Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Connolly on 29 April 2024, following his release from HMP Featherstone

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. 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 Robert Connolly was found hanged at his home on 29 April 2024, following his release from HMP Featherstone on 18 April 2024. He was 46 years old. We offer our condolences to those who knew him.

5. Mr Connolly had a history of substance misuse. He completed a detoxification programme in prison and received appropriate support. Prior to his release he was referred to the community drug and alcohol team.

6. Mr Connolly had anxiety and depression and was prescribed medication, but he declined to be referred to the mental health team for additional support. Prison and probation staff did not identify any concerns relating to his risk of suicide and he was not monitored under suicide and self-harm prevention procedures (known as ACCT) during his time at Featherstone.

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

The Investigation Process

8. HMPPS notified us of Mr Connolly's death on 30 April 2024.

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

10. We informed HM Coroner for Rochdale of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

11. The Ombudsman's office contacted Mr Connolly's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Connolly's family wanted to know what support Mr Connolly received with drug withdrawal in prison and on release. These concerns have been addressed in this report.

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

13. Mr Connolly's family received a copy of the initial report. They did not make any comments.

Background Information

HMP Featherstone

14. HMP Featherstone is a category C prison which holds convicted male prisoners. It is managed by HMPPS.

Probation Service

15. 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

16. The most recent inspection of HMP Featherstone was in May 2022. Inspectors reported mental health and substance misuse services were well-led, integrated, co-located and responded effectively to needs.

17. Patients had swift access to mental health services and the waiting times for non-urgent cases were favourable to what they would expect in the community. The service offered various interventions for different mental disorders.

18. There was efficient planning of care for substance misuse service patients due to be released. Their pre-release concerns were identified to ensure continuity with community agencies.

HM Inspectorate of Probation

19. The most recent inspection of NPS Greater Manchester Division was in May 2023. Inspectors found that the Probation Delivery Units (PDU) within that division had developed strong strategic partnerships and had capitalised on the comprehensive range of services to meet the needs of people on probation.

20. Inspectors stated that it was imperative the region supported all PDU's within it to build on their strong foundations by improving work to keep people safe. This included improving assessment of risk, risk management planning and delivery of case management.

Key Events

Background

21. On 18 May 2023, Mr Robert Connolly was remanded to HMP Dovegate, charged with burglary of a dwelling.

22. On 18 May, a Nurse completed Mr Connolly's initial health screen. She noted he presented with clear signs of substance withdrawal. Mr Connolly said that he had used heroin the previous day and would usually take 75mg of pregabalin and 30mg of mirtazapine daily. He denied any alcohol use. He tested positive for opiates, cocaine and cannabinoids. Mr Connolly was placed on a methadone detoxification programme and was prescribed 10mg of methadone (a substitute medication for opiate addiction). (Mr Connolly's methadone was later increased to 25ml, then to 30ml, because he felt that 25ml was not helping him during the night.)

23. On 19 May, a Nurse saw Mr Connolly. Mr Connolly told her that he suffered with anxiety and depression and was prescribed pregabalin and mirtazapine in the community. He said that he had never self-harmed or attempted suicide and did not have any active thoughts to do so. Mr Connolly was prescribed mirtazapine (antidepressant), he was not prescribed pregabalin. He later declined support from the mental health team.

24. On 28 June, a substance misuse worker offered Mr Connolly naloxone training (a medication that can reverse the effects of an opiate overdose). Mr Connolly declined the offer and said that he would not need it.

25. On 29 June, Mr Connolly was convicted and was sentenced to two years in prison. He remained at Dovegate.

26. On 14 July, the substance misuse worker saw Mr Connolly to discuss the work the drug and alcohol service offered. Mr Connolly declined the offer and said that he had previously completed the work and did not want to do it again.

27. On 28 July, Mr Connolly was transferred to Featherstone.

28. A Nurse completed Mr Connolly's initial health screen. Mr Connolly denied any thoughts of suicide and self-harm. He continued his methadone detoxification programme and was prescribed 30ml of methadone.

29. On 30 July, a nurse completed Mr Connolly's secondary health screen. Mr Connolly said that he suffered with anxiety, depression and post-traumatic stress disorder (PTSD) but declined to be referred to the mental health team. He said that he was happy taking his mirtazapine and did not need additional support, but he was aware of how to access the service if he needed too.

30. On 3 August, a member of the substance misuse team completed an initial assessment with Mr Connolly. He became upset during the assessment and said that he could not think straight. He described his head as being all over the place. He rated himself a seven on a scale of one to ten, (ten being severely depressed), however he would not expand on his feelings. She advised on the counsellors available within the prison, but Mr Connolly did not appear interested in the support.

Mr Connolly said that he did not have anyone in the community to support him and that he did not want to complete any interventions, he just wanted to get a job and to settle into prison. Following this assessment, Mr Connolly was allocated a psychosocial worker to discuss and complete a care plan in preparation for his release in May 2024.

31. On 12 January 2024, a GP at the prison uploaded a letter from the prescribing team to Mr Connolly's medical records. The letter stated that mirtazapine was not recommended for insomnia or normally prescribed to those with significant addiction problems. They had decided it was in Mr Connolly's best interest to reduce and stop his prescription and a GP appointment would be requested to assess his wellbeing.

32. On 22 January, another GP at the prison saw Mr Connolly. Mr Connolly said that he had no thoughts of suicide or self-harm, but he felt that his mirtazapine helped him and that it would not have been stopped in the community. The GP prescribed Mr Connolly sertraline (antidepressant), alongside his mirtazapine as an alternative to support him with his mood. However, Mr Connolly refused to take the sertraline, even after his mirtazapine stopped.

33. On 3 February, an Associate Practitioner Nurse saw Mr Connolly to discuss why he was not collecting his sertraline, and he said he did not want to take it.

