

**Circumstances surrounding the death of a man
In October 2005 at an Approved Premises, under the management of
the Probation Service**

Report by the Prisons and Probation Ombudsman for England and Wales

This is the report of an investigation into the death of a man who died in October 2005. The man had been a resident of an Approved Premises for six days prior to his death.

The man had been released from prison on licence in 2005. He lived at the Approved Premises as a condition of his licence until he was allowed to move to independent accommodation. In June 2006, the man breached his licence conditions by failing to live where approved, and he was recalled to prison. He was subsequently re-released in October, again subject to licence with a condition of residence at the Approved Premises.

The man was close to his sister. She told one of my investigators that her brother's death had been particularly shocking and affected her deeply. I offer her and all the man's family and friends my sincere condolences.

My office investigates the deaths of all residents in Probation Service Approved Premises. The purpose of this investigation was to discover whether the man's risk was properly assessed, whether the level of care provided for him at the Approved Premises was sufficient, and whether there are any lessons that can be learned to help prevent a similar tragedy in the future.

Members of staff in Approved Premises are responsible for the management of high risk offenders on a daily basis. I am satisfied that this one is managed by caring and committed staff, and in accordance with Approved Premises guidelines. However, there are learning points from this investigation which are reflected in the text and in my recommendations.

This final version of my report contains details of the very welcome actions taken by the Probation Area on receipt of my draft findings.

**STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN**

MAY 2006

Contents	Page
Summary	4
Investigation Methodology	6
The Approved Premises	7
The man	8
Events leading to the man's death	9
Consideration and Conclusions	15
Recommendations	17
Response from the Probation Service	18

Annex:

Interviews conducted and documents examined

Summary

1. The man died in his room at the Approved Premises in October 2005. The apparent cause of death was an overdose of heroin.
2. The man had been a drug user for more than 25 years and had committed offences to fund his use. In 2003, he was sentenced to three years imprisonment and was released on licence in April 2004 to reside at a treatment centre for drug and alcohol addiction. The man seemed to make progress for seven months before relapsing. He was recalled to prison in November 2004.
3. Following his re-release in January 2005, the man was resident at the Approved Premises. During his stay, drug use was not noted as a particular problem. Unfortunately, after he had left the premises, he was recalled for a second time when he failed to stay at his address and did not notify his supervising officer of his whereabouts.
4. The man was released on licence for a third time in October 2005, again with a condition to reside at the Approved Premises. He arrived late on the first night and seemed generally reluctant to be there. He expressed concern about his ability to remain drug free in a hostel environment. Nevertheless, the man kept appointments with his supervising officer and with a drugs counsellor. Although it was noted that his appearance had deteriorated since his last stay, he seemed motivated to tackle his drug use.
5. On 30 October, the man told staff he was working with a friend and was absent from the premises all day. On his return, he appeared tired and was annoyed that a meal had not been saved for him. He was concerned about his sister and made telephone calls to her and to his partner, after which he appeared calmer and more relaxed.
6. Before retiring, the man became aware that a fellow resident was unwell and he called staff to assist. He was allowed to remain with the resident for a short time before returning to his room. Later, he was seen in a corridor with other residents, complaining about noise. Staff noted that he was co-operative.
7. On the morning of 31 October, the man failed to 'sign in' as residents are required to do each morning. A member of staff went to check on him and found him kneeling on the floor of his room. She summoned assistance and the emergency services were called. They suggested that the man had been dead for some time when they arrived.
8. My investigation has not identified any changes in procedures or practice that would have helped directly to prevent the man's death. Nevertheless, there are almost always lessons to be learned from the tragic circumstances of a death and I have identified several areas for improvement.

9. I make four recommendations.

The investigation process

10. The investigation was conducted by two of my investigators, with the co-operation of the Probation Area. I am grateful for the assistance that the investigators received from the manager, staff and residents at the Approved Premises. Although all those interviewed were coming to terms with the man's death, they made facilities readily available and participated fully in the inquiry.
11. The investigators visited the Approved Premises where they conducted formal interviews with the manager and three assistant managers, including the man's key worker. A fourth assistant manager was interviewed during a second visit. The lead investigator interviewed the man's supervising probation officer and examined the case file held at the probation office. The investigators spoke with a former resident who had known the man and examined a number of documents provided by the Approved Premises. They were also provided with tapes of the CCTV footage for the hours preceding the man's death.
12. One of my family liaison officers contacted the man's sister who said she was particularly surprised at the nature of her brother's death, as she had not known him to use drugs intravenously in the past. The sister had questions about her brother's death but acknowledged that she might never discover the exact circumstances in which he died.
13. The report is organised as follows. In the first sections, I provide information about the Approved Premises together with some personal details about the man. Next, I provide details of the circumstances surrounding the man's death, followed by my conclusions. One annex completes the report.

