Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Baptiste, a prisoner at HMP Swaleside, on 31 October 2023

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 l 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

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 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.

Mr Christopher Baptiste died of sertraline toxicity on 31 October 2023, while a prisoner at HMP Swaleside. He was 54 years old. I offer my condolences to Mr Baptiste's family and friends.

While we cannot be certain of his motivation, there is no indication that Mr Baptiste was at increased risk of suicide and self-harm in the time before his death, or that this was a deliberate attempt to take his own life.

In the weeks before he arrived at Swaleside, Mr Baptiste was twice found under the influence of drugs. This information was not properly considered in a substance misuse assessment when he arrived at Swaleside.

Mr Baptiste was prescribed both sertraline and olanzapine (which a toxicology examination also identified at a raised level). He was required to take these medications daily in front of a nurse and, while I cannot be certain how he obtained excess quantities of each, the most likely explanation is that he diverted and hoarded them. Poor supervision of medication queues and the trading of prescription medication at Swaleside are issues that have previously been identified by HM Chief Inspector of Prisons as well as by the HMPPS Substance Misuse Group. It is important that the Governor and Head of Healthcare consider how they might better ensure that prescribed medications are harder to divert and trade.

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

Adrian Usher
Prisons and Probation Ombudsman **January 2025**

Contents

Summary

Events

1. On 16 August 2022, Mr Christopher Baptiste was remanded in custody charged with murder and taken to HMP Thameside. On 18 August 2023, Mr Baptiste was sentenced to life imprisonment. He moved to HMP Swaleside on 9 October.

2. Mr Baptiste had a long history of mental health issues, including depression, and experienced several long-term physical health issues. When he arrived at Swaleside he was examined, his health conditions noted, and he was prescribed his usual medications, including an antidepressant (sertraline). Mr Baptiste also had a long history of drug and alcohol misuse, which continued while in prison. Mr Baptiste was prescribed methadone (for opiate withdrawal) and was supported by the mental health and substance misuse teams. A few weeks before his move to Swaleside, Mr Baptiste was twice found under the influence of drugs.

3. At Swaleside, Mr Baptiste was required to collect his medication every day and take it in front of a member of healthcare staff.

4. At around 3.44pm on 31 October, prison staff found Mr Baptiste unresponsive in his cell. Despite resuscitation efforts paramedics declared Mr Baptiste had died at 4.33pm.

Findings

5. The clinical reviewer identified that the psychosocial substance misuse assessment completed at Swaleside was not of the required standard. A lack of detail and professional curiosity, as well as issues with information sharing practice, meant that the assessor did not identify that Mr Baptiste had recently used illicit drugs.

6. We do not know how Mr Baptiste obtained the quantity of sertraline that led to his death. HM Inspectorate of Prisons has previously identified poor supervision of medication queues at Swaleside, and it is possible that action taken to address this has not been effective.

7. While we cannot be certain of his motivation, there is no indication that Mr Baptiste was at increased risk of suicide and self-harm in the time before his death, or that this was a deliberate attempt to take his own life.

8. Mr Baptiste's medication in possession risk assessment was not based on a proper consideration of his history and was not properly communicated to prescribers.

9. The night before he died, an officer found Mr Baptiste in possession of a tampered vape, which might indicate that he had used or was planning to use illicit drugs. The officer did not report this or take any further action.

10. The control room operator gave incorrect information about Mr Baptiste's medical condition to the ambulance service dispatcher.

Recommendations

- The Head of Healthcare should ensure that CGL staff consider all relevant information from a prisoner's medical and prison record, either by accessing the medical record themselves, or asking a member of the healthcare team to provide this information to them.

- The Head of Healthcare should ensure that staff completing medication in-possession risk assessments consider all relevant information, including recent drug or alcohol use.

- The Governor and Head of Healthcare should ensure that suspected drug use is recorded and reported in line with local guidelines, with appropriate testing and support provided to prisoners suspected of using illicit substances.

- The Governor should ensure all discoveries are retrieved in a timely manner, adequately recorded, referred to the police as appropriate and properly stored.

