Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Francis Conlin on 7 October 2024, following his release from HMP Doncaster

A report by the Prisons and Probation Ombudsman

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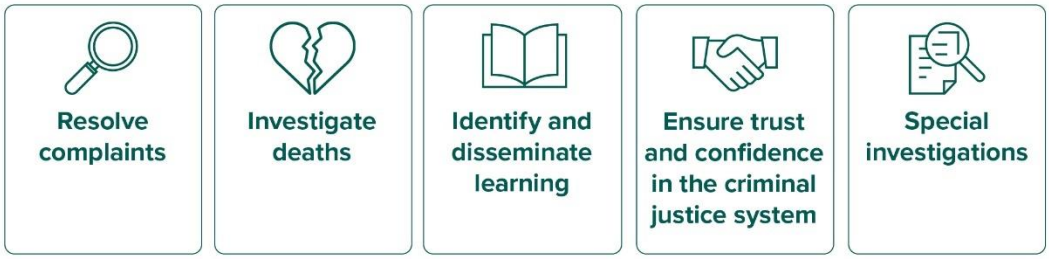
OUR VISION

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. 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 Francis Conlin was found hanged at his home on 7 October 2024, one week after his release from HMP Doncaster. He was 23 years old. We offer our condolences to those who knew him.

5. Mr Conlin gave no indication that he was at imminent risk of suicide, and we are satisfied that his death could not have been foreseen by prison or probation staff.

6. We make no recommendations.

The Investigation Process

7. HMPPS notified us of Mr Conlin's death on 8 October 2024.

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

9. We informed HM Coroner for Teesside of the investigation. They gave us the provisional cause of death and results of the toxicology tests. We have sent the Coroner a copy of this report.

10. The Ombudsman's office contacted Mr Conlin's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted us to consider. She asked:

    - Why Mr Conlin was released after 9.00pm on the day of his release.
    - What financial support and grants Mr Conlin received upon his release.
    - Why Mr Conlin was released without seeing a nurse and without his prescription medication.
    - Why Mr Conlin was released on a GPS monitoring tag, and the conditions attached to this.

    We have addressed these issues in the report.

11. We shared our initial report with HMPPS. They found no factual inaccuracies.

12. We sent a copy of our initial report to Mr Conlin's mother. She did not notify us of any factual inaccuracies.

Background Information

HMP Doncaster

13. HMP Doncaster is a reception and resettlement prison that holds category B male prisoners who have been convicted, as well as those on remand. It is managed by Serco. Practice Plus Group (PPG) provides both the mental and physical healthcare services, as well as substance misuse treatment 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, prepare reports to advise the Parole Board and have links with local partnerships to which they refer people for resettlement services, where appropriates. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Doncaster was in February and March 2022. Inspectors reported that PPG offered a comprehensive range of mental health treatments and interventions, with new referrals being dealt with in a timely manner. PPG also provided clinical and psychosocial substance misuse services which inspectors reported were good and met the needs of the population. There was evidence of joint working taking place between mental health and substance misuse service colleagues, and there were advanced plans for the teams to be co-located. When prisoners were released, PPG provided harm minimisation advice, naloxone (an opiate reversal agent) as necessary and continuity of care with community services. Work with some local drug teams was good, with use of technology to brief community drug workers prior to release, some of whom would pick up vulnerable prisoners on the day of release to ensure that they engaged with the services.

16. Inspectors reported that resettlement needs on arrival were captured well by OMU staff and the custodial integration team, which were often followed up with practical plans to promote resettlement. Specific discharge packs were available for those released to the local authority areas in South Yorkshire, with local details and contact numbers. Doncaster had a 'departure lounge' that prisoners could access on the day of their release. The lounge was supervised by two skilled members of staff who were available to signpost prison leavers to local community support services, as well as provide practical items (such as food, toiletries and clothing) as necessary.

Suspended Sentence Orders

17. Those sentenced to a suspended sentence order (SSO) are given the opportunity to serve their sentence in the community, rather than in prison. The judge can impose various conditions on a suspended sentence order such as (but not limited to) the requirement to engage with relevant support services, complete unpaid

work, or be monitored by a GPS tag. The judge will establish a timeframe within which the individual must comply with the order, along with a suspended prison sentence. If the individual commits further offences, fails to adhere to the imposed conditions, or breaches the terms of their SSO, the suspended term of imprisonment may be activated, requiring them to serve that portion of their sentence in prison.

