Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Leslie Leach, on 7 December 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 Leslie Leach died from bronchopneumonia (inflammation of the lungs) on 7 December 2025, five days after his release from HMP Doncaster. The post-mortem report listed multiple drug toxicity (including heroin and cocaine) as a contributory factor. Mr Leach was 46 years old. We offer our condolences to those who knew him.

5. Mr Leach reported a history of heroin and cocaine use when he arrived at Doncaster. He received appropriate support for his drug use and was referred to community substance misuse services prior to release. He did not report any symptoms of a chest infection or breathing difficulties while at Doncaster.

6. We did not identify any significant learning relating to the pre-release planning or post-release supervision of Mr Leach.

7. We make no recommendations.

The Investigation Process

8. HMPPS notified us of Mr Leach's death on 8 December 2025.

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

10. We informed HM Coroner for Hull of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

11. The Ombudsman's office contacted Mr Leach's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

12. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies.

Background Information

HMP Doncaster

13. HMP Doncaster is a category B men's prison managed by Serco. Practice Plus Group provides healthcare services including mental health services and substance misuse support.

Probation Service

14. 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.

Deaths following release from prison

15. Between September 2021 and the end of March 2026, the PPO started investigations into approximately 300 deaths of people who died within 14 days of release from prison. The PPO has published two learning lessons bulletins about post-release deaths, most recently in July 2024. Our investigations highlight the acute vulnerability of prison leavers, especially during the first few days post-release, and indicate that prison leavers often have multiple risk factors such as mental health and substance use issues and homelessness which further increase their vulnerability and risk of death following release from prison.

Previous deaths following release from HMP Doncaster

16. Mr Leach was the eighth man to die within 14 days of release from HMP Doncaster since December 2022. Up to the end of April 2026, there has been one further death. Seven of the deaths were drug related. Two cases are still being investigated. We found that in five of the cases we have investigated, there were no issues with pre-release planning or post-sentence supervision.

Key Events

Background

17. On 19 September 2020, Mr Leslie Leach was sentenced to six years imprisonment for burglary. He was released on licence on 20 February 2024.

18. On 14 February 2025, Mr Leach was recalled to prison after he was arrested for a domestic incident. During Mr Leach's reception screening, Mr Leach told a nurse he had a history of heroin and crack cocaine use and had been drinking alcohol daily before his arrest. He told her his current methadone dose (an opioid drug used to treat heroin addiction) was 50ml a day. Mr Leach said he had a history of mental health problems including psychosis and schizophrenia but did not have any current issues. The nurse referred him to the in-reach mental health service for an assessment. Mr Leach reported no physical health concerns.

19. On 24 February, a mental health triage nurse assessed Mr Leach. He said he felt 'all over the place' and was stressed by life events before coming into custody. The nurse observed no signs of psychosis, but she was concerned that he was low in mood and struggling with his sleep. She agreed with Mr Leach to start him on an antidepressant and a sleeping tablet to help with his symptoms.

20. Mr Leach continued to take methadone and engaged well with the substance misuse service (SMS). He had regular key work sessions with an SMS support worker.

Pre-release planning

Substance misuse

21. On 16 May, Mr Leach asked his SMS key worker to start reducing his methadone dose. They agreed to reduce Mr Leach's methadone by 2ml per week.

22. On 15 August, Mr Leach told his SMS key worker that he wanted to continue to reduce his methadone dose, which was currently at 24ml. They agreed to continue with a 2ml reduction.

23. On 26 September, Mr Leach asked his SMS key worker to stop his methadone reduction plan. His dose had been reduced to 12ml and he felt he was struggling with withdrawal symptoms. He asked for his methadone to be increased to 20ml. Mr Leach remained on 20ml until his release from Doncaster.

24. On 26 November, during an SMS key work session, Mr Leach asked how he would receive his methadone prescription after release, as he expected to live in Bridlington (around 35 miles from Hull, where he was originally from). His key worker agreed to speak with his community offender manager (COM) to arrange an appointment in the area where he would be living. The SMS worker also agreed to organise blood tests and an electrocardiogram (ECG, a test to check the heart's rhythm) so that he could switch to buprenorphine (a tablet opioid treatment that requires fewer supervised pharmacy visits) once in the community. This would allow Mr Leach to complete a railway course for employment.

25. On 28 November, the SMS key worker referred Mr Leach to the community SMS services.

26. On 1 December, the SMS key worker saw Mr Leach in his cell. Mr Leach said he was feeling overwhelmed with his appointments and trying to see his family on the same day. His key worker supported him by helping him to prioritise what he needed to do on his initial release, and to locate where his appointments were on a map. She also showed him how to use naloxone (a medication that can rapidly reverse opioid overdose) and advised how to minimise harm when using drugs and alcohol and what to do in the event of an overdose. Mr Leach also had an ECG and the required blood test to change to buprenorphine in the community.

Healthcare

27. On 23 September, a GP at Doncaster saw Mr Leach as Mr Leach was concerned his paraumbilical hernia had grown in the past two weeks (he had been diagnosed with this in the community). The GP examined him and completed an urgent hospital referral to general surgery. Mr Leach did not receive a hospital appointment before his release.

28. On 2 October and 4 November, Mr Leach asked for paracetamol for general aches and pains. Aside from this he had no other physical health complaints in the lead up to his release.