The Investigation Process

11. HMPPS notified us of Mr Baptiste's death on 1 November 2023.

12. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact her. She received a letter from a prisoner who did not know Mr Baptiste but asked for a full investigation into his death.

13. The investigator visited Swaleside on 8 November. She obtained copies of relevant extracts from Mr Baptiste's prison and medical records and visited the wing where he died.

14. NHS England commissioned a clinical reviewer to review Mr Baptiste's clinical care at the prison. The investigator and clinical reviewer jointly interviewed seven prison and healthcare staff. In addition, the investigator spoke to a prison officer who worked in the control room.

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

16. The Ombudsman's office contacted Mr Baptiste's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He did not ask any specific questions.

17. Mr Baptiste's brother received a copy of the initial report. He did not identify any factual inaccuracies.

18. The prison also received a copy of the report. They did not identify any factual inaccuracies.

Background Information

HMP Swaleside

19. HMP Swaleside, on the Isle of Sheppey, is part of the long-term high security estate, predominantly holding prisoners judged to be high risk and those serving long sentences. Oxleas NHS Foundation Trust provides physical and mental healthcare services, including 24-hour nursing cover. Oxleas sub-contract Change, Grow, Live (CGL) to provide substance misuse services.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Swaleside was in September 2023. Inspectors reported that safety remained a concern. They noted that Swaleside had made real efforts to improve despite the challenges faced by the restricted regime caused by the difficulties recruiting staff.

21. Inspectors found initial reception and safety interviews were not always thorough enough to identify immediate risks and vulnerabilities. Security measures were found to be proportionate and effective but there was evidence to indicate that illicit drugs were easily available. At the previous inspection, illicit alcohol use was high, but the prison had withdrawn sugar from the prison shop because of its use in brewing alcohol and this had led to a sharp reduction in alcohol production. Inspectors found that supervision of medication queues by officers was variable and reported that they witnessed opportunities for diversion of medication.

22. Inspectors reported healthcare managers provided supportive leadership and there was good partnership working between healthcare and prison staff. However, some aspects of clinical governance were weak and did not ensure patient safety. Record keeping was found to be poor and medicines administration and regimes did not meet national guidance and some PPO recommendations had not been embedded into practice.

23. Inspectors reported that each drug recovery worker had an area of special interest on which they took the lead. High numbers of prisoners were reported to be under the influence of illicit substances and CGL saw each of them. They were all provided with harm minimisation information and encouraged to work with the team. CGL maintained a separate record system and did not contribute to the clinal record, which meant that there was no continuity or sharing of patient information. The assessments and recovery plans that inspectors reviewed met the required standard. They were individualised, updated regularly, and written collaboratively with the patient.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 30 April 2023, the IMB reported that staff shortages had had a major impact on the prison regime, which had

impacted on the wellbeing of staff and prisoners. They noted that 35% of uniform staff had less than two years' experience.

25. The Board noted deaths in custody were at very worrying levels. Staff were frustrated by their inability to implement a full regime due to staff shortages. However, it was noted that the regional and national safety teams had supported the prison to improve the situation.

Previous deaths at HMP Swaleside

26. Mr Baptiste was the 23rd prisoner to die at Swaleside since October 2020. Of the previous deaths, nine were self-inflicted, eleven were from natural causes, one drug related and one unascertained (although likely to be drug related). To the end of May 2024, there have been three more natural cause deaths. There are no significant similarities with Mr Baptiste's death in our findings in these previous investigations.

Incentives and Earned Privileges Scheme (IEP)

27. Each prison has an incentives and earned privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and wear their own clothes. There are four levels: entry, basic, standard and enhanced.

Key Events

28. On 16 August 2022, Mr Christopher Baptiste was remanded to prison charged with murder and taken to HMP Thameside. He had also breached the terms of a previous release licence, which expired on 10 April 2023. Mr Baptiste transferred to HMP Belmarsh on 17 November 2022. On 18 August 2023, he was sentenced to life imprisonment.

29. Mr Baptiste had several physical health conditions, including chronic obstructive pulmonary disease (COPD), asthma (he was prescribed an inhaler and steroids), and he was overweight. Mr Baptiste had a long history of substance misuse and was prescribed methadone (an opiate substitute).

