

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Dent-Jones, a resident at St Catherine's Priory Approved Premises, on 14 July 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 Michael Dent-Jones died of tramadol toxicity and coronary heart disease on 14 July 2018 at St Catherine's Priory Approved Premises (AP). He was 66 years old. I offer my condolences to Mr Dent-Jones' family and friends.

Mr Dent-Jones had been at the AP for a week. He was a polite and respectful resident and fully complied with the rules. He had a history of heart attacks and high blood pressure, for which he took medication. He was not allowed to have his medications in possession, instead they were kept securely in an office and dispensed to him by AP staff. There were no indications that Mr Dent-Jones was misusing medication that was not prescribed to him.

I am satisfied that Mr Dent-Jones received a good standard of care at the AP and that staff could not have predicted or prevented his death.

However, I am concerned that a member of staff at AP incorrectly told his colleague that the requirements for two staff to complete the night time welfare check had been changed, and that she could carry out the welfare checks on her own. While on this occasion it did not affect the outcome for Mr Dent-Jones, or pose a threat to the personal safety of staff, that might not be the case in the future.

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

Sue McAllister CB
Prisons and Probation Ombudsman

January 2020

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Summary

Events

1. On 9 July 2018, Mr Michael Dent-Jones was released on life licence from HMP Lewes to St Catherine's Priory Approved Premises (AP) in Guildford.
2. AP staff noted Mr Dent-Jones' previous medical history of heart attacks and high blood pressure and his prescribed medications. He was not allowed to have his medications in his possession because he had been suspected of diverting his medication while in prison custody. Instead, they were kept securely in an office and dispensed to him by AP staff.
3. Staff noted that Mr Dent-Jones was polite and respectful and he fully complied with AP rules.
4. On 10 July, he had a mandatory drugs and alcohol test and tested negative for both.
5. At approximately 8.35am on 14 July, Mr Dent-Jones' roommate tried to wake him, but he was unresponsive. He left the room to alert staff.
6. Two members of staff immediately went to Mr Dent-Jones' room. They tried to wake him up and noted that his body was cold to the touch. They checked for signs of breathing and a pulse but there were none. They attempted cardiopulmonary resuscitation (CPR) but were unsuccessful.
7. The AP staff telephoned for an emergency ambulance, which arrived within ten minutes. At 8.45am, paramedics confirmed that Mr Dent-Jones had died.
8. The post-mortem report gave Mr Dent-Jones' cause of death as tramadol toxicity and coronary heart disease.

Findings

9. There was nothing in Mr Dent-Jones' behaviour at the AP to indicate that he was misusing medication that was not prescribed to him. He had successfully completed a mandatory drug test shortly before his death. We are satisfied that staff could not have predicted or prevented Mr Dent-Jones' death.

Prescribed medication/Tramadol toxicity

10. We do not know where or when Mr Dent-Jones obtained tramadol. His prescription for tramadol had been stopped while he was a prisoner at HMP Lewes due to suspicions of diverting his medication. He had not been prescribed tramadol while at St Catherine's Priory.

Welfare checks

11. We are concerned that on 13 July 2018, a member of staff at St Catherine's Priory, incorrectly told his colleague that the requirements for two members staff to complete the night time welfare check had been changed and that she was able to carry out the check on her own. While on this occasion it did not affect

the outcome for Mr Dent-Jones, or pose a threat to the member of staff's personal safety, that might not be the case in the future.

Recommendation

- The manager of St Catherine's Priory Approved Premises should ensure that staff conducting welfare checks do so in line with national guidance, and that staff are reminded of the need for two staff to carry out night time welfare checks.

The Investigation Process

12. The investigator issued notices to staff and residents at St Catherine's Priory Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
13. The investigator visited St Catherine's Priory on 8 October 2019 to carry out interviews with two members of staff and to obtain copies of relevant extracts from resident records.
14. We informed HM Coroner for Surrey of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. We wrote to Mr Dent-Jones' next of kin to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). The Probation Service did not find any factual inaccuracies.

