Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sean Heeney, a prisoner at Bridgewood House Approved Premises, on 26 September 2019

A report by the Prisons and Probation Ombudsman

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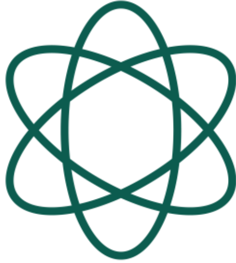
Our vision

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

OGL

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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 Sean Heeney died in hospital of a hypoxic brain injury caused by a cardiac arrest on 26 September 2019. This was caused by the use of heroin and cocaine. He was a resident at Bridgewood House Approved Premises and was found unconscious in his room on 22 September. He was 34 years old. I offer my condolences to his family and friends.

Staff at Bridgewood House had limited contact with Mr Heeney during the two weeks he spent there and therefore lacked insight about how to support him. Mr Heeney's keyworker recorded very little about his time at Bridgewood House. Despite Mr Heeney's history of substance misuse, he was not referred to community substance misuse services. I am also concerned that no formal support arrangements were put in place for residents after Mr Heeney's death.

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 **February 2021**

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Summary

Events

1. On 9 September 2019, Mr Sean Heeney was released on licence from HMP Highpoint to Bridgewood House Approved Premises (AP) in Northampton. He had a history of substance misuse and had ADHD, for which he was prescribed medication.

2. On 11 September, Mr Heeney's offender manager visited him to discuss his supervision and licence conditions, but the meeting was cut short as Mr Heeney had already planned to meet his father. His offender manager was disappointed that AP staff had not reminded Mr Heeney of the meeting.

3. On 12 September, Mr Heeney tested negative for drugs. He tested positive for alcohol but was under the legal limit.

4. On the morning of 18 September, AP staff informed Mr Heeney's offender manager that Mr Heeney had accepted a part-time voluntary job with a local charity. Mr Heeney had not sought permission before doing so, contrary to the requirements of his probation licence.

5. On 21 September, Mr Heeney left the AP at 4.45pm and said he was going to the park. When he returned at 7.00pm, AP staff said they had no concerns about his behaviour and no reason to suspect that he was using drugs. AP staff last saw Mr Heeney shortly after 11.00pm, going into his room.

6. On 22 September, staff found Mr Heeney on the floor of his room, surrounded by vomit, breathing heavily and unconscious. Drug paraphernalia were found nearby. An ambulance was called.

7. When paramedics arrived, they treated Mr Heeney whose condition improved slightly. However, Mr Heeney became verbally aggressive and the paramedics called the police to help them escort him to hospital. When the police arrived, they handcuffed Mr Heeney as a safety precaution to move him to the ambulance. Shortly afterwards, Mr Heeney had serious breathing difficulties and had a cardiac arrest. The police removed the handcuffs and the paramedics administered cardiopulmonary resuscitation (CPR).

8. Mr Heeney was taken to hospital where he was diagnosed with hypoxic brain injury and died on 26 September.

9. The post-mortem report concluded that Mr Heeney's death was not related to the police handcuffing him.

Findings

Keyworker role

10. We found that AP staff did not provide key work sessions to Mr Heeney. This may have contributed to his lack of understanding of his licence conditions.

Substance misuse

11. Despite Mr Heeney's history of substance misuse, he was not referred for any support and there was no evidence that staff reminded him about his likely reduced tolerance to drugs and his increased risk of overdose. Mr Heeney was also not subject to a formal drug testing regime.

Emergency safety equipment

12. AP night staff failed to carry emergency safety equipment during their shift. However, this had no significant effect on Mr Heeney during the emergency.

Naloxone

13. AP staff were not issued with naloxone to administer to residents who have taken an opioid overdose. We understand that the National Approved Premises Team is in the process of rolling out the administration of naloxone across the approved premises estate.

Support and counselling for residents and staff

14. AP staff were not offered formal support after Mr Heeney's death.

Recommendations

- The Bridgewood House Approved Premises manager should ensure that all keyworkers supervise residents in line with national instructions, have regular, quality contact with them and record their interactions in probation system records. In particular, all AP staff should ensure that licences are appropriately reviewed and enforced in line with national standards.