The Approved Premises

14. This is one of several Approved Premises managed by the Probation Area. The house has 20 beds, 18 of which are in single rooms. The accommodation provides breakfast and dinner daily. The Approved Premises accepts offenders on bail and subject to either community penalties or prison licences. From time to time, the house may also accept offenders who are not subject to statutory requirements but need to remain in a secure setting for reasons of public protection. Residents must be between the ages of 18 and 65, but any type of offender will be considered, depending upon the level of assessed risk and the dynamics of the resident group at any particular point in time.
15. Approved Premises were formerly known as Probation and Bail Hostels and are approved by the Secretary of State within Section 9 of the Criminal Justice and Court Services Act 2000. Their purpose is to provide accommodation for persons granted bail in criminal proceedings, and in connection with the supervision and rehabilitation of persons convicted of offences. Approved Premises can provide a supportive, structured environment in the community for high risk and difficult to manage offenders. The management of offenders accommodated in Approved Premises is governed by the National Standards for the Supervision of Offenders and the guidance contained in the National Approved Premises Handbook.
16. The premises is staffed by a manager who is a Senior Probation Officer, a deputy manager (although this post was vacant at the time of the man's death), five assistant managers and two night hostel assistants. Each resident is subject to curfew restrictions, usually from 11:00pm to 6:00am although this may be varied as necessary, for individual offenders. There is no specific, daily routine, but residents are expected to be out of bed and 'signed in' by 10:00 am daily. Handover meetings take place between staff, each morning, when significant events of the previous day and night are discussed, together with any concerns about residents. There is a CCTV system for monitoring purposes.
17. Each resident is allocated an assistant manager as a key worker. Key workers are responsible for monitoring the behaviour of their residents, and for providing advice and encouragement. Residents are expected to meet weekly with their key workers. The contents of these meetings are recorded electronically and any areas of particular concern are noted. Key workers have 'read only' access to supervising officers' electronic case records, and close links are maintained between key workers and supervising officers.
18. To enable oversight of the whole Approved Premises estate in the area, all referrals are made through the area's central referrals scheme. However, the final decision would be made by the manager after a risk conference, attended by all those involved in the management of the case, to develop a management plan.

The Man

19. On 9 July 2003, the man was sentenced to three years imprisonment for an offence of unlawful wounding. It was said that the offence had been committed after he had been smoking crack cocaine and drinking alcohol. He was released on licence on 27 April 2004 with a condition of residence at a treatment centre for drug and alcohol addiction run by a voluntary organisation, ADAPT. For a period of some seven months, the man complied with his licence conditions and appeared to be making progress. Regrettably, he could not sustain the improvement and, by November 2004, he was known to be using both drugs and alcohol and was recalled to prison.
20. In January 2005, the man was released on licence again, with a condition of residence at the Approved Premises. The manager told the investigators that it was known the man had a long history of drug use and drug related offending, but this had not been noted as a significant problem during his stay. Random searches of his room produced no results and he successfully completed his period of residence. However, he was recalled to prison for a second time on 23 June 2005 after he breached one of the licence conditions.
21. On 18 October 2005, the Parole Board decided that the man should be re-released providing a satisfactory accommodation and supervision plan could be arranged. The supervising officer made a hostel referral through the Probation Area central referral scheme and, on 21 October, she discussed his case with the manager of the premises. The manager decided that, as there were no risk factors additional to those present on his first release, he would accept the man without holding a further risk conference.

