Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Connah Fearnley, on 22 October 2025, 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



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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 Connah Fearnley died from combined toxicity of morphine, pregabalin, oxycodone, alprazolam and amitriptyline (drugs overdose) on 22 October 2025, following his release from HMP Wealstun two days earlier. He was 32 years old. We offer our condolences to those who knew him.

5. During his time at Wealstun, Mr Fearnley requested support from the drug and alcohol recovery service (DARS) on several occasions, as he said he was withdrawing from strong illicit painkillers he had used in the community. Although he said he had made applications to the service, DARS had no record of them and Mr Fearnley was not seen. While there were no concerns that Mr Fearnley had used illicit drugs or medication in prison, staff should more proactively help prisoners who make repeated requests for support rather than relying on them to continue making applications.

Recommendations

- The Governor and Head of Healthcare should ensure there is a clear, robust and auditable process for referring prisoners to the substance use service where they have requested it, and ensure that all staff are aware of the importance and purpose of such referrals.

The Investigation Process

6. HMPPS notified us of Mr Fearnley's death on 28 October 2025.

7. The PPO investigator obtained copies of relevant extracts from Fearnley's prison and probation records.

8. We informed HM Coroner for West Yorkshire Eastern District of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

9. The Ombudsman's office contacted Mr Fearnley's former partner to explain the investigation and to ask if she had any matters she wanted us to consider. She raised no concerns and asked for a copy of our report.

10. We also shared the initial report with Mr Fearnley's family. They pointed out some factual inaccuracies and we have amended this report accordingly.

11. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is an additional annex to this report.

Background Information

HMP Wealstun

12. HMP Wealstun is a category C training and resettlement prison in West Yorkshire which holds adult men. Practice Plus Group provides health care services, including substance use services. Primary healthcare services operate daily from 7.00am to 7.30pm.

Probation Service

13. 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.

Deaths following release from prison

14. Between September 2021 and the end of March 2026, the PPO started investigations into approximately 300 deaths of people who died within 14 days of release from prison. The PPO has published two learning lessons bulletins about post-release deaths, most recently in July 2024. Our investigations highlight the acute vulnerability of prison leavers, especially during the first few days post-release, and indicate that prison leavers often have multiple risk factors such as mental health and substance use issues and homelessness which further increase their vulnerability and risk of death following release from prison.

Previous deaths following release from HMP Wealstun

15. Mr Fearnley was the seventh man to die within 14 days of release from HMP Wealstun since October 2022. Five of the previous deaths were due to drugs toxicity, and one man took his own life. To the end of April 2026, one further man has died and the cause of death has yet to be established. We identified no significant similarities between our investigation findings about the previous deaths and those about Mr Fearnley's death.

Key Events

16. On 13 May 2025, Mr Connah Fearnley was convicted of causing serious injury by dangerous driving and sentenced to 26 months in prison. He was sent to HMP Leeds. It was his first time in prison. Mr Fearnley told healthcare staff he had no substance use issues. Mr Fearnley disclosed a history of depression and anxiety, for which he was prescribed mirtazapine (an antidepressant, that was later changed to amitriptyline).

17. The next day, Mr Fearnley told healthcare staff that he was withdrawing from strong painkillers that he had used illicitly in the community for ongoing back pain. He was referred to and supported by the DARS (drug and alcohol support) team. There is no indication that Mr Fearnley used illicit drugs or alcohol during his time at Leeds.

18. On 4 June, Mr Fearnley was transferred to HMP Wealstun. At the reception health screening, Mr Fearnley said that he had no issues with drugs or alcohol. On the same day, Mr Fearnley told prison staff that he had worked with DARS at Leeds and wanted to continue this at Wealstun. They told Mr Fearnley to submit an application to the DARS team so they would be aware that he wanted to continue to receive support.

19. Mr Fearnley was allocated a place on the incentivised substance free living unit (ISFL, for those prisoners who wish to live in a drug-free environment) at Wealstun. On 17 June, he tested negative for drugs in a voluntary drugs test. He continued to return negative tests over the following weeks.

20. On 6 June, a GP prescribed co-codamol for Mr Fernley's ongoing back pain. (Co-codamol is a painkiller that can be bought over the counter at lower strengths.)

21. On 26 June, Mr Fearnley told his key worker that he would like to work with DARS as he was withdrawing from the pain relief he had taken in the community. He said that he had completed an application for this. The DARS manager told us that they had no record of a referral, application or any healthcare tasks being sent to them for Mr Fearnley. There is also no record that Mr Fearnley approached DARS staff who work on the ISFL.

