

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

**Independent investigation into  
the death of Mr Ray Dean Thompson  
a resident at  
St John's Approved Premises  
on 9 April 2018**

**A report by the Prisons and Probation Ombudsman**

## 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 Ray Dean Thompson died of a heroin overdose in his room at St John's Approved Premises on 9 April 2018. He was 41 years old. I offer my condolences to his family and friends.

Mr Thompson had a history of mental health and substance misuse issues. He had been a resident at St John's for only six days before his death. Mr Thompson's death was unexpected, and we are satisfied that staff at St John's could not reasonably have prevented it. They began resuscitation efforts promptly after finding him unresponsive.

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**

**February 2019**

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# Summary

## Events

1. On 3 April 2018, Mr Ray Dean Thompson was released on licence from prison to St John's Approved Premises. He had a history of substance misuse, mental health issues and high blood pressure. He had completed some drug awareness courses in prison but admitted that he had continued to use illicit drugs. After an induction at St John's, Mr Thompson settled in well and staff booked him an appointment with a specialist substance misuse worker for 10 April.
2. At approximately 11.15pm on 9 April, staff found Mr Thompson lying, unresponsive, on his bed. A member of staff called an ambulance, while another staff member immediately began cardiopulmonary resuscitation. At 11.20pm, paramedics arrived and continued resuscitation efforts. At 11.45pm, they confirmed that Mr Thompson had died.
3. The police decided to inform Mr Thompson's next of kin, his mother, of his death and they did so in person in the early hours of 10 April. The manager of St John's subsequently contacted her to offer condolences and support.
4. A post-mortem examination established that Mr Thompson had died of heroin toxicity.

## Findings

5. Mr Thompson received a full induction at the approved premises. Although there is no evidence to say whether or not he received specific advice from staff about the risk of taking drugs on release from prison as his tolerance level would have lowered, staff made an appointment for him to see a specialist substance misuse worker and they assessed that he should collect his medication from a GP. Mr Thompson died unexpectedly, the day before he was due to see a specialist substance misuse worker. We are satisfied that staff could not reasonably have prevented his death.
6. After he was found, resuscitation attempts began immediately and staff called for an ambulance without delay. We do not make any recommendations.

## The Investigation Process

7. The investigator issued notices to staff and prisoners at St John's Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. The investigator visited St John's Approved Premises on 18 April 2018. She obtained copies of relevant extracts from Mr Thompson's approved premises records and interviewed four members of staff.
9. We informed HM Coroner for County Durham and Darlington of the investigation. We suspended our investigation from 21 June to 23 August 2018 pending confirmation of Mr Thompson's cause of death. We resumed our investigation when we received the results of the post-mortem examination. We have sent the Coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted Mr Thompson's mother and sister to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They wanted to know why he had been sent to St John's, what happened and if staff had arranged drug tests for him.
11. Mr Thompson's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out two factual inaccuracies and this report has been amended accordingly.

# Background Information

## St John's Approved Premises

13. Approved premises (formerly known as probation or bail hostels) accommodate offenders released from prison on licence and those directed there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are responsible for their own healthcare and expected to register with a GP.
14. St John's is managed by an independent charity, St John's Approved premises, who work in partnership with the National Probation Service. It has 29 bedrooms. Each resident is allocated a key worker to oversee their progress and wellbeing and to help them adhere to licence conditions and the premises' rules. Staff are on duty 24 hours a day to monitor residents' behaviour and report to their offender manager. St John's operates a curfew for the majority of residents from 11:00pm to 6:00am.

## Previous deaths at St John's Approved Premises

15. Mr Thompson was the second resident to have died at St John's since 2005.

## Key Events

16. On 15 December 2003, Mr Thompson was sentenced to 15 years in prison for two robberies. He was released on licence to St John's Approved Premises on 17 April 2012. When on licence, Mr Thompson committed further robberies. When he was in police custody facing charges, a doctor assessed him and noted that Mr Thompson had been "acting strangely having taken heroin". Mr Thompson admitted that he had used heroin. On 17 January 2013, he was recalled to prison and sentenced to six years and eight months in custody.
17. On 3 April 2018, Mr Thompson was released on licence from HMP Parc to St John's Approved Premises. Records indicate that Mr Thompson wanted to go to St John's as he had previously stayed there and had found it a positive experience. He said that he felt that he knew the staff and would be able to settle there again. He arrived with his mother and aunt. A residential officer completed his induction and showed him to his room. She also assessed that Mr Thompson should not have his medication in-possession but should obtain his medication from the GP. Later that day, Mr Thompson registered with a local GP. Mr Thompson also met his Offender Manager who discussed the conditions of his release with him. A meeting with his key worker was scheduled for 4 April.
18. Mr Thompson had a history of schizophrenia and substance misuse and had completed some drug awareness work during his time in prison. However, he had used illicit drugs in prison. Every two weeks, Mr Thompson had depot antipsychotic medication (slow-release medication given by injection over a number of weeks). On 5 April, Mr Thompson had his last injection at St John's. Staff booked him an appointment with a specialist substance misuse worker for 10 April.

