Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Dixon, a prisoner at HMP Swaleside, on 3 November 2019

A report by the Prisons and Probation Ombudsman

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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 Mark Dixon died in hospital on 3 November 2019, as a result of the misuse of psychoactive substances (PS), while a prisoner at HMP Swaleside. He was 47 years old. I offer my condolences to Mr Dixon's family and friends.

I am concerned that Mr Dixon's persistent use of PS was not reported to the substance misuse service and that his self-referral to the service was not actioned. It is essential that staff follow the expected processes to give prisoners the opportunity of timely support to address their misuse of drugs particularly, as in Mr Dixon's case, during periods of heightened vulnerability.

Mr Dixon's clinical care was equivalent to that he could have expected to receive in the community. However, there was a delay in notifying the emergency when he was found unconscious.

Mr Dixon's sessions with his prison key worker were often cancelled due to staffing problems. The Governor should ensure that sufficient staff resources are allocated to this important function.

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

Sue McAllister CB
Prisons and Probation Ombudsman **April 2021**

Contents

Summary 1

The Investigation Process 3

Background Information 4

Key Events 6

Findings 9

Summary

Events

1. Mr Mark Dixon was recalled to prison in July 2015 and had been at HMP Swaleside since 9 February 2018. He had longstanding physical and mental health problems, as well as a history of suicide attempts and substance misuse. In prison, he was frequently found under the influence of PS.

2. Swaleside provided support for Mr Dixon's problems through several mechanisms, including the complex case arrangements; healthcare-led multidisciplinary meetings; the prison psychiatrist and psychologist; and the suicide and self-harm prevention procedures, known as ACCT. Mr Dixon initially refused to engage with Forward Trust, the prison's substance misuse service, but they reviewed his status every six months.

3. On 7 January 2019, Mr Dixon asked for help from the substance misuse service. During an audit on 12 April, a manager noted that no action had been taken on the self-referral, but Mr Dixon's six-month review was approaching, and a date had already been set. On 16 and 27 April, Mr Dixon made further requests to be seen and a decision was taken to wait for his review date. He refused to cooperate when a caseworker tried to conduct the review on 7 May.

4. In July, Mr Dixon moved to the prison's palliative care suite to help relieve his orthopaedic condition. He found it harder to obtain drugs, but still used PS.

5. Mr Dixon initially had regular meetings with his key worker, but they became sporadic and the last meeting was two months before his death.

6. At around 6.00pm on 2 November, Mr Dixon was found unresponsive. Paramedics assessed him and he was given oxygen. Healthcare staff monitored him hourly through the night. During a check at 5.18am, he was again found unresponsive and staff attempted resuscitation. Mr Dixon was taken to hospital, where he died at 9.45am.

Findings

7. Mr Dixon's clinical care was equivalent to that he could have expected to receive in the community. His persistent use of PS was not due to any deficiency in prescribing painkillers for his physical health problems.

8. Swaleside's substance misuse strategy is wide-ranging and prison managers have actively addressed spikes in PS use.

9. There is no evidence that staff routinely notified the substance misuse service when Mr Dixon was either found, or suspected of being under the influence of PS.

10. The substance misuse service did not offer Mr Dixon an appointment in response to his self-referral in January and, when he twice repeated the request in April, they chose to wait for his scheduled review in May. We consider that this decision was unwise.

11. Although Mr Dixon was well supported by his key worker, he did not have weekly meetings and there were lengthy gaps. These sessions were frequently cancelled when there were not enough staff to safely manage the wing.

12. The healthcare assistant who found Mr Dixon unresponsive did not call a code blue emergency immediately but waited for a nurse to attend. Overall, there was a delay of four minutes between finding Mr Dixon and calling an ambulance.

Recommendations

- The Governor and Head of Healthcare should ensure that all prisoners suspected of substance misuse are promptly reported to the substance misuse service.
- The Manager of Forward Trust should ensure that all referrals for substance misuse support are dealt with promptly.
- The Governor should ensure that staff have meaningful interaction with the prisoners in their care, and that the key worker scheme promotes early and regular contact with prisoners.
- The Governor and Head of Healthcare should ensure that a code blue is called immediately when a prisoner is found unresponsive and that there is no delay in calling an ambulance.
- The Head of Healthcare should share this report with the healthcare assistant who found Mr Dixon unresponsive on 3 November and discuss the Ombudsman's findings with him.

The Investigation Process

13. The initial investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

14. The investigator visited Swaleside on 12 November 2019. He obtained copies of relevant extracts from Mr Dixon's prison and medical record and interviewed the Head of Drug Strategy and Health.

