

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Jonathan Young, a resident at The Pines Approved Premises, Bournemouth, on 11 September 2019**

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

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Jonathan Young died on 11 September 2019, of multi-organ failure and cardiac arrest due to alcohol intoxication, at The Pines Approved Premises (AP), Bournemouth. He was 36 years old. I offer my condolences to Mr Young's family and friends.

Mr Young's offending behaviour was linked to his use of alcohol. He failed to comply with the AP's rules about the use of alcohol. He also failed to comply with a key licence condition to attend a substance misuse service, the aim of which was to help prevent a relapse and reduce the risk of reoffending.

I acknowledge that probation staff tried hard to persuade Mr Young to engage with the substance misuse service and that their intentions were to improve his long-term prospects. However, I am concerned that the delay in taking action in response to his non-compliance may have contributed to raising his risk of relapse. I do not know whether earlier action would have changed the outcome for Mr Young.

I am also concerned that some of the staff responsible for Mr Young's management felt inadequately supported after his sudden and unexpected death. I consider that, in the event of the death of a resident, it would be valuable to hold joint debrief meetings between AP staff and their colleagues in the probation office responsible for the resident's management.

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

**Sue McAllister CB**  
**Prisons and Probation Ombudsman**

**June 2020**

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# Summary

## Events

1. Mr Jonathan Young was a high-risk offender who had been convicted of a sexual offence and sentenced to 22 months in prison. He had a history of substance misuse and his offence had been committed while under the influence of alcohol.
2. Mr Young was released from prison on licence on 15 May 2019 and arrived at The Pines Approved Premises (AP) the same day. He admitted that he had drunk alcohol on the way there. Mr Young's licence conditions included a requirement to attend Addaction, a substance misuse support service, to help prevent a relapse into problematic drinking. He was also forbidden from drinking alcohol and the AP's rules did not allow alcohol in the building.
3. Mr Young did not settle well. He often slept during the day and remained awake at night. He failed to attend mandatory residents' meetings and despite consistent encouragement, he resisted attending Addaction. On 23 May, he appeared to be under the influence of a substance and on 21 May, a breath test was positive for alcohol. In August and September, Mr Young drank alcohol several times.
4. On the morning of 9 September, after two successive days of heavy drinking, the manager of The Pines withdrew Mr Young's place and the offender management team began to consider enforcement action. Mr Young did not know this.
5. At 3.19pm, that afternoon, staff found Mr Young in his room, unresponsive. They attempted to resuscitate him and he was admitted to hospital. Mr Young did not recover and died on 11 September.

## Findings

6. Appropriate preparation was made for Mr Young's release and he was inducted well when he arrived at The Pines.
7. Although staff recorded Mr Young's alcohol use and informally warned him of the consequences of further breaches of the AP's rules and his personal contract not to drink alcohol, there was a significant delay in taking formal action.
8. Mr Young's offence was linked to his use of alcohol and the licence conditions to attend Addaction were put in place as a preventative measure to help him to seek support and minimise his risk of relapse and reoffending. He was expected to attend Addaction within a week of his release, but did not do so until 12 July and he did not actively engage with the service until he attended a drop-in session on 2 September. He then failed to attend an assessment arranged for 5 September. Although his offender managers and supervisors often encouraged him to attend and eventually issued a formal warning on 28 September, we consider that they should have taken enforcement action sooner.
9. The manager of The Pines offered support to AP staff after the emergency response and Mr Young's death. However, the probation office offender managers felt inadequately supported.

10. Given that Mr Young was jointly managed by staff at The Pines and offender managers based at the Weymouth Probation Office and his supervision had not been straightforward, it would have been helpful to hold a team debrief to discuss any learning points about his management.
11. It is unfortunate that staff did not have the full contact details for Mr Young's next of kin, but Mr Young had not cooperated with the many attempts by his keyworker to obtain this information.

