

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Brennan, a resident at Weston Approved Premises, on 2 November 2019

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 Stephen Brennan died of mixed drug and alcohol toxicity at Weston Approved Premises (AP) on 2 November 2019. He was 33 years old. I offer my condolences to his family and friends.

Mr Brennan had a history of significant substance misuse but told staff when he arrived at Weston Approved Premises that he had not used drugs for 15 months. He consistently tested negative for drugs and alcohol during his three and a half weeks at the AP, including on the day before his death. I am satisfied that staff at the AP could not reasonably have prevented his death.

I am concerned that opioid antidotes are not available to staff working in approved premises managed by the National Probation Service. Although we cannot say if this affected the outcome in Mr Brennan's case, we have recommended in several previous investigations that the National Probation Service should review its drugs strategy for approved premises. I am concerned by the length of time this is taking. Urgent action is now required.

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

March 2021

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Summary

Events

1. On 8 October 2019, Mr Steven Brennan was released on licence from HMP Portland and was required to live at Weston Approved Premises (AP).
2. Probation records show that staff conducted ten drug and alcohol tests on Mr Brennan at Weston, the last on the day before his death, and that they were all negative.
3. At 4.45pm on 2 November 2019, Mr Brennan returned to the AP and attended an event with other residents at around 5.30pm. The residential workers on duty told us that Mr Brennan did not present as being under the influence of drugs or alcohol. Mr Brennan went to his room around 9.00pm.
4. At 11.05pm, two residential workers opened Mr Brennan's door to conduct a welfare check and saw him slumped over his television table. A residential worker used her mobile phone to call an ambulance. A residential worker left the room to get a defibrillator and three residents helped to move Mr Brennan onto the floor so staff could start cardiopulmonary resuscitation (CPR).
5. At 11.12pm, paramedics arrived and took over resuscitation efforts. At 11.52pm, a paramedic confirmed that Mr Brennan had died.
6. A post-mortem examination found that Mr Brennan died of mixed drug and alcohol toxicity.

Findings

7. Although Mr Brennan had a history of substance misuse, he told staff he had been drug free for 15 months. He displayed a positive attitude and provided 10 negative drug and alcohol tests during his three and a half weeks at the AP. We are satisfied that AP staff could not reasonably have predicted Mr Brennan's actions.
8. We know that opioid antagonists (antidotes), such as naloxone, are not available to staff at APs managed by the National Probation Service. We cannot say if they might have changed the outcome for Mr Brennan. In several previous investigations, we have recommended that the National Probation Service review its drug strategy for APs. The National Approved Premises Team told us in response that they are currently working on a revised strategy and plan to implement it over the course of 2020 and 2021.
9. We are satisfied that probation staff acted promptly when they found Mr Brennan unresponsive and acted in accordance with ambulance service instructions.

Recommendation

- The Head of the National Approved Premises Team should provide the Ombudsman with an update on the progress of the revised drug strategy, which includes the use of opioid antagonists, and when it will be fully implemented.

The Investigation Process

10. The investigator issued notices to staff and prisoners at Weston Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No residents responded.
11. The investigator visited Weston Approved Premises on 14 November 2019 and interviewed three members of staff on 27 October and 9 and 19 November 2020. She obtained copies of relevant extracts from Mr Brennan's probation records.
12. We informed HM Coroner for Dorset of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. Our investigation was delayed while we waited for the cause of death.
14. We wrote to Mr Brennan's brother, his nominated next of kin, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not ask any questions or raise any concerns.
15. Mr Brennan's brother received a copy of the initial report. He did not raise any further issues, or comment on the factual accuracy of the report.
16. The initial report was shared with the HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

Weston Approved Premises

17. Approved premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. They aim to provide a supportive and structured environment in the community. Residents are responsible for their own health and are expected to register with a GP.
18. Weston AP in Weymouth is managed by HM Prison and Probation Service (HMPPS). It has capacity for 24 residents. Residents are expected to attend a weekly residents' meeting and there is a curfew between 11.00pm and 6.00am. Each resident is allocated a keyworker to oversee his progress and wellbeing, and to ensure that they adhere to licence conditions and the AP's rules. Probation Service employees are on duty at Weston 24 hours a day. Staff complete welfare checks at 7 am and midnight. A curfew check is carried out at 11 pm. As part of the daily checks, staff confirm that they have additionally seen residents in the morning and also in the afternoon unless they are off the premises.