Key Events

Background

18. On 10 June 2024, Mr Francis Conlin was sentenced to 12 months in prison for a public order offence. He was released on licence the same day due to already serving the custodial part of his sentence while on remand.

19. On 11 June, Mr Conlin was arrested, charged with burglary, and remanded to HMP Doncaster where he awaited a date for his trial. Additionally, his community offender manager (COM) initiated recall procedures as he had breached his licence conditions.

Pre-release planning

20. When he arrived at Doncaster, Mr Conlin told the reception nurse that he had a history of anxiety, depression and substance misuse. He said that he often bought illicit prescription drugs, namely pregabalin (used to treat anxiety but widely abused as it increases the euphoric effects of opioids) and temazepam (a type of benzodiazepine that produces a calming effect on the brain and nerves). Mr Conlin said he would like support with his substance misuse, so the nurse completed a referral to the prison's substance misuse service (SMS). The nurse noted a history of self-harm and suicide attempts. When asked, Mr Conlin said he had no current thoughts of suicide or self-harm and declined a referral to the mental health team. The nurse advised Mr Conlin how to self-refer to the mental health team, should he change his mind.

21. The next day, a SMS recovery worker visited Mr Conlin to discuss the support he would like at Doncaster. Mr Conlin said he would like to attend group support sessions. The recovery worker scheduled a full assessment for 13 June. Mr Conlin did not attend this assessment, so it was rescheduled for 20 June.

22. On 13 June, Mr Conlin requested a prescription for fluoxetine (an antidepressant), as he said he had previously taken it to help manage his mood. On 15 June, a GP approved his request and issued a prescription. Additionally, an appointment was scheduled for him to be triaged by the mental health team to further assess his concerns. Mr Conlin collected his first dose of fluoxetine on 16 June and was due to collect it daily thereafter. Staff recorded when he failed to collect it.

23. On 20 June, Mr Conlin attended his SMS appointment. He told his recovery worker that prior to coming to prison, he was smoking cannabis daily, and taking illicit benzodiazepines out of boredom, to cope, and to deal with stress. They completed a 1:1 session on overdose awareness which included advice to not use drugs alone and to use small amounts to test their strength. She also warned Mr Conlin about the dangers of mixing drugs with alcohol and how this could further increase the risks of overdose. The recovery worker gave Mr Conlin information on tolerance levels and overdose awareness, including how to recognise the signs and symptoms of an overdose, and what to do in the event of one. When asked, Mr Conlin said he did not want to be referred to a community substance misuse service in preparation for his release.

24. On 22 June, Mr Conlin did not attend the medication hatch to collect his fluoxetine.

25. On 25 June, Mr Conlin attended his mental health triage appointment. He told the nurse about his history of suicide attempts, and that in May 2024, he had been detained in a psychiatric hospital for 28 days following an overdose. He also disclosed that he had taken another overdose just days before entering custody. When the nurse asked about his reasons for doing so, he was unable to give an explanation. Mr Conlin said that currently, he had no thoughts or intentions of harming himself, and he spoke positively about being released from prison and his plans to live with his mother. The nurse noted that although some of Mr Conlin's answers were vague, he engaged positively throughout the appointment. Mr Conlin said he did not want ongoing support from the mental health team, and he was discharged from their service. The nurse advised Mr Conlin how to access mental health support in the future, should he change his mind.

26. Later that day, Mr Conlin did not attend the medication hatch to collect his fluoxetine.

27. On 3 July, Mr Conlin attended an asthma review where he was prescribed both a preventative and a relief inhaler and shown how to use them. Mr Conlin was able to hold the inhalers in his cell and was not required to collect these from the medication hatch. He declined a copy of his asthma care plan and declined an asthma information leaflet.

28. On 17 July, the recovery worker rang Mr Conlin on his in-cell phone after he had asked to speak to her. Mr Conlin said that over the past few weeks, he had been taking illicit buprenorphine (an opioid medication prescribed to those addicted to opiates, such as heroin) and he wanted help to reduce his use. She said he may need to be prescribed methadone (also an opioid medication used to treat opiate dependence) to safely reduce his use. To prescribe methadone, Mr Conlin was required to undergo three mandatory drug tests, which she arranged. She warned him about the risks associated with opiate use, the dangers of drugs in prison, and advised him against increasing his buprenorphine intake in the interim.

