

**Circumstances surrounding the death of a resident during January 2005
at a Probation Service Approved Premises.**

**Report by the Prisons and Probation Ombudsman for England and
Wales**

April 2005

<u>CONTENTS</u>	<u>Page No</u>
FOREWORD	3
SUMMARY	4
PART ONE:	
Background information –	
The resident	5
The Approved Premises	6
PART TWO	
Events leading up to the man’s death –	
The resident’s time at the Approved Premises	8
The night of the resident’s death	10
PART THREE	
Consideration & Conclusions	14
Recommendations	17

FOREWORD

This is a report into the death of a man who died from an apparent overdose of non-prescription drugs in January 2005. He was subject to supervision on licence following a term of imprisonment, and resident in an Approved Premises.

The man had used drugs for many years and was clearly aware of the dangers associated with such use. He had expressed no desire to change his lifestyle until a short time before his death when he acknowledged the need to address his dependency issues, and began working to do so.

The purpose of the investigation was to establish the circumstances and events surrounding the man's death, and to consider whether the quality of supervision and care provided to him by the Probation Service was adequate and appropriate.

Two investigators from my office carried out the investigation. My thanks go to the Manager and Deputy Manager of the Approved Premises for facilitating the work. I am also grateful for the co-operation received from the Probation Area and, in particular, from the staff and residents of the Approved Premises.

The man was 39 years of age, the father of two daughters, although he was separated from their mother and prohibited from contact with them. His parents had maintained regular contact with him during his residence in the Approved premises and believe that more could have been done to assist their son, whose death was devastating for them. The man's father spoke with one of the investigators on the telephone and provided a written response at the draft report stage. I hope this report will answer some, if not all of their questions and I offer the man's parents and their family my sincere condolences.

The Investigators carried out formal interviews with the Manager of the premises, with the man's key worker, with two workers who were on duty on the night he died, with two other residents, with a drugs worker from the Criminal Justice Intervention Team, and with his supervising probation officer. The interviews were not recorded but the investigating officers' notes have been agreed and signed by interviewees.

The investigators also obtained information from the man's probation file and examined a number of documents provided by the Probation Area.

The report is organised as follows. Part 1 provides some personal details about the man and background information about the Approved Premises. Part 2 considers, as far as it is possible to do so, the circumstances leading to the man's death. My conclusions and recommendations are presented in Part 3.

Stephen Shaw CBE
Prisons and Probation Ombudsman

April 2005

SUMMARY

The man was released from prison in November 2004 on licence, having served a sentence of two years' imprisonment for an offence of assault. The conditions of his licence precluded him from returning to his home area and, although he retained the support of his parents, he was required to reside at the Approved Premises.

The man had been a drug user for more than 20 years and, during his prison sentence, had expressed no desire to change his lifestyle.

He was not happy at the Approved Premises, where he remained aloof from other residents, spending most of his time in his room alone. However, the man presented no apparent management problems. He fulfilled the conditions of his licence and was open with his supervising officer, acknowledging that he was using drugs from time to time. The man accepted a referral to a drug worker and appeared to adopt a positive attitude, expressing his wish to become drug free.

Towards the end of his stay at the Approved Premises, there were marked changes when the man became more sociable with other residents and less unhappy about being in Approved Premises. On the evening before his death he went out with friends before spending time in the common room with other residents, one of whom suggested that the man asked him to acquire drugs.

Later that night, members of staff on duty were informed by the same resident that the man was unwell and it was likely that he had taken heroin. Members of staff found the man to be sleeping heavily but, apparently, breathing normally. He was checked at regular intervals during the next hour until it became apparent that his condition had deteriorated. The emergency services were called immediately and made strenuous efforts to revive the man but were unable to do so. He was found to be dead on arrival at the hospital.

I conclude that, despite his previous history, before 13 January 2005, the man had given the Probation Area no reason to suppose that he was likely to ingest dangerous quantities of drugs. Nor can I identify any changes in procedures that might have helped directly to prevent his death. Nevertheless, when an Approved Premises' resident dies, there are almost always lessons to be learned, and I have identified areas where systems could be improved. I have made six recommendations that can be found in Part 3, section 2.

