Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Hughie Hendry, on 25 November 2023, 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

# 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 been investigating 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 Hughie Hendry died of drug poisoning on 25 November 2023, following his release from HMP Doncaster two days earlier. He was 50 years old. We offer our condolences to those who knew him.

5. Mr Hendry had a history of substance misuse and worked with community and prison drug and alcohol services. After three weeks in prison, he was released unexpectedly following a video-link court appearance. A prison substance misuse worker met him before he left the prison and, later that day, contacted Mr Hendry's community drug and alcohol team to prepare them for his release and to ensure continuity of his methadone prescription. It is not uncommon for our investigations to involve prisoners released unexpectedly with little continuity of care and this was an example of good practice.

## The Investigation Process

6. We were informed of Mr Hendry's death on 4 March 2024. We do not know the reason for the delay.

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

8. We informed HM Coroner for South Yorkshire East District of the investigation. They 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 Hendry's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She asked why Mr Hendry was released from prison without accommodation.

10. Mr Hendry's sister received a copy of the initial report. She notified us of two inaccuracies which have been amended in this report. She also raised further issues on the family's notification of Mr Hendry's death, which have been addressed in separate correspondence.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies in the report.

# Background Information

## HMP Doncaster

12. HMP Doncaster is operated by Serco. Practice Plus Group provides healthcare services. These range from reception health checks on arrival and regular GP services, to help with substance misuse, mental health, chronic or long-term conditions, podiatry, physiotherapy and optometry.

## Probation Service

13. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervise people throughout their licence period and post-sentence supervision.

# Key Events

14. On 2 November 2023, Mr Hughie Hendry was convicted of burglary and theft offences and remanded to HMP Doncaster to await sentencing. At the reception health screening, Mr Hendry said that he used cocaine and heroin daily and drank alcohol two to three times a week. The reception nurse referred him to the prison's substance misuse team. Mr Hendry said that he was diagnosed with schizophrenia but was not currently taking medication for this. The nurse also referred him to the mental health team.

15. Mr Hendry was prescribed methadone (medication for opiate withdrawal) in the community. This prescription was continued in prison, on a reducing dose. Mr Hendry complied with his medication throughout his time in prison.

16. On 3 November, Mr Hendry met with the resettlement team and told them that he had been living at a friend's address in the community, but this was temporary. Mr Hendry said he could not return to the address when he was released and would be homeless in the Doncaster area.

17. On 7 November, Mr Hendry had a follow up assessment with the Community Integration Team (CIT – who work collaboratively to coordinate pre-release planning and support community offender managers to plan resettlement).

18. On 9 November, a substance misuse worker assessed Mr Hendry. He recorded that Mr Hendry had previously engaged with substance misuse services in the community. Mr Hendry said that he did not intend to use drugs on release and that he would attend support groups to help his recovery. He said that he had overdosed on heroin in August 2023. Mr Hendry said that he did not want to be issued with naloxone (medication to reverse the effects of opiate overdose) on release. The substance misuse worker referred Mr Hendry to Doncaster Aspire community drug and alcohol service. Mr Hendry also said that he had no current concerns about his mental health and expected to receive a sentence of two to three years.

19. On 10 November, Mr Hendry had an immediate needs assessment with a probation service officer with the CIT. She recorded that that CIT would refer Mr Hendry to The Growth Company for support with finance, benefits, and debt.

20. On 21 November, Mr Hendry told prison staff that his methadone dose was currently keeping him stable. He said that he had a good support network and spoke to his family via his in-cell phone.

21. On 23 November, Mr Hendry attended a court hearing via video-link. He was given a two-year suspended sentence and was released from prison.

22. Before Mr Hendry left Doncaster, the substance misuse worker met him and advised him to attend Doncaster Aspire either that afternoon or the next morning, in order to ensure continuity of care with his prescribing. Mr Hendry again said that he did not intend to use drugs on release. The substance misuse worker gave him harm minimisation information and warned him of the risk of overdose. He emailed Doncaster Aspire with details of Mr Hendry's methadone prescription and made a follow-up phone call to advise them of Mr Hendry's release and that he may attend the service.

23. Following his release, Mr Hendry stayed at a friend's house. Mr Hendry had been in prison for three weeks and was expected to receive a custodial sentence. There is no record that any work was done to identify more permanent accommodation should he have been released from court.

## Post Release

24. On 24 November, Mr Hendry attended Doncaster Aspire. He said that he had used heroin and cocaine since his release. The substance misuse worker who saw him recorded that she advised Mr Hendry of reports of contaminated heroin and pregabalin (medication to treat epilepsy and anxiety which is also used as a recreational drug) in the town, which had resulted in some recent deaths from overdose. Mr Hendry took his prescribed methadone and agreed to a six-step recovery plan.

25. On the same day, Mr Hendry was allocated a community offender manager (COM).

26. On 27 November, probation staff sent Mr Hendry an initial appointment letter to meet his COM on 30 November. (Mr Hendry died before this appointment.) The letter was sent to the address at which Mr Hendry was living before he was sent to prison and was a different address to that which he had given Doncaster Aspire three days earlier.

## Circumstances of Mr Hendry's death

27. On 25 November, two days after his release from prison, the friend with whom Mr Hendry was staying found him unresponsive and cold to the touch. She told police that he had used 80ml of methadone and that pregabalin prescribed to her had gone.

## Post-mortem report

28. The post-mortem report concluded that Mr Hendry died of drug poisoning. The toxicology examination identified evidence of cocaine use shortly before death. Methadone was present in the overlapping therapeutic/toxic range. The toxicologist noted that use of pregabalin may have enhanced the sedative effects of methadone.

## Contact with Mr Hendry's family

29. The Coroner informed us that he had first contacted Mr Hendry's next of kin, his sister, on 29 November. We do not know when or by whom Mr Hendry's sister was notified of his death.

# Findings

30. Mr Hendry was released from prison on 23 November, having received a suspended sentence following a video-link court hearing. His release was unexpected, and prison and probation staff had not had much opportunity to plan, including finding release accommodation for him. Nevertheless, there was some good practice around his release. A member of the prison substance misuse team saw him before he left the prison to give advice on harm reduction and meeting the community drug and alcohol team. He then both telephoned and emailed the community drug and alcohol team to prepare them for Mr Hendry's visit and to ensure continuity of care with his prescription.

## Head of Probation Delivery Unit to note

31. Probation records noted Mr Hendry's address as the one at which he lived before he was sent to prison, which was different to the release address he gave Doncaster Aspire and which was recorded on his prison record. It is unclear whether his initial appointment letter was sent to the correct address or whether Mr Hendry would have received this had he not died. The COM said that probation staff were required to update the address information, but we found this had not happened. Probation staff could have done more to identify where Mr Hendry was living when released, to ensure that he received important appointment information.

# Inquest

32. The inquest into Mr Hendry's death concluded on the 15 January 2025. The coroner confirmed that Mr Hendry died of mixed drug (cocaine, methadone, pregabalin) toxicity.

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

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