- The Deputy Director of Community Interventions with responsibility for approved premises and the Bridgewood House Approved Premises Manager should ensure that:

  - new residents with known substance misuse issues are referred promptly to community drugs and alcohol support services; and

  - they are tested for drugs within the first day of arrival and at appropriate intervals afterwards in line with the Offender Manager's plans.

- The Bridgewood House Approved Premises manager should ensure that staff always carry emergency equipment with them when conducting welfare checks.

- The Deputy Director of Community Interventions with responsibility for approved premises should update the Ombudsman on the expected timeframe for completion of the roll out of naloxone to the approved premises estate.

- The Bridgewood House Approved Premises manager should ensure that residents are offered support after the death of another resident or a potentially traumatic event.

The Investigation Process

15. The investigator, issued notices to staff and prisoners at Bridgewood House Approved Premises, informing them of the investigation and asking anyone with relevant information to contact him. One resident responded. The investigator obtained copies of relevant extracts from Mr Heeney's probation records.

16. The investigator interviewed seven members of staff and one resident at Bridgewood House on 15 October 2019.

17. In line with the Ombudsman's terms of reference, the investigation was suspended while the Northamptonshire Police and the Independent Office for Police Conduct investigated the circumstances of Mr Heeney's death. The investigator remained in contact with the police during the investigation and shared information with them.

18. We informed HM Coroner for the County of Northamptonshire of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr Heeney's father to explain the investigation. He asked about the circumstances leading up to his son's death. We have addressed this in this report.

20. Mr Heeney's father and sister received a copy of the draft report. The solicitor representing Mr Heeney's father responded and stated that although Mr Heeney did not agree with the findings of the investigation, he had no particular factual issues to raise at this stage.

21. The approved premises also received a copy of the report and did not identify any factual inaccuracies. An action plan for the recommendations is annexed to the report.

Background Information

Bridgewood House Approved Premises

22. 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.

23. Bridgewood House in Northampton is managed by HM Prison and Probation Service (HMPPS). It has capacity for 21 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 Bridgewood House 24 hours a day. Staff complete welfare checks on residents at 6.00am, 9.30am, 5.30pm and 11.00pm.

24. At the time of Mr Heeney's death, Bridgewood House had an improvement plan in place, overseen by the area manager, to improve the efficiency and management of the approved premises. There is no indication that there was a direct link between the improvement plan and the issues raised in this report.

Previous deaths at Bridgewood House

25. Mr Heeney was the first resident to die at Bridgewood House.

Key Events

26. In October 2016, Mr Sean Heeney was sentenced to seven years in custody for driving offences and for robbery and possession of an offensive weapon.

27. He had a long history of drug and alcohol misuse and had attention deficit hyperactivity disorder (ADHD), for which he was prescribed medication.

28. Mr Heeney admitted that he used psychoactive substances (PS) in prison and received support from the substance misuse service.

Bridgewood House AP

29. On 9 September 2019, Mr Heeney was released on licence from HMP Highpoint to Bridgewood House. 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.

30. A residential worker completed Mr Heeney's induction and explained his licence conditions and the AP rules. This included a discussion with Mr Heeney about reduced tolerance to drugs and increased risk of overdose after release from prison. The residential worker noted that she told Mr Heeney that he was to meet his offender manager on 11 September. Mr Heeney told staff that he took medication for his ADHD. He arrived with a five-day supply. The AP rules require all residents to register with their local GP surgery as soon as possible and provide evidence to AP staff. AP staff had no evidence to confirm that Mr Heeney had registered with the local GP.

31. It was noted in the probation records that a probation service officer, was allocated as Mr Heeney's AP keyworker. A keyworker works with the resident and their probation offender manager to addresses any issues that the resident may have.

32. Mr Heeney's offender manager told us that she would have expected AP staff to have tested Mr Heeney for drugs when he arrived. The investigator found no evidence that this was done.