30. Mr Baptiste self-reported a history of schizophrenia, and he was diagnosed with drug induced psychosis for which he was prescribed an anti-psychotic (olanzapine). Mr Baptiste had a history of suicidal thoughts and was prescribed an anti-depressant (sertraline). He was supported under suicide and self-harm prevention measures (known as ACCT) between 23 March and 6 April 2023. Mr Baptiste told staff that he had not been sleeping and heard voices telling him to kill himself or someone else. He was supported by the mental health team and prescribed a short course of sleeping tablets.

31. During his time in prison Mr Baptiste was charged with breaching prison discipline for brewing 'hooch' (illegal alcohol) and for being under the influence of illicit substances. On 27 August 2023, Mr Baptiste was found with 2.5 litres of hooch in his cell. On 9 September, a medical emergency was called as Mr Baptiste was under the influence of a psychoactive substance (PS - known as Spice). Two days later, his behaviour again suggested to staff that he was under the influence of an illicit substance when he was found lying naked on his cell floor. Because of his behaviour, Mr Baptiste was downgraded to the basic level of the IEP scheme for four weeks.

32. On 9 October, Mr Baptiste transferred to HMP Swaleside. At his initial health screen, a nurse noted Mr Baptiste's medical history. A GP at Swaleside reviewed Mr Baptiste and prescribed the medications to manage his physical and mental health conditions, including sertraline (100mg per day) and olanzapine (20mg per day). Mr Baptiste was referred to the mental health team and Change, Grow, Live (CGL) the substance misuse team who provide psychosocial support to prisoners.

33. A nurse completed a medication 'in possession' risk assessment (IPRA), to determine the risks associated with Mr Baptiste holding medication in his cell (rather than having daily supervised medication which he was required to take in front of a nurse). They concluded that Mr Baptiste could have medication in possession for one day; meaning that every day he should collect his medication and take it away with the expectation that he would take it as prescribed. (The exception to this was methadone, which is always supervised, and which Mr Baptiste was required to take in front of a nurse every day.) However, the assessment from the IPRA was not properly conveyed to the prescribers, and Mr Baptiste therefore had daily supervised medication.

34. On 13 October, a support worker for CGL met with Mr Baptiste. She made a summary note of Mr Baptiste's physical and mental health conditions, and his substance misuse history. She recorded that Mr Baptiste was currently stable on 40mls methadone. Mr Baptiste was allocated to a CGL case worker for a full assessment of his needs.

35. On 14 October, a nurse completed a follow-up IPRA. He concluded that Mr Baptiste could now collect seven-days' worth of medication at a time, to keep in his cell and take as prescribed. The Head of Healthcare told us that this assessment was not implemented, and Mr Baptiste continued to collect his medication each day, and was expected to take it in front of healthcare staff.

36. On 16 October, a nurse met with Mr Baptiste to complete a full mental health assessment. He noted Mr Baptiste's account of his mental health history and that Mr Baptiste said he had not used any illicit substances for around two months, since he used PS when he was at Belmarsh. The nurse assessed that Mr Baptiste was mentally stable with no signs of psychosis. It was not deemed necessary to accept Mr Baptiste onto the mental health team caseload, but he was referred to the integrated mental health team for continued psychosocial support. He noted Mr Baptiste's request to move to E Wing (the incentivised substance free living and drug recovery unit) and provided him with in-cell activities to keep him occupied.

37. Later, a case worker for CGL met with Mr Baptiste to complete a full assessment. She noted that Mr Baptiste said he had been substance free for over four years and declined psychosocial support for substance misuse but reiterated that he wanted to move to E Wing. Mr Baptiste did not disclose any physical or mental health concerns.

38. On 17 October, Mr Baptiste moved to E Wing.

39. On 22 October, an officer introduced himself to Mr Baptiste as his key worker. He recorded that Mr Baptiste said that he had no issues to raise at the time.

40. Between 24 and 31 October, Mr Baptiste made seven telephone calls which the investigator listened to. (All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample.) These calls were general conversations and Mr Baptiste said he had pains in his stomach because he was constipated. There was nothing of concern identified, although at times Mr Baptiste sounded drowsy.