Events leading to the man's death

22. The man was released on 26 October 2005 with a condition to reside at the Approved Premises and to report to his supervising officer the following morning. He arrived at 11:30pm on the first evening, after curfew, when the premises had been locked up for the night. The two assistant managers on duty, were in the kitchen when the front door alarm sounded. They found the man outside the office having apparently been let in by another resident. When asked why he was late and where he had been since being released from prison, he refused to answer but no action was taken. The rules were explained briefly and he signed an undertaking to abide by them.
23. The first assistant manager left a message for his colleagues that a full induction should be undertaken the next day, and he reported the man's late arrival to the supervising officer. The assistant manager recalled that, in his previous period of residence, the man had disregarded the rules on more than one occasion but the supervising officer and the manager had decided not to breach him. The assistant manager remembered the man as an 'easy going type of person, tidy and clean' but said he appeared unkempt when he arrived, and presented as more aggressive than he recalled. Other members of staff who remembered the man from his first period of residence commented that his appearance was different, and that he looked pale and unwell.
24. The following day, the man's allocated key worker, conducted a full induction before he reported to his supervising officer. He said he had arrived late at the hostel as he had visited his ex-partner and children. He was warned about curfew requirements, but no action was taken over the breach as it had occurred on his first night, before he had signed a copy of the rules to indicate that he understood what was required of him. He told his supervisor that he had continued to use drugs during his prison sentence, but said he had done so in a way that would ensure negative drug test results. Prior to the man's release, his supervisor liaised with a drugs worker in the prison who had made an appointment for him to see a worker from the Drug Intervention Project (DIP) in Croydon, later that day. The man expressed unhappiness about staying at the Approved Premises, as he believed he should be in a residential rehabilitation unit. He also complained that his belongings were in another town where he had been arrested, and that he had nothing but the clothes he stood up in. In the record of contact, the supervisor described the man as being 'unable to engage in reasonable discussion'. The supervisor said he was 'not aggressive but constantly pushed the boundaries in a demanding way'.
25. On 28 October, the drug worker from DIP informed the supervisor that the man had kept his appointment the previous afternoon. The DIP worker had referred the man to be assessed as to his suitability for a residential rehabilitation unit or a day programme, but he said it would be about two weeks before the man received an appointment. Meantime, he had been

referred to a GP for possible treatment with subutex, a heroin substitute drug. The DIP worker said the man had told him that he was worried about being unable to avoid using drugs while at the Approved Premises. The DIP worker and the supervising officer agreed that the man would be at greater risk in the wider community, where most of his contacts were with those involved in drug misuse.

26. On the same day, the supervisor received several telephone calls from the man demanding to be allowed to go to another town for the weekend to collect his clothing. Given his past behaviour, the supervisor assessed the man as vulnerable, and she had decided to consult with her line manager before making decisions in his case. The supervisor explained that she would consult with the manager after the man had been resident at the Approved Premises for a little longer and the risk could be properly assessed. The record of contact indicates that he became angry and threatening over the refusal. However, he had exhibited similar behaviour in the past and there was nothing to suggest any risk of increased harm to self or others. The record also indicates ongoing liaison between the supervisor and staff at the Approved Premises to ensure a consistent approach to the man.
27. On Saturday 29 October, the man's key worker had a meeting with him. He told her that he did not want to be at the Approved Premises and found being in a structured environment difficult. He resented the curfew that prevented him from going out with his friends. The key worker told the man she was concerned about him, as he appeared to have deteriorated since the last time he was there. She commented on his poor hygiene and bad skin but, although the key worker thought that these were symptoms connected to drug use, she did not say this directly to the man. The key worker thought he appeared unconcerned by what she said and did not seem to pay much attention to her.
28. The man told the key worker either that he had visited, or was going to visit, the GP to obtain a 'script' - by which she thought he meant a prescription for medication. The key worker told the investigators that all residents are registered with a local General Practitioner on arrival. She would usually enquire about a resident's reasons for visiting the GP but she did not ask the man. The key worker did not take the matter further with the man, and I can only speculate as to whether he would have talked more about his drug use if she had done so. However, I am surprised that she did not pursue the issue. Since March 2005 a pharmacy delivery service has been in place enabling prescribed medication to be delivered directly to staff through the pharmacy. The GP prescribed diazepam to the man on 28 October and it was administered by members of staff on 28 and 29 October.

I recommend that the Probation Area reminds staff in Approved Premises to obtain information about prescribed medication from residents, to ensure that procedures for handling and administering prescribed medication are complied with.