15. Another investigator took over the investigation at the end of November.

16. NHS England commissioned a clinical reviewer to review Mr Dixon's clinical care at the prison. The investigator and clinical reviewer jointly interviewed four members of staff on 9 January 2020. The investigator obtained additional information from managers responsible for security, drug strategy and the substance misuse service.

17. Our investigation was suspended while waiting for the cause of death. This delayed the initial report.

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

19. One of the Ombudsman's family liaison officers explained the investigation to Mr Dixon's next of kin, his sister and asked if she had any questions for the investigation to consider. Mr Dixon's sister later engaged solicitors to act on her behalf. Mr Dixon's family asked whether he began using illicit drugs because his medication prescriptions had lapsed, and his painkillers had not been dispensed; and if drugs had been found in his cell on the day he died. They also thought that he had made several complaints about his care.

20. We have addressed these issues in our report.

21. The legal representative acting on behalf of Mr Dixon's next of kin received a copy of the initial report. They made no comments.

22. The initial report was shared with HM Prison and Probation Service. They provided additional information about the key worker scheme and asked for the related recommendation to be recast.

Background Information

HMP Swaleside

23. HMP Swaleside, on the Isle of Sheppey, is part of the Long-Term and High Security estate. It houses up to 1,112 men serving sentences of four years or more. Integrated Care 24 Ltd provides primary healthcare. There is 24-hour nursing cover and a 17-bed inpatient unit. Minster Medical Group provides GP cover on weekdays on Monday to Friday, and Medway on Call Care provides an out of hours GP service. Oxleas NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Swaleside was in December 2018. Inspectors reported that illicit drugs, including PS, were a serious problem and the high rate (25%) of positive mandatory drug tests (MDTs) suggested widespread use. They found that the security and substance misuse departments worked well together, and a good strategy was underway to address the drug problem. Although there had been some success, it was too soon to measure its effectiveness.

25. The Inspectorate conducted a review of progress in September/October 2019, to assess progress against 12 of the 50 recommendations in the inspection report. Inspectors found there had been good progress in reducing the use of illicit drugs and the percentage of prisoners failing random drug tests had fallen.

Independent Monitoring Board

26. 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 April 2019, the IMB reported that that the apparent easy acquisition of drugs, including PS, had caused problems, such as violence and debt and had led to some prisoners choosing to stay in their cells. The introduction of the Rapiscan screening machine and a dedicated search team had significantly reduced the volume of drugs.

Previous deaths at HMP Swaleside

27. Mr Dixon was the 12th prisoner to die at Swaleside since November 2017. Of the previous deaths investigated, one was self-inflicted, nine were due to natural causes and one was due to the effects of a fire. Another prisoner died as a result of using psychoactive substances on the same day as Mr Dixon and there have been two further deaths from natural causes since then.

28. In response to the other drug-related death, we made recommendations about reporting prisoners suspected of substance misuse to the substance misuse service, and about the need to ensure that key workers have regular contact with the prisoners allocated to them. These recommendations were only made in September 2020 and we have not yet received the prison's action plan in response.

Psychoactive Substances (PS)

29. Psychoactive substances (formerly known as ‘new psychoactive substances’ or ‘legal highs’) are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

30. The effects of PS are unpredictable, and prisoners do not know what exactly they are using. In the course of our investigations, we see numerous examples of apparently fit young men dying as a result of the effects of PS.

The key worker scheme

31. HMPPS’s policy document, Manage the Custodial Sentence Policy Framework, sets out the minimum requirements needed to case manage those in custody from reception to the end of post-release supervision. This included the gradual introduction of the key worker role from September 2018, replacing the previous system of personal officers. Requirements of the scheme include:

    - All prisoners in the male closed estate must be allocated to a key worker whose responsibility is to engage, motivate and support them throughout the custodial period.
    - All prison officers who work on a residential unit will be allocated a maximum of six prisoners. Governors must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role which includes individual time with each prisoner.
    - Key workers will record meetings, discussions and any progress that has been made on NOMIS in a detailed manner. These notes will be regularly checked as part of on-going quality assurance, so it is important that they are sufficient.
    - The Governor should ensure that staff have meaningful interaction with the prisoners in their care, and that the key worker scheme promotes early and regular contact with prisoners.

Key Events

32. Mr Mark Dixon had been sentenced to imprisonment for public protection in 2006. After his release on licence on 9 April 2015, he was recalled to prison on 21 July. He was later convicted of assault and received an extended sentence - a custodial period of eight and a half years, with an extension of four years supervision in the community.