33. At 9.45am on 11 September, Mr Heeney phoned the probation manager. He spoke to another offender manager who told him that the probation manager was on her way to see him for an intensive supervised probation (ISP) appointment at 11.00am. (ISP is a form of release into the community that emphasizes close monitoring of convicted offenders.) This meeting had been arranged in August 2019 and AP staff should have been told about it. Mr Heeney said that AP staff had only told him about the meeting that morning and he was unable to attend as he had planned to meet his father. The probation manager told Mr Heeney that he had to attend the meeting and phoned the AP to let them know. AP staff said that they had already told Mr Heeney about the meeting but spoke to him again. Mr Heeney agreed to attend.

34. The probational manager arrived and attended the meeting with Mr Heeney and a probation service officer who worked at the AP and was standing in for his colleague, who was on leave.

35. Mr Heeney told the probational manager that he had not known about the meeting and needed to leave. The probational manager tried to discuss Mr Heeney's rehabilitation in the community (for example, addressing his drug use, accommodation, education and employment) but was only able to do so in a limited way. Mr Heeney said that he would be tempted to misuse drugs when he was around other drug or alcohol users. The probational manager reminded Mr Heeney of his need to comply with his licence conditions. She recorded that Mr Heeney was agitated, distracted and wanted to leave. The meeting ended prematurely, and the probational manager asked a probation service officer to complete Mr Heeney's probation induction paperwork later. She told us that the ISP appointment was important, and she was disappointed that the AP had appeared not to have reminded Mr Heeney about it.

36. That afternoon, the probational manager emailed two probation service officers, to arrange a teleconference with Mr Heeney to complete his ISP.

37. On 12 September, Mr Heeney tested negative for drugs but positive for alcohol and admitted that he had had drunk two cans of beer. As there were no restrictions on Mr Heeney's licence against him drinking alcohol, and his test result was within the legal limit, staff took no action.

38. On 14 September, an offender manager, completed Mr Heeney's probation induction. She raised no concerns.

39. On Tuesday 17 September, a probation service officer emailed the probation manager and told her that Mr Heeney had asked his offender manager to provide a character reference as soon as possible. The probational manager responded that she would discuss it with Mr Heeney during their planned teleconference the next day. The two probation service officers were also due to attend, and she reminded a probation service officer to ensure that Mr Heeney was present.

40. On 18 September, probation service officer emailed the probational manager and a probation service officer. She said that Mr Heeney was due to start a voluntary work placement that morning. Aware that he had a teleconference with the probational manager at 12.00pm, Mr Heeney had asked for the meeting to be postponed to 1.00pm. A probation service officer also asked if she could be included in the teleconference as she was Mr Heeney's keyworker.

41. One of the probation service officers emailed to ask for the teleconference to be rescheduled to 20 September as he was unwell. The probational manager responded by email to suggest an alternative date of 25 September. She asked for all appointments with Mr Heeney to be recorded in the AP diary, and for him to be informed immediately and reminded about them verbally.

42. Afterwards, the probational manager phoned Mr Heeney, who had arrived at his voluntary work placement. She noted that Mr Heeney was frustrated and wanted immediate answers to questions about his employment. She told Mr Heeney that, in line with his probation licence conditions, he should not have agreed to undertake any form of work unless it was approved by his offender manager.

43. The probational manager contacted the manager at Mr Heeney's workplace who assured her that they were aware of his convictions and work restrictions. The

probational manager told the manager that the Probation Service was unable to provide a character reference for Mr Heeney and that she would also need to discuss with her manager whether he was suitable for this work. In the meantime, she spoke to Mr Heeney and told him that he would be allowed to work that week on a probationary basis. She agreed that once she had spoken to her manager, she would confirm whether he could continue to work. She agreed with Mr Heeney that she would send appointments by text to his mobile phone.

44. A probation service officer emailed the probation service officers to say that Mr Heeney was keen to get a job but reminded them that his offences had included aggravated burglary and robbery, so she or her manager had to approve any work requests. She also said that she had read that Mr Heeney had tested positive for alcohol and asked to be kept updated about his behaviour.

45. That day, the probational manager emailed the AP staff to say that, even though Mr Heeney had only recently been released from prison and had not completed his ISP appointment, Mr Heeney could go to his work placement for a week. She noted her dissatisfaction about this and that she would discuss it with her manager and update the AP staff the next week.

46. That evening a residential support worker, completed an alcohol test for Mr Heeney which indicated that he had drunk alcohol but was under the legal limit. No drug test was completed.

