

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Kate Allen, on 8 December 2025, following her release from HMP Low Newton

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. Ms Kate Allen died from sepsis and cardiogenic shock (when the heart suddenly cannot pump enough blood to meet the body's needs), caused by pneumonia and a pulmonary embolism, with chronic intravenous drug use contributing to but not causing the death, on 8 December 2025, following her release from HMP Low Newton on 27 November. She was 36 years old. We offer our condolences to those who knew her.
5. The clinical reviewer concluded that the clinical care Ms Allen received at Low Newton was of a good standard and was equivalent to what she could have expected to receive in the community. She found that pre-release planning arrangements were good, despite the challenges caused by Ms Allen being in hospital at the time of her release and that efforts were made to ensure there was continuity of care in the community regarding substance use.
6. The pre-release work completed by Ms Allen's COM was impacted by Ms Allen being released directly from hospital and relevant accommodation referrals were not made prior to release. This meant that Ms Allen was released from Low Newton without accommodation. Given Ms Allen's recent hospitalisation, poor physical health and long history of substance she was particularly vulnerable, and homelessness would likely have had a significant impact on her.

Recommendations

- The Regional Probation Director for Yorkshire and the Humber should ensure that there are robust pathways to allow administrative requirements for referrals for release accommodation to be completed when a prisoner is a hospital inpatient.

The Investigation Process

7. HMPPS notified us of Ms Allen's death on 28 January 2026.
8. The PPO investigator obtained copies of relevant extracts from Ms Allen's prison and probation records.
9. NHS England commissioned an independent clinical reviewer, to review Ms Allen's clinical care at HMP Low Newton.
10. We informed HM Coroner for North Yorkshire of the investigation. They provided us with Ms Allen's cause of death. We have sent the Coroner a copy of this report.
11. The Ombudsman's office contacted Ms Allen's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They asked about the medical treatment Ms Allen received in prison and the support plans put in place for her release. They asked for a copy of our report. We have answered their questions in our report.
12. 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.
13. We also shared the initial report with Ms Allen's next of kin. They raised some issues/questions that do not impact on the factual accuracy of this report and which we have addressed through separate correspondence.

Background Information

HMP Low Newton

14. HMP Low Newton is primarily a category B (with facilities for some category A prisoners) reception and resettlement prison, holding women who have either been convicted or are on remand. Spectrum Community Health CIC provide physical healthcare services at Low Newton, along with clinical substance use services. Waythrough provide psychosocial (therapy and support based) substance use intervention.

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 appropriate. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

Deaths following release from prison

16. 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 Low Newton

17. Ms Allen was the third woman to die within 14 days of release from Low Newton since December 2022, and the first to die from natural causes. To the end of April 2026, there have not been any further deaths within 14 days of release from Low Newton.
18. We identified no similarities between our investigation findings about the previous deaths and those about Ms Allen's death.

Key Events

Background

19. On 15 August 2025, Ms Kate Allen was remanded to HMP Low Newton, charged with theft. On 16 September 2025, she was sentenced to 22 weeks in prison. This was Ms Allen's first time in prison.
20. On her reception to Low Newton, a substance use worker saw Ms Allen and completed a screening. During this appointment, Ms Allen reported daily intravenous heroin use along with daily cocaine and crack cocaine use (smoking and intravenous). She provided a drug test which was positive for both opiates and cocaine. Ms Allen reported a 20-year history of substance use and said that she was last prescribed methadone (opiate substitute medication) 12 months previously. A nurse saw Ms Allen the same day and prescribed methadone.
21. Between 15 August and 15 October, members of staff from both the healthcare team and substance use team reviewed Ms Allen regularly with no significant issues identified.
22. On 15 October, Ms Allen was released from Low Newton. Her Community Offender Manager (COM) added several additional conditions to her licence, including drug testing and a condition to attend appointments in the community aimed at addressing her substance use. Ms Allen was released to Community Accommodation Service tier 3 (CAS3, a service open to adult prison leavers at risk of homelessness, providing accommodation for up to 84 days) accommodation.
23. On 14 November 2025, Ms Allen was recalled to prison for failing to comply with her licence conditions.
24. A nurse at Low Newton saw Ms Allen and completed a health screening. Ms Allen told the nurse that she had been released with a methadone prescription on 15 October, but had since stopped taking it. She said that she had been using both heroin and crack cocaine in the community, along with varying amounts of illicit pregabalin (medication used to treat epilepsy and anxiety) over the previous week. Ms Allen provided a drug test which was positive for both opiates and cocaine and the nurse recorded that Ms Allen was withdrawing from drugs. The nurse prescribed methadone and placed Ms Allen under substance use monitoring.
25. Later that evening, a member of staff from the substance use team checked on Ms Allen, who said that she felt unwell. Ms Allen reported feeling hot and cold, and said she had a headache and pain in her left thigh. The staff member advised Ms Allen to inform the wing nurse the following day, and checked on Ms Allen throughout the night.
26. Throughout the morning and afternoon of 15 November, various nurses reviewed Ms Allen, who described pain in the front of her thigh. Ms Allen explained that she had previously injected cocaine into her groin and was tasered in the same spot a short while later. (We do not know exactly when this happened but it appears to have occurred between Ms Allen's release and recall to prison.) The nurse recorded that she was unable to rule out deep vein thrombosis and so she arranged for Ms

