Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Paul Dixon, a prisoner at HMP Preston, on 16 June 2024

## 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

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. 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.

3. In September 2023, Mr Paul Dixon was sentenced to nine years imprisonment for sexual offences. He died of bowel cancer on 16 June 2024, at HMP Preston. He was 56 years old. We offer our condolences to Mr Dixon's family and friends.

4. The Ombudsman's office contacted Mr Dixon's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They raised concerns about Mr Dixon's healthcare which are addressed in the clinical review. They also asked why there was a delay with Mr Dixon's last application for early release on compassionate grounds (ERCG) which was still ongoing when he died.

5. The PPO investigator investigated the non-clinical issues relating to Mr Dixon's care. We did not find any non-clinical issues of concern. The last ERCG application was submitted on 29 May and was refused on 18 June (after Mr Dixon had died). We found no undue delay with the application process.

6. NHS England commissioned an independent clinical reviewer to review Mr Dixon's clinical care at HMP Preston.

7. The clinical reviewer concluded that the care Mr Dixon received at Preston was of a good standard and equivalent to that which he could have expected to receive in the community. She found that there was a lack of consistent use of the Malnutrition Universal Screening Tool (MUST) to assess Mr Dixon's risk of malnutrition and that it may have been beneficial to consider nutritional supplements earlier. She noted, however, that there was evidence that healthcare staff encouraged Mr Dixon with fluid and diet and that they supported him to ensure he received the appropriate nutritional diet. We recommend:

   **The Head of Healthcare should ensure that all healthcare staff undertake a MUST assessment when a person is weighed and ensure any concerns are escalated with immediate effect.**

8. We shared our initial report with HMPPS and with the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies.

9. We sent a copy of our initial report to Mr Dixon's next of kin. They did not notify us of any factual inaccuracies.

**Adrian Usher**
**Prisons and Probation Ombudsman** **November 2024**

## Inquest

At the inquest, held on 11 November 2025, the Coroner concluded that Mr Dixon died from natural causes.

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