Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alexander Boy, on 13 April 2025, following his release from HMP Wandsworth

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

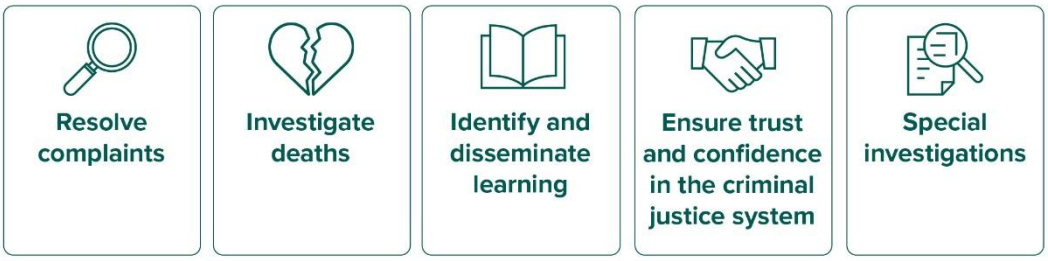
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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 HMPPS in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic process failures.

4. Mr Alexander Boy died on 13 April 2025, following his release from HMP Wandsworth on 31 March. His cause of death was recorded as acute cardiac failure caused by cocaine toxicity. Mr Boy was 30 years old. We offer our condolences to his family and friends.

5. Mr Boy spent around five weeks in prison. He was appropriately referred to community drug and alcohol services on release and engaged with them before his death. Probation staff recorded positive interactions with Mr Boy following his release and he appeared to be committed to living drug and alcohol free. We are satisfied that probation staff engaged appropriately with Mr Boy and did all they could to support his substance use issues.

The Investigation Process

6. We were informed of Mr Boy's death on 16 April 2025.

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

8. We informed HM Coroner for Kent of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

9. The Ombudsman's office contacted Mr Boy's sister to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Boy's sister asked why Mr Boy was fitted with a GPS tag on release from prison rather than an alcohol monitoring tag. She asked about a drugs test that Mr Boy took following release and why she was not initially considered the next of kin.

10. Mr Boy's sister received a copy of the initial report. She raised a number of issues, that did not impact on the factual accuracy of our investigation, that we have responded to in separate correspondence.

11. The prison also received a copy of the report and asked that we clarified the tagging officer is not an employee of HMP Wandsworth.

Background Information

HMP Wandsworth

12. HMP Wandsworth is a local category B and C prison in London. It holds men in eight residential wings. Oxleas NHS Foundation Trust provides physical and mental healthcare services at the prison. There is 24-hour healthcare and the mental health team are contracted throughout this time.

Probation Service

13. The Probation Service work with all individuals over 18 years of age subject to custodial and community sentences. (Children under 18 are managed by the local Youth Offending Team.) 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.

Key Events

14. On 24 February 2025, Mr Alexander Boy was convicted of assaulting an emergency worker and sentenced to three months in prison. He had been to prison before. Mr Boy spent all of the custodial part of his sentence at HMP Wandsworth.

15. Mr Boy was diagnosed with schizophrenia and was prescribed quetiapine (an antipsychotic). He had a history of alcohol use, which was often linked to his offending behaviour, and also told prison staff that he had previously used drugs. Prison staff referred Mr Boy to Change Grow Live (CGL, a provider of drug and alcohol support services in prison and the community).

16. On 18 March, Mr Boy attended a CGL assessment. Staff recorded that he expressed a lack of interest in the process and said that he found the meeting unproductive.

17. On 20 March, Mr Boy's community offender manager (COM) submitted a referral for Community Accommodation Service Tier 3 accommodation (CAS3, providing temporary accommodation for up to 12 weeks for individuals leaving prison who are at risk of homelessness). Mr Boy was allocated accommodation before his release.

18. On the same day, Mr Boy told staff that he was now happy to engage with CGL. He said that he had stopped taking his antipsychotic medication in prison but would now restart the prescription.