Allen to be transported to University Hospital of North Durham (UHND) for further assessment.

27. In the early hours of 16 November, Ms Allen returned to Low Newton having been advised that she needed a course of antibiotics for cellulitis (a bacterial infection affecting the deeper layers of skin and underlying tissue). Members of staff from the substance use and nursing teams checked on Ms Allen throughout the night and the following morning. Ms Allen's medication was collected from a local pharmacy. Later that day, a nurse reviewed Ms Allen who noted that she was short of breath, confused and complained of pain in her back and to the right side of her chest. The nurse called the hospital and spoke to the consultant who had seen Ms Allen the previous day, and they requested that an ambulance be called for her. She was transported to UHND via ambulance.
28. Ms Allen returned to prison a short while later. The hospital provided Ms Allen with a follow up appointment for an ultrasound for the following day, as the machine was unavailable during her visit. A member of staff from the substance use team, and a nurse, saw Ms Allen upon her return from hospital.
29. In the early hours of 17 November, a member of the substance use team reviewed Ms Allen. She described pain to her right side and said she was struggling to pass urine. Later that morning, another member of the substance use team saw Ms Allen and discussed drug use harm minimisation ahead of her release. The member of staff provided information about naloxone (medication to reverse the effects of an opiate overdose) and Ms Allen confirmed she would like a naloxone kit upon her release. Ms Allen confirmed that she felt stable on her methadone prescription.
30. Later that day, Ms Allen attended UHND for a pre-arranged ultrasound appointment. She returned to Low Newton shortly afterwards.
31. On 18 November, various members of the substance misuse and nursing teams reviewed Ms Allen throughout the day. Ms Allen described pain in her leg and a nurse noted that the infection from her leg had spread to cover most of her anterior thigh and some of the posterior area. The nurse recorded that she felt a red lump on Ms Allen's leg and that Ms Allen was taking the course of antibiotics as prescribed by the hospital. The nurse telephoned the hospital and a staff member there advised that Ms Allen should attend the hospital. Ms Allen was transported to UHND where she was admitted. Ms Allen remained an inpatient in hospital, under escort by prison staff, until her prison release date of 27 November.

Pre-release planning

32. On 26 November, a member of the substance use team provided the offender management unit with appointment details for Ms Allen to see Change, Grow, Live (CGL - a charity which offers substance use support) in the community on 28 November, following her release from prison. She also provided a harm reduction pack for prison staff to give to Ms Allen in hospital.
33. Later that day, the substance use worker emailed CGL and told them that Ms Allen was due to be released from prison the following day, but as she was currently in hospital she had not received a naloxone kit. The substance use worker asked CGL to provide this to Ms Allen during her appointment on 28 November. CGL

responded and confirmed that they would issue naloxone to Ms Allen during this appointment.

Post-release management

34. On 27 November, Ms Allen was released on licence from prison. She discharged herself from hospital and attended an appointment with her COM.
35. Ms Allen's COM completed an induction and provided her with a copy of her licence, which she signed.
36. Ms Allen was released from prison with no accommodation. Her COM told us that she was unable to submit a CAS3 application as had been completed ahead of her previous release on 15 October, due to Ms Allen being in hospital prior to her release from prison. She said that as Ms Allen was in hospital, she was unable to gain the necessary consent required to make the referral.
37. During her initial probation appointment, Ms Allen's COM completed an application for supported housing through the council. She also spoke with the housing options team at the council to try to secure Ms Allen emergency accommodation. The housing options team agreed to complete a housing application with Ms Allen the following day. As Ms Allen had no telephone, her COM emailed CGL to ask whether a telephone call could be facilitated between Ms Allen and the housing options team during her appointment with them the following day. Ms Allen told her COM she could stay with a friend overnight. Her COM agreed to this and recorded that should Ms Allen stay at her friend's address longer than one night, she would make relevant police checks. (Her COM told us that no address check was completed due to Ms Allen failing to attend her appointment with CGL and therefore her whereabouts being unknown after this time.)
38. Ms Allen's COM provided Ms Allen with a next appointment for 4 December.
39. On 28 November, Ms Allen did not attend her appointment with CGL. Due to this failure to attend, the arranged telephone housing assessment did not take place. Records show that no warning letter was issued to Ms Allen for this failure to attend.
40. From 1 December to 5 December, community substance use service records indicate that Ms Allen was an inpatient at York Hospital, being treated for pneumonia and sepsis. (Ms Allen did not therefore attend her probation appointment on 4 December, although her whereabouts were unknown to her COM at the time.) She discharged herself from hospital on 5 December.