29. Around 6:00am on Sunday 30 October, the man went to the staff office saying he was going out to work for the day. He asked to use the office telephone to call his friend. He did so and left the premises around 6:20am. The man was out all day, and returned to the house after the evening meal had been served and cleared away. One of the assistant managers commented that the man looked 'a bit rough' on his return. He asked for a meal but had not made a prior request for food to be kept, and there was a minor dispute with a member of staff as no meal had been saved. However, when the key worker arrived back to work at 9:00pm, she put together a meal for the man from food that remained. She reminded him that, if he was working, he was required to provide details and sign in and out, but he became angry and said he was not working again. The key worker stayed with the man while he ate, after which his demeanour improved and he told her he was okay.
30. Later that night, the key worker noted that the man and three other residents left the premises after 10:00pm, and she was concerned whether they would be back in time for curfew at 11:00pm. The four men returned around 10:55pm. Some 20 minutes later, when the man returned to the office, he was allowed to make telephone calls to his girlfriend and to his sister. He said his sister had been burgled and he was concerned about her. When a member of staff commented that the man seemed weary, he said it was due to a hard day's work and he was going to bed.
31. The man left the office but quickly returned saying that another resident had collapsed on the floor in his room. Two members of staff went to the room with the man and lifted the other resident onto his bed. It appeared he had suffered a mild epileptic fit, and he confirmed this to the investigators. He refused to have medical help summoned but, as the two men were friends, the man was allowed to remain in the other resident's room while he drank a cup of tea and recovered. After this, the man returned to his own room around 11:30pm.
32. A short time later, three residents, including the man, were out of their rooms complaining about loud music. The key worker recalled that the man appeared to be a bystander. When she threatened to call the police if there was any more upheaval that night, he said there would be no trouble from him and returned to his room. Thereafter, the two assistant managers commenced their required nightly check to ensure that residents were in their rooms, after which the sleeping-in member of staff, retired to bed.
33. No further checks were required during the night but, around 12:45am, the assistant manager on waking duty went to room seven to talk with the resident who continued to play music loudly. The assistant manager was not required to carry out any more checks of the premises but she monitored the CCTV screen. She thought she saw movement on the screen around 1:00am but it was brief, there was no further noise, and

she did not investigate. The remainder of the night passed uneventfully. Before leaving the next morning, the member of staff reported the night's events to her colleagues who were on duty that day.

34. On Monday 31 October, the man was one of four residents who had not 'signed in' as required by 10:00am. An assistant manager who had arrived on duty around 9:15am, was asked to check their rooms. She recalled knocking on the man's door and receiving no answer. On opening the door, she said she saw the man, apparently kneeling down with his head on the floor, facing away from her with his lower body raised. The assistant manager told the investigator that the man was partially clothed, wearing only a T shirt, and her immediate impression was that he was 'being rude'. She called his name and when he did not respond she left the room, 'thinking he was being ignorant' by taking no notice of her.
35. I recognise that it cannot be easy for a member of staff to be confronted by a resident of the opposite sex in a state of partial undress, and I appreciate that there are issues of propriety to be considered. However, given that the member of staff could see that the man was in an unusual position and had failed to respond to her, I am surprised that she did not immediately recognise that it was an emergency.
36. The member of staff said that, as she closed the man's door, she felt something was wrong and ran downstairs towards the office, calling to her colleagues as she ran. The manager and another assistant manager went quickly to the man's room, where he was kneeling in the same position with his head on the floor. The man did not respond when they called his name, and when they touched him, he was cool. The manager felt for a pulse but indicated he could find none.
37. The assistant manager quickly returned to the office where he telephoned for an ambulance, and was advised to move the man into the recovery position. When he returned to the man's room, the assistant manager and the manager attempted to do so but the man was heavy and his body was unwieldy. The assistant manager noticed dark bruising on the man's face, where blood appeared to have settled. As they moved the man, the members of staff saw a syringe beneath him. An ambulance and paramedics arrived quickly and suggested that the man might have died some time previously. The police also arrived, followed by a police doctor who confirmed death.
38. Probation Circular 40/2004, 'Strategy for preventing sudden deaths in approved premises' sets out what staff should do in the event of a fatality. The circular states:

 'Every possible effort should be made to save life in accordance with the limited skills of Approved Premises staff in first aid and resuscitation.'

