Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dean Watson, on 23 October 2025, 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 Dean Watson died from the toxic effects of pregabalin (a prescription medication that is widely abused and which he was not prescribed) on 23 October 2025, following his release from HMP Doncaster on 10 October. He was 38 years old. We offer our condolences to those who knew him.

5. Mr Watson had a history of drug use, including the use of illicitly obtained pregabalin. The prison's substance misuse team warned him of the risks before his release and referred him to community drug recovery services.

6. We did not identify any significant learning relating to the pre-release planning or post-release supervision of Mr Watson.

7. We make no recommendations.

The Investigation Process

8. HMPPS notified us of Mr Watson's death on 24 October 2025.

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

10. We informed HM Coroner for Sheffield 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 Watson's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He did not have any questions but asked for a copy of our report.

12. We shared our initial report with HMPPS and the prison's healthcare provider, Nottinghamshire Healthcare NHS Foundation Trust. They found no factual inaccuracies.

13. We sent a copy of our initial report to Mr Watson's brother. He did not have any comments.

Background Information

HMP Doncaster

14. HMP Doncaster is a category B men's prison managed by Serco. Nottinghamshire Healthcare NHS Foundation Trust provides healthcare services including mental health services and substance misuse support.

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.

Key Events

Background

16. On 9 June 2025, Mr Dean Watson was sentenced to eight months in prison for burglary. He was sent to HMP Doncaster.

17. On 27 June, Mr Watson was moved to HMP Humber. He was released on 20 August on Home Detention Curfew (HDC, which allows someone to be released from prison early providing they wear an electronic tag and stay at home during set hours).

18. On 25 August, Mr Watson was recalled to prison as he had not attended his probation appointments. He was sent to Doncaster.

19. On 5 September, Mr Watson was released from Doncaster. However, on 13 September, he was recalled on a 14-day recall for alleged further offences. He was returned to Doncaster.

20. On 15 September, Mr Watson was sentenced to nine weeks in prison for shoplifting.

Pre-release planning

Substance misuse

21. On 13 September, Mr Watson arrived at Doncaster with a 60mg bottle of methadone (a synthetic opioid used to treat heroin addiction). He told healthcare staff he had taken methadone in the police cell earlier that day and had last collected it from the pharmacy on 11 September. The dose he had with him was for the next day. The healthcare team referred Mr Watson to the prison's substance misuse services (SMS) at Doncaster for a methadone prescription and support. While at Doncaster, Mr Watson remained on 60mg of methadone daily.

22. On 15 September, an SMS worker at the prison referred Mr Watson to Recovery Steps, the community SMS.

23. On 22 September, an SMS worker spoke to Mr Watson about his upcoming release. They advised Mr Watson about harm minimisation, including using naloxone, which can reverse the effects of an opioid overdose. Mr Watson said he had previously overdosed when using pregabalin (a prescription medication used to treat epilepsy, nerve pain and anxiety, which is widely abused for its euphoric effects when taken alongside opioids and which Mr Watson was not prescribed). The SMS worker advised Mr Watson that non-prescription pregabalin could vary in strength and carried a higher risk of overdose.

Housing

24. On 22 September, Mr Watson's community offender manager (COM) referred Mr Watson to the Community Accommodation Service Tier 3 (CAS3), which provides temporary housing for prison leavers.

25. On 25 September, Mr Watson had an accommodation appointment with commissioned rehabilitative services to discuss housing options. He did not attend this appointment and refused to attend a pre-release planning meeting with his COM the same day.

26. On 2 October, Mr Watson's COM received confirmation that a CAS3 property was available for Mr Watson in Barnsley. The COM asked the CAS3 accommodation team for an alternative property outside of Barnsley due to Mr Watson's Community Protection Notice and Criminal Behaviour Order.

27. On 6 October, Mr Watson's CAS3 accommodation was confirmed in Rotherham. His COM agreed with Rotherham probation office that a probation officer based there would caretake Mr Watson upon his release, to prevent him needing to travel to Barnsley (where his COM was based).

28. On 8 October, Mr Watson's COM emailed the offender management unit at Doncaster with instructions for Mr Watson on the day of his release. This included that he should attend the Rotherham probation office, where he would be given a travel pass to get to his CAS3 accommodation.

