

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jason Maynard on 25 May 2024, following his release from HMP Swansea

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 Jason Maynard died from combined drug toxicity following his release from HMP Swansea on 25 May 2024. He was 43 years old. We offer our condolences to those who knew him.
5. Mr Maynard accessed satisfactory support with his substance misuse issues at Swansea. Substance misuse support was also put in place when he was released from prison. Staff made appropriate referrals to homelessness support services. We did not identify any significant learning relating to the pre-release planning or post-release supervision of Mr Maynard. We make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Jason Maynard's death on 5 June 2024.
7. The PPO investigator obtained copies of relevant extracts from Mr Maynard's prison and probation records.
8. The PPO investigator interviewed Mr Maynard's community offender manager and prison offender manager between 8 October and 10 October 2024.
9. We informed HM Coroner for Swansea of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
10. The Ombudsman's office contacted Mr Maynard's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They asked for a copy of the report and raised concerns over their communication with the Probation Service following Mr Maynard's death. This has been addressed in separate correspondence.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
12. Mr Maynard's family received a copy of the draft report. They did not make any comments.

Background Information

HMP Swansea

13. HMP Swansea is a category B prison which holds convicted and remanded male prisoners. Swansea Bay Health Board provides physical health and mental health services. Healthcare staff are available 24 hours a day. Dyfodol provides substance misuse services within the prison.

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 appropriate. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

Key Events

Background

15. On 16 April 2024, Mr Jason Maynard appeared in court charged with assault and theft offences. He was remanded to prison and taken to HMP Swansea. He was also subject to a community order (meaning he was being supervised by the Probation Service) for theft offences.
16. At his initial health screening on 16 April, Mr Maynard told a nurse that he had a history of substance misuse, depression and anxiety. The nurse referred him to the mental health team. Mr Maynard was prescribed medication to lessen his withdrawal symptoms from alcohol. He declined a referral to a specialist alcohol treatment service. Mr Maynard was prescribed diazepam (to treat alcohol withdrawal and anxiety) and paracetamol and continued to be monitored for signs of alcohol withdrawal over the next few days.
17. On the same day, a GP noted that Mr Maynard had not received repeat prescriptions for his medication since February. She prescribed promethazine (antihistamine) and thiamine (vitamin B) to be given to him the following day.
18. On 17 April, a substance misuse support worker from Dyfodol, saw Mr Maynard. He told her that he was detoxing from alcohol and had used heroin and other drugs in the past. Mr Maynard was given an injection of Budival (a monthly injection of buprenorphine used to treat dependence on opioid drugs).
19. The next day, the substance misuse support worker was allocated as Mr Maynard's caseworker. She completed a substance misuse assessment. Mr Maynard told her that he used cocaine. Mr Maynard disclosed that he had previously overdosed eighteen times but not since 2016. He also spoke about his alcohol misuse. Mr Maynard agreed to continue working with Dyfodol in the community. Mr Maynard was given information on the risks associated with taking drugs, including overdose.
20. On 19 April, Mr Maynard attended court. He was convicted and sentenced to 26 weeks in prison. On 22 April, Mr Maynard requested a prescription of mirtazapine (an antidepressant). Staff added him to a waiting list to be reassessed as he had not taken mirtazapine for over a month. (On 26 April, a GP prescribed him mirtazapine.)
21. The following day, Mr Maynard asked to see a dentist for new dentures as he did not have any at the time. He stated that this had affected his confidence and made him feel depressed. He was put on a waiting list. Mr Maynard saw the substance misuse support worker the same day who noted no concerns.
22. On 24 April, an officer was allocated as Mr Maynard's prison offender manager (POM). He had known Mr Maynard for several years due to previous sentences. Mr Maynard queried whether he was eligible for early release. The POM agreed to find out. On 3 May, Mr Maynard asked to see a dentist again. Healthcare staff sent another request to the dentist.

23. On 9 May, the substance misuse support worker asked Mr Maynard if he wanted to engage in any intervention work, which he declined. Mr Maynard also saw a mental health nurse. He said he did not know why he had been added to a waiting list to see the mental health team. He was removed from the waiting list and encouraged to contact healthcare if he had any concerns.
24. On 15 May, Mr Maynard was given another monthly Bupal injection. On 18 May, Mr Maynard saw his key worker. (Key workers provide prisoners with an allocated officer that they can meet regularly to discuss how they are and any day-to-day issues they would like to address.) Mr Maynard did not raise any significant issues or concerns.
25. On 23 May, Mr Maynard was released from Swansea.

