

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

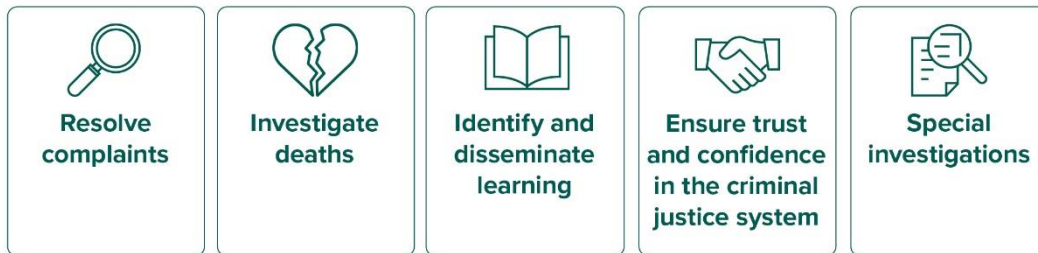
# **Independent investigation into the death of Mr Mark Doab, a prisoner at St Leonard's Approved Premises, on 5 October 2022**

**A report by the Prisons and Probation Ombudsman**

## 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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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.

If my office is to best assist His Majesty's Prison and Probation Practice (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.

Mr Mark Doab died of combined heroin and cocaine toxicity on 5 October 2022 at St Leonard's Approved Premises (AP). Mr Doab was the second resident to die at St Leonard's in three years. He was 37 years old. I offer my condolences to Mr Doab's family and friends.

The care provided to Mr Doab was of a good standard overall. AP staff completed the appropriate risk assessments when Mr Doab arrived and implemented a range of supportive measures to safeguard him and support his recovery from substance use. We found that Mr Doab gave AP staff no reason to consider that he was at imminent risk of an overdose in the days before his death.

This version of my report, published on my website, has been amended to remove the names of staff and residents involved in my investigation.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**October 2023**

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# Summary

## Events

1. Mr Mark Doab was released on licence from HMP Exeter with no accommodation on 15 July 2022. Mr Doab had a history of substance misuse and was prescribed Subutex (an opioid used to treat opioid dependence).
2. On 21 July, after a period of homelessness, the Probation Service found a room for Mr Doab at Meneghy House, an Approved Premises (AP) in Cornwall. The placement went well and was extended a couple of times. On 1 September, Mr Doab's residency was ended as the AP had to make his room available for a newly released prisoner. Probation staff were unable to identify any suitable follow-on accommodation.
3. On 26 September, after a further period of homelessness, a room at St Leonard's AP in Reading became available until 12 November.
4. At around 2.30am on 5 October, AP staff completed a welfare check on Mr Doab and found him lying on the floor. They telephoned for an ambulance and began performing cardiopulmonary resuscitation (CPR) but could not find a pulse.
5. The ambulance crew arrived at Mr Doab's room at around 2.50am and took over the CPR until 3.20am, at which point they confirmed that Mr Doab had died. A post-mortem examination found that Mr Doab died of combined heroin and cocaine toxicity.

## Findings

### Management of Mr Doab's risk

6. AP staff completed the appropriate risk assessments for Mr Doab and put in place supportive measures to support his recovery from substance use. Mr Doab gave AP staff no indication that he was taking any illicit drugs or that he was likely to do so.
7. AP staff did not administer naloxone (a drug that reverses the symptoms of an overdose) when they found Mr Doab unresponsive in his room. They were unsure what had happened and assessed that Mr Doab was near death, so naloxone was not appropriate. Mr Doab had been compliant with substance misuse support in the AP and staff saw no signs of relapse. They administered CPR quickly and tried to revive Mr Doab until paramedics arrived. In the circumstances, we are satisfied with the emergency response.

## The Investigation Process

8. We were notified of Mr Doab's death on 5 October 2022.
9. The investigator issued notices to staff and residents at St Leonard's Approved Premises (AP), informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Doab's prison and medical records. He interviewed six members of staff at St Leonard's AP on 18 January 2023.
11. We informed HM Coroner for Berkshire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. Mr Doab had not identified a next of kin before he died, and therefore the PPO did not make contact with Mr Doab's family.
13. We shared the initial report with HM Prison and Probation Service. They did not identify any factual inaccuracies.