33. Mr Dixon had a history of attempted suicide. He had been diagnosed with post-traumatic stress disorder (PTSD) and had spent time in secure mental health hospitals. A suicide attempt in the community had caused decreasing mobility and persistent back pain, which was managed with strong painkillers. He used walking aids and a wheelchair.

34. Each year, significant anniversaries of family tragedies and bereavements between April and September, triggered grief, guilt and negative thoughts, with increased risk. In prison, Mr Dixon attempted suicide by cutting, ligature, fire, swallowing foreign objects, as well as refusing food and drink. He was frequently managed under the Prison Service procedures to support prisoners at risk of suicide or self-harm, known as Assessment, Care in Custody and Teamwork (ACCT). He was often hostile, abusive and destructive.

35. Mr Dixon also had a history of substance misuse. He continued to use illicit drugs in prison and was often found under the influence of PS. Drug-taking and self-harm sometimes led to medical emergencies and hospital admissions.

Transfer to HMP Swaleside

36. Mr Dixon transferred to HMP Swaleside on 9 February 2018. He was managed under the complex case arrangements and supported through several other mechanisms, including weekly mental health reviews and psychiatry, counselling and psychology sessions. Mr Dixon's mental health nurse noted that he might benefit from working with the substance misuse service and the mental health team simultaneously, with a joint review, rather than waiting for his mental health issues to be addressed first.

37. Mr Dixon admitted that he used PS frequently. Between March 2018 and November 2019, staff found him under the influence of drugs at least 13 times. Staff took disciplinary action under the adjudication system, issued written warnings, or reduced him to the 'basic' regime under the Incentives and Earned Privileges scheme - the process for incentivising and managing behaviour.

38. At mental health reviews in April and early May 2018, Mr Dixon said that he was struggling mentally and had relapsed into using PS to help detach himself and escape from his own thoughts. He was referred to Forward Trust, the prison's substance misuse service.

39. At a substance misuse assessment at the beginning of May, Mr Dixon admitted using PS almost daily to block emotions and past problems that he could not cope with and said he had taken heroin twice to try and end his life. His caseworker created a recovery plan, with aims of having a structured day with education and work; completing in-cell packs to distract from use of PS, heroin

and alcohol; and counselling to cope with bereavement and triggers. On 31 May, Mr Dixon said he had changed his mind. He felt unable to engage with Forward Trust and was "on hunger strike", as he wanted to die. He continued to use PS.

40. Forward Trust reviewed Mr Dixon's treatment status every six months. On 5 November, they wrote to invite him to make an appointment if he wanted support. Mr Dixon did not reply. In December, he was found smoking heroin.

41. On 7 January 2019, Mr Dixon asked to be referred to Forward Trust and the request was passed on during a team handover meeting. In the same week, Mr Dixon's security classification was increased from category C to B. His attitude changed and he became angry, as he had expected to become category D.

42. During a file audit on 12 April, a Forward Trust manager noted that Mr Dixon's self-referral had not been actioned, but that his next review date had already been set for 6 May. On 16 April, Mr Dixon again asked to see his Forward Trust caseworker.

43. On 24 April, staff opened the ACCT procedures as Mr Dixon's significant anniversaries were approaching and he felt suicidal. He refused food and drink over a long period and was supported in several different ways, including a visit to his wife's grave in June. (The ACCT was closed on 1 October.)

44. On 27 April, Mr Dixon told a custodial manager that he was not previously in the right frame of mind to receive substance misuse support, but now wanted help. Forward Trust recorded the request, but it was decided that the existing review date would stand. When Mr Dixon's caseworker tried to conduct the review on 7 May, he refused to participate.

45. In July, Mr Dixon moved to the prison's palliative care suite as he needed a special bed. He told staff he was happier there and it was harder to obtain drugs. As an inpatient, the prison's psychiatrist saw Mr Dixon weekly and he was regularly discussed at the multidisciplinary meeting led by the mental health team. He also had regular meetings with a prison psychologist.

46. In August, the Parole Board refused to recommend Mr Dixon's release, or a transfer to open conditions due to risk factors such as drug and alcohol misuse.

47. In September and October, Mr Dixon refused to attend 'suspicion' MDTs. After a PS incident on 25 October, a nurse asked for Mr Dixon to be referred to Forward Trust, but there is no record that this was actioned.

Events of 2/3 November

48. At around 6.00pm on 2 November, while conducting hourly checks, a healthcare assistant found Mr Dixon unresponsive in his cell. He called a code blue emergency (which indicates that a prisoner is unconscious or has breathing difficulties) and Mr Dixon was given oxygen. Paramedics were already in the prison, attending another PS incident and they advised staff to continue with oxygen. Staff were instructed to get a response from Mr Dixon each time they checked him.

