	REPORT TO PREVENT FUTURE DEATHS
1.	**CORONER** I am Paul Michael Appleton, HM Area Coroner for the Coroner Area of Teesside & Hartlepool
2.	**DATE OF REPORT** 17.08.2026
3.	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
4.	**THIS REPORT IS BEING SENT TO** 1. Medical Director, Practice Plus Group ("PPG") 2. NHS England ("NHSE") You are under a duty to respond to this report within 56 days of the date of this report, namely by 12.10.2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

6.	**SUMMARY OF CORONER'S CONCERN** The NHSE SEAT National Clinical Template for Court, Release and Transfer Out (current version understood to be v4) which is followed during pre-release healthcare screens performed in Prisons, does not include any prompt or questions relating to the detainee's mental health.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 08 October 2024, I commenced an investigation into the death of Francis CONLIN, aged 23. The investigation concluded at the end of the inquest on 12 August 2026. The medical cause of death recorded was: 1a) Pressure on the Neck 1b) Hanging The following narrative conclusion was recorded: *Francis died due to hanging from a self-applied ligature at a time when he had consumed [redacted]. It has not been possible to ascertain Francis's intention at the relevant time.*
9.	**CIRCUMSTANCES OF DEATH** Francis Conlin's past medical history included a diagnosis of mental and behavioural disorder secondary to illicit substance misuse. It was suspected that Francis may also have had Autism; however, this was not formally diagnosed. Francis was released from HMP Doncaster on 30 September 2024. He died on 07 October 2024 at 24 Campion Grove, Marton, Middlesbrough. Francis died due to hanging from a self-applied ligature at a time when he had consumed [redacted]. It has not been possible to ascertain Francis's intention at the relevant time.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

	The **MATTERS OF CONCERN** 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. I am concerned about the absence of the above prompt/questions.
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to the following who were IPs to the inquest: 1. Family 2. Probation Service (Ministry of Justice). I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE** [redacted] **Paul APPLETON** **Area Coroner for** **Teesside and Hartlepool Coroner's Service**