PART ONE

Background Information

The Resident

1. The resident was 39 years of age when he died. Probation records indicate that he had misused drugs since the age of 15 and had experimented with various illicit substances during the ensuing years. Despite this, he worked regularly in the building trade and was not a heavily convicted man.
2. The man lived with his partner, the mother of his children, for ten years before the relationship ended some four years ago. It was said that he found the break up of the relationship difficult to bear and increased his use of heroin and amphetamines to block out his problems. In 2001 he was conditionally discharged for assaulting his partner and in 2002, after another assault, he was sentenced to four months imprisonment together with the imposition of a restraining order.
3. Although his use of drugs was the cause of many of the man's difficulties, it also exacerbated his frustration over his limited contact with his daughters. A series of incidents during a few days in December 2002 resulted in a sentence of two years imprisonment for breaching the restraining order and for assault occasioning actual bodily harm on his ex-partner. At that time the man told a probation officer, who was preparing a report for the court, that he was spending up to £50 daily on amphetamines and £10 on heroin.
4. It was the man's wish to return to his home area upon his release but, as a consequence of the proximity of the proposed address to his ex-partner, the risk was considered too high to manage and he was required to live in Approved Premises. When he was first released from prison in May 2004, the man reported to his supervising officer as required. However, he failed to arrive at the Approved Premises and his licence was revoked. The man was returned to prison where he remained until November 2004. He was unable to provide an address considered suitable for release and he was, again, required to live in Approved Premises. Upon his release from prison, the man went to stay at the Approved Premises where he remained until his death.
5. During his time at the hostel the man presented no management problems. A full analysis completed a few days after his arrival, under the Offender Assessment System (OASys) indicated no risk of suicide or self harm but noted that he had previously breached hostel rules. Although the man was said to have 'kept himself to himself' and spent most of his time in his room, his parents visited him regularly and often took him out for meals. A few days before his death, members of staff noted that the man was spending more time out of his room, associating with other residents. Generally, he appeared to have adopted a more positive attitude.

The Approved Premises

6. Approved Premises, formerly known as Probation & Bail Hostels, 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 supervision of offenders accommodated in Approved Premises is governed by the National Standards for the Supervision of Offenders.

7. The house is one of the Approved Premises managed by the Probation Area. It provides nineteen beds, some of which are for women. The Approved Premises accepts offenders from the age of 18 upwards, many of whom are considered to pose a high risk of re-offending or of harm to the public. Residents are advised not to discuss the nature of their offences with other residents, and staff are not allowed to discuss a resident's past with any other resident.

8. The Approved Premises has a Manager who is a Senior Probation Officer, a Deputy Manager, an administrative assistant, a referrals worker and a handy person. There are six residential social workers (RSWs), two are on duty every day. There are also Night Waking Workers (NWWs) who, as the title implies, work only at night together with the Night Sleeping Worker (NSW), a member of staff who sleeps in and may be called upon if necessary. Each resident has a key worker and there are additional services available as follows:

Drugs workers from the Criminal Justice Intervention Team (CJIT), on Tuesdays and Thursdays.

Educational services on Mondays to Thursdays.

An Employment and Training worker, on Wednesday afternoons.

9. Records are kept on duty sheets, in the premises day book and on residents' personal history sheets, where significant events and progress (or lack of it) are recorded. An electronic system (ICR) could be accessed by all probation staff in the Area so that a member of staff may record any information considered relevant. In practice, the electronic system is mostly used by supervising officers in the field, known as case managers. Significant information is shared at monthly meetings between the resident, the key worker and the supervising officer. Case managers are aware that they may telephone at any time to speak with Approved Premises' staff as necessary and staff on the premises would expect to liaise with the case manager if problems arose over a resident.
10. Staff shifts change three times daily, at 8.00 am, 1.00 pm, and at 5.00 pm. At 10.00 pm, when the NWW arrives for duty, the RSW who arrived at 5.00 pm continues as the sleeping worker and the RSW who arrived at 1.00 pm goes off duty. Succeeding staff are expected to

familiarise themselves with the day's events by speaking with the preceding shift and reading the message book. NWWs are required to check the premises at 11.00 pm when all residents are expected to be in, and at 11.30 pm when residents should be in their own rooms. NWWs are expected to knock on each door and open any if there are indications of any untoward behaviour.