41. On 29 October, Mr Baptiste told an officer that he liked being on E Wing. The officer recorded that Mr Baptiste appeared to have settled on the wing.

42. On the same day, Mr Baptiste completed a voluntary drugs test. The results were negative.

43. On the evening of 30 October, an officer found Mr Baptiste with a capsule that Mr Baptiste said he intended to use with his vape. The officer confiscated the capsule, which he told us he believed contained PS or fentanyl (a strong opioid drug used to treat severe pain). He did not record or report the incident.

Events of 31 October

44. At 8.37am, Mr Baptiste telephoned his partner; the call lasted around ten minutes. During this call, his partner asked Mr Baptiste why he had called at 1.00am the previous night. Mr Baptiste said that he did not recall making the call and that he must have "been out cold". This call was not registered on Mr Baptiste's prison call log (and was presumably therefore made on an illicitly held mobile phone). He told his partner that he wanted to go back to Belmarsh because "stuff up here is expensive" and that there were too many fights; he said he could not say anymore as the telephone call was being recorded. Mr Baptiste was coughing and said that he thought he was getting a cold.

45. During morning association, Mr Baptiste played pool with other prisoners. There was nothing recorded to suggest that he was unwell or had used any substances. At around 12.15pm, after he collected his lunch, an officer locked Mr Baptiste into his cell.

46. At around 3.44pm, an officer unlocked Mr Baptiste's cell to deliver some mail. She saw Mr Baptiste sitting on his bed but when he did not respond she went into the cell. She was unable to rouse Mr Baptiste and she shouted for assistance. Two officers, who were a very short distance away, responded. One officer radioed a code blue medical emergency (used to indicate when someone is unresponsive or not breathing). The officer in the control room contacted the Ambulance Service to request an ambulance. He incorrectly told them that Mr Baptiste was breathing.

47. A Custodial Manager (CM) and an officer also responded to the emergency code. Three officers moved Mr Baptiste to the floor. The CM started cardiopulmonary resuscitation (CPR) and an officer fetched the wing defibrillator. An officer attached the defibrillator pads to Mr Baptiste. No shock was advised, and staff continued with CPR. A short time later, a prison paramedic arrived. He asked staff to move Mr Baptiste to the landing where there was more space. Other healthcare staff responded, including a GP, and CPR continued. Paramedics arrived at 3.58pm and resuscitation efforts continued. At 4.33pm, paramedics declared that Mr Baptiste had died.

48. Staff found what they believed to be a tampered vape in Mr Baptiste's cell.

Contact with Mr Baptiste's family

49. Swaleside appointed two family liaison officers. Together with the Head of Residence, they travelled to Mr Baptiste's brother, his next of kin, to break the news of his death. They offered their condolences and ongoing support. Swaleside also contacted HMP High Down and a prison chaplain informed Mr Baptiste's son of his father's death. In line with Prison Service instructions, the prison contributed towards the costs of Mr Baptiste's funeral, which was held on 12 November.

Support for prisoners and staff

50. After Mr Baptiste's death the Head of Safety held a debrief for all staff involved in the emergency response. A further critical debrief was held on 27 November. The

staff care team and trauma risk management (TRiM) were made available to all staff.

51. The prison posted notices informing prisoners of Mr Baptiste's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Baptiste's death.

Post-mortem report

52. The pathologist concluded that, on the balance of probability, Mr Baptiste died from sertraline toxicity. Toxicology tests showed that sertraline was present at a potentially fatal level, olanzapine was present at an elevated level and methadone and paracetamol were detected. Mr Baptiste had not used any illicit substances prior to his death.

53. Mr Baptiste was never prescribed or given paracetamol at Swaleside. (He was last administered it in October 2022.)

Findings

Substance misuse support

54. The clinical reviewer found that Mr Baptiste had good support from substance misuse services for much of his time in custody. When he arrived at Swaleside, Mr Baptiste was prescribed methadone and was referred to the psychosocial team, CGL, for an assessment of his needs.

