Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Hartley on 31 January 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 Lee Hartley died from multiple drug misuse on 31 January 2025, nine days after his release from HMP Doncaster. He was 52 years old. We offer our condolences to those who knew him.

5. Mr Hartley was offered good support for his substance misuse issues while at Doncaster. Substance misuse support was also put in place for when he was released from prison.

6. We make no recommendations.

The Investigation Process

7. HMPPS notified us of Mr Hartley's death on 24 March 2025.

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

9. We informed HM Coroner for Doncaster of the investigation. They gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

10. The Ombudsman's office contacted Mr Hartley's next of kin, his sister, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

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

Background Information

HMP Doncaster

12. 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 physical and mental health care services, as well as substance misuse treatment services.

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.

Key Events

Background

14. On 3 December 2024, Mr Lee Hartley was convicted of shoplifting and was sentenced to 18 weeks in prison. He was sent to HMP Doncaster.

Pre-release planning

15. When he arrived at Doncaster, Mr Hartley told the reception nurse that he had a history of anxiety, depression and substance misuse. He said that prior to coming to prison, he was taking crack cocaine and heroin. He was also abusing illicit prescription drugs, namely methadone (an opiate substitute), although he was not on a prescribed methadone detoxification programme. The nurse arranged for him to be monitored for opiate withdrawal symptoms over the following days. When asked, Mr Hartley said he would like support with his substance misuse, so the nurse completed a referral to the prison's substance misuse service (SMS).

16. On 4 December, a recovery worker saw Mr Hartley to complete an initial substance misuse assessment. Mr Hartley told the recovery worker that three weeks before, he accidentally overdosed on heroin which resulted in the emergency services being called who attended and administered naloxone (a medication used to reverse the effects of opioid overdose). As a result, the recovery worker and Mr Hartley 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. The recovery worker warned Mr Hartley about the dangers of mixing drugs with alcohol and how this could further increase the risks of overdose. He also warned Mr Hartley about a dangerous batch of heroin that had been reported in South Yorkshire and Lincolnshire. (This batch was laced with carfentanil, an opiate thousands of times more potent than heroin, so the risk of overdose was extremely high.) The recovery worker told Mr Hartley what it looked and smelled like, and how he might be able to recognise it. He gave Mr Hartley 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. The recovery worker noted that Mr Hartley showed a good understanding of this.

17. Mr Hartley said he would like to be released with a naloxone kit and would like to be referred for substance misuse support in the community. Finally, Mr Hartley asked if he could be prescribed a small amount of methadone to help with his heroin withdrawal symptoms. The recovery worker advised him that he already had an opiate substitution therapy (OST) assessment booked for 4.00pm that day. After the appointment, the recovery worker completed a referral to Doncaster Aspire, a community SMS treatment provider.

18. Mr Hartley did not attend his OST assessment. This was rearranged for the next day.

19. On 6 December, Mr Hartley did not attend his OST assessment. This was again arranged for the next day, however again, he did not attend.

20. On 9 December, Mr Hartley attended his OST assessment. The nurse prescriber assessed that Mr Hartley did not require a prescribed heroin detoxification programme. The nurse reminded Mr Hartley about the risks associated with taking drugs and gave advice on harm minimisation.

21. As Mr Hartley was due to be released from prison homeless, his community offender manager (COM) completed a CAS3 housing referral (a scheme providing temporary accommodation and support to prison leavers at risk of homelessness) on 6 January 2025.

22. On 15 January, Mr Hartley was accepted onto the CAS3 scheme. His COM was notified that temporary accommodation had been secured for him for a period of 84 days at an address in Doncaster.