49. Mr Dixon was awake during the night and he was last seen conscious between 4.00am and 4.30am.

50. At 5.18am, a healthcare assistant found Mr Dixon sitting slumped on his bed, unresponsive. He radioed a nurse, who joined him in the cell. They then radioed a code blue at 5.20am and an ambulance was called at 5.22am. The nurse and prison officers performed cardiopulmonary resuscitation, in rotation until the ambulance arrived at 5.30am. Paramedics took Mr Dixon to hospital at 6.40am. He died at 9.45am.

51. The police searched Mr Dixon's cell. They found a kettle on the bed with the back removed, exposing the copper wires, and rolled up tissue paper with burn marks either end. These items are commonly used by prisoners to produce a light for smoking drugs. No drugs were found.

Contact with Mr Dixon's family

52. At Mr Dixon's request, staff had removed next of kin details from his personal records in August 2019. The prison's family liaison officer (FLO) therefore contacted one of Mr Dixon's two emergency contacts. Mr Dixon's sister, his next of kin, telephoned later that day, having learned of his death through social media. The FLO explained and apologised. He provided advice and support over the following weeks and visited her home to return Mr Dixon's property.

53. The prison held a memorial service on 11 November, attended by Mr Dixon's family. Mr Dixon's funeral was held on 27 November, led by one of Swaleside's chaplains. In line with national policy, the prison contributed to the costs.

Support for prisoners and staff

54. After the emergency, staff checked the welfare of prisoners in the inpatient unit and others at risk of suicide or self-harm, in case they had been adversely affected by the events. The chaplain, a member of the care team, spoke to the staff involved in the resuscitation process and offered support.

55. After Mr Dixon's death, a prison manager debriefed the escort staff. The prison posted notices informing staff and other prisoners and offering support.

Post-mortem report

56. The post-mortem report concluded that Mr Dixon's death was due to a heart attack caused by misuse of psychoactive substances. Underlying bronchopneumonia and heart disease contributed to but did not cause Mr Dixon's death.

Findings

Drug Strategy at HMP Swaleside

57. Swaleside has a detailed Drug, Alcohol and Substance Misuse Strategy which was updated in the latter half of 2019. The last HMIP inspection in December 2018 noted considerable problems, but a follow-up review in October 2019 found that new strategic measures had successfully reduced drug use and supply.

58. Our investigation found that monthly, multidisciplinary drug strategy meetings and the day to day actions taken to reduce drug supply and demand were well documented. Security intelligence on supply routes, drug dealing and staff corruption was collated, analysed and acted on. The prison now has a dedicated searching team, as well as 'ring-fenced' MDT staff. Performance targets had been met.

59. Over the course of the 2019/20, an average of 18.7% MDTs were positive. This had reduced from 25% at the time of the 2018 inspection. In addition to MDTs, there were suspicion tests, a frequent testing programme and risk assessment tests for prisoners in trusted positions. Prisoners suspected of drug dealing were moved to other locations to stem the flow of drugs, and those who posed a serious threat were moved to other prisons. Of the tests conducted between July and October 2019, only one was positive for PS. However, from November, there was a notable increase in the use of PS.

60. Mr Dixon and another prisoner at Swaleside both died on the same day as a result of PS use. Within two weeks the security department produced a detailed threat analysis to consider and address the apparent increase in the use of PS. Staff also spoke to known users of PS to emphasise the risks.

61. We are satisfied that Swaleside has a coherent drug strategy and that managers proactively address issues that arise.

Support for substance misuse

62. There appear to be strong and effective links between prison departments and Forward Trust. The Trust receives a copy of the prison's morning briefing sheet, so that they can contact all the prisoners whose drug use led to a medical emergency the previous day; they are routinely informed of men reported to be under the influence, or suspected of drug use; and the Trust's staff are now able to access medical records. A Forward Trust representative attends offender management and parole meetings, suicide and self-harm prevention case reviews, as well as constant watch and complex case reviews. Around 450 prisoners engage with the service, one to one or in groups. Men who do not want to stop using drugs are offered harm minimisation advice on the wing.

63. We found that there are processes in place for staff to report prisoners found under the influence of illicit drugs to Forward Trust, but there is no evidence in Mr Dixon's personal or substances misuse records that such episodes were reported to them in his case. A further concern is that in January 2019, when Mr Dixon felt ready to work with Forward Trust, no action was taken on his referral and there was no attempt to see him until his automatic six-month review in May

2019. By this time, he would have already entered the time of year he found most difficult. It is perhaps therefore not surprising that he was unwelcoming when his caseworker tried to see him.