## **Recommendations**

- The manager of The Pines should ensure that, in line with national instructions, prompt action is taken when a resident repeatedly breaches the approved premises' rules.
- The Deputy Director of the South West & South Central Division of the National Probation Service should ensure that offenders are supervised in line with their risk management plans and that licence conditions are promptly enforced.
- The Manager of the Weymouth Probation Office should ensure that after the death of an offender, staff involved in their supervision are offered appropriate and timely support.
- The manager of The Pines and the manager of Weymouth Probation Office should hold a joint debrief session for staff in the event of a sudden and unexpected death of a resident.

## The Investigation Process

12. The investigator issued notices to staff and residents at The Pines Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator visited The Pines on 1 October. She had a meeting with the manager and the Approved Premises Area Manager and obtained copies of relevant extracts from Mr Young's personal and probation records.
14. The investigator returned to The Pines on 25 October and interviewed six members of staff. On 28 November, she had an informal telephone conversation with one of the residential workers.
15. We informed HM Coroner for the County of Dorset of the investigation. She gave us the cause of Mr Young's death. We have sent the coroner a copy of this report.
16. The Ombudsman's family liaison officer wrote to Mr Young's mother to explain the investigation and to ask if she had any matters for the investigation to consider. Mr Young's sister helped her mother to respond. They were concerned about the monitoring of Mr Young and communication between the Approved Premises team and his probation officer. They felt that staff had not noticed problems and changes in his behaviour and that the policies and procedures had failed him. They also thought that staff might not have been aware that Mr Young sometimes made telephone calls to his sister in the early hours of the morning, while intoxicated, and they questioned whether staff responded appropriately when they found him unresponsive.
17. We have addressed these issues in this report.
18. Mr Young's mother received a copy of our initial report and this was shared with his sister. They raised several issues and concerns that did not impact on the factual accuracy of this report. However, an additional paragraph has been added (paragraph 95) and the remaining issues have been addressed through separate correspondence.
19. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted our recommendations.

## Background Information

### The Pines Approved Premises (AP)

20. Approved premises (formerly known as probation hostels) mostly accommodate offenders released from prison on licence. Their purpose is to provide an enhanced level of residential supervision in the community as well as a supportive and structured environment to reduce the likelihood of further offending.
21. The Pines Approved Premises in Bournemouth has 13 rooms and can accommodate up to 16 men. (At the time of Mr Young's death, there were 11.) All are high risk, with a mix of different types of offending, but occasionally they take a medium risk offender. The standard length of stay is 12 weeks. Every resident attends an induction session and signs to say that they understand the rules, including that they must not bring drugs or alcohol into the AP. Each resident has a key worker to oversee their progress and well-being, and to ensure that they adhere to their individual licence conditions and the AP's rules. They also have an offender manager (probation officer).
22. The Pines operates a curfew between 11.00pm and 6.00am, when all residents are expected to be on the premises. Residents who are considered to be at risk of drug or alcohol misuse are routinely tested.
23. Residents are responsible for their own health. Mr Young was registered with a GP and was receiving treatment for depression.

### Previous deaths at The Pines

24. There were no deaths at The Pines in the two years before Mr Young's death. The previous death in April 2016 was self-inflicted.

## Key Events

25. On 26 October 2018, Mr Jonathan Young was convicted of sexual assault. On 5 November 2018, he was sentenced to 22 months imprisonment. This and previous offences were committed under the influence of alcohol (and in some instances drugs). Mr Young had a history of substance misuse and detoxified from alcohol while in prison.

### Arrangements for release from prison

26. As a high-risk offender, Mr Young was managed under the multi-agency public protection arrangements (MAPPA - for violent and sexual offenders). In preparation for his release from prison, his offender manager (probation officer) and offender supervisor identified his risks. They concluded that these were likely to be greatest with excessive use of alcohol. However, the risk would be reduced if he lived in Approved Premises, as it would provide settled accommodation and monitoring by way of sign-ins, curfews and keyworker support to address his needs. The manager of The Pines and Mr Young's allocated keyworker attended a MAPPA meeting to discuss managing his risks.
27. It was noted in Mr Young's records that if he used alcohol on release, consideration would be given to increasing drug and alcohol testing and his engagement with Addaction (a substance misuse support service), as well as increasing sign-ins and frequency of supervision. If these interventions failed, licence warnings might be issued and if the problem persisted, consideration would be given to revoking his licence and recalling him to prison.