The assistant manager is trained in first aid techniques and could have attempted to resuscitate the man. However, the bruising to the man's face, the temperature of his skin and the stiffening of his limbs, led the assistant manager to believe that such an attempt would be futile. I have no doubt that the assistant manager would have attempted to revive the man if he had thought there was any possibility of success, and I do not question his decision not to do so. Nevertheless, it is crucial that everything that can be done to save life should be done. Decisions as to whether death has occurred should only be taken by those qualified to do so, except when there are very obvious signs such as the onset of rigor mortis. Prison Service Order 2710 provides specific guidance on these issues for those working in prison establishments.

39. I have raised the question of first aid training for staff in Approved Premises in previous investigations and, in November 2004, the National Probation Directorate (NPD) wrote to all Chief Officers to highlight Coroners' concerns, and to draw them to the attention of all relevant staff members. Chief Officers were asked to review the adequacy of first aid training, particularly in response to drug overdoses, and to ensure that guidance is given about the use of mouth to mouth resuscitation. The NPD plans to issue a Probation Circular that will deal with a number of health issues, including first aid training.

I recommend that the Probation Area ensures that all its staff in Approved Premises are familiar with the requirements of Probation Circular 40/2004, and issues clearer guidelines about how and when resuscitation should be attempted.

40. Following a security survey that it commissioned, the National Probation Directorate provided a pin point monitor alarm system to be carried by staff in all Approved Premises. The system incorporates a direct call button to the Approved Premises' alarm system and to the police. No doubt this alarm system is invaluable in some emergency situations, but it does not prevent crucial time being lost when members of staff must return to the office to gain access to a telephone to summon emergency services other than the police.
41. The assistant manager lost no time in summoning an ambulance, and paramedics arrived speedily to attend to the man. Sadly, it seems that he was already beyond their help when they were summoned. In other circumstances, a delay - however brief - could mean the difference between life and death. Although it is not possible for the National Probation Directorate to make such provision, some Probation Areas have provided mobile telephones to be carried by members of staff when checking premises. In different circumstances, vital minutes could have been saved if staff had carried a mobile phone.

I recommend that the Probation Area considers providing a mobile telephone for each Approved Premises, to be carried by staff when making checks of the premises.

42. Before they left the premises, police took statements from the staff who were shocked and saddened by the man's death. Some members of staff told my investigators that they were supported by their managers, and given details of an available counselling service. I have no doubt that the Probation Area takes its responsibilities towards staff seriously, but the level of support provided by management appears to have been perceived differently by different staff. For some, it was sufficient, whereas others would have appreciated the opportunity to return home but were not offered it.
43. The following day, 1 November 2005, the man's room was cleaned, and the key worker placed a vase of flowers as a mark of respect. The Approved Premises log indicates that, when the man's sister visited the house that evening, the key worker took her to see the room and tried to answer her questions according to the information available. The key worker is to be commended for treating the man's sister with respect and sensitivity.

Consideration and Conclusions

44. The man was jailed in 2003 for a drug related offence. At that time, he had been using drugs for some 17 years. By his own admission, his previous offending behaviour was drug related, and he was familiar with a number of illegal substances. During this last sentence, he told drugs workers at the prison that he wished to address his problems and lead a drug free life. As a consequence, arrangements were made for him to be released to a residential drug rehabilitation unit. Assessments from that time describe him as struggling with the programme, and he lapsed after some three months when he used drugs and alcohol.
45. The man was re-released on licence in January 2005, with a condition of residence at the Approved Premises. Several appointments were made with a community drug agency but he missed three assessments, showing little real commitment to participation in a programme. His licence was revoked on 21 June 2005 after he left the hostel without permission and his whereabouts were unknown.
46. The manager at the Approved Premises told the investigators that he knew the man had a long history of drug use and drug related offending. He knew that the man was a drug user during his first period of residence, but there had been no great concern at that time and no firm evidence of drug taking. The manager said that residents may be asked to sign a drug contract if drug use is the primary focus of work to be undertaken but, during the man's first stay, he had not exhibited the profile of a heavy user. No drugs were discovered during random drugs searches and there had been no reason to target him.
47. Nevertheless, during the man's short second period of residence, and although several members of staff noticed a deterioration in his looks and hygiene believing this to a result of increased drug use, no-one addressed their concerns directly to the man. It is clear that the prison drugs worker arranged an appointment for the man with DIP on the day after his release and, in a similarly timely manner, his supervising officer checked that he had kept the appointment. The supervising officer also liaised with DIP about the most appropriate treatment plan for the man, given his previous failure in a residential treatment setting.
48. Another resident, who acknowledged he is a long term drug user himself, told the investigators that he had known the man for some time before the two men met again at the Approved Premises. He alleged that the man was able to join him in his room each night, when the CCTV was unmonitored while staff checked the premises.
49. The resident alleged that, during the night of Saturday 30 October, the man had injected heroin and was unconscious for several hours while he, the resident, did all he could to bring him round. The investigators could not verify this information, but the man was sufficiently well the next

