

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of a man, a resident at Milton Keynes Approved Premises in February 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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.

The man died from a heroin overdose at Milton Keynes Approved Premises in February 2015. He was 32 years old. I offer my condolences to his family and friends.

The man had been released from prison on the day that he died. A last minute change of plan meant that he was required to live in Milton Keynes, where he had no social support. This could have been avoided if earlier arrangements had been made to transfer him to another probation area earlier. He had been at the approved premises only a few hours before he died and I am satisfied that staff there could not have anticipated his actions.

However, it is clear from research that previous drug users who have recently been released from prison are at high risk of relapse and of drug overdoses. Given these known risks, and the frequency with which approved premises are likely to have to manage them, I consider that staff need better training to respond to potential overdoses. In light of the increasing availability and apparent efficacy of opiate antidotes, this training should include the ability to administer such medications.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

October 2015

Contents

Summary	
The Investigation Process	
Background Information	
Key Events	
Findings.....	

Summary

Events

1. In July 2013, the man was remanded to HMP Bullingdon charged with grievously bodily harm and common assault against his partner. In October, he was sentenced to 36 months imprisonment. In May 2014, he transferred to HMP Lindholme.
2. The man had been in prison a number of times before. He had been diagnosed with a borderline personality disorder and suffered from anxiety. He misused drugs and alcohol and had a history of self-harm. He had attempted suicide in the community. At Lindholme, he was diagnosed with Huntington's disease.
3. In November 2014, the man told his offender manager that, when he was released in February 2015, he did not want to go back to Oxford, where his offence had taken place and his offender manager was based. He wanted to live near his family in Chesterfield. He said that he had already spoken to the prison's housing support agencies about this.
4. The man's offender manager did not start to transfer his case to Chesterfield Probation Office until 5 February, about a week before his release on 13 February. This meant that Chesterfield could not complete a risk assessment before his release, and they asked his offender manager to keep responsibility for his supervision until they approved the transfer to their area.
5. On 12 February, prison staff told him that he would have to stay at an approved premises in Milton Keynes and could not live with his family. He was upset about this, as he had planned to live with and support his mother, who also had Huntington's disease. When the man was released from prison and arrived at the approved premises at 2.20pm. He went out twice during the afternoon, saying he was going to the shops, and returned at 7.00pm. Shortly afterwards he went to the communal bathroom. At 11.16pm, staff at the premises found him unconscious in the bathroom with evidence that he had taken drugs. His body was obstructing the door and staff did not force it to get to him, as they were concerned they would injure him. Paramedics tried to resuscitate him when they arrived but a doctor confirmed that he had died.

Findings

6. We consider that the man's offender manager should have arranged to transfer his case to Chesterfield earlier to allow for the possibility of arranging accommodation nearer his family. This meant that he and his family had very little notice that he would have to live in Milton Keynes.
7. The man had been at Milton Keynes Approved Premises only a few hours at the time of his death and we do not consider that staff there could have anticipated his actions. However, when the staff found him collapsed in the bathroom they should have made more active attempts to administer basic life support. We are concerned that the staff were not confident about managing a drug overdose. While better training might not have changed the outcome for him, it could be important in future emergencies.

8. A probation service representative did not contact the man's family until two days after his death to offer support and explain the circumstances of his death and did not offer financial assistance towards the cost of the funeral as national policy requires.

Recommendations

- The National Probation Service, South West and South Central Division, should ensure that all probation staff follow Probation Instruction PI 11/2014 and start preparing for a prisoner's release at least 28 days before their release from custody. When it appears that responsibility for a case needs to be transferred to another probation area this should be done as soon as possible.
- The Director of the National Probation Service should ensure that sufficient staff supervising residents in approved premises have specific training in how to respond to a suspected drug overdose, including the use of opioid antagonists.
- The National Probation Service, South West and South Central Division, should ensure that when a resident dies:
 - The family liaison officer contacts the resident's next of kin at the earliest appropriate opportunity, to offer information and support; and
 - Funeral expenses are offered in line with national guidance; and that the man's family are offered such a contribution.