Release from HMP Doncaster

29. On Friday 10 October, Mr Watson was released from Doncaster. Mr Watson was not eligible for the discretionary Friday release scheme (where prisoners can be released up to two working days early when their release day would fall on a Friday), as he had not served a minimum of 28 days on his current sentence (he had served only 26 days).

30. Before Mr Watson was released, an SMS worker offered him naloxone to take home but he declined. As the community SMS were unable to guarantee an appointment on the day off his release, the SMS worker asked for an FP10MDA (a special type of prescription that allows pharmacies to supply methadone without a community SMS appointment) to be issued. The FP10MDA allowed Mr Watson to receive methadone on 11 and 12 October. His community SMS appointment was booked for 13 October.

31. Mr Watson did not attend his initial probation appointment on 10 October. His probation officer at Rotherham received a phone call from paramedics to say that Mr Watson had got on the wrong train and went to Scunthorpe and had a panic attack and a medical episode when he realised. He said he lost all his paperwork and travel warrant. The probation officer gave police and paramedics Mr Watson's CAS3 accommodation details and key safe details. The police said they would help him get there. The probation officer advised that a housing officer would meet him on Monday at the property and he would need to attend Rotherham probation office.

32. On 13 October, Mr Watson did not attend his probation appointment. His COM contacted his CAS3 accommodation to see if he was there and was told by a staff member that he had not been since Saturday. The CAS3 accommodation worker said the electrics at the property were being fixed and perhaps this was why he had not attended the property. The COM also contacted Recovery Steps, the community SMS service, who confirmed that Mr Watson had collected his methadone that day.

33. The COM spoke with their manager about Mr Watson's missed appointments. They agreed it was positive that he had attended Recovery Steps, so would allow him one more day to attend probation.

34. At around 8.00pm, Mr Watson returned to his CAS3 property.

35. On 14 October, Mr Watson's COM spoke with the housing officer who said Mr Watson had struggled to sort out his methadone the day before and that was why he was not able to attend the probation appointment. He said Mr Watson would attend at 12.00pm that day.

36. At around 4.00pm, the COM contacted the chemist to ask them to tell Mr Watson to attend Sheffield or Rotherham probation office by 2.00pm next day.

Circumstances of Mr Watson's death

37. On 15 October, Mr Watson's community SMS worker contacted the COM. They said Mr Watson had been admitted to hospital after taking an overdose. The COM contacted Mr Watson's CAS3 accommodation to let them know he was in hospital, so that he would not lose his accommodation.

38. On 16 October, members of the public found Mr Watson unconscious in the street (after he had discharged himself from hospital) and called an ambulance. Mr Watson was taken to hospital and placed on a ventilator.

39. On 23 October, after an MRI scan showed that Mr Watson was brain dead, hospital staff turned off his life support. He died at 8.20pm.

Cause of death

40. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave the cause of death as hypoxic ischemic encephalopathy (a brain injury caused by reduced oxygen/blood flow to the brain) due to cardiac arrest, which had been caused by pregabalin toxicity. Mr Watson was not prescribed pregabalin.

Findings

Drug use

41. Mr Watson had a history of drug use, including the use of illicit pregabalin. He received appropriate support in prison and was warned of the dangers of using illicit pregabalin. He was also referred for support from community drug recovery services.

Friday release

42. The Discretionary Friday/pre-Bank Holiday Release Scheme Policy Framework allows prisoners to be released up to two days earlier if their release date falls on a Friday or before a bank holiday, to allow additional time to access resettlement support services and appointments ahead of the reduced availability or closure of services during the weekend. To be eligible for the scheme, prisoners must have served at least 28 days in custody on their most recent sentence.

43. Mr Watson was not eligible for the scheme as he had served only 26 days, so he was released on a Friday. We consider that staff put the appropriate measures in place (including issuing an emergency prescription for methadone) and the Friday release had minimal impact on Mr Watson. He attended his scheduled community SMS appointment on the Monday following his release.

44. We make no recommendations.

Adrian Usher
Prisons and Probation Ombudsman **May 2026**

Inquest

At the inquest, held on 16 November 2026, the Coroner concluded that Mr Watson's death was drug related. The Coroner recorded Mr Watson's date of death as 26 October 2025.

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