Background Information

St Catherine's Priory Approved Premises (AP)

17. Approved Premises (formerly known as probation and 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.
18. St Catherine's Priory AP in Guildford is managed by the National Probation Service. It has 13 bedrooms: six double rooms and one single room in the main house and six other bedrooms spread over two other houses in the grounds of St Catherine's Priory.
19. Each resident is allocated a key worker to oversee their progress and wellbeing and to help them adhere to licence conditions and the AP rules. Staff are on duty 24 hours a day to monitor residents' behaviour and report to their offender manager.

Previous deaths at St Catherine's Priory Approved Premises

17. Mr Dent-Jones is the first resident to have died at St Catherine's Priory.

Key Events

20. On 27 September 2017, Mr Michael Dent-Jones was released from HMP Lewes on life licence to Brighton Approved Premises (AP). He was recalled to Lewes on 3 November when the results of mandatory drug (MDT) test and alcohol test carried out at the AP showed that he had used cannabis and alcohol and had breached the conditions of his licence. He also had a confrontation with another resident.
21. Mr Dent-Jones was suspected, although it was not proven, of illicit substance misuse while in prison custody at Lewes. On 2 December 2017, Mr Dent-Jones was reviewed by a prison GP after staff reported him he was unwell in his cell. He told the GP that he had not eaten for the previous two days because his prescription for tramadol (a strong painkiller) had been stopped because he was suspected of diverting his prescribed medication. The prescription was not re-started.
22. On 9 July 2018, Mr Dent-Jones was released on licence to St Catherine's AP, Guildford. When he arrived he had an induction session with a member of AP staff. She explained his licence conditions to him and that he would be subject to a 7.00pm to 7.00am curfew. She also told him that he was expected to sign in at the AP in person at 11.00am and 3.00pm.
23. She told Mr Dent-Jones that he would be subject to mandatory drug and alcohol testing twice a week. She gave him the address of the local GP surgery and advised him to register. Mr Dent-Jones signed the residents' induction form to confirm that he had understood what had been explained to him and would comply with what was expected of him.
24. During his induction, AP staff noted Mr Dent-Jones' previous medical history, including high blood pressure, arthritis, two previous heart attacks and that he had undergone surgery to remove two cancerous lesions on his oesophagus.
25. AP staff also noted his prescribed medications: atorvastatin (used to lower cholesterol), lansoprazole (used to reduce acid in the stomach), ferrous sulphate (used to treat anaemia), amlodipine (for treating high blood pressure), aspirin (prescribed for patients suffering from heart conditions) and mirtazapine (prescribed as an antidepressant). Mr Dent-Jones was not prescribed tramadol. He was not allowed to have his medications in his possession, instead they were kept securely in an office and dispensed to him by AP staff.
26. Mr Dent-Jones was allocated a double room, which he shared with another resident.
27. Over the following week, staff considered Mr Dent-Jones to be polite and respectful and noted that he complied with the AP rules. On 10 July, he had a mandatory drug and alcohol test, and the results were negative.
28. Staff at the AP were aware of his history of substance misuse, but had no suspicion that Mr Dent-Jones was involved with substance misuse at St Catherine's Priory. Mr Dent-Jones told staff that he was looking forward to being released from the AP and re-establishing links with his family.

29. On the morning of 13 July, Mr Dent-Jones left the AP at the same time as another resident. Staff suspected that the resident was involved with illicit drug use. Although Mr Dent-Jones and the resident left the AP together, staff do not believe that they spent the day together because they had not witnessed any previous contact between them while at St Catherine's Priory. (The resident no longer lives at the AP and was not available for interview.)
30. It is not clear where Mr Dent-Jones spent the day, but he returned to the AP at approximately 7.00pm and signed in. Staff noted that he was hot and sweaty. However, it was a hot day and residents had to walk up a hill to get the AP, so it was not unusual for them to be out of breath when they arrived. Mr Dent-Jones fell asleep in a chair. Staff said that he was looking 'quite out of it' in the lounge in the evening, and had to be roused and helped to bed by another resident. He told a residential worker that when they returned to their room, they had spent time talking.
31. At 11.30pm on 13 July, the residential worker carried out a routine welfare check on the residents to ensure they were all present and in their rooms. She was not expected to gain a response from the residents, but she noted that Mr Dent-Jones and the other resident were both present.
32. At 8.00am on 14 July, the other resident went to collect his breakfast. He returned to his room at 8.35am and noticed that Mr Dent-Jones was in the same position as when he left. He tried to wake him but he was unresponsive. He left the room to alert staff.
37. The residential worker and two other AP staff immediately went to Mr Dent-Jones' room. They tried to rouse him but noted his body was cold. They checked for a pulse and for signs of breathing but there were none. They attached a defibrillator to Mr Dent-Jones' chest but it indicated that there was no shockable rhythm. They attempted CPR but were unsuccessful. They telephoned for an emergency ambulance, which arrived within ten minutes.
38. At 8.45am, paramedics confirmed that Mr Dent-Jones had died.