The Investigation Process

9. The investigator issued notices to staff and residents at Milton Keynes Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator visited Milton Keynes on 18 February. He obtained copies of relevant extracts from the man's records. He also contacted HMP Lindholme and obtained relevant prison and medical records for him.
11. The investigator interviewed five members of staff at Milton Keynes on 23 March.
12. We informed HM Coroner for Milton Keynes of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted the man's father to explain the investigation process. He had the following questions that he wanted the investigation to cover:
 - When was his son diagnosed with Huntington's disease?
 - How did he travel from HMP Lindholme to Milton Keynes?
 - Why was he sent to Milton Keynes, and not to live with his mother?
14. The family received a copy of the draft report. They gave some feedback which has not impacted on the factual accuracy of the report.

Background Information

Milton Keynes Approved Premises

15. 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. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment.
16. The National Probation Service, South West and South Central Division, manages Milton Keynes Approved Premises. It accommodates up to 16 residents. There is an overnight curfew between 11.00pm and 6.00am. There is a CCTV system, which records the movements of residents in and out of the premises. Residents must sign in and out when they leave the building. Some residents are required to sign in at specific times to help manage their risk. Subject to a risk assessment, residents are allowed to keep medication in a safe in their room and staff conduct routine checks to ensure compliance. Staff hold controlled drugs in the office and issue it as required.
17. There have been no previous deaths at Milton Keynes Approved Premises

Key Events

18. The man received 59 criminal convictions between October 1999 and October 2013 and had been in prison more than 20 times. He suffered from borderline personality disorder and anxiety. He had drug and alcohol misuse problems and had harmed himself and attempted suicide in the community.
19. On 2 July 2013, the man was charged with grievously bodily harm and common assault (against his partner) and remanded to HMP Bullingdon. On 18 October, he was sentenced to 36 months in prison. The court imposed a restraining order prohibiting him from contacting his partner. On 8 November 2013, he transferred to HMP Ranby, and then to HMP Lindholme on 27 May 2014.
20. The man's family had a history of Huntington's disease. On 10 September 2014, a consultant in genetics told him that test results confirmed that he had some symptoms of Huntington's disease but would need further tests.
21. A mental health nurse supported the man from September 2014 onwards. She recorded in his medical record that his mood and mental health had deteriorated while he waited for the test results. He self-harmed twice, on 6 October, when he took an overdose of paracetamol and quetiapine, (an antipsychotic) and on 7 October, when he cuts his right arm. He said that he was frustrated that he had not received his test results and firmly believed that he had Huntington's disease. Staff monitored him using Prison Service suicide and self-harm procedures, Assessment, Care in Custody and Teamwork, known as ACCT.
22. On 9 October, the man was diagnosed with Huntington's disease. He harmed himself again on 14 October, but, by 28 October, staff thought he had come to terms with his diagnosis and ACCT monitoring was ended. He continued to receive support from the mental health team and he said he would not start taking drugs again. He told the mental health nurse that he wanted to move to the Chesterfield area of Derbyshire, when he was released from prison in February 2015.
23. On 12 November 2014, the man's offender manager in Oxfordshire spoke to him via video-link about his forthcoming release on licence on 13 February. She had been his offender manager for several years when he lived in Oxfordshire. He said he wanted to move to be near his family and, in particular, his father who lived in Chesterfield. She agreed and said that she would contact Chesterfield Central Probation Office, to transfer his case.
24. The offender manager spoke to the man's father, who was supportive but unable to offer his son a place to live. The man said he had spoken to prison support services about finding suitable accommodation for his release. They had not yet found anywhere, so he thought he might initially stay with his mother in Chesterfield, until he found accommodation. She spoke to his mother, who was happy with this.
25. On 8 January 2015, the man told his substance misuse worker that he did not need any more support and did not have any drug or alcohol problems. She told him about services she could refer him to in the community, but he said that if he needed any help after he was released he would access support himself.

