RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS
REGULATION 29 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

THIS RESPONSE IS BEING SENT TO:

The Area Coroner, Paul Michael Appleton for the Coroner Area of Teesside & Hartlepool in response to a **REPORT TO PREVENT FUTURE DEATH REGULATION 28'** following an inquest into the death of **Francis CONLIN** that **concluded on 12 August 2026.**

1.	**RESPONDENT** In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, **Practice Plus Group** provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths.
2.	**DATE OF RESPONSE** **12/10/2026**
3.	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The **MATTERS OF CONCERN** were identified in the report are as follows: 1. Evidence provided by the PPG Head of Healthcare ("HOH") for HMP Doncaster confirmed that a standard, national template is followed during pre-release healthcare screens. It was confirmed to me that the template is a document controlled by NHSE. The template is understood to be the SEAT Court, Release & Transfer Out Screen (with the current version understood to be v4). The PPG HOH confirmed that the national template does not include any pre-release questions or prompts related to the mental health of the detained person who is being released. However, the nurses performing the healthcare screens are expected to consider, and if relevant ask questions about, the detainee's mental health state.

	1am concerned about the absence of the above prompt/questions.
4.	**DETAILS OF ACTION TAKEN,** how has the concern been addressed. Practice Plus Group would like to express its condolences to Mr Conlin's family and friends. This response addresses the matters of concern to you insofar as they relate to Practice Plus Group only. As confirmed at the inquest, the SEAT Court, Release and Transfer Out Screen template (the "template") is a national NHS England clinical template used across the adult prison estate in England and is not owned or controlled by Practice Plus Group. Consequently, Practice Plus Group is unable to make local amendments to the template itself. The HOH at HMP Doncaster notified the Commissioner for Yorkshire and the Humber at NHS England of the Regulation 28 report and received a response indicating the Regulation 28 report has been escalated and is sitting with the NHS England national team. No further update on the template has been received by Practice Plus Group to date. **Local Response** The HOH gave evidence at the inquest that nurses performing the pre-release screens are expected to consider and, if relevant, ask questions about the patient's mental health state. To ensure this is being done, and to mitigate risk until an update on the template is received from NHS England, Practice Plus Group has introduced additional safeguards within its own pre-release healthcare screening process. The template has been reviewed locally and guidance has been provided to nurses performing the pre-release screens in handovers and via email that for any immediate releases, they must tick the 'Exceptional Post-Release' box which opens the 'Exceptional Post-Release Template' page. The nurses are expected to ask all questions on that page, as well as additional questions relating to the mental health of the patient. The questions should cover the patient's current mental state, supply of any prescribed mental health medication, and if the patient is aware of how to access a GP and obtain medication on release. The HOH is finalising a summary sheet of questions for the nurses performing the pre-release screens, to clarify the questions which should be asked. The nurse should then enter comments in the 'Action Taken' free text box on the 'Exceptional Post-Release Template' page, to evidence that they have asked key pertinent questions around the patient's mental health and to document any other issues, risks or concerns relating to their mental health. The templates will be audited monthly to ensure compliance with the above steps, or until such a time that the template is updated by NHS England. The Local Operating Procedure (LOP) for completion of pre-release templates is in the process of being updated to ensure it reflects the current practice detailed

above.

Whilst this does not alter the nationally controlled template itself, it provides an additional local safeguard whilst the national NHS England clinical template is reviewed.

National Organisational Response

As part of our Patient Safety Incident Response Framework (PSIRF), Practice Plus Group routinely reviews thematic learning and wider sources of patient safety intelligence across our Health in Justice services. This enables us to identify areas requiring a systematic response and to develop improvement activity across our services, rather than considering learning from individual incidents in isolation.

Safer release has been an organisational patient safety priority over the past year, supported by a dedicated national workstream. As part of this work, we have undertaken two focused learning events, bringing together national clinical colleagues from across the country to review learning, identify variation and consider opportunities for improvement. This has included consideration of appropriate mental health assessment and response, continuity of care and the safeguards required at the point of release.

The wider programme of work has included:

• national scoping of current provision, activity and the role of healthcare teams in release planning;

• strengthening continuity-of-care arrangements between prison and community services, including work with mental health services and RECONNECT;

• improved communication of risk information between non-custodial services, prisons and prison healthcare teams (pilot in Yorkshire currently);

• development of a standardised discharge pack incorporating safety-netting information, support and signposting; and

• continued staff training and work to reinforce that safe release planning begins at reception and is a shared responsibility throughout an individual's time in custody.

We actively escalate learning that requires action beyond our direct organisational control through the appropriate commissioning and system routes. In relation to this case, as identified above the Regulation 28 report and the issues identified regarding the national template have already been escalated through the NHS commissioning arrangements for Yorkshire and Humber for consideration within the appropriate NHS England processes.

Alongside this system-level escalation, local safeguards have already been introduced in response to the learning from this case. As described above these include additional guidance for staff regarding pre-release planning and associated processes, together with work to strengthen the recording and

	communication of relevant information at the point of release. In particular, the service has utilised the exceptional post-release section within the existing national template to address identified gaps in the information currently captured, particularly in relation to mental health needs and associated risks at the point of release. As part of our national safer release work, we will review these local safeguards and the learning from their implementation, including the use of the exceptional post-release section, and consider whether these approaches could provide additional safeguards across our wider Health in Justice services. This will sit alongside our continued escalation through NHS commissioning routes of any limitations identified within the national template itself. Learning from this case will therefore be considered alongside our existing safer release work and wider patient safety intelligence, enabling us to identify any further opportunities to strengthen practice and organisational assurance.
5.	**DETAILS OF FURTHER ACTION PROPOSED** Practice Plus Group will continue to work with NHS England and the relevant national template governance arrangements to support consideration of a more definitive national solution to the inclusion of mental health prompts in the template. In addition, Practice Plus Group will continue to escalate any concerns with other national clinical templates to NHS England through Regional Commissioners at NHS England.
6.	**SIGNATURE**  **Medical Director Health in Justice** **Practice Plus Group**