### Arrival at The Pines

28. On 15 May 2019, Mr Young was released from HMP Channings Wood, on licence. Arrangements had been made for him to stay at The Pines for three months until 7 August. Mr Young's licence conditions included reporting to staff every day at 12.30pm and a daily curfew between 9.00pm and 7.00am. There were also two separate conditions relating to Addaction - the first was to attend as required by his supervising officer for drug tests, and the other to attend to address his dependency on, or propensity to misuse a controlled drug.
29. Mr Young arrived at The Pines 90 minutes late and said he had missed a train connection. His allocated keyworker held an initial induction meeting in which she explained Mr Young's licence conditions and the AP rules. She also told him that he would be on a 'zero-alcohol' contract (a MAPPA requirement), meaning that he was not allowed to drink alcohol. During the meeting, Mr Young said that he had mental health problems which had been managed with support from his GP and that he planned to register with a local GP. Mr Young appeared to be unclear about the rules and his appointments, so his keyworker agreed to give him extra support for at least a week. Mr Young signed documents to confirm that he understood and would comply with all the rules.
30. Although there were no obvious signs of alcohol use, his keyworker mentioned that Mr Young might be tested that evening and encouraged him to tell her if he had had a drink. He admitted that he had drunk a can of alcohol about three hours earlier.

31. The next day, Mr Young and his keyworker completed a wellbeing assessment. They discussed his physical and mental health and his past substance misuse. Thereafter, he had weekly one to one meetings with his keyworker, additional meetings, as required, and offender management supervision with his offender manager and offender supervisor.
32. Throughout Mr Young's time at The Pines, he was forgetful and spent a lot of time sleeping in his room, mostly during the day, and staying awake at night. There were complaints of noise from other residents. His keyworker and offender manager discussed this with him and he attributed this to a heavy dose of medication. Mr Young failed to attend many of the mandatory residents' meetings and staff would help him to remember dates by writing them on slips, leaving notes under his door, or going to his room to remind him. Other residents would help by booking his evening meals.
33. There were frequent discussions about Mr Young's mental health. Probation staff referred him to mental health support services and encouraged him to engage with relevant groups, but he found it difficult to access support as there was a lack of clarity about his diagnosis, treatment and who should be responsible for leading on his mental health.
34. At 7.34pm on 23 May, Mr Young had a negative alcohol test. Mr Young's room was directly above the staff office. At 10.50pm, staff heard a bang and went to his room to check on him. His speech was slurred and his eyes were moving in different directions and he denied there had been a noise.
35. During meetings on 24 and 29 May, his keyworker and offender manager encouraged Mr Young to attend Addaction and gave him the contact details and drop-in times. He told them that he had no urge to drink and he had been to the pub a couple of times and had drunk water.
36. On 30 May, Mr Young's offender manager contacted Addaction, who said that as Mr Young had not attended within a week of his release, they had closed his case. She realised that, due to an oversight on her part, she had not informed Mr Young of this deadline, but Addaction agreed to reopen his case if he attended a drop-in session.
37. On 4 June, Mr Young's keyworker reminded him to attend Addaction that week and arranged for a discussion on how to remember his commitments.
38. At a meeting on 6 June, Mr Young's keyworker and offender manager discussed his non-attendance at mandatory residents' meetings and Addaction. Mr Young asked why he had to go, as he had detoxified in prison and they reiterated that it was a licence condition and important for support. They praised him for not using alcohol and avoiding lapses and set a deadline for him to attend by 14 June. Mr Young said that his mental health was "really bad" and "worse than before". His offender manager confirmed that his GP had made a referral to the community mental health team (CMHT). (The CMHT later rejected the referral on the basis that Mr Young did not meet their criteria, or have a serious mental illness. They signposted Mr Young to other services to manage his anxiety and depression.)