47. On 20 September, a probation service officer recorded that AP staff had completed Mr Heeney's probation induction paperwork and forwarded it to the probational manager.

48. That day, a residential worker noted that Mr Heeney had returned to the AP to sign in at 4.00pm and tried to bring a ten-year old boy, who he said was his friend's son, into the AP. A residential worker met Mr Heeney at the entrance and told him that he was not allowed to bring a child onto the premises. Mr Heeney said that he had only returned to sign in and planned to leave. The residential worker agreed to wait outside with the child while Mr Heeney signed in. Mr Heeney returned shortly afterwards and left.

49. On 21 September, a residential worker emailed the probational manager to tell her about Mr Heeney trying to bring a child into the AP. She said she had spoken to Mr Heeney again about the incident and he eventually said he understood the issues and risks and agreed not to repeat his actions.

50. That afternoon, Mr Heeney failed to return to the AP by 4.00pm to sign in. A residential support worker tried unsuccessfully to phone Mr Heeney. On the last occasion that he tried, a young child answered Mr Heeney's phone and said that Mr Heeney was his uncle.

51. At 4.15pm, the residential support worker informed the out-of-hours probation on-call manager that Mr Heeney had failed to return to the AP on time. The on-call manager said that Mr Heeney should be allowed a little more time to return to the AP before taking any formal action. (Formal recall procedures could be considered.)

52. At 4.30pm, Mr Heeney phoned the AP and said that he had fallen asleep in the park and was on his way back. He arrived at 4.40pm. He apologised for being late and said that his nephew had answered his phone because he was sleeping. A residential support worker noted that Mr Heeney looked like he had been drinking. However, he told the investigator that Mr Heeney's behaviour was not a cause for concern. A night residential support worker agreed and said Mr Heeney had not caused any problems.

53. Mr Heeney ate his evening meal and staff saw him talking to other residents. Mr Heeney left the AP at around 4.45pm and said he was going to the park. He returned at 7.00pm.

54. At 9.30pm. A night residential support worker started duty and joined a residential worker. She told us that she had had a short conversation with Mr Heeney at around 10.30pm but had no concerns.

55. At 11.00pm, the two residential workers completed a night welfare check of all residents and confirmed that they were all present. Mr Heeney was not in his room but was taking a shower in the communal shower room. A residential worker asked Mr Heeney if he was okay and Mr Heeney replied yes. A residential worker later saw Mr Heeney on CCTV leave the shower room and return to his room. Mr Heeney showed no signs of being unwell.

Events of 22 September

56. Two residential workers started the morning welfare check of all residents in the AP. CCTV footage shows that one of them arrived at Mr Heeney's room at 5.58am, opened the door and looked in. She told the investigator that his light was on but Mr Heeney was not in his bed. She cautiously stepped into the room and saw Mr Heeney, lying on his side on the floor. He was snoring loudly and there was vomit on and around him. She called Mr Heeney's name several times but he did not respond.

57. CCTV footage shows she left Mr Heeney's room after about a minute. She quickly completed welfare checks of other residents and then alerted her colleague, who was in the office downstairs, that she had concerns about Mr Heeney. The residential worker told us she thought Mr Heeney may have fallen asleep in his vomit and wanted her colleague to help her check he was okay.

58. CCTV footage shows the two residential workers returned to Mr Heeney's room at 6.02am. One of them told the investigator that Mr Heeney was in an unnatural position on his side on the floor, with vomit all over his body and he appeared to be struggling to breath. He told a residential worker to call an ambulance. She returned to the office and did so. The ambulance log recorded the emergency call at 6.02am.

59. A residential worker tried to put Mr Heeney in the recovery position, but he was too heavy to move. A resident who lived in the room next to Mr Heeney's, came out of his room to use the toilet. The residential worker asked the resident to help him and they put Mr Heeney in the recovery position. The residential worker saw drug paraphernalia near Mr Heeney's body and moved it to a safe place. The resident told the investigator that he saw a needle in Mr Heeney's arm and carefully pulled it

out and put it in a safe place. He said Mr Heeney was making a “rattling noise”. A residential worker removed vomit from Mr Heeney’s mouth to clear his airway.