Previous deaths at Weston Approved Premises

19. Mr Brennan was the second resident to die at Weston. There were no similarities with the previous death (which took place in 2011).

Key Events

20. On 25 May 2018, Mr Stephen Brennan was sentenced to three and a half years in prison for robbery and was sent to HMP Portland.
21. Mr Brennan had a long history of drug and alcohol misuse and poor mental health and received help from the prison's substance misuse team and mental health team. He had a history of threatened and attempted suicide and was managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT) on seven occasions while he was in prison. Prison staff stopped ACCT monitoring for the final time on 3 July 2019.

Weston Approved Premises

22. On 8 October, Mr Brennan was released on licence from Portland. His licence conditions included requirements to attend appointments with his offender manager (probation officer), to abstain from using drugs and to comply with drug testing. Mr Brennan's licence required him to be at Weston AP between the hours of 7pm and 7am.
23. A residential worker completed Mr Brennan's induction and explained his licence conditions and the AP rules. This included a discussion with him about a reduced tolerance to drugs and an increased risk of overdose after release from prison. She noted that Mr Brennan intended to register with a GP practice and needed to be tested for drugs and alcohol at least four times a week. Mr Brennan was tested for drugs and alcohol and the results were negative.
24. The same day, Mr Brennan met with his offender manager. He said that he had been drug free for 15 months and had not consumed alcohol for two months. Mr Brennan was assessed as a low risk of suicide and self-harm. His prescribed medication included zopiclone (for insomnia), diazepam (an antidepressant) and quetiapine (an antipsychotic). Staff kept his medication in the office, and he had to collect it daily.
25. Probation records show that a residential worker was allocated as Mr Brennan's AP keyworker. A keyworker works with the resident and their probation offender manager to address any issues that the resident might have. Mr Brennan met with his keyworker on 9 October.
26. On 10 October, a residential worker completed the second stage of Mr Brennan's induction. She noted that he had registered with a GP, had a bank account and had made an application for universal credit.
27. Probation records show that staff conducted drug and alcohol tests on 11, 12 and 14 October and they were all negative.
28. On 16 October, Mr Brennan returned to Weston in a distressed state. He told staff that he had argued with his girlfriend because she had given him a cigarette which contained crack cocaine. Staff decided not to test Mr Brennan for drugs because he was extremely emotional and upset. The next day, Mr Brennan tested negative for drugs and alcohol. Mr Brennan received support from his

offender manager and key worker and denied any feelings of suicide and self-harm.

29. On 19 and 20 October, Mr Brennan tested negative for drugs and alcohol. On 22 October, Mr Brennan told his keyworker that he had ended his relationship with his girlfriend. His GP had prescribed pregabalin (for anxiety) and arranged an appointment with the community mental health team on 11 November. He tested negative for drugs and alcohol.
30. Mr Brennan told staff that he was still experiencing difficulties with his ex-partner. On 29 October, a residential worker went with Mr Brennan to Weymouth police station to report alleged harassment from his ex-partner. The police advised Mr Brennan to ignore any contact.
31. On 31 October, the offender manager told Mr Brennan that she had arranged an appointment with a domestic abuse advisor on 6 November. The same day, Mr Brennan told his keyworker that he was short of money and had been offered money to sell drugs. Mr Brennan asked staff to accompany him to his appointment with the community mental health team and the domestic abuse advisor. Probation records show Mr Brennan tested negative for drugs and alcohol on 31 October and 1 November.