55. However, the clinical reviewer identified that the psychosocial substance misuse assessment completed at Swaleside was not of the required standard and not equivalent to that he could have expected to receive in the community. This was partly because CGL staff do not have access to the medical record (SystmOne) and rely on their own electronic recording system; something HMIP Inspectors reported on during their most recent inspection.

56. As well as this, the assessment for Mr Baptiste lacked detail, accuracy, and there was no evidence of professional curiosity, which may have influenced the care he received. CGL staff who had contact with him based their assessment on what Mr Baptiste told them. He said that he had been substance free for four years, but had they looked at his prison record, which CGL do have access to, it would have identified that Mr Baptiste had been found under the influence as recently as September 2023. The Head of Healthcare told us that there are plans to ensure CGL staff have access to the medical record, but there was no date for this to be implemented. We therefore make the following recommendation:

    The Head of Healthcare should ensure that CGL staff consider all relevant information from a prisoner's medical and prison record, either by accessing the medical record themselves, or asking a member of the healthcare team to provide this information to them.

57. The clinical reviewer made other recommendations not directly related to Mr Baptiste's death that the Head of Healthcare will wish to address.

Prescribed medications

58. The cause of Mr Baptiste's death was recorded as from sertraline toxicity. Mr Baptiste was prescribed a combination of medications (olanzapine, sertraline, and methadone) known to have a sedative effect that, as such, may cause respiratory depression. The clinical reviewer noted that Mr Baptiste was at greater risk due to his underlying COPD and weight.

59. While we cannot be certain of his motivation, there is no indication that Mr Baptiste was at increased risk of suicide and self-harm in the time before his death, or that this was a deliberate attempt to take his own life.

Medication in possession risk assessment (IPRA)

60. The IPRA assessment consists of several questions to determine whether there are any factors that might present a risk were a prisoner to hold medication in their cell. This includes questions about any recent drug or alcohol use, history of self-harm or suicide attempts, whether the prisoner has been bullied for or known to have traded

medication, and whether there are any physical or mental ill health issues that might affect their capacity to take medication as required.

61. On 9 October, a nurse concluded that Mr Baptiste was suitable to have one days' medication in his possession. However, in making this judgement, he incorrectly recorded that Mr Baptiste had not had any issues with drugs or alcohol in the previous three months. On 14 October, when a nurse reviewed the IPRA, he also did not identify that Mr Baptiste had been found under the influence as recently as 9 September and concluded that he was suitable to have seven days' medication in his possession. However, neither IPRA was actioned because the outcomes of the two assessments were not properly communicated to the dispensing team, and Mr Baptiste continued to have his medication dispensed daily, which included 100mg of sertraline, supervised by healthcare staff.

62. The Head of Healthcare has already issued a Learning Lessons Bulletin to all healthcare staff and GPs reminding them of the correct procedure to follow for IPRA outcomes. All healthcare staff are now required to communicate via an auditable task, and not a message, on the medical record system (SystmOne).

63. We also make the following recommendation:

The Head of Healthcare should ensure that staff completing medication in-possession risk assessments consider all relevant information, including recent drug or alcohol use.

Suspicion of drug use the night before Mr Baptiste died

64. Swaleside's Drug Strategy 2023 – 2024 states that the Intelligence Reporting (IR) system should be used to help gather information on all substance misuse concerns. It states that any prisoner whom staff have reason to believe has misused drugs should be referred to CGL.

65. When Mr Baptiste was discovered, an officer can be heard on bodyworn camera footage saying he was under the influence night before. In interview, the officer said that he confiscated a vape from Mr Baptiste the evening before he died, but because he did not seem under the influence and Mr Baptiste assured him it was "nothing", he did not make an entry on his prison record or take any further action. He said he did not want to penalise him, which he said could happen when being considered for parole. He said that for similar reasons he did not make an entry on the wing observation record as he was not certain Mr Baptiste was under the influence. He accepted that it was an oversight not to have submitted a security intelligence report. Any intelligence about illicit drug use should be properly recorded. We make the following recommendation:

The Governor and Head of Healthcare should ensure that suspected drug use is recorded and reported in line with local guidelines, with appropriate testing and support provided to prisoners suspected of using illicit substances.