60. The ambulance control room operator asked a residential worker a number of questions about the emergency and Mr Heeney’s condition. She tried to obtain the answers from her colleague by radio while speaking to the operator. As the information requested became more specific, the residential worker ran to the office to speak to the operator. He left a resident monitoring Mr Heeney.

61. The ambulance controller asked for a residential worker be located close to Mr Heeney so that he could report his symptoms to them. The operator transferred the phone call to the residential worker mobile phone, and he returned to Mr Heeney’s room. The other residential worker stayed in the office as she needed to keep the building secure.

62. The ambulance control room operator instructed the residential worker how to maintain Mr Heeney’s breathing until the ambulance crew arrived. He continually cleared Mr Heeney’s airways, monitored and checked his breathing and constantly shouted his name as, at times, Mr Heeney became motionless and had breathing difficulties.

63. At around 6.20am, a residential worker phoned the AP on-call manager and updated him. In his statement, the AP on-call manager said he told the on-call duty director.

64. The ambulance paramedics arrived at the AP at 6.38am and took over Mr Heeney’s care. He was unresponsive, with noisy breathing, and he had poor vital signs. The paramedics called for urgent assistance and administered oxygen and naloxone, a drug used to reverse the effects of opiates. (AP staff are not currently issued with naloxone pens.)

65. A resident and a residential worker said that the naloxone appeared to improve Mr Heeney’s condition. He became more conscious of his surroundings and answered to his name. However, as Mr Heeney’s level of consciousness increased, he became aggressive, told paramedics to leave him alone, was resistant and tried to pull off the oxygen mask and heart monitor clips attached to his chest. The paramedics discussed how to move Mr Heeney safely from the AP to hospital.

66. At 6.50am, a residential support worker arrived at the AP to start work and a residential worker updated him on what had happened.

67. At 7.00pm, the ambulance log noted that Mr Heeney was agitated and confused. At 7.15am, two more paramedics arrived. At 7.27am, the ambulanced log noted that the paramedics had called the police to help them move Mr Heeney to hospital. It was noted that he was a large man and a violent offender.

68. A residential worker and the resident left Mr Heeney’s room and went to the office to update the AP staff about Mr Heeney’s condition. The residential support worker noted that the paramedic told AP staff that they had requested police assistance to move Mr Heeney. They were concerned Mr Heeney could become aggressive while they were moving him.

69. By 7.49am, four police officers had arrived. Shortly after this, the ambulance log noted that Mr Heeney had become agitated and the police had restrained him with handcuffs. This was considered appropriate to reduce the risk of him becoming physically agitated while being moved and causing injury to himself or paramedics.

70. Mr Heeney remained handcuffed for approximately six and a half minutes. He was able to follow instructions, the police helped him sit up and he was given a glass of water at his request. Mr Heeney stood up with assistance but could not walk and was placed back on the floor. One of the paramedics got a carry chair. The paramedics asked if a resident could accompany Mr Heeney to hospital as he appeared to respond positively to his voice. AP staff contacted the resident, who confirmed that this would be okay.

71. The ambulance log noted that at 7.59am, Mr Heeney became unresponsive and, within a minute, had a cardiac arrest. The police removed the handcuffs from Mr Heeney and the paramedics started cardiopulmonary resuscitation (CPR). The paramedics phoned for the assistance of an emergency doctor.

72. At 8.15am, a probation service officer who had arrived for duty, noted that she had phoned the AP on- call manager and asked if she should tell Mr Heeney's father, his next of kin, what had happened. The AP on-call manager told her to wait until the paramedics had treated Mr Heeney.

73. When the doctor arrived, he helped treat Mr Heeney. At 8.36am, the paramedics noted that Mr Heeney started to show signs of life. At 8.45am, the paramedics and the police moved Mr Heeney out of the building and took him to hospital by ambulance. The police told AP staff that they had told Mr Heeney's father of the events of the morning and he had agreed to meet them at hospital.

74. The ambulance arrived at hospital at 9.10am. At around the same time, the AP on-call manager arrived at the AP and offered support to staff.

23 – 26 September

75. When the AP Manager, arrived for duty on 23 September, she phoned the hospital to ask about Mr Heeney's condition. They told her that Mr Heeney was in the intensive care unit and any updates would only be disclosed to his family and the police.

