HM Inspectorate of Probation

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Independent serious further offence review of Damien Bendall

17 January 2023

(This review was completed in January 2022 and was published following the completion of the criminal proceedings in December 2022).

Contents

Acknowledgements

This independent review was led by Simi O'Neill, Head of Probation Inspection at HM Inspectorate of Probation and HM Inspector Annabel Mullender-Francis. We would like to thank all those who helped plan and took part in the review.

The role of HM Inspectorate of Probation

HM Inspectorate of Probation is the independent inspector of youth offending and probation services in England and Wales. We report on the effectiveness of probation and youth offending service work with adults and children.

We inspect these services and publish inspection reports. We undertake independent reviews upon the request of Ministers. We are independent of government and speak independently.

Please note that throughout the report the names in the practice examples have been changed to protect the individual's identity.

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1. Foreword

In September 2021, Damien Bendall was charged with the murders of Connie Gent (aged 11), Lacey Bennett (aged 11), John Paul Bennett (aged 13) and Terri Harris (aged 35), who was pregnant, and with raping Lacey. These shocking crimes have devastated families, friends, and the local community in Killamarsh, Derbyshire and beyond. In December 2022, the courts imposed a whole life sentence.

Damien Bendall was on probation when he committed these crimes. The Probation Service typically conducts a Serious Further Offence (SFO) review when an individual on probation commits a serious violent or sexual offence. However, in this case, the Secretary of State for Justice asked me, as Chief Inspector of Probation, to conduct an independent SFO review into the Probation Service's management of Damien Bendall.

This report sets out the findings of that independent review. My inspectors found that the Probation Service's assessment and management of Mr Bendall at each stage of the process from initial court report to his supervision in the community were of an unacceptable standard and fell far below what was required.

Vital information about the serious risks posed by Mr Bendall to those he lived with, and the public, was not included in the Probation Service's report and recommendations to the judge when he was sentenced for an arson offence in June 2021. As a result, he was sentenced to an entirely inappropriate curfew condition to reside with Ms Harris and her children. This was then compounded by a failure to allocate his case to an appropriately experienced and trained probation officer who could have managed him at the higher risk of serious harm level his past history certainly warranted. Several opportunities to correct these mistakes and amend his risk of harm classification and reallocate Mr Bendall's supervision to an appropriate practitioner were missed in the period from June to September 2021.

Inspectors found successive probation practitioners missed opportunities to ensure vital information known about Damien Bendall was included in assessments and plans to manage and address the risk of serious harm he posed to both women and children. Practitioners did not carry out safeguarding enquiries when he was sentenced for his most recent offence of arson. The impact of unmanageable workloads at both the probation practitioner and senior probation officer levels resulted in reduced oversight of new or struggling staff, frequent role changes and sickness absence. This made consistency and continuity of practice challenging. In this case, there was an increasing reliance on unqualified and trainee staff to manage workloads; this contributed to emerging factors linked to risk of harm not being recognised and escalated appropriately.

This is a deeply concerning case that raises serious issues around the Probation Service's assessment and management of risks of harm. This is a subject that has been of repeated concern to us in our local inspections and on which I have commented in my annual reports and in relation to other SFOs,[1] including that of Joseph McCann,[2] on which we reported in 2020.

[1] HM Inspectorate of Probation. (2018). *Independent review of the case of Leroy Campbell: final report*.
[2] HM Inspectorate of Probation. (2020). *Independent review of the case of Joseph McCann.*

As a result of our findings, we make 17 recommendations for improvements to His Majesty's Prison and Probation Service, His Majesty's Courts and Tribunals Service and the Ministry of Justice regarding safeguarding and risk assessment practice and procedures, which I expect the service to respond to as a matter of urgency. It is vital that key lessons are learned from this awful case.

Justin Russell
HM Chief Inspector of Probation

2. Background information

In September 2021 Damien Bendall (DB) was charged with the murders of Terri Harris (aged 35), John Paul Bennett (aged 13), Lacey Bennett (aged 11) and Connie Gent (aged 11) at 54 Chandos Crescent in Killamarsh, Derbyshire. He was also charged with one count of rape against Lacey Bennett. In December 2022, he received a whole life sentence.

At the time of these offences, DB was subject to a 24-month Suspended Sentence Order (SSO), imposed on 09 June 2021, with 175 hours of Unpaid Work, a five-month curfew, a 20-day Rehabilitation Activity Requirement and a six-month Alcohol Treatment Requirement (ATR) for an offence of arson (not endangering life). This order was due to end on 08 June 2023.

Serious Further Offences (SFOs) are serious violent or sexual offences committed by people on probation that lead to an automatic internal review of the supervision of the case prior to the offence being committed. When a person under probation supervision is charged with an SFO, probation services notify Her Majesty's Prison and Probation Service (HMPPS) SFO central team and a review of practice in the case is completed by regional SFO teams. The central HMPPS SFO team is responsible for quality assuring the completed SFO reviews and collating SFO learning to inform practice and drive improvements in policy.[3] HM Inspectorate of Probation is not responsible for conducting SFO reviews, but does quality assure a sample of reviews to provide independent oversight. Occasionally, the Secretary of State for Justice asks the Inspectorate to review a particular case or aspects of a case – as requested in this instance.