39. Probation staff discussed whether Mr Young's lethargy and sleep patterns were ingrained learned behaviour to cope with avoiding drugs and alcohol. His offender supervisor spoke to Mr Young's GP, who said that his medication was unlikely to make him sleepy and it was probably a coping mechanism.
40. On 13 June, Mr Young said he would only attend Addaction if he was driven there and that he had not left The Pines as he was having a bad week.
41. At a meeting on 17 June, Mr Young reported that his mental health was still poor and he had continued to isolate himself. His offender supervisor reminded him that managing his mental health was critical to remaining abstinent from alcohol, as his poor mental health had previously been a trigger for his alcohol use.
42. During the meeting, when told he would be moved to a double room, Mr Young instantly became angry and threatened to get sectioned under the Mental Health Act, imprisoned or homeless. He was advised to see his GP and, if there was a medical reason why he could not share, they would consider it. Immediately after the meeting, Mr Young went to his GP and said that he was suicidal. He was therefore allowed to remain in a single room. The next day he self-referred to two wellbeing and recovery services.
43. During the evening of 21 June, staff smelt alcohol on Mr Young's breath and a test was positive. His offender manager held a meeting on 26 June, to discuss the test result and his zero-alcohol contract. Mr Young said he had had a couple of cans of drink due to having a bad day and it took him out of the headspace he was in, but he maintained that he was not drunk. His offender manager explained that he needed to demonstrate that he was addressing his alcohol use and he was at risk of being recalled to prison if there was a recurrence. She told him to attend Addaction and Mr Young agreed to do so.
44. On 4 July, Mr Young's offender supervisor again reminded him of the benefits of Addaction's support service and that it was a licence condition. At first, he argued and then said he would go if she drove him there. She replied that it was reasonable for him to walk as he had no mobility issues and that he might receive a warning if he failed to attend within the next week.
45. On 9 July, Mr Young's offender manager noted that she would issue a formal warning if Mr Young did not attend Addaction by 12 July. Later that day, Mr Young telephoned her from the Addaction office. The receptionist had questioned why he was attending as he had said that he had stopped drinking. The offender manager explained to the receptionist that Mr Young needed to develop strategies to prevent relapsing. The receptionist gave Mr Young details of their aftercare groups. (Afterwards, in a telephone conversation, Mr Young said he was reluctant to attend as he felt anxiety in groups.)
46. On 12 July, the offender manager asked the manager of The Pines if he would consider extending Mr Young's stay at The Pines beyond 7 August, while they arranged permanent accommodation. (There had been difficulty finding appropriate housing as Mr Young was subject to an exclusion zone and, due to the nature of his offence, they were unable to place him in properties with vulnerable women.)

47. Between 12 July and 8 August, email exchanges reflected The Pines manager's concern that they had spoken to Mr Young several times about his lack of engagement and failure to comply with the rules.
48. His offender manager and offender supervisor thought Mr Young was very likely to return to drinking if they were unable to find accommodation, as this was how he had coped before, and they referred him for a place in a dry house to support his continued abstinence. On 8 August, it was agreed that he could stay at The Pines on a day by day basis while there was a vacancy, but he would have to leave at short notice if his place was required for an agreed admission. Mr Young's GP requested priority for his housing needs due to his significant mental health difficulties.
49. Mr Young failed to attend a meeting with his offender manager and offender supervisor on 19 August. His offender manager sent a first warning letter to The Pines and it was issued to Mr Young on 20 August.
50. At 10.17pm on 23 August, Mr Young left the building without signing out and returned at 10.22pm. During checks at 11.00pm and midnight, he appeared to be under the influence of alcohol and staff noticed a can of cider in his room.
51. On 25 August, Mr Young returned to The Pines just after 7.00pm. One of the residential workers asked him to take an alcohol test. He tried three times, but they could not obtain a reading and he then admitted that he had drunk a can and a half of cider. A bag search revealed five further cans of cider and Mr Young became irate when told he could not have them. He said they were going to send him back to prison and he stormed out of the building.
52. Shortly afterwards, another resident reported that he had seen Mr Young locally and he had been drunk and abusive. Mr Young returned at 9.02pm, and was obviously drunk. Staff confiscated another can of cider in his bag. He walked out again and returned at 9.40pm, very drunk. At 11.00pm, a further three unopened cans of alcohol were found in his room. The next day, another resident disclosed that Mr Young had been drinking alcohol every day. (It was noted that he had not been tested for alcohol since 25 July.)
53. On 27 August, Mr Young was again under the influence of alcohol. A breath test registered 77. (The threshold for drink driving is 0.35 and the approved premises threshold is 0.5.) As there was a strong smell of cannabis, staff asked Mr Young to take a drug test. This was positive for THC (the main psychoactive compound in cannabis). Mr Young claimed he had smoked a bag of CBD (the non-psychoactive element) and staff told him that this would not have given a positive reading for THC.
54. On 28 August, Mr Young's offender manager consulted a Senior Probation Officer about Mr Young's increasing risk of a complete relapse into drinking and questioned whether they needed to consider other enforcement action.
55. Later that day, Mr Young's offender manager held a teleconference with Mr Young and his keyworker. Mr Young told his offender manager that he had been drinking to calm his anxiety and once he had started, he had had a few cans. His offender manager informed him that he could stay at The Pines on a weekly