morning to leave the premises early to go to work. The resident also said that, when the man returned to the premises on Sunday night 31 October, he smoked cocaine and injected heroin in the resident's room, before returning to his own room after midnight. The investigators found nothing on the CCTV tapes that they viewed to indicate the man either leaving or returning to his room.

50. The Approved Premises operates a policy of random drug testing and room searches, but staff may not conduct personal searches nor prevent residents from using drugs outside the house. The rules of the Approved Premises state that drugs or drug paraphernalia are not allowed in the house, and that residents are not allowed in each other's rooms. Clearly, the man did use drugs on the premises on at least one occasion and, according to the resident, did so on a number of other occasions in a room other than his own. Although I have no specific recommendation to make, the Probation Area will wish to investigate whether there is a loophole in the current procedures that allows residents to enter rooms without the knowledge of staff.
51. Accidental overdosing is relatively common amongst offenders who resume use of illegal drugs when they are released from a prison sentence. Consequently, it is crucial that they are reminded of the risks of lapse and relapse, particularly that tolerance to drugs will be less after a period of reduction or abstinence. All new residents are required to be inducted within 24 hours of their arrival and the process includes an explanation of hostel rules, a briefing on health and safety and a discussion of the Approved Premises' drug policies. However, the induction checklist for staff does not mention giving warnings about tolerance and overdose.
52. It was clear from the outset that the man was a reluctant resident at the Approved Premises. His key worker and his supervising officer indicated that he paid little heed to the advice he was given. Drug taking is a risky activity at all times, and the man used a number of different drugs over a long period of time. Although there are indications that the man was relatively new to the intravenous use of heroin, it is reasonable to suppose that, from his past experience, he would have been well aware of the risks involved. Although it is unlikely that further warnings would have prevented his death, nevertheless everything that can be done to encourage behavioural change should be done.

I recommend that the Probation Area includes in the induction checklist a section indicating that the necessary warnings and advice about reduced tolerance to drug use have been given to residents released from custody.

Recommendations

I recommend that the Probation Area reminds staff in Approved Premises to obtain information about prescribed medication from residents, to ensure that procedures for handling and administering prescribed medication are complied with.

I recommend that the Probation Area ensures that all its staff in Approved Premises are familiar with the requirements of Probation Circular 40/2004, and issues clearer guidelines about how and when resuscitation should be attempted.

I recommend that the Probation Area considers providing a mobile telephone for each Approved Premises, to be carried by staff when making checks of the premises.

I recommend that the Probation Area includes in the induction checklist a section indicating that the necessary warnings and advice about reduced tolerance to drug use have been given to residents released from custody.

Response from the Probation Service

Having seen a draft of this report, the National Probation Directorate and the London Probation Area have accepted my recommendations and have told me of the following positive actions.

A full review of all processes and procedures within the Approved Premises department of the London Probation Area is currently underway and focuses particularly on the issues of prescribed medication. A standard letter has been developed for use when residents have a GP external to the hostel's GP, with the aim of enabling Approved Premises staff to better manage medication prescribed by external GPs. Medication must be signed for by both staff and resident, and a check is made of medications at the beginning and end of each staff shift. A pharmacy delivery service is in operation at a number of units and the London Probation Area is working with the local Primary Care Trusts to ensure that a similar service may be made available across the Approved Premises estate in London.

The National Probation Directorate has confirmed that the well-being of residents is of the highest priority and in the London area this has been reinforced with Approved Premises staff through individual line management. Procedures have been amended to ensure that the requirements of PC 40/2004 are regularly discussed at team meetings in Approved Premises.

The London Probation Area has provided each Approved Premises with a mobile telephone and issued specific instructions about their use. All Approved Premises' managers have been advised that staff must address issues of drug use during induction procedures, and the Induction Checklist will be amended as part of the review process.

I commend the Probation Service for these developments.