64. The failure to report instances of PS use to the substance misuse service and respond in a timely way to requests for support was poor practice. We also believe that the decision not to offer an assessment because a scheduled review was pending was ill-judged. We cannot say whether seeing Mr Dixon sooner would have made a difference to his actions, but he was likely to have been more receptive to support at the times when he actively sought it. We have previously raised concerns about substance misuse referrals for those found under the influence of drugs at Swaleside. We make the following recommendations:

The Governor and Head of Healthcare should ensure that all prisoners suspected of substance misuse are promptly reported to the substance misuse service.

The Manager of Forward Trust should ensure that all referrals for substance misuse support are dealt with promptly.

Clinical care

65. The clinical review report describes in detail Mr Dixon's physical and mental health problems and how they were addressed by prison healthcare staff. The clinical reviewer concluded that Mr Dixon's care was equivalent to that which he could have expected to receive in the community, and she made no recommendations.

66. Mr Dixon's family thought that Mr Dixon had been dissatisfied with his care and they were concerned that his substance misuse might have been due to a lack of effective pain relief.

67. Mr Dixon's records showed that he had criticised some aspects of his clinical care at previous prisons, such as problems with his pain relief in 2017. He said this had led to frequent use of illicit drugs and accruing a debt of £400 over two weeks. Entries at Swaleside noted Mr Dixon's frustrations with the dosage and dispensing of his morphine and that he had threatened to self-medicate with illicit drugs. Healthcare staff explained to him the reasons for the variation of his dosage when he changed from a morphine patch to tablets. Mr Dixon's formal complaints were mostly about non-clinical issues and we are satisfied that his drug use was not due to problems with his prescribed medication.

Key worker meetings

68. All prisoners in closed prisons must have a key worker to engage with them, identify their needs and provide one to one support through their sentence. Key workers should document meetings in prisoners' electronic case notes and management checks should be made.

69. Mr Dixon's key worker made full and detailed notes of their sessions. He showed great diligence in trying to resolve issues raised by Mr Dixon. However, at times, there were significant gaps between meetings. In the six months before Mr Dixon's death, there were only six key worker sessions, the last on 3 September.

The prison explained that Mr Dixon's key worker was away for two periods in mid-September and early October. We also found that many of the meetings were cancelled due to staff shortages and the need to ensure safe levels of staffing on the wing. When this happened, Mr Dixon's key worker made time for short informal conversations as an alternative. However, it was not possible to have impromptu discussions after Mr Dixon moved to the inpatient unit in July 2019.

70. In response to the initial report, Swaleside said that staffing constraints had delayed implementation of the keyworker scheme and staff did not have the time or resources to complete this role to the required standard. All staff on site had been trained by November 2019, and all wings had begun keywork. However, several risks were highlighted and there was a general lack of understanding among staff. In January 2020, the national team assisted staff across various disciplines to ensure an effective roll out, and official sign off. There was then a significant increase in keywork delivery, as well as an increase in Prison Offender Managers.

71. We are satisfied that Mr Dixon received a lot of support across several disciplines. However, we are concerned that, given the breadth of his problems and the delay in implementing the key worker scheme, he did not have consistent key worker sessions. Such meetings seem to have been routinely sacrificed for resource reasons, an issue we recently raised following a death in similar circumstances a few hours after that of Mr Dixon. We make the following recommendation:

The Governor should ensure that staff have meaningful interaction with the prisoners in their care, and that the key worker scheme promotes early and regular contact with prisoners.

Emergency response

72. Prison Service Instruction (PSI) 03/2013 *Medical Emergency Response Codes* sets out the actions staff should take in a medical emergency, including mandatory instructions on efficiently communicating the emergency, to ensure staff take the relevant equipment to the incident and that there are no delays in calling an ambulance.

73. When the healthcare assistant found Mr Dixon unresponsive, he spent time trying to reach the nurse before calling a code blue and there was a further delay of two minutes before an ambulance was called. A total of four minutes therefore elapsed between finding Mr Dixon and requesting an ambulance. We cannot say if this affected the outcome for Mr Dixon, but we know that a delay of even a few minutes may make a critical difference in a medical emergency. It is imperative that staff follow the prescribed procedures and do not delay seeking assistance. We make the following recommendations:

The Governor and Head of Healthcare should ensure that a code blue is called immediately when a prisoner is found unresponsive and that there is no delay in calling an ambulance.

The Head of Healthcare should share this report with the healthcare assistant who found Mr Dixon unresponsive on 3 November and discuss the Ombudsman's findings with him.

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