Mental Healthcare

66. The clinical reviewer found that the assessment, monitoring and care Mr Baptiste received for his mental health throughout his time in prison was of a good standard and likely above the standard he would have received in the community. She found that a nurse completed a thorough assessment on 16 October, including detailing Mr Baptiste's mental health history and completing a care plan.

Emergency response

67. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, sets out the actions staff should take in a medical emergency. Two distinct codes are used; code blue if a person is unresponsive or not breathing, and code red if there is significant blood loss or burns. It contains mandatory instructions for Governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident, that there are no delays in calling an ambulance and must prevent any unnecessary delay in escorting ambulances and paramedics to the patient.

Requesting an ambulance

68. The investigator listened to the recorded telephone conversation between the control room and the ambulance service. When asked by the call handler if Mr Baptiste was breathing, an officer incorrectly said that he was. It is not clear that he knew for certain what Mr Baptiste's clinical condition was and could not recall during interview what was said to him. Providing the wrong or inaccurate information when requesting an emergency ambulance could have resulted in a delay. We are satisfied in this instance an ambulance was dispatched as a Category 1 emergency (the most rapid response).

69. It has been acknowledged by HMPPS nationally that policy and practice with regard to calling ambulances is not optimal. We are aware of ongoing work, commissioned by the Director General of HMPPS and in collaboration with health partners, to address the issue of calling a code blue, and control room staff immediately calling an ambulance, and being unable to answer basic questions about the prisoner's medical condition so we make no recommendation.

Evidence retrieval

70. Several members of staff referred to a tampered vape that they saw in Mr Baptiste's cell when he died. However, Swaleside were unable to provide any further information or evidence of what happened to the vape, or if it was tested for any substances. The investigator was informed on 6 March 2024, over four months after Mr Baptiste died, that staff had only just retrieved some vape capsules from Mr Baptiste's cell. Given the potential significance of this type of evidence, we draw the Governor's attention to the need to ensure all discoveries are retrieved in a timely manner, adequately recorded, referred to the police as appropriate and properly stored.

The Governor should ensure all discoveries are retrieved in a timely manner, adequately recorded, referred to the police as appropriate and properly stored.

Governor to Note

71. The toxicology identified that sertraline was present at a potentially fatal level, and olanzapine at an elevated level. Mr Baptiste was prescribed both of these medications but was required to take them at the medication hatch under the supervision of healthcare staff. An officer is also expected to supervise medication queues and the taking of medication.

72. We do not know how Mr Baptiste obtained the amounts of sertraline and olanzapine that he took before his death. One explanation is that he did not properly swallow his medication when it was issued and hoarded it in his cell to use later. He might also have traded for it with other prisoners. In their latest inspection report, HMIP reported that medication queues were poorly supervised and that there were opportunities to divert medication.

73. The Operational Implementation and Delivery Team (OIDT), part of HMPPS Substance Misuse Group, were tasked with undertaking a rapid diagnostic visit to HMP Swaleside in November 2022, following a number of substance related deaths, to support the prison. Their visit identified that prescribed medication featured highly in intelligence reporting. The OIDT recommended that Swaleside circulate regular security briefings to staff to highlight the issues and associations, regarding PS, hooch, and trading of prescribed medication. The Head of Safety said that in response, the Senior Leadership Team (SLT, attended by all functional heads including security, drug strategy and healthcare), met weekly to discuss all risks, including those relating to drug availability. He said any emerging themes or threats are then discussed in detail by the relevant functions in an SLT meeting to consider a strategic response to those areas of concern.

74. Swaleside has a Drug Strategy that was last revised in April 2023. It details several actions that the prison intends to take to try to eliminate the supply of drugs into the establishment. The strategy states that medication queues “will be monitored correctly”.

75. Despite these measures, it is concerning that Mr Baptiste was seemingly able to circumvent security processes and illicitly obtain significant quantities of medication. We bring this to the attention of the Governor.

Inquest

76. The inquest into Mr Baptiste’s death concluded on 12 December 2024. Mr Baptiste’s death was due to sertraline toxicity.

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

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T l 020 7633 4100