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IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Michael Dent-Jones
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted] Director General of Probation and Wales HM Prison and Probation Service 3rd Floor Churchill House Churchill Way Cardiff CF10 2HH
2	**CORONER** Miss Anna Crawford, HM Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INQUEST** The inquest into the death of Michael Dent-Jones was opened on 5 February 2019 following an investigation which was commenced on 30 July 2018. The inquest was resumed on 4 February 2021 and the conclusion was handed down on 5 February 2021. The medical cause of Mr Dent-Jones's death was: 1a. Tramadol Toxicity 2. Coronary Artery Disease The inquest concluded with a short-from conclusion of 'Drug-Related Death' and a Narrative Conclusion as set out below.

	'Drug-Related Death. The Approved Premises Manual 2014 (Version 2), which was in force at the time and remains in force, states that residents in Approved Premises should not be allowed to collect their prescribed medication themselves. The Approved Premises Manual requires each Approved Premises to have a system in place so that the residents' prescribed medication can be provided directly to staff at the Approved Premises. There was a failure on the part of the National Probation Service, contrary to the Approved Premises Manual, to set up such a system at St. Catherine's Priory and as a result Mr Dent-Jones was able to gain access to his Tramadol prescription which he then overdosed on resulting in his death.'
5	CIRCUMSTANCES OF THE DEATH On 10 March 1994 Mr Dent-Jones received a life sentence with a minimum term of 12 years. Whilst he was in prison he was suspected of misusing alcohol and prescription and illicit drugs. On 27 September 2017 Mr Dent-Jones was released on licence to an Approved Premises in Brighton run by the National Probation Service. On 2 November 2017 he was recalled to prison for breaching the conditions of his licence, due to a pattern of alcohol and drug misuse which culminated in his admission to hospital due to suspected illicit drug use. On 15 November 2017, whilst Mr Dent-Jones' was in prison, his prescription for Tramadol, which was prescribed in relation to chronic back pain, was stopped by the healthcare team due to concerns that he was pretending to swallow the tablets when they were dispensed to him but was in fact concealing them. On 9 July 2018 Mr Dent-Jones was again released on licence, on this occasion to St Catherine's Priory, an Approved Premises in Guildford, also run by the National Probation Service.

	On his arrival at St.Catherine's Priory, Mr Dent-Jones was assessed as not being suitable to keep his medication in his own possession due to his history of drug abuse and he agreed to hand in his prescribed medication to staff. On 11 July 2018 Mr Dent-Jones registered at Dapdune House GP Surgery in Guildford and requested a prescription of Tramadol for long standing back pain. He informed the prescribing GP that he had been taking Tramadol for many years and that he got withdrawal symptoms if he did not take it. The records available to the prescribing GP at the time confirmed that Mr Dent-Jones had had a long-term prescription for Tramadol. However, the prescribing GP was not aware that Mr Dent-Jones had a history of drug abuse or that his prescription of Tramadol had been stopped in November 2017 due to concerns that he had been concealing the tablets. Accordingly, a prescription of [redacted] Tramadol tablets was issued to Mr Dent-Jones and Mr Dent-Jones subsequently collected the prescription from Dapdune House Pharmacy. Mr Dent-Jones did not inform staff at St.Catherine's Priory that he had obtained the Tramadol tablets or hand them in. On 14 July 2018 Mr Dent-Jones was found deceased in his bed at St Catherine's Priory, having last been known to be alive at approximately 11pm the night before. Mr Dent-Jones' death was caused by an unintentional overdose of Tramadol, and contributed to by his Coronary Artery Disease, which reduced his cardiac reserve. The inquest concluded with the following short-form and narrative conclusion as set out in Box 4 above.

6	**CORONER'S CONCERNS** The Coroner's concerns are as follows: During the course of the inquest the court heard the following evidence: - The National Probation Service Approved Premises Manual 2014 requires Approved Premises to put in place a local procedure for the collection/delivery of residents' prescribed medication. The residents are not to be permitted to collect it themselves; - In December 2018 the National Probation Service introduced the Safe Working Practices Document which sets out NPS policies and procedures in relation to various aspects of resident safety. Each Approved Premises is required to adapt the document to include their local procedure in respect of the delivery/collection of residents' prescribed medication. Each Approved Premises is also required to maintain a Register confirming that every member of staff has read and understood the Safe Working Practices Document for the particular Approved Premises they work in. - However, the Area Manager for Approved Premises in Surrey, Sussex and Bedfordshire gave evidence that prior to the inquest she had not previously been aware of the requirement to set up a system for the delivery/collection of prescribed medication as set out in the Approved Premises Manual 2014 and she had not previously seen a copy of the Safe Working Practices Document 2018. - The witness also gave evidence that until very recently there had not been no procedure in place for the collection/delivery of residents' prescribed medication at St. Catherine's Priory in Guildford or at the Approved Premises in Brighton. - The National Probation Service was unable to provide the court with a copy of the Safe Working Practices Document for St. Catherine's Priory. - St. Catherine's Priory does not have a Register confirming that every member of staff had read and understood the Safe Working Practices Document.

	Accordingly I am concerned that: - Staff at St Catherine's Priory Approved Premises in Guildford, as well as staff in other Approved Premises nationally, may not be familiar with, or applying, the guidance set out in the Safe Working Practices Document in relation to the delivery/collection of residents' prescribed medication, but also more generally in relation to the other policies and procedures pertaining to resident safety in that document. The **MATTER OF CONCERN** is: - Staff at St Catherine's Priory Approved Premises in Guildford, as well as staff in other Approved Premises nationally, may not be familiar with, or applying, the guidance set out in the Safe Working Practices Document in relation to the delivery/collection of residents' prescribed medication, but also more generally in relation to the other policies and procedures pertaining to resident safety in that document.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

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9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Dapdune House Surgery 3. Guildowns Group Practice 4. Prisons and Probation Ombudsman
10	**Signed:** **Anna Crawford** **H.M. Assistant Coroner for Surrey** **Dated this 12th Day of February 2021**