## Background Information

### St Leonard's Approved Premises

14. Approved Premises (formerly known as probation or bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are responsible for their own healthcare and are expected to register with a GP.
15. St Leonard's is an Approved Premises (AP) in Reading managed by the Thames Valley Probation Trust. It can accommodate up to 22 residents. Staffing at St Leonard's includes managers, offender supervisors (previously known as keyworkers) and support staff, with two staff on duty at night. Residents are always required to sign in and out of the AP and all are subject to standard curfew conditions over night. During the day, residents are free to go out unaccompanied, although they must state where they are going. Alcohol and drugs are strictly forbidden in the AP, but residents can consume alcohol when they are out.
16. Residents are risk-assessed and allowed to hold medication in their own possession if staff are satisfied that it is safe for them to do so, apart from certain excluded classes of medication which cannot be held by residents. These medicines are always retained by staff and issued to residents according to the prescription. For residents whose risk assessment concludes that they should not retain possession, all their medicines are retained by staff.

### Previous deaths at St Leonard's AP

17. Mr Doab's death was the only one at St Leonard's in three years. The last death was in July 2020 and there are no significant similarities between our findings.

# Key Events

## Background

18. Mr Mark Doab was released on licence from HMP Exeter with no fixed abode on 15 July 2022. He had a long history of crack cocaine and heroin use and was prescribed Subutex (a heroin substitute) to support his recovery. Mr Doab also experienced anxiety and depression, for which he was prescribed medication. He had a history of self-harm and had attempted to take his own life by hanging and drug overdose.
19. Mr Doab continued to take his prescribed medications (including Subutex) after his release from Exeter.
20. On 21 July, after a period of homelessness, probation staff found a room for Mr Doab at Meneghy House, an Approved premises (AP) in Cornwall. The stay went well, and staff had no concerns about him. On 1 September, Mr Doab left Meneghy House when his residency had come to an end and there was no space to enable staff to extend the stay.
21. The Probation Service sent Mr Doab to Taunton in Somerset to be re-housed. Mr Doab's Probation Practitioner (PP explained in interview that Mr Doab was originally from the Manchester area but moved further south over time, out of choice. During the COVID-19 pandemic, he was housed in Wellington in Somerset, which led to him having links with probation services there and they agreed to try to house him in Somerset. They could not initially find any alternative accommodation for him.
22. Mr Doab experienced another period of homelessness until 26 September, when a room at St Leonard's AP in Reading became available. The room was available until 12 November.

## St Leonard's AP

23. When Mr Doab arrived at St Leonard's on 26 September, his key worker completed his induction which included a 'risk to self' assessment. The AP Manager completed a Support and Safety Plan (SASP) assessment for Mr Doab which considered his level of risk in relation to his substance use, mental health and risk of suicide and self-harm. AP staff referred Mr Doab to 'Change, Grow, Live' (CGL), a national charity specialising in substance misuse support, to support him with his recovery. He engaged with the substance misuse service (CGL) and his Subutex treatment.
24. Following these assessments, the AP Manager put several support measures in place to manage Mr Doab's risks. Firstly, that staff must complete four additional welfare checks on Mr Doab during the night, including two 'rousable' checks (waking the resident up) at roughly 12.00am and 2.00pm, to ensure he was safe and well. Staff should also have daily interactions with Mr Doab, including one meaningful conversation each day. The AP Manager arranged random alcohol testing, drug testing on suspicion (including evidence of a negative drug test before removing the additional welfare checks) and ensured that Mr Doab's medications for depression and anxiety were kept behind the counter for AP staff to distribute to him. Finally, Mr Doab was offered a Naloxone kit (an emergency medication that

can reverse the effects of an overdose of opioids like heroin or methadone), which he accepted.

25. On 28 September, AP staff issued Mr Doab with a verbal warning when he responded angrily to a rousable welfare check. No further concerns were raised. AP staff did not complete a drug test on Mr Doab while he was at St Leonard's.