Events of 2 November

32. Probation records shows that Mr Brennan left Weston on three occasions. He returned at 4.45pm and attended a Caribbean food night with other residents. Two residential workers were on duty at Weston that evening. They said they saw no signs that Mr Brennan was under the influence of drugs or alcohol. Mr Brennan returned to his room at approximately 9.00pm.
33. At 11.05pm, both residential workers conducted the residents' welfare checks. They knocked on Mr Brennan's door and entered when he did not respond. Mr Brennan was slumped over his television table. One lifted Mr Brennan's head and saw that he had vomited. The other used her mobile phone immediately to call an ambulance and the other left the room to get a defibrillator. When she returned, three residents helped move Mr Brennan to the floor to enable the residential worker to start CPR and to attach the defibrillator in accordance with ambulance service instructions.
34. At 11.12pm, paramedics arrived at Mr Brennan's room and took over resuscitation efforts. At 11.52pm, a paramedic pronounced that Mr Brennan had died.

Contact with Mr Brennan's family

35. The normal practice when a resident dies in an AP, is for the police to inform the next of kin. The AP manager told the investigator that staff gave the police Mr Brennan's brother's contact details as he had named him as his next of kin. As Mr Brennan's brother was serving in the Army overseas, the police broke the news of Mr Brennan's death by telephone. The next day, the AP area manager emailed Mr Brennan's brother to offer her condolences and support.

36. The AP area manager continued to provide ongoing support to Mr Brennan's brother. Mr Brennan's body was returned to Ireland, where his funeral took place. The Probation Service contributed towards the cost, in line with national policy.

Support for prisoners and staff

37. After Mr Brennan's death, the AP manager offered immediate support to the staff on duty. Support was offered to all the staff who worked at the AP the next day.
38. Staff held a meeting and told all the residents that Mr Brennan had died and offered support. Notices were posted.

Post-mortem report

39. The post-mortem found that Mr Brennan had a level of quetiapine in his blood above that is usually associated with therapeutic use. Buprenorphine (a semi-synthetic opioid, also known as Subutex), cocaine and alcohol were also detected at levels associated with recreational use. The report concluded that the most likely cause of Mr Brennan's death was mixed drug and alcohol toxicity.

Findings

Substance misuse

40. The post-mortem report established the cause of Mr Brennan's death as mixed drug and alcohol toxicity. Mr Brennan told his offender manager that he had been drug free for 15 months and he displayed a positive attitude towards avoiding situations where he could be tempted to use illicit substances. Mr Brennan received support from Weston staff when he experienced difficulties with his ex-partner and an appointment was made with a domestic abuse advisor. Mr Brennan provided ten negative drug and alcohol tests during his three and a half weeks at Weston. The last of these was on 1 November, the day before his death.
41. The staff who had contact with Mr Brennan on 2 November said that he appeared normal and did not present as being under the influence of drugs. We are satisfied that AP staff did not have sufficient reason to suspect that he might be using drugs or to conduct a drug test. We do not consider that staff could reasonably have prevented his death.
42. However, we are concerned that staff in approved premises, which hold a particularly high-risk group of people, are apparently ill-equipped to respond to drug overdoses. In November 2014, the World Health Organisation launched new guidelines on the management of heroin overdoses in the community which recommended training first responders, including non-medical first responders, to administer opiate antagonists (antidotes), such as naloxone.
43. Historically, opioid antagonists were used only by clinicians but are now being provided to drug users, their families and other potential first responders who may not be clinically trained. Given the potentially lifesaving properties of opioid antagonists, we are concerned that they are not available to staff in approved premises managed by the National Probation Service (although some approved premises residents may have them on a personal basis). While we cannot say whether the outcome would have been different in Mr Brennan's case if staff had had access to naloxone, it could be critical in other emergencies.
44. In several investigations dating back to 2016, we have recommended that the National Probation Service review its drugs strategy for approved premises. The Deputy Head of the National Approved Premises Team told us that a substance misuse subgroup was working on a revised strategy, which would include the use of opioid antagonists. She said that after a period of consultation and liaison, they aimed to roll out the strategy nationally over the course of 2020. While we appreciate that the COVID pandemic may have caused some delay, we are concerned that this strategy has been in the development stage for a significant period and consider that urgent action is needed to ensure it is implemented at the earliest opportunity. We make the following recommendation:

The Head of the National Approved Premises Team should provide the Ombudsman with an update on the progress of the revised drug strategy, which includes the use of opioid antagonists, and when it will be fully implemented.

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