23. On 21 January, Mr Hartley attended a pre-release appointment with his recovery worker. The recovery worker warned Mr Hartley of his low tolerance after a period of abstinence, and how this would make him more susceptible to overdosing. The recovery worker told Mr Hartley that recently, some of the street drugs had been found to be contaminated with substances such as Fentanyl and Nitazenes which, due to their higher potency, had led to several deaths and numerous overdoses. It was noted that Mr Hartley had a good understanding of the risks, and he said he was going to try and abstain from taking drugs after his release from prison. Mr Hartley completed the training on take home naloxone and was told he could collect a kit from reception on the day of his release. Finally, the recovery worker gave Mr Hartley a letter detailing his release appointment with Doncaster Aspire.

Release from HMP Doncaster

24. On 22 January, Mr Hartley was released from Doncaster with a naloxone kit, a copy of his licence, and details of his probation and CAS3 induction appointments. He attended Doncaster's 'departure lounge' (offers prisoners advice and support with accommodation, finances, employment, education and training immediately after their release) and was met by a recovery worker from Doncaster Aspire. They completed an initial substance misuse care plan that focused on relapse prevention, and the recovery worker reminded Mr Hartley of the risks associated with substance misuse and advised him how he could minimise these risks. The recovery worker issued Mr Hartley his next appointment for 29 January at Prince's House, Doncaster.

25. Mr Hartley did not attend his induction at his CAS3 temporary accommodation at 2.00pm or his initial appointment at Doncaster Probation Office at 4.00pm.

26. Approximately an hour later, a resident welfare officer from the CAS3 temporary accommodation telephoned Mr Hartley's COM. He told her that Mr Hartley had been taken to Doncaster Royal Infirmary after being found unresponsive by a member of the public in Hexthorpe.

27. The next morning, the COM called the hospital and was told that Mr Hartley had been discharged in the early hours. The COM relayed this information to the CAS3 temporary accommodation who advised her that if Mr Hartley did not attend the accommodation for his induction by 5.00pm that day, then he would lose his bed

space. The COM did not have a telephone number for Mr Hartley and therefore could not contact him to tell him this.

28. Later that evening, Mr Hartley telephoned Doncaster Probation Office and asked for the address of his CAS3 temporary accommodation. The duty officer told him that, unfortunately, because he had not contacted either the accommodation service or probation after his release the previous day, he had lost his bedspace. The duty officer advised him to go to the local council office and present himself as homeless and gave him details of his next probation appointment. Probation records note that Mr Hartley became rude and abusive on the phone, so the duty officer ended the call.

29. On 28 January, Mr Hartley did not attend his scheduled probation appointment.

Circumstances of Mr Hartley's death

30. On 28 January, Mr Hartley's partner found him collapsed and unresponsive, so she called the emergency services. Paramedics attended and found Mr Hartley in cardiac arrest. He was subsequently taken to hospital and admitted to the intensive care unit (ICU). Mr Hartley remained in the ICU where medical tests showed he had significant brain damage and multi organ failure. On 31 January, his family made the decision to withdraw treatment and he died later that day.

Post-mortem report

31. The post-mortem report concluded that Mr Hartley died from hypoxic brain injury caused by multiple drug misuse (synthetic cannabinoids, cocaine, diazepam and pregabalin).

Findings

Substance misuse support

32. Mr Hartley had a history of substance misuse. Although he was in prison for only eight weeks, during this time, he was appropriately supported by the prison's SMS team and warned about the risks and dangers associated with substance misuse. The prison promptly and appropriately referred Mr Hartley to Doncaster Aspire so he had access to substance misuse support upon release. He was also trained in the use of naloxone and released with a supply of this.

33. We are satisfied that Mr Hartley's COM took appropriate measures to address his substance misuse upon his release from prison. This included securing a space in CAS3 temporary accommodation to ensure he was not homeless upon his release from prison. Additionally, Mr Hartley's COM added licence conditions to comply with any requirements relating to addressing his substance misuse issues.

Good practice

34. Staff from Doncaster Aspire met Mr Hartley in the prison's departure lounge after Mr Hartley was released and reiterated messages about the dangers of drug use after a period of abstinence.

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

36. We make no recommendations.

Inquest

37. The inquest, held on 12 June 2025, concluded that Mr Hartley's death was drug related.

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

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