#### **4 – 5 October**

26. At around 12.30pm on 4 October, the PP emailed a senior probation officer based at St Leonard's, asking for the rousable welfare checks to be reduced. Mr Doab said the checks were making him anxious and unsettled. The senior probation officer responded the same day to say that they were following policy guidance in completing the checks, because Mr Doab was a new arrival with previous and current drug use. She said checks would be reviewed at the three-week stage, in line with policy.
27. At 11.10pm, Mr Doab came downstairs to take his medication before returning to his room. Staff raised no concerns about him.
28. At around 12.00am, two residential workers at the AP completed the first of their two rousable welfare checks on Mr Doab. They found he was in bed awake and raised no concerns.
29. At around 1.20am, both residential workers completed a non-rousable welfare check on Mr Doab. They saw his chest and leg move, noted breathing and raised no concerns.

#### **Emergency response**

30. At around 2.30am, both residential workers went upstairs to complete the second of their two rousable welfare checks on Mr Doab and heard a wheezing sound coming from his room. They entered the room and saw Mr Doab lying on his back on the floor, between his bed and a cupboard. Residential Worker 1 checked for a pulse but could not find one. Residential Worker 2 got the naloxone pen out but was shaking so passed it to Residential Worker 1. In interview, Residential Worker 1 told us that he did not administer the naloxone because he thought Mr Doab was dead and not breathing.
31. Residential Worker 2 telephoned for an ambulance and Residential Worker 1 began performing cardiopulmonary resuscitation (CPR). Residential Worker 2 then took over CPR and Residential Worker 1 went outside to wait for the ambulance. The ambulance crew arrived at Mr Doab's room at around 2.50am and took over the CPR. The paramedics stopped performing CPR at 3.20am and confirmed that Mr Doab had died.

#### **Contact with Mr Doab's family**

32. Mr Doab had not identified a next of kin when he arrived at St Leonard's. Police and social services were unable to locate any of Mr Doab's family members after his death.

## **Support for residents and staff**

33. The AP manager spoke to staff who had had interactions with Mr Doab and arranged further support for those who wanted it. He also spoke to AP residents and offered further support if needed.

## **Post-mortem report**

34. A post-mortem examination identified Mr Doab's cause of death as combined heroin and cocaine toxicity.

## Findings

### ***Management of Mr Doab's risk***

35. PI 30/2014 '*Drug Appointment and Drug Testing for Licence Conditions and Post-Sentence Supervision Requirements*' states that testing in Approved Premises (APs) is either random, on suspicion or risk-based (i.e., if there is reason to believe that either their risk of harm or their risk of reoffending is elevated through misuse of illegal drugs). The type of testing is decided by staff during the induction stage, based on an individual risk assessment.
36. Staff at St Leonard's AP were aware of Mr Doab's history of substance use and completed the appropriate risk assessments on arrival. They put in place a range of supportive measures (including additional welfare checks and drug tests on suspicion) to safeguard him and support his recovery.
37. All of the staff that worked with Mr Doab at the AP told us he was presenting and behaving well and engaged with staff, so they did not have any reason or justification to complete a drug test and/or room search during his time there. He engaged with the substance misuse service (CGL) and his Subutex treatment.
38. We are satisfied that the approach was proportionate, in the circumstances, and compliant with policy. We do not make a recommendation.

### ***Naloxone***

39. National Approved Premises policy guidance on how to respond to a suspected drug overdose is set out in the *Standard Operating Procedure (SOP)*. It requires staff to administer naloxone (a drug that reverses the symptoms of an overdose) wherever there is a potential overdose.
40. In interview, Residential Worker 1 told us he thought Mr Doab was dead – or close to death when he found him because he was not breathing. Both residential workers retrieved a naloxone kit but did not use it because they did not know if Mr Doab had overdosed and understood from their training that it was only usable when an individual was conscious. Mr Doab had been compliant with substance misuse support during his time at the AP and gave staff no reason to suspect he had relapsed. We are satisfied that staff made a reasonable assessment in the circumstances and do not make a recommendation.

### ***Inquest***

41. The inquest into Mr Doab's death was held on 22 January 2024, and concluded that his death was drug related.

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