Pre-release planning

26. On 7 May, Mr Maynard saw a resettlement probation practitioner for a resettlement interview. Mr Maynard told him that he would be homeless upon release. The resettlement probation practitioner agreed to refer him for support with completing a homelessness referral and complete a referral to the Department for Work and Pensions (DWP) to assist with his benefit payments. He told the resettlement probation practitioner that he was working with the substance misuse team and receiving medication to support his mental health needs.
27. On 8 May, Mr Maynard's POM emailed his community offender manager (COM), stating that he was eligible for release under the End of Custody Supervised Licence (ECSL) scheme. (This allowed prisoners to be released up to 70 days early from 23 May 2024 to ease overcrowding in prisons.) Mr Maynard's new release date was 23 May.
28. On the same day, the COM requested additional licence conditions (including drug testing) be added to Mr Maynard's licence to address his substance misuse issues and offending behaviour.
29. On 10 May, Mr Maynard's COM spoke to the Centralised Operational Resettlement, Referral and Evaluation hub (CORRE - a central team in probation that assist with referrals to services and interventions) about Mr Maynard. On 15 May, a resettlement probation practitioner gave Mr Maynard his community substance misuse appointment for 24 May at 9.00am. CORRE completed a sentence plan on 16 May. This needed to take place before any homelessness applications could be made for Mr Maynard.
30. On 20 May, a GP prescribed Mr Maynard a week's worth of mirtazapine, to be given to him on 23 May before he was released. On 21 May, Mr Maynard saw a Forward Trust worker (substance misuse service) to complete a homelessness referral to the local authority, which was sent on the same day. Mr Maynard's COM also referred him to St Giles Trust for one to one wellbeing sessions in the community for support around resilience, coping with challenges and overcoming barriers. A telephone appointment with them was arranged for 31 May.
32. On 22 May, a resettlement probation practitioner saw Mr Maynard to complete a release plan. She told him that he would have a lower tolerance to drugs when

released and discussed the risk of overdose and risks associated with combining different drugs, as well as nitazene awareness. The resettlement probation practitioner also told Mr Maynard how to administer naloxone (used to reverse the effects of an opioid overdose) and advised him to take it on release. Mr Maynard told her that he hoped to remain on his medication, sort out his benefits and communicate more with probation and the community drug and alcohol service. She gave Mr Maynard a copy of his community substance misuse appointment.

31. Mr Maynard was instructed to attend Swansea probation office on 23 May immediately after his release. On 23 May, Mr Maynard was released from Swansea with a naloxone kit.

Post-release management from HMP Swansea

32. On 23 May, Mr Maynard attended his initial probation appointment with the COM as required at 10.00am. She noted that Mr Maynard was familiar with probation due to his extensive offending history. Mr Maynard was aware of his licence conditions and drug testing requirement.
33. The COM told the investigator that Mr Maynard presented well during his initial appointment, with no evidence that he was under the influence of drugs or alcohol. Mr Maynard told her that he was experiencing some relationship issues.
34. On the day of his release, a homelessness caseworker emailed the COM to confirm that the local authority had placed Mr Maynard in temporary accommodation in a hotel. Mr Maynard went to the hotel by 4.00pm. He had no confirmed move out date.
35. Mr Maynard did not attend his initial substance misuse appointment on 24 May. He attended on 25 May and staff recorded that he had 'blue around his mouth', which raised concerns about possible drug use. He told substance misuse staff that he was well. Due to the bank holiday, he agreed to attend another appointment on 28 May. Mr Maynard was scheduled to see the COM for his next probation appointment on 30 May.

Circumstances of Mr Maynard's death

36. According to the post-mortem report, on 24 May, members of the public alerted police to Mr Maynard as he had a cut above his eye and was incoherent. Mr Maynard would not engage with the police and refused to attend hospital. They took him to his mother's address.
37. That evening and throughout the next day, Mr Maynard took drugs with his friends and consumed alcohol. He fell asleep in his friend's car, while his friends had gone inside their address. His friends later found Mr Maynard unresponsive in the back of the car and called an ambulance. At 5.56pm, paramedics confirmed that Mr Maynard had died.

Post-mortem report

38. The post-mortem report concluded that Mr Maynard died from combined drug toxicity. Toxicological tests identified the presence of cocaine, alprazolam (a sedative not prescribed in the UK), bromazepam (an illicit sedative), mirtazapine, pregabalin (used to treat epilepsy, anxiety and nerve pain), promethazine and buprenorphine (used to treat opioid misuse) and synthetic cannabinoids.

Inquest

39. At the inquest held on 27 March 2025, the Coroner concluded that Mr Maynard's death was drug related.

Findings

Substance misuse support

40. Before Mr Maynard was released from Swansea, staff gave him a naloxone kit and told him about his reduced tolerance and the dangers of overdose. He was also given an appointment to attend community drug services. Post-release, the COM put appropriate measures in place to address Mr Maynard's substance misuse issues. She included addressing his drug and alcohol issues, engaging with community drug and alcohol services and drug testing as conditions of his licence.
41. Mr Maynard's drug key worker told the COM that Mr Maynard attended the community substance misuse service on 25 May, following a missed appointment. However, he died later that day.
42. Mr Maynard received appropriate substance misuse support both pre and post release.

Accommodation

43. Mr Maynard was appropriately referred to the local authority for accommodation before he was released. The local authority offered Mr Maynard temporary accommodation which he attended on the day of his release.

Adrian Usher
Prisons and Probation Ombudsman

September 2025

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