Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Dixon on 23 April 2024, following his release from HMP Nottingham

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

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 Stephen Dixon died from methadone (a synthetic opioid used to treat heroin addiction) and alcohol toxicity on 23 April 2024, following his release from HMP Nottingham on 22 April. He was 57 years old. We offer our condolences to those who knew him.

5. Mr Dixon had a history of drug and alcohol misuse. He was on a methadone programme in prison and was offered naloxone (a medication that rapidly reverses opioid overdose) on release but declined it.

6. We did not identify any issues with or learning from the pre-release planning or post-release supervision of Mr Dixon.

7. We make no recommendations.

The Investigation Process

8. HM Coroner for Derbyshire notified us of Mr Dixon's death on 12 September 2024.

9. The PPO investigator obtained copies of relevant extracts from Mr Dixon's prison and probation records.

10. The Coroner for Derbyshire gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. 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 did not respond.

12. We shared our initial report with HMPPS. They found no factual inaccuracies.

Background Information

HMP Nottingham

13. HMP Nottingham is a reception and resettlement prison serving the courts of Nottinghamshire and Derbyshire. It is managed by His Majesty's Prison Service. Nottinghamshire Healthcare Foundation Trust provides healthcare services.

Probation Service

14. 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 appropriates. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

Key Events

Background

15. On 24 January 2024, Mr Stephen Dixon was sentenced to 12 weeks in prison for an assault on an emergency worker. He was sent to HMP Nottingham.

16. Mr Dixon had a history of drug and alcohol abuse. He received support from the prison's substance misuse team and was on a methadone maintenance programme. (Methadone is a synthetic opioid that is used to treat heroin addiction as it reduces withdrawal symptoms.)

17. On 21 February, Mr Dixon was released from Nottingham under the early release scheme for prisoners. Mr Dixon was released to temporary accommodation under the Community Accommodation Service Tier 3 (CAS3) scheme, which provides accommodation to prison leavers to prevent street homelessness at point of release.

18. Two days later, the Probation Service decided to recall Mr Dixon as he had missed an appointment to fit his electronic tags and an appointment with the community substance misuse team, Derbyshire Recovery Partnership.

First recall to Nottingham

19. On 2 March, Mr Dixon was arrested by the police and returned to Nottingham.

20. On 28 March, Mr Dixon's community offender manager (COM) completed a Duty to Refer to Derby Council as Mr Dixon was no longer eligible for CAS3 accommodation and was due to be homeless on release.

Release from Nottingham

21. On 2 April, Mr Dixon was released from Nottingham. He was released homeless. Mr Dixon attended Chesterfield Probation Office and they told him to present at the local homeless persons unit (though he did not attend).

22. On 3 April, Mr Dixon failed to attend Derbyshire Recovery Partnership to collect his methadone prescription. The next day, he failed to attend an appointment with his COM.

23. On 5 April, the Probation Service decided to recall Mr Dixon for the second time for non-compliance and failing to attend the above appointments.

Second recall to Nottingham

24. On 9 April, Mr Dixon was arrested by the police and returned to Nottingham.

25. On 11 April, Mr Dixon was offered naloxone by the prison's substance misuse team but he declined it. He gave no reason for this.

26. On 15 April, the substance misuse team referred Mr Dixon to Derbyshire Recovery Partnership in preparation for his release.

27. On 16 April, Mr Dixon's COM completed another Duty to Refer to Derby Council.

Release from Nottingham

28. On 22 April, Mr Dixon was released from Nottingham. He was released homeless. He reported to Derby Probation Office on the day of his release.

29. Later that day, Mr Dixon attended his appointment with Derbyshire Recovery Partnership. They offered Mr Dixon naloxone but he declined it.

30. Mr Dixon reported to Chesterfield Town Hall Homeless Persons Unit.

Circumstances of Mr Dixon's death

31. On 23 April, Mr Dixon was found dead at the property of an associate. There were no suspicious circumstances.

Post-mortem report

32. The post-mortem report concluded that Mr Dixon died from combined alcohol and methadone toxicity. Mr Dixon's blood alcohol level was high, but below the fatal range. However, methadone has similar effects on the body to alcohol, causing drowsiness, coma and respiratory depression and would have added to the effects of alcohol, increasing the risk of death.

Findings

33. Mr Dixon was released homeless on 22 April. He had previously been released to CAS3 accommodation but due to his non-compliance, was no longer eligible. We are satisfied that the COM completed a duty to refer to the council to try to prevent Mr Dixon from being street homeless upon release. The council's provision of accommodation to prison leavers is an issue outside the COM's control.

34. Mr Dixon was supported by substance misuse services at Nottingham and was referred to the community substance misuse services prior to release. He was offered naloxone both prior to his release and after release but declined on both occasions.

35. We make no recommendations.

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

Inquest

36. The inquest, held on 4 March 2025, concluded that Mr Dixon's death was alcohol and drug related.

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