Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Hagan a prisoner at HMP Featherstone on 23 September 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Mark Hagan died on 23 September 2017 at HMP Featherstone. The cause of his death is unknown. He was 48 years old. I offer my condolences to Mr Hagan's family and friends.

While exactly how Mr Hagan died has not been established, it is likely that illicit drug use played a part in his death. He had a history of drug misuse and despite being offered support and being made aware of the risks to his health, he continued to misuse drugs while in prison.

The investigation found that the standard of care provided to Mr Hagan was equivalent to that which he could have expected to receive in the community. I am concerned, however, that the roll check carried out on the morning Mr Hagan was found dead fell below the standards expected and it is possible that he could have been found earlier than he was.

I am also concerned that individual prisons are being left to develop local strategies to reduce the supply and demand for drugs. In my view there is now an urgent need for national guidance on the best measures to combat this serious problem. I have made a recommendation to this effect to the Chief Executive of HM Prison and Probation Service.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Elizabeth Moody
Acting Prisons and Probation Ombudsman **October 2018**

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Summary

Events

1. On 17 October 2015, Mr Mark Hagan was sentenced to four years imprisonment for robbery and sent to HMP Hewell. He was transferred to HMP Featherstone on 17 June 2016.

2. Between June 2016 and September 2017, Mr Hagan was found under the influence of psychoactive substances (PS) on 25 occasions. Despite being offered support and being made aware of the dangers of PS, he refused help to stop.

3. On 22 September, Mr Hagan was locked up for the evening at around 6pm. Staff who completed the evening roll check reported no issues. The next morning, an operational support grade (OSG) completed a roll check of the wing, checking Mr Hagan's cell at 6.36am. He raised no concerns.

4. At 9.30am on 23 September, when an officer unlocked Mr Hagan's cell, he was found unresponsive lying face down on the floor. The officer called a medical emergency code blue on his radio. Healthcare staff attended but did not attempt to resuscitate him as he appeared to have been dead for some time. West Midlands Ambulance Service confirmed Mr Hagan's death at 10.08am.

5. After Mr Hagan's death, a plug socket in his cell was found to have foil sticking out of it. We were told that prisoners used this method to give themselves an electric shock while taking PS for 'an extra high'. A burn mark was found on Mr Hagan's hip. The cause of death listed in the post-mortem report was "unascertained but not natural on balance of probabilities". While PS was found in Mr Hagan's system, the pathologist was not satisfied that PS was the primary cause of death and thought electrocution could have been responsible.

Findings

6. Mr Hagan received help for his substance misuse and was made aware of the risks of using PS but continued to use them frequently. We consider that the care Mr Hagan received at Featherstone was equivalent to that which he could have expected to receive in the community.

7. When Mr Hagan was found at 9.30am on 23 September, he had been dead for some time. Although we cannot be sure when he died, we are concerned that the morning roll check was not carried out properly at 6.36am and an opportunity to attend to Mr Hagan earlier might have been missed. CCTV footage shows that the check took only two seconds and that the OSG did not use a torch or night light when looking into the cell. Although the OSG told the investigator that he saw nothing of concern and would have sought assistance if he had, we are not satisfied that the check was adequate to confirm that Mr Hagan was alive and well.

8. We are concerned at the availability of PS at Featherstone. Despite a comprehensive local drugs strategy, it is clear that more needs to be done to limit

supply and demand. In our view there is now an urgent need for HMPPS to issue national guidance on this to prisons, rather than leaving individual establishments to develop their own local strategies on a piecemeal basis.

Recommendations

- The Governor of HMP Featherstone should ensure that staff completing roll checks are aware of their responsibilities and that they must satisfy themselves all prisoners are present and correctly accounted for, that they have not escaped, and are not obviously ill or dead.
- The Chief Executive of HM Prison and Probation Service should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons and should write to the Ombudsman by the end of August 2018 with an update on progress towards this.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Featherstone informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. The investigator interviewed six members of staff and five prisoners at HMP Featherstone on 2 October, 9 November and 7 December 2017.

11. NHS England commissioned a clinical reviewer to review Mr Hagan's clinical care at the prison. He attended all interviews at the prison.

12. The investigation was suspended on 5 October 2017 while we awaited toxicology results and a cause of death. The investigation was resumed on 5 February 2018.