19. On 31 March, Mr Boy was released from prison on licence. His licence conditions included for him to wear an alcohol monitoring tag (to track an individual's alcohol consumption by measuring sweat for alcohol levels), to refrain from drinking alcohol and to engage with CGL. Healthcare staff arranged for Mr Boy's prescription to continue on release.

20. Before his release, a tagging officer (this is not a prison process and is an outsourced service) fitted Mr Boy with a GPS tag (which monitors the individual's location), rather than an alcohol monitoring tag, having seemingly mixed him up with another prisoner.

Post Release

21. On 31 March, Mr Boy attended his release appointment with his COM and told her that the wrong tag had been fitted. The COM noted that he was fully aware that he could not drink alcohol and that he had various appointments over the following week that he would attend. After the meeting, the COM contacted the Electronic Monitoring Service (EMS) to highlight the mistake with Mr Boy's tag and to ask for it to be rectified. EMS arranged for an alcohol tag to be fitted that night. Due to contract restrictions with the GPS tag provider, they could not visit a private residence to remove that tag and it was therefore arranged for them to remove the GPS tag at Mr Boy's next probation appointment (on 8 April).

22. On the same day, Mr Boy attended an initial appointment with CGL. He moved into his CAS3 accommodation and completed their induction. In the evening, Serco staff visited to fit an alcohol monitoring tag.

23. On 2 April, the COM spoke to Mr Boy on the telephone and noted that he seemed positive. Mr Boy said that he had registered with a GP, was continuing to take his medication and that his mental health was “really well”. He said that his appointment with CGL went very well.

24. On 8 April, Mr Boy attended an appointment at the probation office, after which his GPS tag was removed. Mr Boy gave a drug sample which was sent off for testing. (The results were not available until after Mr Boy’s death and later came back as negative.) Mr Boy said that drugs were not an issue for him but that alcohol was. He said that he was currently abstinent from alcohol and planned to remain so after his licence expiry date. Mr Boy spoke positively about the effects that sobriety had on his lifestyle and relationships, and said that his mental health remained well.

25. On the same day, Mr Boy completed a telephone appointment with CGL. (This appointment would usually be in-person, but was completed over the telephone due to renovation works at the CGL office.)

26. On 9 April, the COM spoke to Mr Boy on the telephone. She noted that he sounded positive, confirmed his engagement with CGL and said that he had started attending a gym. Mr Boy said that his mental and physical health were good and that he felt positive for the future. He said that he had had a job interview and had another later in the week.

Circumstances of Mr Boy’s death

27. On 14 April, Mr Boy was found deceased in his CAS3 property, after neighbours raised concerns. Police estimated that he might have died the previous day, although his exact time and date of death is uncertain. Police noted that they found drugs in the property.

28. Mr Boy’s had named his step-father as next of kin, and the police therefore notified him of the death.

Post-mortem report

29. The post-mortem examination concluded that the cause of death was acute cardiac failure due to cocaine toxicity.

Findings

30. Mr Boy had a history of alcohol use and had also previously used drugs. During his short time at Wandsworth, he seemingly remained drug and alcohol free. While he engaged poorly with CGL at his initial assessment, Mr Boy became more positive about working with them and engaged fully following his release.

31. As well as working with CGL following his release, Mr Boy engaged positively with his probation appointments and appeared to be progressing well. Staff who had contact with him after his release had no suspicions that he was using alcohol or drugs (and the results of the drug test came back negative after his death). We are satisfied that prison and probation staff took appropriate action to support Mr Boy to remain drug and alcohol free.

32. An error by the tagging officer on the day of his release meant that Mr Boy was mistakenly fitted with a GPS tag rather than an alcohol monitoring tag. Mr Boy's COM took immediate action when Mr Boy highlighted the mistake, and the correct tag was fitted that same day. While this appears to be a case of human error, the Governor will want to ensure that there are appropriate systems in place to quality assure the fitting of monitoring tags ahead of release.

Inquest

33. The inquest into Mr Boy's death concluded on 10 December 2025 and concluded that his death was drug related.

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

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100