Circumstances of Ms Allen's death

41. The Coroner told us that Ms Allen died in Harrogate Hospital on 8 December 2025.
42. We have no other information regarding Ms Allen's whereabouts between 5 December and the date of her death.

Cause of death

43. A post-mortem examination was not carried out as the Coroner accepted the cause of death provided by a hospital doctor. The doctor gave the cause of death as sepsis and cardiogenic shock, caused by pneumonia and a pulmonary embolism, with chronic intravenous drug use contributing to but not causing the death.

Findings

Clinical care

44. The clinical reviewer concluded that the care Ms Allen received in the lead up to her release from Low Newton was of a good standard and was equivalent to that which she could have expected to receive in the community.
45. Ms Allen had a longstanding history of substance use. While she was in prison, she was regularly reviewed by members of staff from the healthcare and substance use teams. Ms Allen was provided with methadone throughout her time in prison. (Arrangements to collect methadone upon release were made by the hospital.)
46. The clinical reviewer concluded that the pre-release planning arrangements were good, despite there being challenges due to Ms Allen being in hospital at the time of her release. Staff at Low Newton made appropriate referrals to community substance use services to ensure Ms Allen would receive continued support following her release. This included planning for a naloxone kit to be provided to Ms Allen during her CGL appointment following release. Despite the challenges of Ms Allen's hospital admission and her release planning needing to take this into account, the substance use team at Low Newton worked hard to ensure the continued management of Ms Allen's substance use needs following her release.
47. The clinical reviewer highlighted the excellent information sharing demonstrated by the healthcare team following Ms Allen's transfer to hospital on 18 November, when they made daily contact with the various departments there to obtain updates on Ms Allen's condition.

Pre-release planning

Accommodation

48. Ms Allen was released homeless from prison on 27 November. Homelessness on release is a significant and complex challenge. If an individual is homeless, it can increase the likelihood that they will commit further crimes or seek shelter and support in harmful places. Ms Allen's recent hospitalisation, poor physical health and long history of substance use meant that she was particularly vulnerable, and homelessness would likely have had a significant impact on her.
49. When Ms Allen attended her initial probation induction, she reported that she could stay with a friend that night. We do not know where she stayed between 27 November and 1 December, when she was admitted to York hospital.
50. Ms Allen's COM told us that she was unable to complete a CAS3 housing application prior to release, due to Ms Allen's hospital admission. She said that this admission prevented her from being able to speak to Ms Allen to ask for consent to allow her to complete the accommodation application. While it is evident that Ms Allen's COM made efforts to support Ms Allen to source accommodation following her release, we consider that there was a missed opportunity to support Ms Allen with her accommodation needs prior to release.

51. Given that Ms Allen remained under escort by prison staff during her hospital admission between 18 and 27 November, we consider there was ample opportunity for Ms Allen's COM and her prison offender manager (POM) to work together to plan for Ms Allen's release. This could have included Ms Allen's COM asking prison staff to speak to Ms Allen to gain her consent to complete the CAS3 referral.
52. HMPPS will want to ensure that members of staff from both the prison and probation service communicate effectively and work together to ensure that any barriers which may impact on release planning are addressed. This will ensure that resettlement plans for prisoners who are released directly from hospital are adequately considered and actioned. We make the following recommendation:

The Regional Probation Director for Yorkshire and the Humber should ensure that there are robust pathways to allow administrative requirements for referrals for release accommodation to be completed when a prisoner is a hospital inpatient.

Adrian Usher
Prisons and Probation Ombudsman

August 2026

Inquest

The inquest concluded on 14 October 2026. The coroner returned a narrative conclusion that Ms Allen died as a consequence of naturally occurring disease against a background of chronic intravenous drug use. The coroner found that it was not possible to determine whether her death would have been prevented had she remained in hospital and continued treatment.



Annexes

1. Clinical review
2. Action plan