Probation services underwent a major change in the summer of 2021. In 2014, the government's *Transforming Rehabilitation* programme split probation services into two; services were unified again last summer into one Probation Service. Preparations for, and the management of, this unification took place while services were disrupted by the Covid-19 pandemic. DB's most recent order was imposed two weeks before the unification of probation services.

We have looked at the quality of work undertaken in the two probation regions involved in the management of DB. In the period from May 2011 to August 2019, DB was subject to various prison sentences and periods of probation supervision, which we describe in sections 7 and 8. In May 2020, DB committed arson in the town of Swindon. Probation practitioners from the Swindon court team of what was then the National Probation Service (NPS) South West & South-Central Division completed a 'fast delivery' pre-sentence report for the court in June 2021. This made sentencing proposals for Unpaid Work hours and an Alcohol Treatment Requirement. The report also found a curfew requirement to be suitable. Upon sentencing, DB provided an address (that of Terri Harris and her children) in Derbyshire, and so the probation court team allocated the case to what was then the National Probation Service's East Midlands Division (which following unification became part of the unified Probation Service – East Midlands region). The quality of the work undertaken in both regions has been scrutinised in this SFO review.

[3] HM Inspectorate of Probation. (2019). *A thematic inspection of the Serious Further Offences investigation and review process.*

3. Terms of reference

HM Inspectorate of Probation approached this review in two parts:

Part one

A review of the case, including the period of supervision leading up to the SFOs and any relevant previous periods. This involved reviewing case material, and interviews with the individuals involved in managing the case and relevant external partners. The aim of this process was to identify key learning. We have directed the recommendations to HMPPS to ensure national learning.

The lines of enquiry were:

- assessment of risk of serious harm
- quality of pre-sentence assessment, court reports and appropriateness of recommendations for sentencing
- management and delivery of sentence requirements, including variation of electronic monitoring conditions and any delays in delivering key interventions
- decisions on the allocation of this case for supervision and the quality of management oversight
- staff training, learning and development
- child safeguarding and domestic abuse procedures.

Part two

Our original terms of reference suggested that the second part of this review should identify areas of national practice and policy for further enquiry. However, we are satisfied that our 17 recommendations to HMPPS, HMCTS and the Ministry of Justice, set out on pages 14 and 15, cover all of the urgent national learning points from this case. They should be read alongside the recommendations on risk management set out in our thematic inspection of electronic monitoring, published on 18 January 2022, and our recommendations on the effectiveness of recall procedures following our review of the case of Joseph McCann in 2020.

4. Chronology of events

This chronology outlines the significant events relating to DB's offending history and identifies any practice issues that emerged while he was subject to prison and probation supervision.

06 January 1990	DB was born.
07 January 2004	DB received a reprimand for criminal damage.
20 April 2010	DB received a caution for possession of cocaine.
03 June 2010	Committed robbery.
30 June 2011	Sentenced to three years' imprisonment for robbery. DB was managed by probation services in the south west.
16 August 2012	DB released on home detention curfew to his mother's house.
07 June 2015	Committed attempted robbery and is in possession of a knife.
21 August 2015	Sentenced to three years' imprisonment. DB was managed by probation services in the south west.
10 May 2016	Committed grievous bodily harm and two counts of assault occasioning actual bodily harm against prison officers after being denied a prison transfer.
25 May 2016	Prison officer recorded that an ex-partner of DB contacted the prison and disclosed domestic abuse in their relationship.
05 July 2016	Same ex-partner contacted a probation practitioner disclosing domestic abuse in their relationship and seeking guidance on how to obtain a restraining order.
12 July 2016	New partner of DB's ex-partner contacted the probation practitioner stating his view that more should be done to protect her and that he wanted to speak to a manager.
20 December 2016	DB released from prison on licence and directed to an approved premises (AP).
21 December 2016	Recalled to prison for breaching his licence.
29 January 2017	Sentenced to 30 months' imprisonment for grievous bodily harm (GBH) and two counts of assault occasioning actual bodily harm against prison officers. DB was managed by the South West division of the National Probation Service.
31 October 2018	Released from prison on licence and directed to an AP.
28 November 2018	DB was recalled to prison due to poor behaviour at the AP, which included staying out all night and missing curfew and drinking alcohol on site.
13 December 2018	First recall review report did not recommend release.
10 June 2019	Second recall review report did not recommend release.
27 June 2019	Parole review – not released. DB refused to engage in the parole process again.
09 August 2019	Released from prison at the end of sentence period so no post-release probation supervision was possible.
17 March 2020	Wiltshire police's child sexual exploitation team contacted probation to confirm DB's last known address. They held evidence of sexual risk of harm to girls.