Post-mortem report

39. The post-mortem report gave Mr Dent-Jones' cause of death as tramadol toxicity and coronary heart disease.

Contact with Mr Dent-Jones's Family

40. At 10:45am, the AP manager telephoned Mr Dent-Jones' next of kin who he had listed as his next of kin, but there was no answer. She eventually contacted him at 11.24am. She informed him of his death and offered him support. Mr Dent-Jones' next of kin was extremely upset and told her that he would ring her back when he had composed himself. He returned her telephone call at 11.45am. He asked for more details of his death. She told him the circumstances of Mr Dent-Jones' death and remained in regular contact with him, offering him support.
41. Mr Dent-Jones' funeral was held on 8 August. In line with national guidance, the National Probation Service contributed toward the costs of Mr Dent-Jones' funeral.

Support for prisoners and staff

42. After Mr Dent-Jones' death, the AP manager debriefed all the staff to ensure they had the opportunity to discuss any issues arising, and to offer support.
43. She held a meeting with the residents at the AP to tell them of Mr Dent-Jones' death and to offer them support.

Findings

Prescribed medication

44. The Approved Premises Manual sets out what staff and residents must do about residents' prescribed medication. It says that staff should assess whether it is appropriate for residents to have their medication in possession or whether staff should retain it and dispense it to them. Factors they should consider include whether residents are at risk of misusing or selling their medication, or are at risk of self-harm and/or bullying.
45. Unlike the prison environment, where the medical and pharmacy provision is contained within the establishment, residents in Approved Premises are in the community and therefore can access their own prescriptions through a GP, Accident and Emergency departments or other medical drop-in facilities, and can collect their prescriptions themselves from any pharmacy.
46. Staff must arrange with "relevant pharmacies" to collect the prescribed medication for all residents or have it delivered. Residents must also sign a contract to say they will hand in any medication that they collect from the pharmacy if they are not allowed to keep their medication in possession.
47. Tramadol is an opioid based painkiller prescribed to control severe pain. Toxicology tests carried out as part of the post-mortem indicated that Mr Dent-Jones had 3.96mg/l (milligrams per litre) in his blood stream. A prescribed dose of tramadol would result in a reading of approximately 1.0mg/l, indicating he had taken an excessive amount of tramadol shortly before his death.
48. Excessive amounts of tramadol can result in tachycardia (fast heart rate) seizures, respiratory issues, unconsciousness or coma. Mr Dent-Jones was known to have a history of heart attacks.
49. We do not know where or when Mr Dent-Jones obtained tramadol. His prescription for tramadol had been stopped while he was at HMP Lewes due to suspicions that he was diverting his medication and he was not prescribed tramadol while at St Catherine's Priory. It is possible that he obtained it illicitly in the community or through a hospital or a medical drop-in facility.
50. We are satisfied that AP staff could not have predicted or prevented Mr Dent-Jones' death. We make no recommendation.

Welfare checks

51. The AP Manual says that staff should carry out welfare checks on residents twice daily, once at 11.00pm and again at 8.00am. It is AP policy that the night welfare check is to be carried out by two members of staff, and the morning check is completed by one member of staff.
52. We are concerned that on 13 July, AP staff incorrectly told the residential worker that the requirement for two members staff to complete the night-time welfare check had been changed. He told her that she could carry out the check on her own.

53. While on this occasion it did not affect the outcome for Mr Dent-Jones, or pose a threat to the residential worker's personal safety, that might not be the case in the future. We make the following recommendation:

The manager of St Catherine's Priory Approved Premises should ensure that staff conducting welfare checks do so in line with national guidance and that staff are reminded of the need for two staff to carry out night time welfare checks

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