basis provided his behaviour improved and there were no further incidents of drinking. She added that because of his drinking, attending Addaction was an enforceable requirement and he must attend by 30 August. She informed him that he was being issued with a Senior Probation Officer (SPO) warning and read the letter to him. It set out his failure to comply with key licence requirements and informed him that the Probation Service would follow enforcement procedures and that he risked losing his place and being recalled to prison if he failed to adhere to his licence conditions. Mr Young's keyworker, who facilitated the meeting, agreed to help Mr Young with telephone calls to the CMHT and his GP.

56. On 29 August, The Pines manager handed the warning letter to Mr Young, explained the contents and informed him that a repeat of recent behaviour would lead to his place being withdrawn.
57. One of the Addaction team telephoned Mr Young's offender manager on 2 September, to say that Mr Young had attended the drop-in session that day. He had admitted to binge drinking once a month and had booked an assessment and care plan for 5 September.
58. Mr Young did not attend on 5 September, despite a reminder two hours before the appointment. His keyworker informed him that if he failed to rearrange the assessment appointment before 10 September, enforcement action would be taken. Mr Young made a new appointment for 12 September.

#### **7 and 8 September**

59. On 7 September, Mr Young left The Pines after his curfew and returned at 11.05pm. A staff member noted that he appeared to be under the influence and smelt of alcohol, but did not test him as she felt it was more important to get him to bed. During room checks at around 3.00am, she noticed half a bottle of vodka in Mr Young's room. Shortly afterwards, he went downstairs, clearly intoxicated, staggering and speaking erratically. One of the staff escorted him back to his room and persuaded him to hand over the alcohol.
60. At 6.50pm on 8 September, Mr Young was asked to take an alcohol test. He initially refused and said that he had had alcohol when he woke up that morning. After a few failed attempts, a high reading of 98 was recorded.
61. At 7.50pm, Mr Young asked for his medication (amitriptyline - for depression and anxiety). Given his earlier intoxication and high alcohol reading, staff sought medical advice from the NHS helpline. A doctor advised that he should not be given the medication as it would dangerously increase sedation. However, if he struggled to get through the night, they could give him a lower dose. At 10.15pm, Mr Young went down to the office, demanding his medication. He was still very drunk. Staff eventually took him back to his room and found three empty bottles of vodka and one nearly full. Mr Young drank one of the bottles before handing it over and became more aggressive. The staff member noticed dried vomit in his washbasin.