09 May 2020	Committed arson (without intent) in Swindon, Wiltshire.
07 June 2021	A member of the-then National Probation Service's court team, CO1, completed a pre-sentence report to the court. Without safeguarding checks, CO1 submitted a fast delivery report with sentencing recommendations. CO1 described a curfew requirement as 'suitable', and the court included a curfew requirement on the SSO. CO1 did not read the previous contact regarding police evidence of a sexual risk of harm to girls. CO1 (incorrectly) found that DB posed a medium risk of serious harm to the public, and a low risk of harm to partners and to children.
09 June 2021	Sentenced to a 17-month SSO, with 175 Unpaid Work hours, 20 Rehabilitation Activity Requirement days, a six-month Alcohol Treatment Requirement, and a five-month curfew requirement.
14 June 2021	The court assigned the case to the Probation Service – East Midlands region. The case was allocated to a probation practitioner (PSO1).
06 July 2021	PSO1 conducted a risk assessment. The contingency plan noted that any resumption of alcohol or drugs would increase the risk of serious harm. A senior probation officer (SPO3) countersigned the assessment.
02 August 2021	DB disclosed smoking cannabis and drinking strong alcohol.
13 August 2021	Probation practitioner contacted children's services asking whether a referral was suitable due to DB's cannabis use, but no formal referral was made or recommended. Risk was underestimated.
14 June-28 August 2021	During the first six weeks of DB's case management he did not begin Unpaid Work or alcohol treatment. DB attended four appointments in person and complied with three appointments over the phone. He failed to attend on 18 June 2021, which was not enforced.
28 August 2021	Case reallocated from PSO1 to PQiP1.
10 September 2021	DB failed to comply with a telephone appointment with PQiP1, for which an initial warning was sent.
19 September 2021	Arrested in connection with the murders of Terri Harris, John Paul Bennett and Connie Gent, and the rape and murder of Lacey Bennett.

We interviewed the following staff with direct knowledge of the case.

Probation staff based in the south west.

- Probation officer (PO1) case manager between May 2016 and April 2017
- Probation officer (PO2) case manager between June 2017 and July 2019
- Senior probation officer with oversight for PO1 and PO2 (SPO1)
- Court report author (CO1)
- Senior probation officer for courts with oversight for CO1 (SPO2)
- Head of Service for the Probation Delivery Unit with oversight for SPO1 and SPO2 (HOS1)
- Head of Operations (HoOP1)

- Regional Probation Director (RPD1)

Probation staff based in the East Midlands

- Probation services officer (PSO1) case manager between 14 June and 28 August 2021
- Trainee probation officer (PQiP1) case manager between 28 August and 20 September 2021
- Practice tutor assessor working with PSO1 (PTA1)
- Practice tutor assessor working with PQiP1 (PTA2)
- Senior probation officer with oversight for PSO1 and PQiP1 (SPO3)
- Head of Service for the Probation Delivery Unit with oversight for SPO3 (HOS2)
- Unpaid Work officer (UPW1).

Additionally, we interviewed or had contact with:

- Head of Practice Development for Courts
- Detective Constable in the Public Protection Police Team, Wiltshire Police Service
- the author of HM Inspector of Probation's electronic monitoring thematic inspection report
- the author of the early look report for these SFOs (EL1).

Inspectors also read the following documents to assist with the review:

- probation case records, NDelius and OASys
- Parole Board decision letter
- psychological risk assessment report
- recall and related reports
- Pre-sentence report
- Multi-Agency Public Protection Arrangements (MAPPA) Q form[4]
- Alcohol Treatment Requirement (ATR) referral
- MAPPA minutes
- staff supervision notes
- training records for relevant staff.

[4] A MAPPA Q form is an identification and screening form that affords probation practitioners and their managers an opportunity to review a case.

5. Executive summary

Inspectors found that, at every stage of probation involvement, from the pre-sentence report provided to the court on 08 June 2021 to the commission of the SFOs in September 2021, the Probation Service's assessment and supervision of DB fell well below the necessary standard. A failure to assign the correct risk of harm level to DB (which should have been 'high' risk of serious harm given his past history) meant that the court was missing vital information when reaching its sentencing decision. It is possible that, had a holistic assessment been provided to court (including his pattern of offending against Asian men, use of callous and organised violence against prison staff, an analysis of previous non-compliance and the most recent high risk of serious harm assessments), an immediate, rather than suspended, prison sentence might have been imposed.

As it was, the court imposed a suspended prison sentence, which included an entirely inappropriate curfew condition to reside with Ms Harris and her children. The case was then allocated for community supervision to an inexperienced and inappropriate practitioner.

There were then subsequent failures by supervising managers and new practitioners to adequately read the case and amend the initial, incorrect 'medium risk of serious harm' to 'high risk of serious harm'.

Had DB's risk of serious harm to the public and children been correctly assessed as high, and had his risk of serious harm to partners been correctly assessed as medium, the court may not have curfewed him to an address with Ms Harris and her children. He would have been allocated to an experienced probation practitioner. This would have led to enforced weekly face-to-face appointments and improved communication with partner agencies, and assertions lacking evidence would not have been relied upon and repeated in future assessments.

In sections 7 to 11 of this report, we analyse the management of DB during his two most recent sentences, the first a prison sentence with probation licence supervision imposed on 29 January 2017 and the second a suspended sentence order managed in the community imposed on 09 June 2021. In this summary we focus on our key lines of enquiry and summarise why, in our view, the following deficiencies occurred.