26. The offender manager contacted the housing adviser at Lindholme on 28 January, who said that they would not be able to confirm whether there was a space in supported accommodation until the day the man was released. North Derbyshire Council had said that he might be treated as a homeless person if he had no other accommodation and, because of his illness, they could arrange for him to stay in supported accommodation.
27. On 5 February, the offender manager emailed a senior probation officer in Chesterfield. She explained the man's licence, his illness, history of self-harm and substance misuse problems, and asked if a probation officer from Chesterfield could be assigned as his offender supervisor, with his case to be transferred later if he settled well. She replied quickly with transfer documents, but noted that they would need to complete a risk assessment on his proposed address and that he would remain her responsibility until the transfer was completed. At 12.00pm, she phoned the man's mother, who said that she would be happy for him to live with her. The offender manager told her that they had also submitted applications for him to live in supported accommodation.
28. The mental health nurse saw the man for about 30 minutes on the morning of 5 February and they talked about his release. He said that he did not have any thoughts or self-harm. She had no concerns about his mental health.
29. On 6 February, the offender manager phoned Derbyshire police to check whether they had any intelligence or reservations about the man living at his mother's home. The police had no concerns. The housing adviser from Lindholme phoned her that day and told her that she had made an appointment for him to see a housing advisor from Derbyshire County Council at 2.30pm on 13 February. She had not been able to get a place at an approved premises in Derby and planned that he would stay with his mother before moving to other accommodation.
30. On 9 February, the Thames Valley Police Domestic Abuse Unit told a worker in the offender manager's office that they had information that the man had recently contacted his ex-partner by letter, which was in breach of the restraining order. As a precaution, the police asked them to add an exclusion zone for the Oxford area to his release licence, to reduce the risk to his ex-partner.
31. On Tuesday 10 February, the offender manager emailed the man's release licence to the offender management unit at Lindholme. She said she would forward his pre-discharge form and further details once she had received his reporting instructions from Chesterfield.
32. That morning, the offender manager emailed the Chesterfield senior probation officer, and confirmed that Derbyshire Police had no concerns about the man's mother's address. She said that the man had an assessment arranged for a shelter for homeless people on the day of his release. She said that she hoped to speak to him before he was released but if this was not possible, she intended to speak to him on 13 February when he reported to the Chesterfield Probation Office. She also noted that an additional condition had been attached to his licence, to exclude him from the Oxford area.

33. On 11 February, the Chesterfield senior probation officer told the offender manager that she had received the man's transfer request and noted that it was a late application. She was concerned that his ex-partner would not be properly protected unless he was subject to a curfew restriction. She said she would speak to her Area Chief Officer as she thought that he should live in an approved premises where a curfew would operate. As there were no spaces in Derbyshire, she asked the offender manager to check availability in the Thames Valley area.
34. At 7.40am on Thursday 12 February, the offender manager recorded in the probation log that the Thames Valley Domestic Abuse Unit had emailed her to say that the man's ex-partner had received a letter and a phone call in the last three weeks from him. He told her that would be released on 13 February to stay with his mother and intended to borrow money from his mother so that he could visit her on 14 February, Valentine's Day. The Domestic Abuse Unit was concerned that his impending release from prison might increase the risk to his ex-partner.
35. At 11.20am, the Chesterfield senior probation officer emailed the offender manager and noted that the man's new offender manager would assess the suitability of his mother's home as a place for him to live and would notify the offender manager whether they had approved the transfer request within five working days. This would be subject to the offender manager being satisfied about management of risk.
36. At 12.25pm, the offender manager emailed the offender management unit at Lindholme that the man would have to live in an approved premises in the Thames Valley (probably Milton Keynes) because of the risk to his ex-partner when he was released. She told the investigator that the prison was unable to arrange a phone call for her to speak to him so that she could tell him about this. She therefore asked someone to tell him about his release plans that evening. She said that she intended to meet him at the approved premises on Monday 16 February.
37. At 12.36pm, the offender manager recorded in the probation log that the Chesterfield senior probation officer had called her and said that Chesterfield Probation area was not prepared to accept the man until they had visited his mother and risk assessed the accommodation, which they would do as soon as possible. Chesterfield expected her to find a space for him at a local approved premises.
38. The offender manager spoke to the manager at Milton Keynes Approved Premises, who agreed to give the man an emergency space in a shared room. She said that he should arrive by 5.00pm on 13 February. As part of his licence conditions, he was required to sign in every two hours to reduce the risk of him travelling to Oxford to see his ex-partner.
39. At 1.45pm, the offender manager phoned the Lindholme offender management unit to confirm that the man had a place at Milton Keynes and asked them to tell him about his release and licence conditions.
40. An officer at Lindholme told that investigator that, at around 4.00pm, he was asked to tell the man about the changes to his release arrangements. The officer

said the man was not happy and said that his mother needed him for support. He refused to sign the paperwork given to him until he had spoken to his offender manager.