76. The AP Manger phoned Mr Heeney's father who was upset and told her that his son was on a life support machine. She offered to meet him and offered support. He said he would contact her if he needed anything. She remained in daily contact with Mr Heeney's father.

77. That day, the AP Manager also contacted the residential workers to check on their welfare and offer them support. She also told a probation officer what had happened.

78. On 24 September, the AP Manager spoke to Mr Heeney's father and he agreed to meet her at the hospital. Mr Heeney's father was angry that his son had been handcuffed in the AP. (A resident had apparently told him about the incident.) Other members of Mr Heeney's family voiced their concerns about the ambulance

crew's inability to remove Mr Heeney from the AP. The AP Manager later told the AP Area Manager, of Mr Heeney's family's concerns. As she had only been in post for a few months, the AP Area Manager offered her support and guidance.

79. On 26 September, the police phoned the AP Manager and told her that Mr Heeney had died that afternoon.

Support for residents and staff

80. The AP Manger informed all staff on duty about Mr Heeney's death and offered individual and group counselling to those staff directly involved in the incident. An AP Area Manager visited the AP on 27 September and offered support to the AP Manger

81. The AP Manager told the investigator that one resident was offered support but other residents were not offered support before or after Mr Heeney's death. This resident had regularly updated the other residents about Mr Heeney's health condition as he had visited the hospital.

82. The AP contributed to the costs of Mr Heeney's funeral.

Post-mortem report

83. The post-mortem report established that Mr Heeney died from hypoxic brain injury caused by a cardiac arrest. This in turn was caused by aspiration pneumonia which resulted from his use of cocaine and heroin, which were found in his blood. The report noted that Mr Heeney's death was not related to police handcuffing him.

Findings

Keyworker role

84. Probation Instruction (PI) 32/2014 says that all residents should be assigned a keyworker on arrival or as soon after arrival as possible. Keyworkers play a fundamental role in supporting AP residents. Keyworker contact should be at least weekly, recorded and provide interventions to manage any risks in line with the offender manager's supervision plan.

85. We were not persuaded by the service officer's interview that he knew much about Mr Heeney, and there was no evidence that he had much contact with him, despite being his keyworker for most of his time at the AP. There was no evidence in Mr Heeney's probation records that the two service workers (who resumed keyworker duties from 18 September) had conducted any key work sessions with Mr Heeney. We found very little recorded information about Mr Heeney in the probation records. For example, no one noted how he was settling into life at the AP, how he spent or intended to spend his time, or what support the AP had arranged for him. No AP staff checked whether he had registered or intended to register with a GP when he finished his ADHD medication on 14 September.

86. Mr Heeney's offender manager raised concerns about whether AP staff had told Mr Heeney about his ISP appointment. She was unable to complete the ISP interview successfully because Mr Heeney said he was unaware of it and had made alternative plans. This was an important meeting, it was mandatory and was part of Mr Heeney's rehabilitation and supervision back into the community. AP staff noted that they had informed Mr Heeney of this meeting during his induction on the day that he arrived at the AP. However, Mr Heeney said that he had not known about the meeting.

87. Mr Heeney accepted a voluntary job without obtaining permission from his offender manager. This was against the terms of his licence but no AP staff challenged him about this or checked that he had complied with his licence.

88. Overall, there was a lack of engagement between AP staff and Mr Heeney about his licence conditions. While induction is essential and was carried out on Mr Heeney's first day, AP staff should recognise that residents like Mr Heeney, who had been in prison for some time, may struggle to take on board all the details given to them on their first day. Mr Heeney may have forgotten about the ISP interview and it would have been good practice to remind him of the meeting and its importance. We make the following recommendation:

The Bridgewood House Approved Premises manager should ensure that all keyworkers supervise residents in line with national instructions, have regular, quality contact with them and record their interactions in probation system records. In particular, all AP staff should ensure that licences are appropriately reviewed and enforced in line with national standards.

Substance misuse

89. PI 32/2014 says that a main cause of death among AP residents is drug overdose, often due to a reduced tolerance after release from prison, and that APs can play a major part in helping offenders not to misuse substances.