Process for recommending curfew requirements

The Criminal Justice Act 2003[5] requires that, 'before making a relevant order imposing a curfew requirement, the court must obtain and consider information about the place proposed to be specified in the order (including information as to the attitude of persons likely to be affected by the enforced presence there of the offender)'. The current court process requires that court officers undertake domestic safeguarding enquiries 'in order to assess risk of harm and suitability for sentencing options in all offences involving domestic abuse',[6] which DB's index offence did not.

HM Inspectorate of Probation recently published a thematic inspection on electronic monitoring, including its use for curfews. In this report, we recommended that HMPPS:

- mandate the requirement to make domestic abuse and safeguarding checks before recommending a sentence or release on electronically monitored curfew

[5] *Criminal Justice Act 2003*. 204 Curfew requirements (6).
[6] Probation Instruction 04/2016.

- work with the police and children's social care at a national level to ensure that probation practitioners in every region are provided with domestic abuse and safeguarding checks in a timely manner.[7]

Before DB's sentencing for arson, the court officer did not carry out domestic abuse enquiries on the address, find out whether Ms Harris's children were known to children's services or speak directly to Ms Harris to ensure she consented to her home being used as a curfew address by DB. The *Sentencing Act 2020* requires courts to have sight of this information before imposing a curfew order. However, it appears that courts do not have a mechanism to ensure this information is seen in every case. In this instance, important checks were not carried out and the court proceeded to issue a curfew order without them.

Child safeguarding

Inspectors found that probation practitioners in this case based their risk of harm assessments on whether DB had convictions against children or for domestic abuse, or if children's services were involved with the family. These are highly relevant factors, but probation practitioners should delve deeper to explore the broader attitudes and behaviours of the person under supervision, including their *impact* on the children in their lives. DB did not have a history of offending against children. However, we found that insufficient consideration was given to whether his racist, manipulative and controlling attitudes and his violent and unpredictable behaviour would have a negative impact on the wellbeing and safety of children.

We did not find evidence of sufficient professional curiosity about the nature and level of the role he played in the lives of the children of his partners.

Intelligence was available to the Probation Service from Wiltshire police's child sexual exploitation team regarding DB's risk of serious sexual harm to girls. However, this information was not explored or recorded sufficiently to inform the risk of serious harm assessment and plans to keep children safe.

The probation practitioner who prepared the court report following DB's arson conviction took his account and version of events in relation to his offending and circumstances at face value. This included DB's assertion that he played an important part in taking care of Lacey and John Paul Bennett. This information was not checked with their mother. There were no checks to find out if children's services were currently working with the family or had previously done so. Most egregiously, the report stated that DB was 'suitable' for a curfew at Terri Harris's address. When considering a curfew in the home of children, the attitudes of the people in that home[8] and the best interests of the child should be given weight.[9]

At the start of the most recent order, in June 2021, there was again a failure to be professionally curious about the children living with DB. To probation practitioners, DB presented himself as a father figure to the children of Terri Harris and this was accepted without challenge. No contact was made with the children's parents. When DB admitted to using drugs and alcohol this was not escalated to a manager and a children's safeguarding referral was not completed. We found that the risk of serious harm to children was inaccurately assessed and seriously underestimated.

[7] HM Inspectorate of Probation. (2022). *The use of electronic monitoring as a tool for the Probation Service in reducing reoffending and managing risk.*
[8] Sentencing Council. (2017). *Imposition of community and custodial sentences*. https://www.sentencingcouncil.org.uk/overarching-guides/magistrates-court/item/imposition-of-community-and-custodial-sentences/
[9] United Nations. (1989). *The United Nation's Convention on the Rights of the Child*.

It is our view that there should be a section of the offender assessment system (OASys) that solely considers the wellbeing and safety of the children – actual and potential – in the life of the person on probation. This would separate children from assessments of broader familial and intimate relationships, and specific prompts should be used to facilitate a more rigorous and defensible assessment of the impact on a child's ability to thrive.

Domestic abuse

During previous orders, DB's relationships with his mother and grandmother were not explored appropriately. Probation practitioners did not demonstrate sufficient professional curiosity, did not conduct safeguarding enquires, and took information from DB, again, at face value.

Inspectors found that key information on risk from prison and from DB's ex-partner and her current partner was not given due consideration and was not recorded appropriately. The impact of this failure was significant, as successive probation practitioners did not recognise that DB posed a risk of serious harm within relationships.

Probation at court appeared to take DB's word without verification. The author of the court report noted that a curfew would be 'suitable'; they did this without undertaking safeguarding enquiries on the address or communicating with the owner/lead tenant of the property. This loophole in the mandated checks required before a curfew recommendation needs addressing urgently.

Probation practitioners should have explored DB's relationship with Ms Harris in greater depth, including whether he was coercively controlling her. DB was open about the fact that he had very limited income and that Ms Harris was paying for his accommodation, bills and food. Inspectors conclude that contact with Ms Harris by the Probation Service before sentencing, and at key assessment stages and when there was evidence of increasing risk, would have been appropriate.

Inspectors found that the risk of serious harm to known adults, including partners, was underestimated. There was no focus on safeguarding in this case and, as a result, DB was sentenced to an inappropriate curfew requirement that may have exacerbated the risk of harm to Ms Harris and her children.