PART TWO

Events leading up to the man's death –

The man's time at the Approved Premises

- 11.** The man was admitted to the premises in November 2004, and went through an induction procedure in which the rules and expectations of the premises were explained to him. He readily acknowledged that he had regularly used drugs in the past but said he did not consider his lifestyle problematic and had no wish to change it. He was reminded that illicit drugs were not allowed on the premises and told that help could be made available if he changed his mind at any time.
- 12.** The hostel log indicates that very little was seen of the man around the premises. There are entries noting, 'X in his room', 'Spent the whole evening in his room', and 'When X returned to the hostel he went to his room, had no contact with anyone not even staff except on curfew and closedown checks.' His key worker told the investigators that the man said he had been told that the place was full of 'bad 'uns' with whom he had no wish to associate. She said he had been very withdrawn and had little contact with anyone.
- 13.** The key worker was allocated the man's case almost two weeks after he arrived at the house and immediately initiated a formal key work session with him, after which she met and talked with him informally on several occasions. No record was kept of these informal meetings. The key worker told the investigator that, as all seemed well with the man, there was no apparent focus for further formal meetings.
- 14.** The records of the man's meetings with his supervising officer also indicate that his initial attitude towards the Approved Premises was far from positive. He continued to dispute that a condition of residence was necessary for risk management, as he believed he was unlikely to offend against his ex-partner again. The man was particularly unhappy about the curfew restrictions, expressing the desire to go out at night with friends. At various times he told the key worker and the supervising officer that he 'hated' living at the house and the records indicate their efforts to encourage him to become more settled.
- 15.** On 30 November 2004, The man told his supervising officer that he had contemplated breaching his licence in order to leave the approved Premises by being recalled to prison. He was dissuaded when he was

told that he could seek alternative accommodation in his home area, outside the exclusion zone. On 1 December, during the man's meeting with his supervising officer at the Probation Office, he indicated that he had used heroin twice and amphetamine once since his release. However, the session was more positive when the man told the supervising officer that, for the first time in 28 years, he felt that he wanted to stop using drugs completely and was beginning to understand that help could be made available to him. He was referred to a drug worker from CJIT who worked in partnership with the probation office providing a service for offenders who reported there.

16. The drug worker explained to the investigators that her usual procedure would be to complete a feedback form for the supervising officer after each session with an offender. However, she did not do so for this man as she and the supervising officer would talk after each session to discuss progress and plan future work. The supervising officer's records confirm that such discussions took place but there is no complete record of the work undertaken.

I recommend that the probation area develops a protocol with the CJIT team for the formal sharing and recording of information.

17. The drug worker recalled that she had seen the man on five or six occasions and had discussed with him various strategies for remaining drug free. She did not undertake any drug testing as he was, apparently, being open about his drug use. At that time, no drug testing equipment was available at the Approved Premises although it has, since, been provided. The Manager told the investigator that one member of staff has been trained in the use of the equipment and another is about to be trained. It is now possible for random drug tests to confirm if residents are drug free.
18. The man and the drug worker had identified the risk he would run if he mixed with other drug users, and he cited this as one reason why he had kept himself separate from other residents at the Approved Premises. His key worker also noted the man's concerns about whether he might meet drug dealers in the area around the house and he had been careful about where he went outside.
19. An entry in the record of contact log for 15 December indicates that the man continued to question the need to live in Approved Premises. He said he hated the curfew arrangement that prevented him from going 'out clubbing' with his friends. He told the case manager that he would do something 'stupid' to escape the hostel and, when questioned about what he meant, the man said he might overdose on heroin to get moved. The case manager told the investigators that, from his knowledge of the man, he did not believe this to be a real threat. The man had tried many other ways of reminding the case manager that he was not happy at the Approved Premises and the officer believed this to be a further manipulative ploy. Nevertheless, the officer knew that

the man had been spending long periods alone in his room and alerted the hostel duty worker to record that his attitudes and moods should be monitored.