90. The PI instructs that on the day of release, the offender manager should make the resident aware of the risks of overdose if he returns to using drugs. AP staff did this during Mr Heeney's initial AP induction on the day he arrived. However, there is no evidence that staff spoke to him specifically about his reduced tolerance to drugs and increased risk of overdose. Key work sessions should also cover substance misuse, but no sessions were held for Mr Heeney.

91. The PI also states that testing known drug users on arrival at an AP (or when they are suspected of renewed drug use) is a prudent use of resources. AP staff did not drug test Mr Heeney when he arrived but did so three days later on 12 September, when he tested negative. No further drug tests were completed during his stay.

92. Mr Heeney had a history of substance misuse, and it would have been good practice for AP staff to have tested him for drugs on more than one occasion. His offender manager and the AP manager told us that it was a requirement of his licence to abstain from drugs and agreed that he should have been drug tested more. There should have been a plan in place to set out the frequency of drug testing needed for Mr Heeney.

93. Despite Mr Heeney's known history of substance misuse, AP staff did not refer him to the local drug and alcohol services. A service officer told us that he did not know whether Mr Heeney had received any support in prison previously. Mr Heeney's probation records noted in May 2019 that his offender manager had said that he should be referred to the local drug and alcohol service after release from prison. However, there is no evidence that anyone took any action after this. We would have expected AP staff to have checked that support was in place and if not, to have referred Mr Heeney for support. We make the following recommendations:

The Deputy Director of Community Interventions with responsibility for approved premises and the Bridgewood House Approved Premises Manager should ensure that:

- **new residents with known substance misuse issues are referred promptly to community drugs and alcohol support services; and**
- **they are tested for drugs within the first day of arrival and at appropriate intervals afterwards in line with the Offender Manager's plans.**

Emergency equipment

94. AP night staff are required to carry emergency equipment with them when completing welfare checks.

95. The investigation found that the night staff who discovered Mr Heeney unconscious in his room were prompt in raising the alarm. However, neither had a mobile phone (or other emergency aids) with them as they should have done. This prevented them from contacting the emergency services immediately. A residential worker had to go to the AP office to call for an ambulance and the ambulance operator then transferred the call to his mobile phone so that he could return to Mr Heeney's room. We make the following recommendation.

The Bridgewood House Approved Premises manager should ensure that staff always carry emergency equipment with them when conducting welfare checks.

Naloxone

96. Naloxone is the emergency antidote for overdoses caused by heroin and other opiates or opioids (such as methadone, morphine and fentanyl). The main life-threatening effect of heroin and other opiates is to slow down and stop breathing. Naloxone blocks this effect and reverses the breathing difficulties. It can be administered by injection or nasal spray, and can be used by anyone in an emergency, not just medical professionals.

97. Historically, opioid antagonists (antidotes) such as naloxone were only used by clinicians, but they are now being provided to drug users, their families and other potential first responders who may not be clinically trained. 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.

98. 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. Given the potentially lifesaving properties of opioid antagonists, we are concerned that opioid antagonists 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). We cannot say whether staff having access to naloxone would have changed the outcome for Mr Heeney. However, it could be critical in other emergencies.

99. In several investigations dating back to 2016, we have recommended that the National Probation Service should review its drugs strategy for approved premises. The National Approved Premises Team has since been working on a revised strategy, including the use of opioid antagonists, and anticipated rolling out the administration of naloxone to around 40% of the approved premises estate by October 2020. We make the following recommendation:

The Deputy Director of Community Interventions with responsibility for approved premises should update the Ombudsman on the expected timeframe for completion of the roll out of naloxone to the approved premises estate.

Support and counselling for residents and staff

100. The PI notes that after a sudden death, AP staff should consider providing support, including counselling services, to both staff and residents. While staff and one resident was offered support, other residents were not. We make the following recommendation:

    The Bridgewood House Approved Premises manager should ensure that residents are offered support after the death of another resident or a potentially traumatic event.

Inquest

101. The inquest into Mr Heeney's death was held in July 2023. The conclusion was that Mr Heeney's death was drug related, contributed by the failings of EMAS in the management of Mr Heeney's care by Ambulance staff following the initial 999 emergency call.

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