Housing

29. On 1 October, Mr Leach's COM made a referral to the local council for social housing under the Duty to Refer (requires probation staff to refer individuals who are homeless or at risk of homelessness to a local housing authority). She also referred Mr Leach to the Community Accommodation Service Tier 3 (CAS3), which provides temporary housing for prison leavers.

30. On 27 November, Mr Leach's COM confirmed he had been allocated CAS3 accommodation in Bridlington (around 26 miles from Hull, where Mr Leach was from). The COM explained this was temporary and they would continue to look for long term accommodation in Hull.

Release from HMP Doncaster

31. On 2 December, at around 10.30am, Mr Leach was released from HMP Doncaster. He declined to take home naloxone and had a travel warrant to Bridlington.

32. His initial appointment with probation and SMS appointment had been arranged for Bridlington (where his CAS3 accommodation was). However, Mr Leach had arranged his universal credit appointment for Hull so travelled there first.

33. Mr Leach returned to Bridlington to the CAS3 accommodation but had missed his initial probation and SMS appointment. Mr Leach spoke to his COM over the phone. They agreed that as he had attended his universal credit appointment, they would mark his initial appointment as attended. Mr Leach's community SMS appointment was rescheduled to the next day at 11.00am.

34. The next day, Mr Leach attended Hull probation office unplanned. His COM agreed to see him as she had availability. She queried why he had attended the probation office in Hull, given he knew his appointments would be arranged for Bridlington, while he was in temporary accommodation there. Mr Leach said had been offered a house through a charity, CU Support, so his COM said she would confirm this. She explained that it would not be confirmed that day and he would need to return to the property in Bridlington. Mr Leach talked about feeling overwhelmed and low since his release. He had managed to get his methadone prescription sorted but found this process stressful as he did not know the area. His COM talked through steps they could both take to work with agencies and get the appointments he needed.

35. Later that day, Mr Leach had an alcohol monitor fitted. This detected that he had used alcohol.

36. On 4 December, Mr Leach phoned his COM to pass on his new phone number. His COM told him that alcohol had been detected when his tag had been fitted and asked if he had been drinking. Mr Leach said that he drank two pints of beer the previous day as he was feeling overwhelmed, but now he felt calmer and was going to stay sober. His COM advised that he was due to attend his community SMS appointment that morning, but she had not been able to pass this on to him as she did not have his updated phone number. Mr Leach said he had received his methadone successfully and would feel more settled once he got into a routine.

37. The community SMS contacted the COM as Mr Leach had not attended his appointment. The COM explained she had not been able to pass on appointment details due to issues with Mr Leach's phone, and him having a new number. They agreed a new appointment at 1.30pm on 8 December.

38. On 7 December, the COM received confirmation that Mr Leach had a property confirmed through CU Support for longer term housing in Hull.

Circumstances of Mr Leach's death

39. On 7 December, Mr Leach was at his sister's house. At around 1.30pm, she went to check on him and found him collapsed in a bedroom with drug paraphernalia nearby. She went to get help from a neighbour and they called an ambulance.

40. When the ambulance arrived, the paramedics observed Mr Leach had hypostasis (blood settling in the body after death) and fixed pupils, which indicated he had died and CPR would not be appropriate. At 1.49pm, they pronounced life extinct.

Post-mortem report

41. The post-mortem report concluded that Mr Leach died from bronchopneumonia (inflammation of the lungs). Multiple drug toxicity, including heroin and cocaine, plus various prescription medications including methadone, diazepam (used to treat anxiety, muscle spasms and seizures), fluoxetine (an antidepressant), pregabalin (used to treat nerve pain and anxiety) and promethazine (an antihistamine), were listed as a contributory factor. The post-mortem report said that the combination of drugs had caused respiratory depression and contributed to Mr Leach's death.

Findings

Healthcare

42. The post-mortem report concluded that Mr Leach died from bronchopneumonia. We found no evidence in Mr Leach's medical records that he had reported any symptoms of a chest infection or breathing difficulties at Doncaster in the lead up to his release.

43. Mr Leach had one GP appointment to discuss a pre-existing hernia, where he was appropriately referred to the hospital for further investigation. Mr Leach did not receive an appointment from the hospital prior to his release. Mr Leach's only other interaction with healthcare staff was to ask for paracetamol for general aches and pains. We are satisfied that he received appropriate care.

Drug use

44. When Mr Leach arrived at Doncaster, he said he had a history of heroin and crack cocaine use. He had been taking methadone in the community to treat heroin addiction and continued his treatment at Doncaster. Mr Leach engaged well with SMS and successfully reduced his methadone dose while in prison. He took steps to move on to buprenorphine in the community to enable him to start a training programme on the railway.

45. Before release, an SMS worker referred Mr Leach to the community SMS to ensure continuity of care. Mr Leach was offered naloxone and declined. We are satisfied that he received appropriate support relating to his drug use.

Housing

46. Mr Leach's COM made the appropriate housing referrals for him and managed to secure CAS3 accommodation for his release. Although the CAS3 accommodation was outside Mr Leach's local area, the COM worked with a charity, CU Support, to secure long-term housing in Hull.

Adrian Usher
Prisons and Probation Ombudsman **June 2026**

Inquest

At the inquest, held on 9 October 2026, the Coroner concluded that Mr Leach died from natural causes contributed to by a combination of drugs.

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