Fast delivery report

The use of a short format report in this case, rather than a standard delivery report, was incorrect. Mr Bendall's criminal history was complex and as such met the threshold for a suitable adjournment period to allow for a thorough read of his case to inform the completion of a more detailed report. This case met HMPPS's own criteria for a standard delivery report as 'additional assessment, professional discussion and multiple enquiries [were] required to aid risk assessment' and 'liaison where medical report [was] unavailable on the day'.[10]

Senior probation officer workload

Inspectors found that high workloads and staff shortages in the Swindon office impacted on the ability of probation practitioners to undertake high-quality work. Inspectors heard that this was a long-standing issue that they had experienced since the changes introduced with *Transforming Rehabilitation*.[11]

[10] HMPPS. (2019). *Pre-sentence reports: interim guidance on report format*.
[11] Ministry of Justice. (2013) *Transforming Rehabilitation: A strategy for reform*.

HM Inspectorate of Probation has often found that the span of line management control for senior probation officers (SPOs) is concerning. SPOs increasingly deal with complex staffing and human resources issues, for which some feel unequipped. This also reduces the time they have available to provide effective professional oversight of the work of the practitioners they line manage with individual cases. HM Inspectorate of Probation has previously found that SPOs do not have enough time to supervise all members of their teams to the standard they would wish, and when they do hold supervision sessions, there is often a focus on managing volumes of work rather than improving quality.[12] This case highlighted this issue on two specific occasions.

Firstly, there was insufficient oversight of a member of the probation court team, which led to a poor-quality fast delivery report being presented to the court. This was due to SPO sickness and a lack of resources to cover the absence.

Secondly, SPO3, who managed the probation practitioner responsible for DB after sentencing from June 2021, was unable to engage with the case fully. SPO3 managed a large number of staff. She directly managed 16, but when covering for colleagues she had oversight of up to 30 PQiPs[13]. This is far in excess of the line management span recommended by HMPPS, of 10 full-time equivalent posts for SPOs. This prevented her reading DB's case at the allocation stage and from providing the necessary oversight.

Inspectors found that the SPOs were also not given meaningful, regular and effective supervision and support.

Professional qualification in probation and probation services officer training and oversight

The probation practitioners who managed DB from June to September 2021 were inexperienced, unqualified and had insufficient support to understand and recognise the risks and needs in the case. We conclude that they should not have been exposed to cases such as DB at this stage in their careers. Following the unification of probation services, new guidance on allocations has been published, and this is welcomed. This guidance sets out clearly that 'some case allocation decisions will rely on the judgement of the operational manager to decide whether a case is suitable to be managed by a probation officer or a probation services officer (PSO). This decision will be based on individual circumstances of the case, and the skills, ability and experience of the individual officers.'[14]

Inspectors heard concerns about the efficacy of online training, especially for key learning on domestic abuse and child safeguarding, from all grades of staff, not just professional qualification in probation (PQiP) and PSO staff. There had been an understandable reliance on this method during the period of Covid-19 restrictions; however, some staff noted that prior to the pandemic there had been a trend towards self-reliant e-learning and development. Practitioners said that such self-selective training and development suffered when staff spent their hours 'firefighting' with excessive caseloads. DB's case was one of 10 being managed by a staff member who had yet to complete basic safeguarding training.

[12] HM Inspectorate of Probation. (2020). *An inspection of central functions supporting the National Probation Service.*
[13] A PQiP refers to someone completing the Professional Qualification in Probation.
[14] HMPPS. (2021). *Unified Tiering/Case Allocation Framework.*

6. Recommendations

We have directed the recommendations to HMMPS and the Ministry of Justice to ensure national learning.

HMPPS should:

Court work and curfew requirements

1. ensure that domestic abuse enquiries are carried out on everyone sentenced so that accurate risk assessments can be made and safe proposals are made in court reports
2. ensure that child safeguarding enquiries are made in all cases where the person being sentenced lives with, is responsible for, has access to, or is likely to have a negative impact on the wellbeing or safety of a child
3. develop a mechanism and reliable processes with relevant agencies to allow sufficient safeguarding enquiries to be completed, to verify information and therefore reduce reliance on self-disclosure
4. ensure that sufficient safeguarding enquiries with relevant agencies are always carried out before finding a curfew requirement suitable, and that policy/practice guidance clarifies that assessment of suitability post-sentence should be ongoing.
5. quality-assure risk assessments and proposals to the courts for accuracy and suitability
6. introduce a process to contact relevant adult residents of the proposed curfew address and obtain their prior consent to a curfew condition at their address to assess whether the address is suitable for an electronically monitored curfew
7. ensure that court reports provide a sufficient analysis of the person's circumstances, including analysis of risk of harm, to provide safe sentencing options.

Child safeguarding

8. include a specific section in OASys that is dedicated to assessing and planning for the safety of children, and ensure that the nature of contact and impact the person on probation has in the life of the child have been considered on both current and future children in the person's life
9. ensure that the impact on children's safety and wellbeing is sufficiently considered in every case.

Risk management plans

10. ensure that probation practitioners contact partners, family or other key adults in the lives of the person under supervision to determine and discuss their inclusion in risk management plans.