20. On 23 December, the man told his supervising officer that his smoking of heroin had increased and blamed this on the hostel environment. However, on 30 December, the man reported that he had not used drugs since Christmas Eve. The record of contact notes that he recognised he had been drifting into regular drug use again. Both the supervising officer and the drug worker reinforced how well the man had done to focus on remaining drug free over the Christmas period. The supervising officer noted that the drug worker had arranged for liver function and blood tests to be carried out the following day and for a prescription to be available on 7 January 2005.
21. At his meeting with the case manager, on 6 January, the man admitted that he had used amphetamine and alcohol over the past week. He said that he wanted to go drinking with his friends on his 40th birthday - the next day - and was angry that the officer continued to refuse to grant an extension of the curfew. The record of contact describes him as being angry and intimidating but not depressed. The man again threatened to breach his licence to escape the restrictions upon him but acknowledged that any breach would result in a return to prison.
22. As arranged by the CJIT worker, the man attended a local clinic on 7 January and was prescribed naltrexone, an opiate blocker drug. He handed in his medication to staff at the Approved Premises, as required, and the medication record shows that one 50mg tablet was dispensed on Saturday 8 January. However, later that day, a rash appeared on the man's chest and he reported difficulty in breathing. The clinic was consulted and suggested that he could be allergic to the naltrexone. He was advised to stop taking the medication and to seek further advice from the doctor after the weekend. The investigators were unable to clarify whether the man did so, although the CJIT worker confirmed that when she spoke with him on 10 January she explained that people may have adverse reactions to the medication and reiterated the advice that he should stop taking it.
23. When the key worker spoke with the man about his medication on Tuesday 11 January, he said he was reluctant to leave the hostel and return to the clinic as he feared that local drug dealers could target him. She therefore arranged for him to see a different drug worker who was due to visit the premises later in the day. The hostel log indicates that the drug worker believed the man to be 'struggling' as his efforts to remain drug free were hampered by his adverse reaction to the naltrexone. The worker decided to investigate the possibility of an acupuncture course for him. The CJIT worker expressed some surprise to the investigators that hostel staff had decided to involve a second drug worker with the man, particularly as there had been no consultation with her. She explained that, although the aims of various

drug workers are almost certainly the same, different styles of working could cause confusion.

- 24.** On the day before he died, the man kept appointments with the case manager and with the CJIT worker. Both separately noted a considerable difference in him. He told the case manager that he had been out to celebrate his birthday but had managed to return to the Approved Premises within the curfew time, albeit under the influence of alcohol. He also said that he was beginning to like the house and was starting to mix with other residents. The case manager noted this as, 'a major breakthrough'. The man told the CJIT worker that he had used 'a bit of amphetamine and a bit of heroin' two days earlier but it had done nothing for him and he was not going to bother again. She described him to the investigators as being 'completely different', positive and in a confident mood. He told her that he felt 'really happy'.

The night of the man's death

- 25.** The NWW told the investigators that he arrived on duty around 9.30 pm on the night of the man's death and went directly to the residents' common room. He was surprised to see the man there for the first time and, from the man's tone of voice and demeanour, the NWW thought he had probably been drinking. The NWW said that another resident, Mr A, approached him and said that the man had asked him to go out to obtain drugs. The NWW described a 'fatherly chat' with Mr A in which he was told clearly not to procure drugs for the man. The resident agreed that he would not do so and said that he was 'not daft'. Around 9.40 pm the NWW went to the office to tell his colleague of what had happened and as he did so, Mr A left the premises.
- 26.** Another resident, Mr B, told the investigators that he had been talking with the man in the common room that evening and found him to be in good spirits. He said that the man had been out for a drink with friends and was talking about his future in positive terms. The man told Mr B that he was looking forward to leaving the hostel and getting himself off drugs. Mr B described a 'normal, general sort of conversation' and thought that the man left the common room around 9.45 pm to go to his room.
- 27.** The NWW said he watched for Mr A's return to the house around 10.40 pm, and questioned him about procuring drugs. Mr A categorically denied that he had obtained drugs, either for himself or anyone else. He was adamant that nothing would be found on him if he was searched, but the NWW noted that he was well aware that hostel workers have no powers to search residents, and are not allowed to do so. Mr A went upstairs but the NWW was unable to say whether or not he went directly to his own room.
- 28.** A third resident, Mr C, told the investigators that, on his return to the house earlier in the evening, the man had tried to persuade him to get

drugs. Mr C described it as 'hassling' but refused. Mr C said that Mr A knocked on his door between 10.45 pm and 11.00 pm asking the resident to accompany him to another room as he (Mr A) thought someone had overdosed. The resident observed that Mr A was agitated and perspiring and the resident said he thought that Mr A might have taken 'something'. The resident said that he had previously used illicit drugs and did not want to become involved. However, he said that, against his better judgement he went with Mr A to the man's room where he saw the man lying crossways across the bed.