## Events on 9 September

62. At 12.35am on 9 September, Mr Young returned to the staff office and was given one amitriptyline tablet.
63. Just after 9.00am, The Pines manager withdrew Mr Young's place at The Pines as, despite a final warning about his alcohol use, he had been heavily intoxicated and drinking in his room during the previous two days. Mr Young's offender supervisor said she would speak to the duty senior probation officer, with a view to recalling Mr Young to prison. (Mr Young was not told of either the decision to withdraw the place, or the possibility of recall.) During the morning, various discussions took place between members of the offender management team to discuss the implications and next steps. The Pines manager agreed that Mr Young could stay at The Pines that night.
64. At 1.37pm, Mr Young went out, without signing out. He returned five minutes later, highly intoxicated and incoherent. He admitted he had been drinking vodka that morning.
65. At 3.19pm, staff heard banging above the office, which sounded like someone having a seizure. Mr Young's keyworker and two staff members immediately went to Mr Young's room and found him lying on his back, unresponsive. He did not appear to be breathing, he had a yellow pallor and his face felt very cold. Mr Young's keyworker could not find a pulse.
66. One of the staff members went to the office to call the emergency services, while another fetched a defibrillator. When they returned to the room, staff lifted Mr Young off the bed and placed him on the floor. They began cardiopulmonary resuscitation and the Ambulance Service call handler guided them through the process until the paramedics arrived. (One staff member had completed first aid training two weeks before and the other's training was also up to date. There was always at least one first aid trained member of staff on each shift.)
67. Ambulance Service records show that the telephone call was received at 3.20pm and the paramedics arrived at 3.26pm. They took Mr Young to Royal Bournemouth Hospital at 4.37pm. (After they had left, staff found half a bottle of vodka in Mr Young's room.)
68. While the emergency was taking place, the duty senior probation officer was having a case discussion with the Assistant Chief Officer. They agreed that in view of Mr Young's poor engagement with interventions, relapse into use of alcohol and his lack of motivation to address this, the likely outcome was to recall him to prison. However, they planned to see him the following day to assess his motivation for change, before taking a final decision. Immediately after the discussion, they were informed of the emergency and Mr Young's condition, so they stopped the enforcement action.
69. The next day, the police searched Mr Young's room and found three empty bottles of wine, two empty bottles of vodka and one partly empty bottle of vodka.
70. Mr Young did not recover and died in hospital on 11 September.

## Contact with Mr Young's family

71. At 9.31pm on 10 September, a hospital doctor telephoned The Pines to request the details of Mr Young's next of kin. Although staff had the name of Mr Young's sister, there were no contact details. The manager was not on site, but authorised staff to search Mr Young's room. They found a phone, but could not access any content as it required fingerprint recognition. Staff then asked the police to trace Mr Young's sister.
72. The Pines manager later telephoned the hospital for an update and was told that Mr Young was in a medically-induced coma. The hospital confirmed that they had contacted his mother and sister, who were with him.
73. The area manager for The Pines was away at the time of Mr Young's death. The area manager for the adjacent area acted on her behalf as the Probation Service family liaison officer. He unsuccessfully tried to telephone Mr Young's next of kin a number of times on 13 September. He finally made contact with Mr Young's sister and mother on 16 and 17 September, respectively. He offered condolences and support and explained the processes to be followed. He also arranged for them to visit The Pines on 18 September. He spoke to Mr Young's mother several times over the following days and visited on 1 October, to answer further questions and clarify processes.
74. The family liaison officer and The Pines manager attended Mr Young's funeral on 3 October. In line with national policy, the Probation Service contributed to the funeral expenses.

## Support for residents and staff

75. During the emergency, staff checked the welfare of other residents and kept them together, away from Mr Young's room, while the resuscitation procedures were taking place. The Pines manager subsequently held a meeting to inform residents of his death.
76. The manager spoke to the AP staff individually after the emergency response and after Mr Young's death, to offer support and he reminded them of the services of the Employee Assistance Programme.
77. The offender manager and offender supervisor had brief conversations with their managers.

## Post-mortem report

78. The report of the post-mortem examination gave the cause of Mr Young's death as multi-organ failure due to a (hypoxic) cardiac arrest caused by alcohol intoxication.