22. On 6 July, Mr Fearnley told healthcare staff he had no current issues with alcohol or drug use.

23. On 28 July, Mr Fearnley told his key worker that he had now submitted several applications to DARS and would like to work with them. Mr Fearnley's key worker recorded that she told him that she would try to chase this up when she had a chance. (There is no evidence that his key worker or anyone else followed up on Mr Fearnley's applications.)

24. On 3 August, an officer found a tampered vape in Mr Fearnley's cell. There is no indication that he was referred to the DARS team. He continued to return negative drugs tests afterwards.

25. On 11 August, Mr Fearnley met his community offender manager (COM) at a prison video call meeting. The prison offender manager (POM) was also present. The COM said there were no concerns for Mr Fearnley during this meeting. Mr Fearnley

was looking forward to release and discussed this with the COM. He had his own property that he could move back to on release.

26. During the remainder of his time in prison, Mr Fearnley received positive reports from staff.

27. On 21 August, Mr Fearnley told healthcare staff that he had an ongoing struggle with sleep. Staff prescribed a short course of medication to aid with sleep.

28. On 23 September, Mr Fearnley saw healthcare staff who diagnosed chronic back pain and increased the dose of co-codamol.

29. On 20 October, Mr Fearnley was released from prison on home detention curfew (HDC, which allows the early release of prisoners under electronic monitoring). His licence included the condition that he attend his local probation office for drug testing and that he be at home from 7.15pm to 7.15am every day.

30. A nurse saw Mr Fearnley in reception and identified no concerns. The nurse issued a supply of discharge medication, including co-codamol and amitriptyline. As he had not been working with substance support services, Mr Fearnley was not given a naloxone pack (reverses or reduces the effects of opiate overdoses).

Post Release

31. Mr Fearnley met his COM at 1.00pm on the day of release. The COM said Mr Fearnley appeared very eager to understand his licence conditions and was motivated to work with them. The COM had no immediate concerns at the time regarding Mr Fearnley, who presented as pleased to have left prison and talked in detail about his plans for the future. The COM told us that as there were no active concerns around drug use by Mr Fearnley when in prison, that licence conditions were in place for drug testing, and that referrals for additional support via commissioned rehabilitative services (CRS, probation-based programmes to provide tailored support to reduce reoffending) would have been made should this have been required.

Circumstances of Mr Fearnley's death

32. On 22 October, Mr Fearnley's father asked the police to attend his son's home. Police arrived and forced entry into the property and found Mr Fearnley unresponsive. Ambulance paramedics attended and confirmed life extinct.

Post-mortem report

33. The post-mortem report confirmed that Mr Fearnley died from combined toxicity of morphine, pregabalin, oxycodone, alprazolam and amitriptyline (drugs overdose).

34. Of these medications, Mr Fearnley was only prescribed amitriptyline. Morphine and oxycodone are opiate based painkillers. Pregabalin is used to treat epilepsy, anxiety and nerve pain. Alprazolam is a benzodiazepine used to treat anxiety and panic disorders.

Findings

35. Following his transfer to Wealstun, Mr Fearnley told staff on three occasions that he would like to work with DARS and said that he had submitted several applications. Prison and healthcare staff could find no evidence that an application was submitted and it is therefore not certain whether Mr Fearnley ever did so. The DARS manager also told us that Mr Fearnley was not referred to them and that they had no record of a referral or any tasks being sent regarding him.

36. While we cannot be sure what motivated Mr Fearnley to use illicit medication in the time before his death, we note that he had previously used strong illicit painkillers to try to manage back pain. He spoke of experiencing withdrawal symptoms from these in prison and, despite Mr Fearnley saying that he had repeatedly requested DARS support at Wealstun, this did not happen. While there were no active concerns around drug use by him in prison, and he was supported in the ISFL unit at Wealstun, it is concerning that Mr Fearnley seemingly did not receive the support he asked for.

37. Mr Fearnley's insistence that he had made applications that had not been answered ought to have prompted someone to make a referral on his behalf or to seek clarification with the DARS team help Mr Fearnley to receive their support. One of the aims of key work is to identify a prisoner's needs and risks and to ensure meaningful actions have been taken forward. Prison officer guidance identifies that if they cannot help a prisoner swiftly then they should contact the appropriate department to resolve or provide the answer. We make the following recommendation:

    The Governor and Head of Healthcare should ensure there is a clear, robust and auditable process for referring prisoners to the substance use service where they have requested it, and ensure that all staff are aware of the importance and purpose of such referrals.

38. While he had received it at other times in prison, there is no evidence that Mr Fearnley was offered harm reduction advice on release. The Head of Healthcare will wish to ensure that this offered to all prisoners who have lived on the ISFL or are released with medications that could cause harm if misused.

Inquest

39. The inquest into Mr Fearnley's death concluded on the 3 June 2026. The coroner confirmed that Mr Fearnley's death was an accident.

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

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