Friday 13 February 2015

41. The man was released from Lindholme on the morning of 13 February, after he signed his licence. There is no record of whether he received advice about harm reduction and the risk of overdose before he was released. He arrived at Doncaster Station at 10.30am and made two phone calls, to an offender supervisor at Milton Keynes and to his offender manager.
42. The offender manager at Milton Keynes told the investigator that the man asked her if he could stay with his mother so they could support and care for each other. She reminded him that it was a licence requirement for him to live at Milton Keynes and that they could discuss it further when he arrived. He then phoned his offender manager, repeated his concerns and said he did not want to move to Milton Keynes as he was not from there. She said he had to live there and that she would see him on 16 February.
43. At around 11.50am, the offender manager phoned the man's mother, who said that she knew that her son would not now be coming to live with her. She was upset and said that she needed him for support. The offender manager told her that a member of staff from the Chesterfield office would visit her soon and that it was still possible that he could stay with her, once a risk assessment had been done.
44. The man arrived at the approved premises in Milton Keynes at 2.20pm. The offender manager completed his initial induction, which took 45 minutes. She reminded him not to take illicit substances. He arrived with a week's supply of medication issued by Lindholme: fluoxetine (for depression) and quetiapine (an antipsychotic drug), which were locked in the medication cupboard. He told her that he was unhappy that he had to stay at Milton Keynes and did not want to share a room. He said he did not understand why he had to sign in every two hours. Despite his concerns, she noted that he appeared relaxed. She completed a self-harm assessment and noted that staff should check him twice at night because of his history of self-harm, his mental health problems and because he did not want to be at Milton Keynes.
45. After his induction, a residential assistant took the man to his room, which he was going to share with someone else who had been released from another prison that morning. The man was not there at the time. The assistant told the investigator that he had no concerns about him.
46. At 3.54pm, the man signed the register at the front desk and went out. He told the residential assistant that he was going to get something to eat. He came back at 4.07pm, but signed out again at 5.00pm and said he was going to buy some clothes. The assistant spoke to him when he came back at 7.00pm and had no concerns about him.

47. CCTV footage shows that, at 7.15pm, the man went into the downstairs bathroom. He did not come out and no one else went into the bathroom until staff later found him.
48. Between 8.00pm and 8.30pm, the residential assistant and the offender supervisor handed over to the night staff: an offender supervisor and a residential assistant. They noted that the man should be observed twice at night.
49. At 11.00pm, the offender supervisor and residential assistant said that they went to each room for a curfew check. The man was not in his room and his roommate said that he had not met or seen him since he had arrived. (The register confirmed that his roommate had gone out at 1.57pm and returned at 10.42pm.) As they had not seen him during their checks, they started to look for him.
50. At about 11.10pm, the offender supervisor tried to open the downstairs bathroom door but it was locked and he could get no response from anyone inside. He unlocked the door and pushed it but realised that someone was behind the door. He managed to open it enough to see that the man was lying on the floor. His upper body was against the wall, his feet were against the door and his head was facing away. He did not respond when his name was called.
51. The offender supervisor told the investigator that the man looked grey and showed no signs of life. He went to the office and dialled 999. Emergency calls from the office go to the police first. Police records logged that the offender supervisor called at 11.16pm and said that a man had collapsed in the bathroom. He asked for an ambulance and the police. The ambulance log recorded that they were contacted at 11.18pm. He called the manager to let him know what had happened.
52. The offender supervisor went back to the bathroom and tried to get in. He pushed the door again but it did not open any wider. He saw a syringe lying on the floor. He said he was concerned that he would injure the man if he forced the door open. He was first aid trained, but said from his appearance he was not confident that he could have done anything to help him. He then waited for the emergency services to arrive.
53. The residential assistant stayed in the hallway while the offender supervisor tried to get into the bathroom and kept the area secure to ensure none of the other residents got involved. He had no recent first aid training and relied on the offender supervisor's account of what he had seen. He did not try to open the door in case this harmed the man.
54. Two police officers arrived at 11.26pm and forced the bathroom door open. They noted the man showed no signs of life. There was blood coming from his nose and drugs paraphernalia, including needles and spoons, around him. The police officers moved him to the hallway for more space and began to try cardiopulmonary resuscitation. Paramedics arrived at 11.37pm and continued the resuscitation attempt. The manager arrived at Milton Keynes just after the paramedics. A GP was called and, at 12.10am, confirmed death.