29. On 9 July, Mr Conlin attended Teesside Crown Court where he pleaded guilty to the charge of burglary. He remained at Doncaster while he waited for a date to be sentenced.

30. On 10 July, Mr Conlin attended the medication hatch to collect his fluoxetine. As he attended without his prison identification card, he was sent away to collect this and told to return for his medication straight away. Mr Conlin did not return.

31. On 17 July, Mr Conlin did not attend the medication hatch to collect his fluoxetine.

32. On 23 July, the recovery worker spoke with Mr Conlin after five litres of hooch (illicitly brewed alcohol) were found in his cell. She warned Mr Conlin that if he continued to be found with illicit items then this may interfere with his chances of being prescribed methadone. They completed a comprehensive session around hooch and the dangers associated with consuming it. Mr Conlin completed a second mandatory drugs test, and two days later, completed the final one. On each occasion he tested positive for buprenorphine only.

33. On 26 July, staff discussed Mr Conlin at the SMS multidisciplinary team meeting. They concluded that Mr Conlin was not suitable to be prescribed methadone as he had never been on it before and had only been taking buprenorphine for a few weeks. It was agreed that Mr Conlin should complete additional psychosocial work and consider moving from his current wing to get away from illicit substances.

34. On 31 July, Mr Conlin's mother rang Doncaster's safer custody hotline over concerns that he was not being prescribed medication for his mental health or asthma. Later that day, a member of the safer custody team contacted Mr Conlin's mother and told her that all medication had been prescribed, however, Mr Conlin had failed to collect it on several occasions. She was told that the prescriptions remained active, and Mr Conlin just needed to attend the medication hatch to collect his medication.

35. On 1 August, Mr Conlin did not collect his fluoxetine from the medication hatch. He told a nurse that he did not want to wait in the queue.

36. On 7 August, a pharmacist noted that Mr Conlin did not attend the medication hatch to collect his fluoxetine, despite being unlocked and called to attend several times.

37. On 14 August, Mr Conlin attended a routine asthma review, where he told a nurse that his symptoms had significantly improved since starting the preventative inhaler.

38. On 26 August, a pharmacist noted that Mr Conlin was unlocked for medication but failed to attend.

39. On 5 September, Mr Conlin attended a structured psychosocial appointment with his recovery worker. Mr Conlin said that he was no longer using illicit buprenorphine and had not used it for several weeks. Mr Conlin said that he had recently smoked 'Spice' (a form of psychoactive substance, PS) with his cellmate. She warned Mr Conlin about the dangers associated with PS, including that there are multiple different batches with varying strengths and potency and therefore the risk of overdose is greater. She said it was therefore very important to test its strength with small doses, avoid smoking it through pipes, and avoid mixing it with other drugs.

40. On 18 September, Mr Conlin was prescribed a stronger preventative inhaler, after he told the asthma nurse that he was still needing to use his relief inhaler regularly. This was the last time Mr Conlin was seen by healthcare staff before his release.

41. On the afternoon of 30 September, Mr Conlin attended his sentencing hearing by videolink at Teesside Crown Court. He was sentenced to an 18-month suspended sentence order (SSO) for burglary. As part of his SSO, the judge sentenced him to a nine-month drug rehabilitation requirement (DRR), and a nine-month GPS monitoring requirement. The judge enforced the GPS monitoring condition to allow probation to continuously track Mr Conlin's whereabouts and ensure compliance with specific conditions. While his tag did not include exclusion zones or a curfew, he was under police investigation for a separate offence and was subject to bail conditions prohibiting him from entering a designated area of Stockton-on-Tees.

42. At 5.27pm, a member of the offender management unit emailed the healthcare department letting them know that Mr Conlin would be released the same day following sentencing. This email was not picked up until the next morning, when

healthcare staff were back on duty. As a result, Mr Conlin was not seen by a nurse prior to his release and was not given a seven day prescription of his fluoxetine.

Release from HMP Doncaster

43. Before Mr Conlin could be discharged from Doncaster, the Offender Management Unit had to complete thorough release checks and send the necessary paperwork to reception for processing. However, after reception received the documents, a delay in the evening routine roll count resulted in Mr Conlin's release being delayed until approximately 9.03pm. Mr Conlin was given the money from his prison account in cash, which totalled £2.43. Prisoners who are released from court after a period on remand are not eligible to receive the standard discharge payment of £86. Mr Conlin was instructed to report to Middlesborough Probation Office the following day.

