Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jonathan Leask on 28 October 2023, following his release from HMP Winchester

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 Jonathan Leask died by self-strangulation on 28 October 2023, following his release from HMP Winchester on 19 October. He was 53 years old. We offer our condolences to those who knew him.

5. We are satisfied that Mr Leask's risk of harm was adequately assessed by prison and probation staff and that he gave no indication that he was suicidal. We are satisfied that Mr Leask's death could not have been foreseen by those working with him in the short time that he was in prison and on probation.

6. We make no recommendations.

The Investigation Process

7. HMPPS notified us of Mr Leask's death on 6 November 2023.

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

9. We informed HM Coroner for Hampshire 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 family liaison officer contacted Mr Leask's next of kin, his wife, to explain the investigation and to ask she had any matters she wanted us to consider. She asked if Mr Leask was given substance misuse support and mental health support while in prison and after his release. This has been addressed in the report.

11. Mr Leask's next of kin received a copy of the draft report. They pointed out some factual inaccuracies and this report has been amended accordingly. Mr Leask's next of kin also raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Winchester

13. HMP Winchester is a category B reception prison which holds up to 564 men who have either been convicted or are on remand. It is managed by His Majesty's Prison and Probation Service (HMPPS).

Probation Service

14. 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.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Winchester was in February 2022. Inspectors reported that over half of all prisoners were unsentenced and nearly 90% had been at Winchester for three months or less. The prison and health care staffing challenges were having a detrimental impact on the delivery of mental health and pharmacy services. This resulted in delays for mental health assessment and delays in treatment.

16. On average, a total of 80 prisoners were released from the establishment each month. Leaders did not collate and review data on prisoner outcomes, such as sustainable accommodation and work on release. Inspectors saw evidence of good work to support prisoners approaching release, although details were often not settled until their last few days in the prison.

Key Events

17. On 28 September 2023, Mr Jonathan Leask was remanded to HMP Winchester, charged with harassment (committed against his wife).

Pre-release planning

18. When he arrived at Winchester, Mr Leask told the reception nurse that he did not have any thoughts of suicide or self-harm. He said that he had never tried to harm himself, had had no previous involvement with mental health services, and had never received medication for his mental health. The prison requested his medical records from his community GP, which confirmed that he did not have any history of mental health issues.

19. The nurse asked Mr Leask about his alcohol consumption. He told the nurse that he drank alcohol two to four times a month, and that this was not in excessive amounts. The nurse asked if he would like support from the prison's substance misuse service, but Mr Leask declined. The nurse told Mr Leask about the support services at Winchester and how he could access them, should he change his mind.

Release from Winchester

20. On 19 October, Mr Leask attended court. He was convicted of harassment and sentenced to 28 days in prison. He was released that day due to time served on remand. As he had not yet been allocated a community offender manager (COM) due to being sentenced the same day, he attended Aldershot Probation Office to see the duty probation practitioner. The probation practitioner went through his licence conditions and Mr Leask signed to say that he understood them. Mr Leask said that he had accommodation to return to, and that he was hoping to return to previous employment.

21. The next day, Mr Leask was allocated a COM who issued him with his next appointment.

22. On 27 October, Mr Leask attended his planned probation appointment. During the appointment, Mr Leask became very emotional when speaking about the breakdown of his marriage. Mr Leask said he felt remorse for his actions and said that he sometimes felt overwhelmed with feelings of sadness. The COM asked Mr Leask if he would like to be referred to Catch-22, an agency that offers emotional well-being support. Mr Leask agreed to this and said that he would like to work on himself. Mr Leask then asked his COM if he could travel to Italy for a cycling trip with his son. The COM told Mr Leask that he was not allowed to go overseas while on licence. The COM noted that the appointment ended more positively, and she issued Mr Leask with his next appointment. After the appointment, the COM completed the referral to Catch-22.

Circumstances of Mr Leask's death

23. Mr Leask was found in a van situated in a layby in Odiham on 28 October 2023. He was found with a rope around his neck which had snapped. The rope had been tied to a tree and then fed through the rear of the van.

24. On 1 November, Mr Leask's next of kin notified his COM that he had died. This was later confirmed by the police.

Post-mortem report

25. The post-mortem report concluded that Mr Leask died of strangulation by ligature.

26. The pathologist noted the presence of alcohol and cocaine in Mr Leask's system, however noted that the presence of cocaine in Mr Leask's blood was far below the average concentration associated with fatalities.

Findings

27. As Mr Leask had already served his prison sentence whilst on remand, he was released straight from court on the day that he was sentenced. Due to this, he had not been allocated a COM and no pre-release work had been completed, and he was released with a set of standard licence conditions. As this was Mr Leask's first offence, once a COM was allocated, she had limited information on his mental health history, his risk factors or his triggers. The COM began to explore these with Mr Leask during his next appointment and through formulating his initial sentence plan. When Mr Leask became visibly upset during the appointment, she offered him support and referred him to an agency that could help him with his emotional wellbeing. We consider that she responded appropriately.

28. We are satisfied that whilst in prison, Mr Leask raised no concerns regarding his mental health and said that he did not have any thoughts of harming himself. He had no documented history of suicidal thoughts or attempts or self-harm. When asked, Mr Leask said that he did not want any help regarding his alcohol consumption, which he described as moderate and not problematic, from the substance misuse service.

29. We are satisfied that Mr Leask's risk of harm was adequately assessed by prison and probation staff and that he gave no indication that he posed a significant risk to himself. We are satisfied that Mr Leask's death could not have been foreseen by those working with him in the short time that he was in prison and under probation supervision.

Adrian Usher
Prisons and Probation Ombudsman **April 2024**

Inquest

The inquest, held on 25 June 2024, concluded that Mr Leask died by suicide.

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