13. We informed HM Coroner for Staffordshire South of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. The investigator sent a letter to Mr Hagan's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. One of the PPO's family liaison officers spoke to Mr Hagan's sister on 17 November to discuss the investigation. She asked for information about the healthcare provided and if her brother showed any signs of illness in the days before his death.

15. Mr Hagan's sister received a copy of the initial report. A copy of the report was also sent to the solicitor representing her. They did not make any comments.

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

Background Information

HMP Featherstone

17. HMP Featherstone is a medium security, Category C prison, holding around 650 convicted men. Healthcare services are provided by Care UK.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Featherstone was in October 2016. Inspectors reported drugs were widely available. In a survey, 63% of prisoners said that it was easy to get drugs at the prison, which was far more than the 43% in comparator prisons and the 54% at the time of the previous inspection. 22% of prisoners reported developing a drug problem at the establishment (against the 10% comparator). Prisoners and staff alike said that psychoactive substances (PS) were a huge problem. There were regular acute health incidents, some severe, caused by prisoners' use of these drugs.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 October 2017, the IMB reported concerns about the availability of drugs, mobile phones, sim cards, and tobacco that came into the prison in a variety of ways, such as drones, throw-overs, sprayed on paper and brought in by visitors. The Board said this was a nationwide problem and certainly not unique to Featherstone.

20. The Board was alarmed at the frequency of drug-related incidents and the numbers of staff who had to deal with these matters, including outside agencies such as the Ambulance Service. The Board reported that the Governor and his senior management team had recently implemented strategies to help reduce violence in the establishment and make Featherstone a safer and decent place in which to live and work.

Previous deaths at HMP Featherstone

21. Mr Hagan was the eighth prisoner to die at Featherstone since September 2014. Three prisoners took their own lives and four died from natural causes. Two further deaths are yet to be classified. There were no similarities between Mr Hagan's death and previous deaths at the prison.

Psychoactive substances (PS)

22. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

23. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

24. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

25. On 17 October 2015, Mr Mark Hagan was sentenced to four years imprisonment for robbery and sent to HMP Hewell. He had a history of drug misuse and told a nurse during an initial health screen that he used heroin and cocaine and drank alcohol on a daily basis. He was referred to the prison's substance misuse team and put on a methadone programme. While at Hewell, Mr Hagan was found under the influence of psychoactive substances (PS) on 12 November 2015 and 8 June 2016.

26. Mr Hagan was transferred to HMP Featherstone on 17 June 2016. Between 7 July and 8 August, Mr Hagan was found to be under the influence of PS on four occasions. After each occurrence Mr Hagan was managed under the Incentives and Earned Privileges scheme (IEP) and was reduced to basic regime. (The IEP scheme aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of their cell and to wear their own clothes. There are three levels, basic, standard and enhanced.)

27. On 8 August, Mr Hagan asked to be referred to the drug and alcohol recovery service (DARS). He had an initial assessment on 16 August. During this assessment he explained that he was addicted to PS and would use it roughly every three days. Mr Hagan met with the DARS team again on 19 August, 14 September and 19 October. During these meetings they discussed harm reduction, his mental health, a recovery plan and motivation to stop using drugs in prison. Attendance at these meetings was voluntary and there are no further entries in his DARS record after 19 October.

28. Mr Hagan was found under the influence of PS on 21 and 22 October, and 25 November. He was again reduced to basic regime which resulted in a removal of certain prison privileges.

29. On 2 February, Mr Hagan met with a member of the violence reduction team after being found under the influence of PS. He said that he did not have a problem with drugs and would seek help if he needed it.

30. On 30 March, RESOLVE (a prison programme run by the psychology team) spoke to Mr Hagan. He admitted to using PS almost daily but did not want to engage with their service as he did not feel very motivated at the time.

31. A psychosocial support worker from the DARS team, spoke to Mr Hagan on 5 April. She made a note in his prison record to say that he "needs to gain a deeper understanding of the negative effect PS has on his physical, psychological and social wellbeing".