55. The paramedics noted recent needle marks in the man's groin. There was also a large burn mark to his left shoulder and arm, probably caused by a radiator he was slumped against. There were two further marks on his body that appeared to be carpet burns from where he had been moved from the bathroom to the communal area.
56. Senior police officers arrived and interviewed the staff and reviewed CCTV footage. The police found four wraps (used to carry drugs) in the bathroom. The man appeared to have used two of the wraps and administered them intravenously.

Contact with the man's family

57. In the early hours of Saturday 14 February, Thames Valley Police asked Derbyshire Police to visit the man's father to notify him of his son's death. However, his father was on holiday abroad. The police then visited the man's mother and broke the news to her. She asked his step-father to speak to the police.
58. Thames Valley Police phoned the man's stepfather around 4.00am, and explained the circumstances of his stepson's death. The stepfather said that he had already contacted his stepson's father, and they agreed that the stepfather would act as the family's main point of contact until the father returned to the UK.
59. On Monday 16 February, the probation service family liaison officer phoned the man's father, but he was still abroad and had a poor phone connection. He spoke to him the next day and several times afterwards. He confirmed that the police had the man's personal property and would release it to them as soon as possible. The funeral took place on 6 March 2015. The probation service did not offer to contribute to the cost of the funeral, as national policy requires.

Support for residents and staff

60. After the man's death, the manager spoke to the night offender supervisor and residential assistant to offer them support and discuss what happened. The probation area manager visited the next morning to offer further support to the staff and residents.
61. Staff posted notices informing other residents of the man's death, and offering support. None of the residents had met him.

Post-mortem report

62. The toxicology report concluded that the cause of the man's death was central respiratory depression caused by heroin (opiate) use. Quetiapine and fluoxetine were present at a level consistent with his prescription. No alcohol was detected.

Findings

Management of the man's release from prison

63. Before the man was released from Lindholme, he had completed a drug rehabilitation programme and he said that he had not abused drugs for over seven months. He also received ongoing support to manage his personality disorder, anxiety and feelings of depression, especially when he was diagnosed with Huntington's disease.
64. Probation Instruction (PI) 11/2014, which covers probation licence conditions, states that the offender supervisors should put together a risk management plan before a prisoner is released. They should contact the local police force and other partner agencies to assess whether there should be any additional or bespoke licence conditions. A pre-discharge form should be completed no later than 28 days before the prisoner's release.
65. The offender manager discussed the man's release with him when they spoke in November 2014, four months before his release. He had told her that he intended to live with one of his parents or near to them. He said that he had spoken to prison support agencies to find accommodation in his home area. However, she did not contact probation staff in Chesterfield until 5 February 2015, which did not leave them enough time to risk assess his proposed address before his release from prison. In the event, because of the new information from the Thames Valley Police domestic abuse unit on 9 February, probation staff decided that, initially, he needed to live in supervised conditions to minimise the risk to his victim. As there was no space in approved premises in Derbyshire at the time, this meant that there was little option other than to require him to move to Milton Keynes. However, earlier planning and transfer of his case to Derbyshire would have avoided this. He did not learn of this decision until the night before he was released, which caused him and his family some distress.
66. We consider that the offender manager did not start to arrange the transfer of the man's case early enough. This meant that he was given very little notice about his move and he went to a place where he had no social support, which increased the risk of his relapse into taking heroin. We make the following recommendation:

The National Probation Service South West and South Central Division should ensure that all probation staff follow Probation Instruction PI 11/2014 and start preparing for a prisoner's release at least 28 days before their release from custody. When it appears that responsibility for a case needs to be transferred to another probation area this should be done as soon as possible.

Assessment of the man's risk at Milton Keynes

67. The man was unhappy that he was required to stay at Milton Keynes and about his additional licence restrictions. However, he said that he would speak to his offender manager on 16 February and discuss the possibility of moving to his mother's home. Staff at the approved premises identified that he had previously attempted suicide and had self-harmed, and decided to monitor him overnight.

Although there is no evidence that he intended to kill himself, we consider that this was an appropriate precaution.