### Events on 9 April 2018

19. During the night, staffing levels at St John's are at a minimum, with one Residential Officer, who sleeps on site, and one Assistant Residential Officer on duty. The Assistant Residential Officer responds to and supports the Residential Officer, as required. The Residential Officer acts as the first contact point for the Assistant Residential Officer. The Residential Officer and Assistant Residential Officer both check that residents are in the building by carrying out a curfew check and then locking the entrance doors. During the checks, they carry an emergency medical bag which contains gloves, a face mask and a knife or scissors and the hostel telephone. Mr X was the Acting Residential Officer and Mr Y was the Assistant Residential Officer.
20. Records show that Mr Thompson left St John's at 9.10am and, as required by his licence conditions, returned at 7.00pm. At 10.00pm, the Acting Residential Officer and the Assistant Residential Officer began the curfew check on the ground floor. At approximately 11.15pm, they arrived at Mr Thompson's room. As there was no response to knocks on the door, the Assistant Residential Officer opened the door and saw that Mr Thompson was lying on his bed, flat on his back, with his head tilted back and his mouth open. He stood at the door as the Acting Residential Officer also looked in and said that Mr Thompson was probably sleeping. However, the Assistant Residential Officer said to the Acting

Residential Officer that he did not have a good feeling and asked the Acting Residential Officer to check Mr Thompson. The Acting Residential Officer approached the bed and tapped Mr Thompson on his leg, but did not get a response. He began cardiopulmonary resuscitation (CPR) and the Assistant Residential Officer called for an ambulance. When paramedics arrived, they continued resuscitation efforts. Mr Thompson was declared dead at 11.45pm. Police attended and a smoking pipe was found in his room.

21. The Acting Residential Officer said that he had received training in first aid, including CPR, that his certificate was up to date. The manager of St John's confirmed that all her staff held current first aid certificates.

### **Contact with Mr Thompson's family**

22. The police officers who attended the incident regarded it as their role to notify Mr Thompson's next of kin of his death and that they should do so in person. The police broke the news to Mr Thompson's mother at her home in the early hours of the morning. The manager of St John's spoke to Mr Thompson's mother on the day that the police broke the news to her. She offered her condolences and explained the procedures to be followed. In the following days, she continued to support Mr Thompson's family. In line with national instructions, the National Probation Service contributed to the costs of Mr Thompson's funeral, which was held on 8 May 2018.

### **Support for residents and staff**

23. After Mr Thompson's death the on-call duty manager spoke to the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. As staff came to work, he briefed them individually. Staff told the investigator that they felt well supported.
24. He informed the other residents of Mr Thompson's death at a morning meeting and posted notices about it. Staff offered immediate support to residents.

### **Post-mortem report**

25. The post-mortem examination found that Mr Thompson had died from heroin toxicity. The level of heroin in his blood was within a fatal range. Although the examination found evidence of recent cocaine use, the post-mortem report found that it was less likely to have contributed to his death.

# Findings

## Management of Mr Thompson

26. Approved premises staff fully inducted Mr Thompson. Although there is no evidence to say whether or not he received specific advice from staff about the risk of taking drugs on release from prison as his tolerance level would have lowered, staff made an appointment for him to see a specialist substance misuse worker and they assessed that he should collect his medication from a GP. Mr Thompson died unexpectedly, and we consider that staff could not reasonably have prevented his death.

## Emergency response

27. We are satisfied that there was no delay in calling an ambulance and that the Acting Residential Officer began the resuscitation attempts immediately. We commend the staff for their prompt actions.

## Illicit substances

28. Toxicology tests after Mr Thompson's death showed heroin and cocaine in his system, which indicate that he was using illicit substances in the community.
29. For the short time that Mr Thompson lived at St John's, there were no indications that he was using illicit substances. His first appointment with a specialist referral substance misuse worker was scheduled for the day after his death.

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