Training and support

11. consider the suitability and efficacy of online training, particularly on domestic abuse, child safeguarding and other key training required to correctly assess and robustly manage risk of serious harm
12. ensure that each PQiP has access to a mentor who has at least two years' experience as a qualified probation practitioner.

13. dedicate time for probation practitioners to engage in reflective discussions with colleagues and the line manager regarding cases.

Allocation practice

14. ensure that NDelius entries for 'management oversight – allocation' include evidence that the manager has considered the complexity of the case and the capabilities and capacity of the probation practitioner receiving the case.

Oversight of SPOs

15. review and monitor SPO workloads to ensure that sufficient line management and management oversight of case work can be provided effectively
16. review the line management responsibilities and supervision of SPOs responsible for PQiPs to ensure the standard of PQiP management and oversight is appropriately robust, including the suitability of the cases allocated to them.

Ministry of Justice should:

17. amend legislation to be more prescriptive of the information that should be obtained and considered by the court, to assure themselves of the safety of other household members at a proposed curfew address before they impose an electronically monitored curfew.

Until this can be actioned **HMCTS** should issue guidance to court staff requiring them to satisfy themselves that relevant checks have been undertaken by the probation courts team.

7. Relevant information about DB prior to 2014

From 2011 to 2021, DB was subject to three separate periods of involvement with probation services.

In June 2011, DB was sentenced to three years' imprisonment for robbery and was managed on licence in the community by probation services in the south west from August 2012 to June 2014.

In August 2015, DB was sentenced to three years for attempted robbery and possession of a knife. During this sentence, in May 2016 DB committed grievous bodily harm and two counts of assault occasioning actual bodily harm against prison officers. Due to a delay in DB being charged with these matters, he was released in December 2016. Failure to report to the approved premises as directed saw him recalled the day after release.

DB was still in prison when he was convicted of the offences against the prison officers in January 2017 and was sentenced to 30 months' imprisonment. DB was managed on licence in the community by the probation services in the south west from October 2018 until his recall back to prison in November 2018 due to poor behaviour at the approved premises where he was staying. DB remained in prison until August 2019, when he was released at the end of his sentence without probation supervision.

Inspectors spoke to staff who worked with DB and reviewed his case files. They learned that DB repeatedly alluded to having been a victim of physical abuse from his stepfather during his childhood and stated that he socialised with older peers for a feeling of belonging. He told his previous probation practitioner in the south west that he started selling drugs aged nine, indicating that as a child he was not protected from criminal activity or illegal substances.

DB was reprimanded in January 2004 for criminal damage, after throwing an egg at a woman's house; he was aged 13 at the time of the offence. In April 2010, aged 19, DB received a caution for possession of cocaine in December 2009.

DB has repeated the claim to successive probation practitioners that he was a high-ranking member of a white supremacist group called the Aryan Brotherhood. He disclosed using significant levels of violence, for which he was not convicted, related to gang affiliation throughout his youth and into his twenties. DB has reported having two Nazi-inspired tattoos. Probation practitioners in the south west have recorded that DB can tell grandiose stories. We found no evidence that probation undertook checks with the police gang unit to ascertain the truth of his claim to have been a member of the Aryan Brotherhood.

In June 2011, DB was sentenced to his first period in prison – three years for a violent robbery against a lone Asian man. The victim reported hearing racially abusive language before he lost consciousness. The risk of serious harm posed by DB to known adults (as opposed to strangers) and children throughout this order was assessed as low. This sentence ended in June 2014.

Key findings/missed opportunities

- The early concerns about his attitudes and beliefs were missed.

8. Case management between August 2016 and August 2019

8.1 Relevant information – lost in transition

In August 2015, DB was sentenced to a further three years in custody for attempted robbery of a newsagent and possession of a knife. DB used a six-inch knife to intimidate the victim, who successfully fought him off. The victim was an Asian man. This sentence was managed by South West probation region.

During this sentence, DB disclosed to his probation officer a significant Class A drug habit and admitted frequently taking money from his family and his ex-partner to fund his drug use. DB was assessed as posing a high risk of serious harm to the public for the first time since being known to probation; however, his probation practitioner continued to assess the risk to partners and children as low.

In May 2016, a woman contacted HM Prison Exeter and identified herself as DB's ex-partner. She made a request for him to be prevented from contacting her. She told the prison that DB had been violent to her during their relationship and that he had stolen from her. She disclosed that she had never reported this to the police. Staff at the prison recorded this intelligence in the case management system, which is used jointly by prison and probation staff. There was no record of what had prompted DB's ex-partner to contact the prison.

In July 2016, the same woman contacted DB's previous probation practitioner (PO1). She explained that she was a fearful ex-partner who wanted to know DB's release date and whether she could obtain a restraining order. Three days later, PO1 spoke to police colleagues about how this woman might obtain a restraining order. Two days after this, DB's ex-partner's new partner contacted PO1. He said that more should be done to protect her and that he wanted to speak to a manager. Although the Probation Service is not empowered to grant or request restraining orders, it does have a responsibility to be aware of them and, where they exist, include them in risk management plans.