44. The next day, Mr Conlin attended Middlesborough Probation Office as instructed. The COM completed his induction, went through his licence conditions, and Mr Conlin signed a copy to say that he understood them. She noted that she was initially concerned that the judge had imposed a GPS monitoring condition, as she thought Mr Conlin would struggle to keep it charged and may end up in breach of its conditions. However, after giving him some advice, she noted that Mr Conlin spoke practically about how he would manage his tag, ensuring he charged it every day before leaving the house. Finally, they discussed his drug rehabilitation requirement (DRR) and reviewed his licence conditions relating to drug and alcohol misuse. Mr Conlin said he wanted to stop using drugs as they had negatively impacted on his life, and said he was looking forward to doing 1:1 work as part of his DRR contract. Since Mr Conlin's GPS tag was registered at his mother's address, where he was living, she scheduled their next appointment (4.00pm on 7 October) as a home visit. (Home visits enable probation officers to assess an individual's living environment and ensure compliance with probation conditions.)

Circumstances of Mr Conlin’s death

45. On 7 October, Mr Conlin sent a text message to his mother, saying that he was at home and intended to harm himself. She asked her brother to check on him, but Mr Conlin did not answer the door, so he called the emergency services. When they arrived at around 3.00pm, they discovered that Mr Conlin had hanged himself. They started CPR but resuscitation attempts were unsuccessful and paramedics pronounced life extinct.

Cause of death

46. At the time of issuing this report, the official cause of death and full post-mortem report was not available. However, the coroner gave a provisional cause of death as pressure of the neck due to hanging. Toxicology tests showed that Mr Conlin had cocaine and pregabalin in his blood at the time of his death.

Findings

Assessment of risk

47. Mr Conlin had a documented history of suicide attempts, which staff recorded when he arrived at Doncaster. He said he had no current thoughts of suicide and self-harm at that time and declined a referral to the mental health team. He subsequently requested fluoxetine (an antidepressant) which was prescribed. However, he frequently failed to collect it from the medication hatch.

48. At a mental health assessment in June, Mr Conlin reassured the nurse that he had no thoughts of self-harm and spoke positively about his release and future. When asked, he said he did not want further support from the mental health team and was subsequently discharged from their service. The nurse told him how he could access future mental health support, should he change his mind. Mr Conlin was not subject to suicide and self-harm prevention procedures while at Doncaster.

49. Mr Conlin was released directly from Teesside Crown Court via videolink on the day of his sentencing. As his release was unplanned and notice of it came late in the day, the healthcare department was unable to arrange for him to be discharged with a prescription for fluoxetine and no specific pre-release preparations had been completed.

50. Despite the unexpected nature of his release, we found that Mr Conlin's COM responded promptly to implement measures to support his rehabilitation. She ensured that Mr Conlin fully understood the conditions of his SSO and what was expected of him, while also arranging a home visit. During his initial appointment, Mr Conlin did not express any concerns related to suicide or self-harm.

51. We are satisfied that Mr Conlin's risk of harm was adequately assessed by prison and probation staff and that he gave no indication that he was at imminent risk of suicide. We are satisfied that Mr Conlin's death could not have been foreseen by prison or probation staff.

Substance misuse support

52. Mr Conlin had a history of substance misuse. While he was in prison, he was seen regularly by the SMS team and warned about the risks and dangers of taking drugs. Mr Conlin had no prior history of opiate use, however, while in prison, he told his recovery worker that he had begun using illicit buprenorphine (an opioid). We found that the substance misuse services at Doncaster did not discuss or offer him a take-home naloxone kit, which is used to rapidly reverse opioid overdoses, upon his release. However, we consider this to be reasonable, as they were unaware of his release on 30 September.

53. We are satisfied that Mr Conlin's COM took appropriate measures to address his substance misuse upon his release from prison. Although he was sentenced to a Drug Rehabilitation Requirement, she also ensured that his licence conditions included compliance with any necessary interventions to address his substance misuse issues.

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

Adrian Usher
Prisons and Probation Ombudsman **May 2025**

Inquest

At the inquest, held on 12 August 2026, the Coroner reached a narrative conclusion:

“Francis died due to hanging from a self-applied ligature at a time when he had consumed cocaine and non-prescribed pregabalin. It has not been possible to ascertain Francis’s intention at the relevant time.”

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