32. Mr Hagan continued to take PS and was found under the influence of PS again on 12 and 14 May. He was reduced to basic regime and suspended from his job. On 22 May, Mr Hagan was found choking on his own vomit after taking PS. An officer called a code blue (an emergency response code to indicate that a prisoner is unconscious, or having breathing difficulties) and healthcare staff

attended. When a nurse examined Mr Hagan, his blood oxygen level was dangerously low at 82%. (Normal blood oxygen levels are 95% or above.) After using suction to clear his airway his condition stabilised and his oxygen levels increased to 98%. Mr Hagan admitted to taking PS and said that another prisoner had given him 'a pipe' which had resulted in the attack.

33. Three days later on 25 May, Mr Hagan attended a disciplinary hearing and was given five days cellular confinement (segregation) and located in the Care and Separation Unit (CSU). His prison NOMIS record also shows that extra days were added to his prison sentence.

34. On 31 May, Mr Hagan spoke to a mental health nurse. He said that he was aware of the impact PS was having, but believed he had an addictive personality and found the temptation difficult, especially at weekends due to boredom. The nurse referred Mr Hagan to SMART recovery and relapse prevention team around drug use. The very next day, 1 June, Mr Hagan was again found under the influence of PS.

35. On 15 June, Mr Hagan attended a PS awareness group. (This is a group session designed to raise awareness of the effects of PS and offer harm reduction advice.) During this session Mr Hagan disclosed that he had traded food and other items to buy PS.

36. Despite attending the awareness session only two weeks earlier, Mr Hagan was found under the influence of PS on 29 and 30 June. He admitted to taking PS but said that he did not want help from DARS as he would do it on his own.

37. During July, Mr Hagan used PS on four occasions. On 17 July, Mr Hagan was found collapsed while at work in the engineering workshop. A code blue was called and when examined by healthcare his oxygen saturations were found to be dangerously low again at 74%. Oxygen was given and his oxygen levels returned to normal. Mr Hagan was dismissed from his job as a result of this.

38. Mr Hagan spoke to a support worker on 17 July. When questioned about his repeated PS use, recent code blues and days added to his sentence he could not explain why or the root cause for his persistent use, apart from it helped to 'waste his time'. He confirmed that he was fully aware of the negative consequences of using PS on his mental, physical and social wellbeing. During this meeting Mr Hagan stated that he was fully equipped through previous work completed, and felt that he did not need any further input. He did however agree to meet with the support worker again to look at future goals and coping strategies.

39. Mr Hagan continued to take PS and was found slumped on the floor of his cell on 18 August. He did not attend a Smart Recovery Group session arranged for 29 August.

40. A code blue was called on 15 September when Mr Hagan was found unresponsive on the wing. His blood oxygen levels were dangerously low at 73% and a nurse found that he had mild central cyanosis (cyanosis is a blue or purple coloration of the skin due to low oxygen levels) and a clenched jaw. Oxygen was given via a face mask and his oxygen levels returned to normal. Mr

Hagan was found under the influence of PS again two days later on 17 September. A prisoner told the investigator that he saw Mr Hagan on 21 September and he appeared normal.

41. A prisoner told the investigator that he saw Mr Hagan around 4pm on 22 September and that he had a yellow/grey complexion but he did not mention feeling unwell. At 5.03pm, a nurse gave Mr Hagan pregabalin and quetiapine at the medication hatch. The nurse told the investigator that he did not recall Mr Hagan looking or complaining of being unwell and he did not appear to be under the influence. Mr Hagan took his medication and returned to his cell. A prisoner told the investigator that he saw Mr Hagan at around 5.15pm and he appeared to be under the influence. CCTV shows that Mr Hagan was locked in his cell at 6pm.

42. A prisoner (who lived in the cell next door) spoke to Mr Hagan through the wall of the cell at approximately 11.30pm. He could hear him moving around and asked how he was. Mr Hagan said he was making a drink. The prisoner then fell asleep.

43. An Operational Support Grade (OSG) arrived for his night shift duty at 8.30pm. A roll check of the wing had already been completed by the day staff and no issues reported. He completed a security check of the wing to ensure that all doors were secure.

44. The next morning, Saturday 23 September, the same OSG completed a roll check of the wing, checking all prisoners in their cells. CCTV shows that the OSG checked Mr Hagan's cell at 6.36am. He made an entry in the wing observation book to say, "Very quiet night. No concerns or issues to report".

45. At 7.30am, an officer arrived to start his day shift. The OSG spoke to the officer to provide a handover before finishing his shift and leaving the prison.