The case files do not record what happened next and we could find no record of a restraining order having been granted. We are not clear if PO1 raised the incident with a manager or if further questions were asked about DB's ex-partner and whether she had children. This was a missed opportunity for a probation practitioner to have been professionally curious about the risks of serious harm DB posed to women and potentially children in a domestic setting.

Inspectors interviewed PO1, who described DB as a man who exhibited "*extreme behaviours*", was "*cold and calculated and quite psychopathic*". PO1 also recalled that DB would use violence in a calculated manner, rather than losing control. We found that, during this time, the Probation Service's focus was on DB's extreme right-wing views and his prison-based violence, rather than on domestic harm.

8.2 Staff workloads – firefighting and high pressure

Probation practitioners informed inspectors that workloads were very high during this phase of DB's management. This was due to a high number of vacancies and short placements of PQiPs, who would leave upon qualification. These pressures were compounded by sickness absence. Despite supportive line management, practitioners were under pressure and did not have the time to be investigative and reflective when managing cases. One probation practitioner said: "*You end up dealing with things as they happen. You have limited*

cognitive ability under that level of demand". The high-pressure workload at the Swindon office since 2014 has been corroborated by PO2, SPO1 and HOS1.

While inspectors acknowledge the impact of high workloads, we still expect to see an appropriate response when an alleged victim of domestic abuse contacts the Probation Service. This response should have included conversations with a manager, clear recording of the allegation, risk review and the details of all involved, including children.

While in prison, DB's case was managed by PO1 from August 2016 to June 2018. The case was transferred to PO2 (an agency worker) in June 2018 before DB's release from prison on licence on 31 October 2018 and transferred again to PP3 in June 2019. Inspectors found evidence of high staff turnover and the use of agency staff to pick up large caseloads at short notice. HM Inspectorate of Probation has previously highlighted the importance of probation practitioners having adequate time to become familiar with complex cases for which they assume responsibility.[15] The agency staff member PO2 was not given the necessary time to become familiar with this case, or the bulk of cases that were transferred to them.

DB was released from prison on licence briefly at the end of October 2018, before being recalled on 28 November 2018 for missing his curfew and drinking alcohol at the approved premises where he was directed to reside. During this time in the community he met a woman and told PO2 that he wanted to live with her at the end of his sentence. He did not share any further information on her with the Probation Service. Inspectors found evidence that, throughout April and May 2019, prior to DB's release in August 2019, efforts were made by probation, in collaboration with the police, to contact this woman in order to disclose to her DB's history of violence; however, this disclosure was never made. Probation practitioners reported that there was *"little more that could be done"*. The case was reduced to MAPPA level 1 in August 2019, having been assigned to MAPPA level 2 during his time in custody. DB was released from prison on 09 August 2019 at the end of his sentence, having refused to cooperate with the parole process for earlier release. No further probation supervision after release was therefore possible.

8.3 Management oversight

Inspectors found that SPO1 was unable to provide the necessary level of oversight and case management support between August 2016 and August 2019. Despite being aware of what good management oversight required, SPO1 told inspectors: "*I didn't do [case work] as I'd like. It was a time issue"*. We found there was insufficient cover arrangements in the SPO role at Swindon Office. SPOs were trying to manage large teams and oversee a high volume of cases. SPO1 reported that they did not "*have the time to check that people had done what I had asked them to do"* and appropriately robust handovers of cases were rare.

Inspectors found that senior leaders in the South West were aware of the long-term challenges to staffing the Swindon office and that it struggled in this regard more than any other office in the area. Managers told us that the Swindon office invested resources in training PQiPs. However, once the PQiPs received their qualifications, they asked to be transferred to other offices and therefore: "the cavalry never comes".

We heard that SPOs felt powerless to improve their workload situation, as vacancies were managed by the NPS nationally, rather than at a local level. We conclude SPOs faced significant challenges in this case.

There was a brief period, from 10 June 2019 to 08 July 2019, towards the end of his 30-month prison sentence, that DB's case was allocated to an SPO due to a lack of probation

[15] HM Inspectorate of Probation. (2019). *Independent review of the case of Joseph McCann.*

practitioner capacity. This was further evidence of poor resourcing; SPOs were covering frontline work rather than providing much-needed quality assurance and management oversight.

8.4 Termination of probation service oversight

Just before the end of his 30-month prison sentence on 09 July 2019, DB's case was reallocated again for the completion of a termination OASys assessment. PP3's assessment found that DB posed a high risk of serious harm to the public, a medium risk to known adults and staff, and a low risk to children. The relationships section states that: "*relationships require exploring and monitoring to establish whether he uses violence within intimate relationships"*. The intelligence from the prison and the phone calls from the ex-partner were not included. The completion of the OASys termination was process-driven and missed vital information that could have informed future supervision.

8.5 Contact from the child sexual exploitation team

In March 2020, in between periods of probation supervision, the Wiltshire police child sexual exploitation unit contacted the Probation Service. They wanted to confirm DB's most recent known addresses. A response was sent by a duty probation practitioner, which included DB's most recent address and confirmed that he was not currently managed by probation. There was no evidence that the Probation Service enquired about why the police were interested in DB at this time.

The contact log included the contact details of the detective constable. Inspectors contacted the detective constable retrospectively and the information provided was sufficient to confirm that DB posed a high risk of serious harm to girls and this harm was sexual in nature.