34. Mr Connolly's mirtazapine was reduced to 15mg for one month, then reduced to every other day until the prescription stopped on 21 March.

Pre-release planning

35. On 26 March, Mr Connolly's allocated Community Offender Manager (COM) completed a CAS3 referral (provides temporary accommodation for up to 84 nights for those being released homeless from prison).

36. On the 10 April, Mr Connolly was approved for End of Custody Supervised Licence Scheme (ECSL) which allowed prisoners to be released up to 70 days early to ease overcrowding in prisons. This meant that Mr Connolly would be released on 12 April instead of in May. Mr Connolly said that he felt overwhelmed knowing that he was going to be released so quickly.

37. Mr Connolly was referred to Rochdale Turning Point (community drug and alcohol service) who gave him an appointment for 12 April.

38. On 11 April, the Offender Management Unit (OMU) at Featherstone was told that additional days were to be added to Mr Connolly's sentence because he had tested positive for synthetic cannabinoids (spice) the previous month, and therefore his release date had been changed to 18 April. Turning Point arranged another appointment for 19 April at 11.00am.

39. On 11 April, a member of the substance misuse team, met with Mr Connolly and gave him advice on harm reduction. Mr Connolly said that when he was released, he wanted to get the keys to his flat, engage with Turning Point, work with probation, stay away from others and remain drug free.

40. Mr Connolly was approved for CAS3 accommodation. He was given a self-contained flat and would be given the keys at his initial probation appointment, on the day of his release. Mr Connolly called his COM, as he was worried about losing his accommodation because additional days had been added to his sentence. She reassured him that his accommodation would still be available.

Release from HMP Featherstone

41. On 18 April, Mr Connolly was released from Featherstone under ECSL. Mr Connolly declined a supply of naloxone kits.

42. Mr Connolly attended his initial probation appointment with the duty COM (his allocated COM was not available that day). No concerns were identified during the meeting.

43. On 19 April, Mr Connolly attended his appointment with Turning Point for his initial assessment and to collect his methadone. Mr Connolly said that he was suffering with PTSD but had no suicidal thoughts. He did not go into any more detail about this. Mr Connolly was given his methadone prescription for 19 to 24 April, and a medical review appointment was scheduled for 24 April.

44. The COM had an appointment with Mr Connolly on 22 April. She said Mr Connolly did not express any suicidal ideations during this meeting, or during any contact she had with him. Mr Connolly told her that he felt overwhelmed by the rush of his release. They discussed his mental health, but Mr Connolly said that he was doing okay and planned to book an appointment with his GP. Mr Connolly said that he was previously involved with the community mental health team before he went to prison, but he was unsure as to what degree, and he could not confirm his diagnosis. It was agreed that she could investigate this further if Mr Connolly felt he needed additional support, but the first step was for Mr Connolly to book an appointment with his GP. She did not know if Mr Connolly had booked an appointment with his GP.

45. On 22 April, Turning Point was informed that Mr Connolly had not taken his prescription to the pharmacy and was therefore out of treatment.

46. On 24 April, Mr Connolly attended Turning Point for his medical review and was restarted on a methadone script. He did not express any thoughts of suicide or self-harm. That day, Mr Connolly collected his methadone from the pharmacy.

Circumstances of Mr Connolly's death

47. On 29 April, the COM spoke to a CAS3 support worker, and told her she had not had any recent contact with Mr Connolly. The support worker went to Mr Connolly's address and found him hanging from the stairs with a ligature around his neck. She left the property and called the COM immediately.

48. The COM said that the support worker sounded extremely stressed by what she had seen, so the COM called the emergency services.

49. The police and paramedics arrived promptly, and Mr Connolly was pronounced dead.

Inquest

50. At the inquest held on the 5 August 2024, the Coroner concluded that Mr Connolly died of suicide.

51. The toxicology results showed low levels of alcohol, nicotine, cannabis and methadone in Mr Connolly's system at the time of his death. While these drugs did not directly contribute to his death, the toxicologist said that it was not possible to determine whether the use of cannabis had an effect on Mr Connolly's state of mind at the time of his death.

Findings

Mental health

52. Mr Connolly said that he suffered with anxiety, depression and PTSD. While he was initially prescribed antidepressants, he declined any further support from the mental health team.

53. Mr Connolly's antidepressant prescription was changed while he was at Featherstone after the prescribing team advised mirtazapine was not suitable for people with a history of addiction. Mr Connolly was prescribed an alternative but refused to take it. Healthcare staff explored his reason for refusing the prescription.

54. Mr Connolly did not have a history of suicide attempts or self-harm. He was not subject to suicide and self-harm monitoring (ACCT) while serving his most recent sentence. Prison staff had no concerns about his risk of suicide and his COM had no concerns about his risk after his release. Because Mr Connolly declined to be referred to the mental health team, he was not referred to any community mental health services.

55. We are satisfied that neither prison nor probation staff had any reason to consider Mr Connolly at imminent risk of suicide and that they took appropriate steps to support his mental health.

Substance misuse

56. Mr Connolly had a history of substance misuse. While he was in prison, Mr Connolly was promptly referred to the substance misuse team who saw him and warned him about the risks and dangers of taking drugs. He declined to complete any interventions, but he was placed on a methadone programme and was also allocated a psychosocial worker to complete a discharge plan with him. He was trained in the use of naloxone but declined a supply of this on release.

57. Although Mr Connolly did not complete any interventions with the SMS at Featherstone, he was appropriately referred to the community drug and alcohol service, and Mr Connolly engaged with them on release. He was provided with ongoing support in the community.

58. We are satisfied that both the prison and probation services did all they could to manage the risks associated with Mr Connolly's substance misuse.

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

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