29. Mr C described moving the man round, to place him in a more comfortable position. He said Mr A told him that he had bought two bags of heroin for the man but did not say how much had been taken by whom. The resident thought that Mr A seemed panicky, trying to decide whether to inform staff about the man. However, having satisfied himself that the man was alive and breathing well, Mr C returned to his room, taking no further action. The investigators were unable to corroborate Mr C's information and, unfortunately, Mr A failed to return to the Approved Premises later in January. Consequently, it was not possible for the investigators to interview him or for him to answer the allegations against him. The other resident also failed to return to the Approved Premises in February.
30. The residential social worker who was on duty as the night sleeping officer that night, told the investigators that she and her colleague, the NWW, started their curfew check at 11.00 pm. They checked the rooms of those residents who were not in the common room, to ensure that they were on the premises. She said she saw Mr A and Mr C talking together but she did not address them. After checking other rooms, she saw Mr A in his room, seeming flustered. When she asked him if all was well, Mr A told her he thought there might be something wrong with the man and she went directly to the man's room where she met the NWW around 11.00 pm.
31. The NWW said that, when he opened the room door, he saw the man asleep, lying on his side with his head facing towards the bed, snoring. The NWW believed that the man had been drinking earlier in the evening and, mindful of what Mr A had said, he knew there was a possibility that the man had also taken drugs. He turned the man's head to the side and ensured that his airway was clear. The NWW told the investigators that he and his colleague took those precautionary measures although he was not overly concerned as the man appeared to be sleeping naturally. He explained that he had previous experience of finding people asleep when he knew they had taken drugs. He would keep a regular watch on them until he was sure that all was well. He said it had been his experience that people would wake after a few hours.
32. The NWW said that he left the light on in the man's room and visited the room again four times during the next hour. He said that on the

first three occasions there was no cause for concern, the man was breathing heavily and snoring. However, on the fourth visit, the man had stopped snoring and the NWW noticed a residue that he took to be either mucus or vomit around the man's mouth. He said he tried to find a pulse or sign of breathing but could not, although the man was warm. He banged on his colleague's door and went downstairs as quickly as he could to call the emergency services.

33. The NWW was joined by his colleague, who switched the call to the mobile phone, before both workers returned to the man's room. There they followed instructions from the emergency services to place the man on his back although they were not able to get him onto the floor. The NWW returned to the office for the face guard to give mouth to mouth resuscitation, as instructed over the telephone. As he did so, the paramedics arrived. Although the paramedics worked for some time to resuscitate the man before taking him to Queen's Medical Centre, he was declared dead on arrival.

PART THREE

Consideration & Conclusions

34. It was my role to consider whether the level of care provided for the man at the Approved Premises was adequate. In doing so, I also considered whether the hostel procedures were clear to staff and commensurate with the requirements for all Approved Premises as defined in the Approved Premises Handbook. I conclude that, before the night of his death, the probation Area had no reason to suspect that the man might have, or had in fact, ingested dangerous quantities of drugs. Nor have I identified changes in its procedures that might have helped directly to prevent his death.
35. It is apparent that, from the outset, the man was a reluctant resident at the Approved Premises, withdrawn and unwilling to participate in the daily routine of the house beyond what was specifically required of him. His avoidance of contact with residents and staff presented no management problems and the man was not a focus for concern. Consequently, there was little of note to report to the supervising officer. Nevertheless, communication between those who have specific roles to play in the supervision of offenders is crucial for the identification and management of problem issues and, in this man's case the level of communication appears to have been less than satisfactory.
36. Although the man kept appointments with his supervising officer and met with his key worker in the Approved Premises, there was only one key work session during approximately 8 weeks residence and there appears to have been little meaningful contact between the workers. In a telephone conversation on 1 December, the supervising officer suggested to the key worker that the man's use of alcohol should be

monitored but there was no further indication of work to be undertaken by the key worker. During the eight weeks that the man spent at the Approved Premises no three way meeting took place and there was no regular sharing of information between the supervising officer and the key worker.

37. The key worker was, therefore, unaware of all the occasions when the man had 'lapsed' into drug use and knew nothing of his contact with the CJIT worker at the probation office. It is a matter of speculation whether the key worker would have learned of these issues had she met with the man more regularly or whether she could have done more for the man had she been kept better informed. However, it is unlikely that she would have referred him to the hostel drug worker had she known of CJIT's involvement.

I recommend that the Probation Area reminds staff about the required level of formal contact between Key workers and residents.

I recommend that the Probation Area reminds staff about the required level of communication between case managers and key workers in Approved Premises.

(Since the completion of this investigation, this recommendation has been addressed as the new version of National Standards, published in March 2005, places a requirement on all probation staff to ensure that relevant information is properly communicated.)