68. The man told the substance misuse worker at Lindholme that he did not have any drug problems and would seek support if he needed to. He had completed a methadone detoxification programme in June 2014 and appeared motivated to remain drug free. Staff at Milton Keynes were not concerned about his presentation when he arrived, or when he came back to the approved premises just after 4.00pm or 7.00pm. It seems likely that he bought heroin when he was out but we do not know where he obtained the drugs from and there was no apparent reason for staff at the approved premises to have suspected him of bringing in drugs.

Response to the man's overdose

69. The offender supervisor could not fully open the bathroom door when he found the man unconscious. He immediately went to call the emergency services. He told the investigator that he thought that he might hurt him if he tried to force the door. The residential assistant, who did not have any recent first aid training, did not assist. The offender supervisor said that he did not feel confident that he could safely gain access to the bathroom in order to attempt resuscitation and he decided to wait for the emergency services. He said he thought that the man was already dead.
70. The investigator reviewed CCTV footage. A police officer forced the bathroom door open wide enough to get in, as soon as he arrived. It is not clear that earlier intervention would have affected the outcome for the man. However, we consider that, in line with national guidance, which states that every possible effort should be made to save life, the night staff should have continued to try to get into the bathroom to assess him and administer basic life support if possible. We recognise that this was a difficult judgement call for the staff involved. The offender supervisor could see that it looked likely that he had overdosed on drugs. He thought he was dead but, if not, he was understandably nervous about harming him further by forcing the door and he was unsure about how to respond to a drug overdose.
71. The risk of relapse for a released prisoner with a history of drug abuse is high, especially someone like the man who had been moved to an unfamiliar area, away from his family and with no social support. Opioid dependence is a chronic disorder with high relapse rate even after prolonged periods of abstinence and it was apparent that he was stressed by his circumstances. The risk of fatal overdose is also a high risk, as opiate users are particularly vulnerable due to diminished tolerance - especially in the immediate post-release period.
72. A 1999 study found that, relative to the general population, people discharged from prison were 40 times more likely to die in the first week after discharge and 92% of the deaths were drug-related. Mainly this is caused by reduced tolerance levels after limited access to drugs in prison, but there is also a risk that the strength and purity of heroin might have increased from what users were previously accustomed to. Using other medication also increases the risk and the man was taking prescribed medication including an antidepressant and an antipsychotic.

73. Against this background, 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 community management of heroin overdoses and emergency administration of opiate antagonists (antidotes), such as naloxone, by people who are not medically trained. They recommended training first responders, including non-medical first responders to use it. Opioid antagonists counteract the effects of opioids and can bring an overdose patient back to consciousness in minutes.
74. Historically, opioid antagonists, such as naloxone, were used only by clinicians but are now being provided increasingly to drug users, their families, and other potential non-medical first responders. In Scotland (the first country to introduce a national programme to provide naloxone), the proportion of deaths from opioid overdose among people just released from prison has reduced substantially since the introduction of the programme. Currently, naloxone can only be supplied under prescription (although patient group directions for the supply to groups of patients can be used). This requirement will be eased in October 2015, when a change to medicine regulations is expected to take effect.
75. Given the potentially life saving properties of opioid antagonists and because some approved premises residents might already be prescribed naloxone, we consider that the National Probation Service should introduce specific training to help staff respond appropriately to suspected opiate overdoses, including the use of opioid antagonists. We make the following recommendation:

The Director of the National Probation Service should ensure that sufficient staff supervising residents in approved premises have specific training in how to respond to a suspected drug overdose, including the use of opioid antagonists.

Family liaison

76. Derbyshire Police informed the man's family a few hours after his death. However, we are concerned that the probation family liaison officer did not contact the man's family for another two days. We consider that this contact should have been made earlier, particularly as his stepfather had indicated he would act as the principal family contact until his father returned from holiday.
77. The Approved Premises Manual (paragraph 23.40), states that the organisation responsible for the approved premises is required to offer to pay reasonable funeral costs of up to £3,000. The family liaison officer said that he did not offer a contribution to the cost to the man's family and he told us that he was not sure how this was done. We make the following recommendation:

The National Probation Service, South West and South Central Division, should ensure that when a resident dies:

- **The family liaison officer contacts the resident's next of kin at the earliest appropriate opportunity, to offer information and support; and**
- **Funeral expenses are offered in line with national guidance; and that the man's family are offered such a contribution.**

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