# Findings

## Management of Mr Young at The Pines

79. Mr Young's offender manager coordinated the arrangements for his place at The Pines in the months leading to his release. When Mr Young arrived, he went through the induction process and subsequent meetings were held with his keyworker and offender manager at the agreed and specified intervals. There was close liaison and frequent communication between the AP staff, offender managers at the probation office responsible for supervising him and other stakeholder agencies. Comprehensive records of information and significant interaction were kept, which gave a clear picture of events and the resulting action taken by staff.
80. Mr Young failed to comply with some of the AP rules, such as attending mandatory residents' meetings, due to self-isolation, forgetfulness and sleeping during the day. Mr Young's keyworker said that some of the residential workers felt it was due to laziness, but she thought there was a psychological block. In view of this, she gave Mr Young additional support by waking him up, reminding him of appointments and putting his name down for meals.
81. We are satisfied that the formal arrangements for Mr Young's supervision and release to The Pines were appropriate. However, he relapsed into alcohol use and this, together with the related issue of his licence conditions, are discussed below.

## *Alcohol and drug use*

82. Residents at The Pines are prohibited from taking alcohol into the premises and are required to take drug and/or alcohol tests, when asked to do so. Mr Young was on a zero-alcohol contract. Between May and July, he was tested for alcohol two or three times a month and, with the exception of a test conducted on 21 June, the outcomes were negative. However, tests on 27 August and 8 September showed high alcohol readings. Four drug tests in June were all negative, but one on 27 August was positive for a cannabis compound.
83. Section 83 of Probation Instruction (PI) 32/14, about approved premises, states that the aim of some rules is to help residents live an ordered life, rather than to directly manage their risk, but repeated breaches of even minor rules might indicate underlying attitudes which can give concern over risk. It also says that offender managers should react quickly, appropriately and consistently on non-compliance with the rules. This is reinforced in the *Approved Premises Manual*, which indicates that signs of substance misuse, or evidence of alcohol consumption on the premises should not necessarily be grounds for breach action, but this should always be considered and there should be appropriate enforcement action.
84. The Pines manager explained that they had tried to manage Mr Young's drinking as withdrawal of his place might have increased his risk of returning to street drinking.

85. Mr Young's offender manager said that probation staff would not necessarily recall an offender to prison immediately they had a drink, particularly if there were no significant management issues. They prefer to give continued encouragement to seek support. She felt that his situation might have become worse if he had returned to prison without such support and was then eventually be released without accommodation. However, she admitted that they might have acted differently if Mr Young's place at The Pines had been withdrawn, as it would have increased his risk of relapse.
86. The approach to Mr Young's consumption of alcohol while resident at The Pines appeared to be lenience and encouragement to access support services. We acknowledge that the rationale for not taking immediate action was to improve Mr Young's long-term prospects in the community. However, we are concerned that the lack of early formal warnings, or implementation of the contingency plans noted when planning his release (such as increasing testing, sign-ins and supervision by staff) was not in his best interests and allowed him to undermine the rules about alcohol on the premises, as well as his own contract not to consume alcohol. We make the following recommendation:

**The manager of The Pines should ensure that, in line with national instructions, prompt action is taken when a resident repeatedly breaches the approved premises' rules.**

#### *Enforcement of licence conditions*

87. Mr Young had two specific licence conditions to engage with Addaction and, before he left prison, arrangements were made for him to access their support. (The licence specifically referred to drugs, but probation staff recognised that this included alcohol use.) No timescale for attendance was given on the licence, but Addaction later made clear that they had expected him to attend for assessment within a week of release.
88. At interview, Mr Young's keyworker explained that the process for managing non-adherence to rules or licence conditions was that the keyworker would report the information to Mr Young's offender manager and the offender management team were responsible for making decisions on enforcement. She told the investigator that there were several levels of warning, beginning with an approved premises warning, then a Senior Probation Officer warning and ultimately an Assistant Chief Officer warning. An offender did not have to go through each level before recall was considered, this could be done at any time.
89. Despite repeated reminders, encouragement and attempts to motivate him, Mr Young did not attend Addaction until 9 July, eight weeks after he arrived at The Pines. After this brief visit (in which there had been no substantive engagement as his case had been closed due to non-attendance), he did not attend again for eight weeks (2 September). He then failed to attend an assessment on 5 September.
90. Mr Young's offender supervisor said they often explained to Mr Young that although he had been abstinent, the reason for engaging with Addaction was to develop strategies to maintain this and prevent a relapse; and to learn how to resist temptation and control his emotions without turning to alcohol. However,

they had used their professional judgment in terms of enforcement, as Mr Young's priority was his mental health and he was motivated to address this. She said they had been lenient in terms of warnings to enable him to focus on this. In their discussions, Mr Young said that he had started drinking again due to anxiety and the alcohol calmed him down, but he did not give a specific reason or trigger for his anxiety.