38. The Night Waking Worker's previous experience was in the Prison Service and he was very clear about his role in supervising residents and dealing with difficulties. He also had previous experience of monitoring those sleeping off the effects of drug taking and, in his words, 'they usually wake after a few hours.' He was aware of the problems that may be caused by the use of alcohol and opiates together and it was a fine judgement as to whether medical assistance should be sought. The man's condition did not appear to be life threatening and, on the basis of his previous knowledge and experience, the NWW decided not to call a doctor.
39. It may be that, in similar circumstances, other staff would have acted differently but I do not consider the NWW's decision was unreasonable, given that he continued to check the man's condition at regular intervals and observed no deterioration. However, the NWW accepted that he did not record the checks that he made, in the hostel log, and said that this was an oversight. The Night Sleeping Worker was present at the checks before she retired to bed but, thereafter, the NWW was alone. I have no reason to doubt the NWW's word but, without any records, there is necessarily no corroboration of his evidence.

I recommend that the National Probation Directorate reminds staff working in Approved Premises of the need for vigilant recording of significant issues and actions, to protect themselves and residents.

(This recommendation is also addressed by the new National Standards that require Approved Premises staff to 'maintain a daily house record of any significant events that happen within approved premises' and cross reference them to individual offender records where appropriate.)

40. The NPD has confirmed that there is no national requirement for Approved Premises staff to carry mobile telephones. However, given that one was available, the investigators were surprised that the NWW had neither the telephone nor the face guard with him when he discovered the man in difficulties. The investigators were told that the waking staff member usually carries the mobile telephone but, on the night of the man's death, the battery had run low and it was 'on charge'.
41. The man's room was on the first floor and, without the mobile telephone, the NWW could not summon the emergency services until he had returned downstairs to the office where the main telephone is situated, thus costing time. When the emergency services instructed the workers to commence mouth to mouth resuscitation, pending their arrival, further time was spent retrieving the face guard from the office. The Night Waking Worker believed there was virtually no loss of time by not having the equipment with him, and there is no evidence to suggest that a speedier response would have prevented the man's death. However, there may be occasions when the loss of time, however brief, could mean the difference between life and death for others.
42. Following a previous investigation into the death of a hostel resident in another Probation Area, I recommended that a reminder be issued to all areas of the requirement for Approved Premises' staff to carry radios with them when they are available. I make a similar recommendation about the use of other equipment.

I recommend that the National Probation Directorate issues a reminder to all Probation Areas about the protocols for carrying and use of mobile telephones and other essential emergency equipment in Approved Premises.

(At the draft report stage, the NPD explained that staff in Approved Premises are required to carry personal alarms and, as part of the implementation of the recommendations of a security survey, new alarms will be supplied. I note that these will have a direct call button to the approved Premises alarm system and directly to the police, although not to other emergency services.)

43. Probation Circular 40/2004 required all Probation Areas to devise by October 2004 a strategic plan to reduce incidents of sudden death in Approved Premises. This Probation Area has fulfilled the requirement

and the plan is available in Approved Premises. However, the Manager of the house told the investigators that, although he was familiar with the contents of the strategy, he could not guarantee that all his staff knew of its contents as its existence was relatively new. NPA is to be applauded for allocating resources to the production of such a comprehensive plan. However, this will not be cost effective if staff in Approved Premises are not familiar with the document. The plan states:

'Hard copies [of the plan] will be given to each member of the core staff and to staff dealing with referrals.'

I recommend that NPA takes steps to ensure that all staff working in Approved Premises have access to a copy of the strategic plan and are familiar with its contents.

Recommendations

National recommendations:

I recommend that the National Probation Directorate reminds staff working in Approved Premises of the need for vigilant recording of significant issues and actions, to protect themselves and residents.

I recommend that the National Probation Directorate issues a reminder to all Probation Areas about the protocols for carrying and use of mobile telephones and other essential emergency equipment in Approved Premises.

I recommend that NPA takes steps to ensure that all staff working in Approved Premises have access to a copy of the strategic plan and are familiar with its contents.

Area Recommendations:

I recommend that the Probation Area develops a protocol with the CJIT team for the formal sharing and recording of information.

I recommend that the Probation Area reminds staff about the required level of formal contact between Key workers and residents.

I recommend that the Probation Area reminds staff about the required level of contact and communication between case managers and key workers in Approved premises.

