to engage in the interview and did not answer the questions. The team member recorded that his COM should complete a Commissioned Rehabilitative Service (CRS) referral for housing and a referral to the local authority under the legal duty to refer those at risk of homelessness. The CRS work in partnership with the Probation Service to support and enable rehabilitation when someone is released from prison.

18. On 13 February 2023, a trainee probation officer emailed Mr Hague to invite him to meet her by video link the next day to discuss his recall. Mr Hague did not attend, so she sent a second email asking him to write back if he wanted to engage.

19. On 27 February, Mr Hague saw St Giles (a national charity which aims to support people held back by homelessness, unemployment and the criminal justice system). They advised Mr Hague to present as homeless to the local authority on release and that a referral to HMPPS' Community Accommodation Service Tier 3 (CAS3) had been made. However, Mr Hague was being released following the completion of his sentence so did not qualify for assistance from CAS3. (CAS3 is open to adult prison leavers who are at risk of homelessness on release from prison. The service provides access to up to 84 days of accommodation. However, CAS3 is not available to those released from custody once their sentence has expired.)

20. On 4 May 2023, Mr Hague was transferred to HMP Wealstun.

21. During his healthcare reception screen, Mr Hague told the nurse that he had used drugs in the past, but he had not had any problems with alcohol or drugs in the previous three months.

22. Mr Hague told the nurse that he had mental health problems for which he was taking medication.

23. On 11 May, a drug and alcohol inclusion worker from the drug and alcohol rehabilitation service (DARS) visited Mr Hague. He asked him if he wanted support from DARS. Mr Hague told him that he did not need any.

24. On 28 May and 2 June, a mental health nurse met Mr Hague to discuss his mental health. He told her that he had misused drugs and alcohol in the past, including heroin. She concluded that the mental health team should continue to monitor and support him.

25. The nurse regularly saw Mr Hague in relation to his mental health issues, and the prison psychiatrists assessed him on 6 June and 26 September.

26. In August, DARS sent Mr Hague leaflets about minimising the harm from substance misuse and a service referral form which he could use to access the service in the future.

27. On 10 August, the COM tried to meet Mr Hague by video link, but he did not attend.

28. During a psychiatric assessment on 26 September, a psychiatrist spoke to Mr Hague about substance misuse and told him that the dangers of using illicit drugs included the risk of accidental death and a deterioration in his mental health. He also warned him about the risk of accidental overdose because of a reduced tolerance to drugs. After the assessment, the psychiatrist recommended that Mr Hague should be referred to the community mental health team and that he should receive further advice about the dangers of using illicit drugs.

29. On 28 September, a nurse met Mr Hague to give him his mental health medication by depot injection, which is a slow-release, long-acting medication method. She discussed his release plans with him. Mr Hague confirmed that he had no accommodation in place.

30. During early October, a nurse contacted a number of agencies to help Mr Hague find accommodation and to ensure that he could access mental health support once he was released. She also arranged an appointment for Mr Hague to register with a GP.

31. On 11 October, the nurse met Mr Hague. She told him that she had made an appointment for him to see a GP and had arranged for him to have a telephone call with the Saviours Trust (an accommodation provider) on 12 October.

32. On 12 October, Mr Hague was released homeless. Before he left prison, the nurse met Mr Hague in reception to facilitate the call to the Saviours Trust. There was no answer, so she gave him their address. Mr Hague was given information about agencies that could support him with homelessness and mental health.

33. Mr Hague was not given a naloxone kit. (Naloxone is medication to reverse the effects of opiate overdose.) This is because the substance misuse team had not undertaken a comprehensive assessment of his substance misuse history as Mr Hague had not engaged.

34. As Mr Hague's sentence had expired, he was not subject to post-release supervision by the Probation Service.

Circumstances of Mr Hague's death

35. At 6.05am on 15 October, the police and Ambulance Service were called to a property in Leeds. They found Mr Hague dead and evidence of substance misuse.

Post-mortem report

36. The post-mortem report concluded that Mr Hague died of acute heroin, flualprazolam and pregabalin toxicity in association with cocaine use.

Findings

Pre-release engagement and planning

37. Although probation staff tried to engage with Mr Hague after he was recalled into custody in February 2023, he was reluctant to engage. Following the resettlement team's meeting with Mr Hague on 9 February, a member of the resettlement team noted that Mr Hague's COM would need to refer him to the CRS and to submit a DTR. This information was recorded in the probation case management system, and she would therefore have had access to view it.

38. The COM told the investigator that she was not made aware of the actions that she was given following this meeting. She said that she therefore did not submit a referral to the local authority under the legal duty to refer those at risk of homelessness. She said that as a CRS referral had already been made, a second referral was not needed.

39. The next attempt to contact Mr Hague to discuss his resettlement needs was not made until August 2023, six months later and only two months before Mr Hague was due to be released.

40. All of the COM's attempts to meet Mr Hague were by video link and he did not attend any. Mr Hague had significant mental health issues while in prison which meant that he tended to self-isolate and did not always engage with staff or the prison regime. Although she followed the basic standard process in contacting Mr Hague, we consider that given his vulnerability and risk history, she should have made further attempts to contact Mr Hague to try to engage him. And, if Mr Hague persistently did not engage, she should have escalated the matter to her manager for discussion and help. We make the following recommendations:

    The Head of the Probation Delivery Unit should ensure that COMs escalate their concerns about non-engagement to their manager to discuss and identify what further action can be taken when prisoners repeatedly fail to engage, and a COM cannot support their needs as they prepare for release.

Substance misuse services

41. During the reception health screen, Mr Hague said that he had used drugs in the past but had not had any problems with drugs or alcohol for the previous three months. He also declined support from DARS in May 2023. However, in June, he disclosed to the mental health team that he had previously used heroin. This was not identified by DARS because his initial health screen had preceded this meeting and his case was not subsequently reviewed.

42. Due to a suspicion that Mr Hague may have used spice (synthetic cannabinoids) while in custody, he was offered but declined substance misuse support at HMP

Wealstun. A further opportunity for him to access support was made in August 2023 and he was advised about the risks of illicit drug use on a number of occasions during the months before his release.

43. On the day of his release, Mr Hague was given information about the support services available to him and was reminded to abstain from all illegal and illicit substances. However, he was not given a naloxone kit. The investigator was told that this was because Mr Hague had not engaged with the substance misuse service, and they had not been able to complete a comprehensive assessment of his previous drug use (which he later revealed included regular use of heroin).

44. The local policy at Wealstun states that a prisoner's entitlement to a naloxone kit is based on a need being identified during the assessment. As Mr Hague chose not to engage, he did not meet the criteria for a naloxone kit.

45. While staff adhered to the naloxone policy, Mr Hague had a number of risk factors, including previous opiate use, homelessness and mental health problems and he therefore may have benefitted from being offered naloxone on release. While the local policy was followed, we note the wide regional differences in approach to and criteria for distributing naloxone on release and make the following recommendation:

The Head of Healthcare should work in partnership with Practice Plus Group, the regional Health and Justice Leads and regional drug providers to satisfy themselves that:

- **the local policy on the offer and issue of naloxone on release captures prisoners with previous opiate use and other relevant risk factors; and**
- **they are collaboratively engaging with individuals who are persistently difficult to engage to achieve better outcomes for them.**

Good practice

46. A nurse tried to help Mr Hague find somewhere to live, even though this fell outside the remit of her role. She also contacted a number of agencies to try to ensure that Mr Hague could access healthcare services. Her efforts to support Mr Hague went above and beyond what could have been expected of her.

47. Mr Hague was well supported by the mental health team at Wealstun.

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

Inquest into Mr Hague's death

48. The inquest into Mr Hague's death was held on 23 October 2024 and a verdict of misadventure was recorded. The coroner concluded that Mr Hague's death was due to acute heroin, flualprazolam and pregabalin toxicity with cocaine use.

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