91. Mr Young's offender manager agreed that Mr Young should have attended Addaction within the first few weeks of his arrival at The Pines, but said there was initially no evidence that he was drinking. She explained that if an offender fails to adhere to licence conditions, the offender manager would take account of their level of risk and assess whether the individual will not, or cannot comply. A slightly different approach is taken with those who cannot comply, as they try to work with them to overcome the barriers to compliance. She added that drug and alcohol services preferred users to engage voluntarily, rather than supervisors forcing them to attend.
92. Attending Addaction was planned as a fundamental and preventative measure to manage Mr Young's risk of reoffending and help him to avoid a relapse into substance misuse. Probation staff adopted a measured approach to his failure to adhere to this licence condition, to give him every opportunity to obtain substance misuse support. We recognise that this was well-intentioned, but it meant that Mr Young had started drinking again by the time he first visited Addaction; and they were unable to help him immediately as his case had been closed due to the lapse of time. While we do not wish to second-guess staff judgements, Mr Young was a high-risk offender, who had committed a sexual assault while under the influence of alcohol. We are therefore concerned that stronger enforcement action was not taken sooner when he did not comply with such an important licence condition within a reasonable timescale. We make the following recommendation:

**The Deputy Director of the South West & South Central Division of the National Probation Service should ensure that offenders are supervised in line with their risk management plans and that licence conditions are promptly enforced.**

#### **Next of kin details**

93. Residents at approved premises are required to provide next of kin details during their induction. Mr Young insisted that he wanted his sister recorded as his next of kin. At that time, he did not have a mobile phone or a written record of her telephone number, but said he would get it. Mr Young's keyworker frequently prompted Mr Young in the first few weeks after his arrival, but he avoided giving the details and she then lost sight of it. She said that it was difficult to get Mr Young to remember anything, even providing his own phone number when he bought a phone. There was no formal process to trigger reminders for this information and if a resident refused to give the details, there was nothing they could do about it.
94. We are satisfied that Mr Young's keyworker made reasonable attempts to obtain the contact details for Mr Young's next of kin. Mr Young chose not to provide their details and there was little that staff could do about this.

95. In response to the initial report, Mr Young's mother said that she had telephoned The Pines with concerns about Mr Young, but had been told that he was okay. During the investigation, the investigator spoke to a residential worker. He recalled speaking to Mr Young's mother. He could not remember the exact date and had not noted it in the records, as it was a general enquiry rather than specific concerns, but he thought it might have been around two weeks before Mr Young was first found with alcohol. He told Mr Young's mother that he could not discuss details of Mr Young's residence at The Pines, but confirmed that he was safe.

### **Support for staff**

96. The staff at The Pines felt well supported after Mr Young's death. Those at the Weymouth Probation Office felt there were only cursory references to their wellbeing and neither of them had been offered formal support. While they might not have had day to day interactions with Mr Young and were not directly involved in the emergency, we consider that the possibility of trauma due to their significant and regular contact merited the offer of support, particularly as his death was sudden and unexpected.
97. Probation staff at The Pines worked in close partnership with their colleagues at the Weymouth office to supervise Mr Young and his supervision had not been straightforward. In view of this, we believe that it would have been beneficial to hold a joint debrief session after Mr Young's death. This would have given staff the opportunity to discuss Mr Young's management and share any learning points. We make the following recommendations:

**The manager of the Weymouth Probation Office should ensure that after the death of an offender, staff involved in their supervision are offered appropriate and timely support.**

**The manager of The Pines and the manager of Weymouth Probation Office should hold a joint debrief session for staff, in the event of a sudden and unexpected death of a resident.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations