

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Mark Johnston, on 7 April 2024, following his release from HMP Swansea**

**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**



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## Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.
2. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of the person's release from prison.
3. 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.
4. Mr Mark Johnston died from drug toxicity on 7 April 2024, following his release from HMP Swansea five days earlier. He was 49 years old. We offer our condolences to those who knew him.
5. The prison's resettlement team saw Mr Johnston and completed housing referrals for him just five days before his release. As a result, there was limited time for Mr Johnston to secure accommodation and he was released homeless. We make the following recommendations:

## Recommendations

**The Governor of HMP Swansea should ensure that a process is created to identify newly arrived prisoners who are at risk of homelessness and that the resettlement team sees them at the earliest opportunity to maximise their chance of finding post-release accommodation.**

**The Regional Probation Director for Swansea Neath Port Talbot should ensure that all probation practitioners are aware of the Duty to Refer policy framework and remind them of their responsibility to complete housing referrals.**

## The Investigation Process

6. HMPPS notified us of Mr Johnston's death on 8 April 2024.
7. The PPO investigator obtained copies of relevant extracts from Mr Johnston's prison and probation records.
8. The investigator interviewed Mr Johnston's Community Offender Manager as part of the investigation.
9. We informed HM Coroner for Swansea of the investigation. They gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
10. The Ombudsman's office contacted Mr Johnston's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Background Information

### HMP Swansea

12. HMP Swansea is a category B reception prison which holds men who have been convicted or remanded into custody. Swansea University Bay Health Board provides healthcare, including mental health services, at the prison. Dyfodol provides substance misuse services.

### Probation Service

13. The Probation Service works with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, prepare reports to advise the Parole Board and have links with local partnerships to which they refer people for resettlement services, where appropriate. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

### HM Inspectorate of Prisons

14. The most recent inspection of HMP Swansea was in March 2023. Inspectors made reported that in the previous 12 months, a third of prisoners were released homeless or to transient accommodation.

### End of Custody Supervised Licence (ECSL) scheme

15. The ECSL scheme was in operation from October 2023 to September 2024 and allowed certain determinate sentenced prisoners to be released before their conditional release date. At the time of Mr Johnston's death, prisoners in certain prisons could be released a maximum of 18 days before their conditional release date.

## Key Events

### Background

16. On 19 December 2023, Mr Mark Johnston was convicted of theft and was sentenced to 18 weeks in prison. He was sent to HMP Swansea. During his initial health screen, Mr Johnston disclosed that he had attempted suicide in 2010 by jumping off a roof. He told staff that he had no thoughts of suicide and self-harm and was detoxing from alcohol and drugs.
17. On 21 December, the substance misuse team saw Mr Johnston. He told them that he had recently used heroin and crack cocaine. He was offered naloxone (a medication that reverses an opioid overdose) on release which he declined. (There is no evidence to explain why.) He also stated that he had anxiety and depression.
18. On 27 December, Mr Johnston saw a resettlement officer who told him that once he was allocated a community offender manager (COM), substance misuse and accommodation referrals would be completed to the Forward Trust (a charity which helps prison leavers find accommodation on release) and Crisis CTI.
19. On 11 January 2024, the resettlement officer completed a housing application to the local authority for Mr Johnston.
20. On 17 January, the substance misuse team discussed Mr Johnston's care plan with him. He said he was stable on his prescription for buprenorphine tablets (an opioid used to treat opioid use disorder).
21. On 23 January, Mr Johnston received a negative drug test result. On 25 January, Mr Johnston did not attend a planned substance misuse appointment as he said he did not need one.
22. On 30 January, Mr Johnston met his community offender manager (COM) and his prison offender manager (POM). They told him a housing application had been completed. He told them that he struggled to attend Dyfodol meetings in the community as he was around other drug users.
23. On 1 February, Mr Johnston was released from Swansea 18 days early under the ECSL scheme. He failed to attend his appointments with the Probation Service and with Dyfodol.
24. The local authority offered Mr Johnston post-release accommodation, but he declined it and did not discuss the reasons why with the local authority.

### Recall to Swansea

25. On 12 February, Mr Johnston was recalled to Swansea for breaching his licence conditions. During his initial health screen, Mr Johnston denied substance misuse issues. He told a substance misuse nurse that he was 'done with drugs' and had not used them for some time.
26. On 13 February, Mr Johnston had a substance misuse induction appointment. He told the substance misuse team that he used alcohol in the community and so was

prescribed Valium for alcohol detoxification. The substance misuse team deemed him a high risk of substance misuse and added him to their caseload. They signposted him to local support services for post-release and provided harm minimisation advice.

27. During an appointment with his substance misuse caseworker on 15 February, he said that he smoked a lot of crack cocaine but had not used heroin (an opioid) in a few months (so did not need opioid substitution treatment). He said he had taken a Valium overdose two years earlier and accepted a naloxone kit for his release.
28. On 16 February, Swansea's substance misuse team referred Mr Johnston to Dyfodol for psychosocial intervention.
29. On 20 February, Mr Johnston admitted he was struggling with his mother's recent cancer diagnosis and had taken drugs to cope.
30. On 26 February, Mr Johnston was moved to the incentivised substance-free living unit, where he tested negative for drugs.
31. On 28 March, Mr Johnston again tested negative for drugs. That day, he saw a prison resettlement officer and told her that he would be released homeless. She referred him to the local authority for housing under the statutory duty to refer those at risk of homelessness. She told the investigator that workload pressures had delayed the resettlement team seeing Mr Johnston. She said the policy was for the COM to complete a referral, but she had done so on the COM's behalf as it had not been done. The COM told the investigator that this was not the case, and it was the prison resettlement team's responsibility to complete the referral.
32. No accommodation had been identified for Mr Johnston before his release.

### **Release from Swansea**

33. On 2 April, Mr Johnston was released from Swansea. He was given harm minimisation advice but was not given a naloxone kit as had been agreed. A substance misuse nurse told the investigator that the process at the time of Mr Johnston's release was that the pharmacy held a ledger of the names of prison leavers who had agreed to be released with naloxone, and the pharmacy then issued it with any other medications they were prescribed. There is no record to explain why Mr Johnston was not given naloxone when he was released.
34. That day, he attended his probation appointment. The COM included additional licence conditions for Mr Johnston to attend substance misuse appointments.
35. However, Mr Johnston failed to attend further appointments, including with the local authority housing provider and with the Probation Service. There is no evidence to explain why he did not attend these appointments.

### **Circumstances of Mr Johnston's death**

36. On 5 April 2024, Mr Johnston and a friend visited an associate's home, where they drank alcohol and took drugs until 7 April, when their associate found him unresponsive on the sofa. Mr Johnston's friend administered naloxone, but it did not

work as Mr Johnston had been dead for some time. Their associate left to find a police officer. Police and paramedics attended, and Mr Johnston was declared dead at 2.45pm. Drug paraphernalia was found at the property. (We have not received any further information about the type of property.)

### **Post-mortem report**

37. The post-mortem report concluded that Mr Johnston died from drug toxicity. The toxicology report found a low concentration of bromazolam (a benzodiazapine), alcohol, paracetamol and various other drugs.

### **Inquest**

38. At an inquest held on 18 February 2025, the Coroner concluded that Mr Johnston's death was drug related.

## Findings

### Naloxone policy

39. Mr Johnston was not given a naloxone kit, even though he had agreed to have one on his release. Swansea told us that at the time of Mr Johnston's release, they did not have a naloxone policy in place and their process required the pharmacy department to issue naloxone to prison leavers. The substance misuse manager told the investigator that the policy has since changed, and all substance misuse staff can now provide naloxone to their service users before release. We therefore do not make a recommendation about this.

### Referrals to housing and the local authority

40. Homelessness on release from prison is a significant and complex challenge. Even when prison and probation staff refer prison leavers at risk of homelessness to local authorities and charities to find them accommodation, there are occasions when beds are not available, or individuals do not meet the eligibility criteria for housing. They are then released homeless and expected to report to the local authority on the day of their release in the hope of receiving emergency housing. Homelessness increases the likelihood that prison leavers seek shelter and support in harmful places, turn to substance misuse and/or commit further crimes.
41. The prison resettlement team referred Mr Johnston to the local authority for accommodation under the statutory duty to refer just five days before his release. The resettlement officer told the investigator that it was the COM's role to do so but as it had not been done so close to his release, she had referred him on the COM's behalf. In contrast, the COM told the investigator that she knew that Mr Johnston was a repeat offender so would be homeless on release, but it was the resettlement team's role to refer him to the local authority.
42. The duty to refer policy framework states that while the statutory obligation to refer falls predominantly on the COM, anyone can refer an individual at risk of homelessness.
43. The confusion about whose responsibility it was to refer Mr Johnston to the local authority led to a significant delay in referring him and he was released homeless. As Mr Johnston was identified as at high risk of using drugs in the community, homelessness and reoffending, housing referrals should have been completed in a timely manner to give the local authority and housing charities adequate time and opportunity to try to find Mr Johnston appropriate accommodation. We make the following recommendation:

**The Governor of HMP Swansea should ensure that a process is created to identify newly arrived prisoners who are at risk of homelessness and that the resettlement team sees them at the earliest opportunity to maximise their chance of finding post-release accommodation.**

**The Regional Probation Director for Swansea Neath Port Talbot should ensure that all probation practitioners are aware of the Duty to Refer policy**

**framework and remind them of their responsibility to complete housing referrals.**

**Good practice**

44. Swansea's substance misuse team saw Mr Johnston the day after he was recalled to prison and referred him to the community service in advance of his release from prison. They saw him regularly, even though he was not receiving opiate substitution treatment. The substance misuse care he received was well-planned and an example of good practice.

**Adrian Usher  
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**February 2025**

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