46. At 9.30am, an officer went to Mr Hagan's cell to unlock him so he could collect his medication. When he unlocked the cell he found Mr Hagan unresponsive lying face down on the floor. He immediately called a code blue on his radio. He was unable to find a pulse.

47. A nurse was already on the wing when he heard the code blue and responded immediately. Mr Hagan was cold to the touch, mottled and rigid. Cardiopulmonary resuscitation (CPR) was not attempted as it appeared Mr Hagan had been dead for some time.

48. West Midlands Ambulance Service records show that they arrived at the prison at 9.49am. They confirmed the presence of rigor mortis and certified Mr Hagan's death at 10.08am.

49. After Mr Hagan's death, a plug socket in his cell was found to have foil sticking out of it. During the investigation we were told that prisoners would give themselves an electric shock for 'an extra high' while taking PS. They would balance a spoon on rolled up silver foil/wire inserted into a plug socket, fill the spoon with shower gel and then touch it to get an electric shock.

Contact with Mr Hagan's family

50. Mr Hagan's mother was listed as his next of kin. A prison family liaison officer (FLO), and the governor travelled to Mr Hagan's mother's address at 1pm on 23 September. They were unable to locate her at the address given and they did not have a telephone number. They were also unable to contact his daughter. She was not at her address and the phone number listed did not connect. A note was left asking them to contact the prison.

51. On 25 September, Mr Hagan's sister telephoned the prison. The FLO spoke to her and obtained a contact number for her mother. The FLO telephoned her the same day and passed on her condolences and offered support. Mr Hagan's mother asked that her daughter (Mr Hagan's sister) be the prison's point of contact. The FLO kept in regular contact with the family. Mr Hagan's funeral was on 31 October 2017. The prison did not send a representative to attend the funeral at the family's request. The prison contributed to the cost of the funeral in line with national prison policy.

Support for prisoners and staff

52. After Mr Hagan's death, The Head of Residence and Safety, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

53. The prison posted notices informing other prisoners of Mr Hagan's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by the death.

Post-mortem report

54. The cause of death listed in the post-mortem report was, "unascertained but not natural on balance of probabilities". The pathologist noted that the toxicologist had detected Diphenidine (a psychoactive substance) in Mr Hagan's blood and bodily tissue and said, "The high level detected in his tissue suggested previous use and accumulation. However, the low blood levels and the apparent sudden death seem to exclude the abuse of drugs as the primary cause of death".

55. Mr Hagan had a burn mark on his hip. The pathologist was unable to establish the cause. The pathologist concluded, "I have found no convincing natural cause of death. I am not convinced that drug abuse is the main causative agent in death in this case and suggest that electrocution could be responsible".

Findings

Clinical care

56. Mr Hagan received help for both his mental health and substance misuse problems. He was given information on the dangers of PS and appeared to be aware of the risks. There is no evidence to suggest that Mr Hagan was physically unwell prior to his death on 23 September 2017. There is also no evidence to suggest that Mr Hagan was under the influence of PS prior to being given his prescribed medication on 22 September. The clinical reviewer concluded that the clinical care Mr Hagan received at Featherstone was equivalent to that which he could have expected to receive in the community.

Morning roll check

57. The purpose of a roll check is to confirm that all prisoners are present and correctly accounted for, that they have not escaped, and are not ill or dead. CCTV footage shows that the OSG arrived at Mr Hagan's cell at 6.36am to conduct the morning roll check. He lifted the flap on the door and looked through before shutting it and moving onto the next cell. The roll check on Mr Hagan's cell lasted two seconds, the lights were off on the wing and the OSG did not use a torch or the cell night light when looking into the cell.

58. The OSG said that nothing stood out as being unusual when he did his roll check and because he had not used his torch or the night light, he must have been able to see into the cell with the light coming in from the window. He said he was aware of the correct procedure for completing a roll check but that if he had to check that every prisoner was breathing his roll check would take around two hours because of the number of cells he had to check.

59. The investigator showed the OSG a still picture from body-worn camera footage taken during the emergency response. He said that he did not remember seeing Mr Hagan on the floor in the position shown and that, if he had seen this, he would have called his senior officer as he had done with other prisoners of concern in the past.

60. Paramedics who attended to Mr Hagan at 9.49am confirmed that he had rigor mortis which indicated that he had been dead for some time. We cannot be sure when Mr Hagan died, or when he ended up lying on the floor of his cell. It is possible that he was dead at the time of the morning roll check but we cannot be certain. Although we cannot say for certain that the morning roll check failed to identify that Mr Hagan was dead, the minimal time it took to undertake the roll check and the fact that no light was used when looking into the cell, causes us concern. We make the following recommendation:

    The Governor of HMP Featherstone should ensure that staff completing roll checks are aware of their responsibilities and that they must satisfy themselves all prisoners are present and correctly accounted for, that they have not escaped, and are not obviously ill or dead.

61. When an officer found Mr Hagan unresponsive on the floor at 9.30am he called a code blue without delay. A nurse was already on the wing when he heard the

officers call and attended immediately. CPR was not attempted as there was evidence to show that Mr Hagan had been dead for some time. The decision to not attempt resuscitation was appropriate, showed dignity and respect towards Mr Hagan and was in line with the European Resuscitation Council Guidelines for Resuscitation 2015.

Cause of death and electrical supply to HMP Featherstone

62. The pathologist stated that electrocution could be responsible for Mr Hagan's death.

63. In an email dated 12 February 2018, The Service Delivery Manager said that the prison, including all cell power and lighting, was rewired in 2011 to the IEE 17th Edition Regulations. He also said that this was in line with National Offender Management Services safety specifications.

Illicit substances

64. Mr Hagan had a history of taking illicit substances. He had regular contact with DARS and openly spoke about taking PS on a regular basis.

65. Featherstone has a Supply Reduction Strategy, issued in April 2017. It states that the use of PS by prisoners has had a significant effect on Featherstone and the wider prison estate. PS has been linked with serious acts of indiscipline, assaults on staff and prisoners, damage to property, restricted regimes and self-harm and bullying to name a few. It says that PS is considered to be one of the biggest threats to the good order and discipline of prisons as well as the safety of staff and prisoners at this time.

66. Featherstone told us that they hold monthly drug strategy meetings to discuss intelligence and identify areas of weakness around the prison to prevent the trafficking of drugs. They found that drug prevention strategies used for illegal drugs such as cocaine could alienate people who took PS, so they have focused on education and information sharing, targeting people who are either at high risk of PS use or who are currently using PS.

67. They have developed an action plan designed to ensure that tackling drugs and PS remain a key focus for the establishment. This is a live action plan that aims to contribute actively to the reduction in both the supply and demand for PS. New actions are added at any time in response to the changing need and environment.

68. Care UK, the healthcare provider, has a policy to withhold all non-essential medication for 24 hours if illicit drug taking is suspected until a doctor can complete a medication review. This is to avoid any adverse effects of taking prescribed and non-prescribed drugs together.

69. The PPO's Learning Lessons Bulletin on PS, published in July 2015, set out why these substances were a source of increasing concern in prisons. There was emerging evidence that PS posed dangers to both physical and mental health. In addition, trading these substances could lead to debt, violence and intimidation. In our Annual Report for 2016/2017 we noted that the number of deaths where the use of PS may have played a part continued to rise and that there was a

greater need than ever for more effective drug supply and demand reduction strategies, including better monitoring by drug treatment services and effective violence reduction strategies.

70. While we accept that Featherstone has a drug strategy in place and staff are working hard to implement it, Mr Hagan was apparently able to obtain and use PS without difficulty at Featherstone and continued to do so despite being made aware of the dangers and despite losing privileges. It is clear, therefore, that more needs to be done to reduce both the supply and the demand for PS.

71. Featherstone is not alone in facing this problem – it is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, in the PPO's view there is now an urgent need for national guidance to prisons from HMPPS providing evidence-based advice on what works.

72. For example, Mr Hagan said that one of the reasons he used PS was that he was spending long periods in his cell with nothing else to do, but the sanctions imposed on him because of his drug use meant that he spent more time in his cell. We know that other prisons are taking a different approach to this conundrum. The PPO is not qualified to say what the most effective approach is, but this is the kind of guidance that should be set out in a national strategy. We therefore make the following recommendation:

The Chief Executive of HM Prison and Probation Service should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons and should write to the Ombudsman by the end of August 2018 with an update on progress towards this.

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