We found this information was readily available to any probation practitioner who read the contact log and contacted the police. The police told us that if probation practitioners requested a police national database check, this information would have been available. Inspectors found that probation practitioners and managers all failed to read this contact.

This was another significant missed opportunity to identify DB's high risk of serious harm to children. It was an opportunity to work with the police to understand these concerns and review the management of the risk of harm posed.

Key findings/missed opportunities

- Probation practitioners did not demonstrate sufficient professional curiosity when receiving allegations of domestic abuse.
- Intelligence available to probation from the prison was not used to review the risk of serious harm he posed to partners and potentially children.
- New information was not recorded using the appropriate risk tools, such as the NDelius risk flags, the OASys relationship section or the risk of harm section.
- Risk of serious harm to potential partners and potential children was underestimated.
- The impact of high workloads and staff shortages in the Swindon office affected the ability of probation practitioners and SPOs to undertake work of sufficient quality.
- Police intelligence available to probation staff regarding DB's risk of serious sexual harm to girls was not explored or recorded sufficiently.

9. Court practice prior to DB's sentencing for arson

On 24 February 2021, nine months after his original arrest, DB appeared in court for arson (without intent to endanger life) and the court requested that a pre-sentence report be completed by a probation court report author (CO1). CO1 interviewed DB on two occasions via telephone, as was standard practice during the Covid-19 pandemic.

After a series of delays in arranging the interview with CO1, and pandemic-related delays in court, CO1 completed the fast delivery report, which is a shortened form of pre-sentencing report, on 07 June 2021. CO1 submitted it to court the next day, for the sentencing on 09 June 2021. It is unclear why CO1 backdated the report to 24 March 2021.

9.1 The quality of the court report

Inspectors found that the quality of the court report was very poor. The report lacked critical analysis or professional curiosity and, as a result, significantly misrepresented to the court the risk of harm that DB presented to others, which in the view of inspectors was clearly high rather than medium.

For example, the report noted that the victim was an Asian man, as were DB's previous victims, but did not explore how his attitudes motivated or contributed towards his offending. The court report omitted his previous conviction for attempted robbery and incorrectly stated that DB had desisted from offending since 2017. This was inaccurate, as DB had been in custody for much of this time and was only released from prison in August 2019. He then committed arson in May 2020, which was nine months later.

We found that the significant level of violence that DB employed during his previous offending was not sufficiently examined. During the robbery (in 2010) the victim was left unconscious; during the attempted robbery (2015), DB was in possession of a knife and the victim had to fight him off with a golf club. The GBH incident (2016) involved a planned act of violence towards prison officers as revenge for not being granted a prison transfer. One of these victims required surgery, months of physical rehabilitation and a considerable period of time away from work.

CO1 failed to use information that was readily available. When interviewed by inspectors, CO1 stated: "*It depends how much you have going on really. If you have reports right, left and centre, you do not usually have time to go back"*. Because CO1 did not access or verify relevant information, there was an over-reliance on DB to provide a narrative of what had occurred during the commission of the arson, and previous offences. This was illustrated in the following quote from CO1: "*I took his presentation into account. He came across really well. He stated during interview that he was willing to comply and change.*" The report also failed to scrutinise DB's self-reported medical issues, for example stating without evidence that: "*DB has been diagnosed with a mass on the brain that is still undergoing investigation"*. We found that this claim had been taken at face value throughout the management of this sentence.

DB was described as being articulate and charismatic, and CO1 recognised that this influenced her approach to risk assessment.

CO1 was able to identify specific areas that were relevant to DB and his current circumstances, such as accommodation, finance, substance misuse, thinking and behaviour, caring responsibilities, employment, relationships, physical and mental health, and experience of trauma. However, these were not sufficiently explored to consider the link with risk of serious harm or likelihood of reoffending.

Inspectors were concerned by omissions in the relationship section of the report. This section should have examined his relationship with Ms Harris and contact with children. There is no evidence that appropriate safeguarding enquiries were made, or that there was any contact with Ms Harris regarding the prospect of a curfew. The report repeats DB's assertions that Ms Harris was "*aware of this court case"*, "*extremely supportive"* and "*happy for their home to be used by DB to be tagged"*.

The Probation Service is aware of HM Inspectorate of Probation's expectation that:

- Court officers initiate domestic abuse enquiries with the police in all cases at the point when a report is ordered by the court. Those enquiries, and responses from the police, should be clearly recorded on NDelius. We expect the Probation Service to work with police forces to facilitate a clear, detailed and speedy response to all enquiries.

- Court officers initiate child safeguarding enquiries with children's social care in all cases where the individual has children, is in contact with children or presents a potential risk of harm to children. Enquiries should be made at the point a report is ordered by the court. Those checks, and responses from the police, should be clearly recorded on NDelius. We expect the Probation Service to work with local authorities to facilitate a clear, detailed and speedy response to all enquiries.

HM Inspectorate of Probation has recommended on several occasions that domestic abuse and child safeguarding enquiries should be conducted in a timely manner in cases where reports are being presented at court.[16,17] In DB's case, the Probation Service could have requested a national database search. This would have identified the police child sexual exploitation unit's recent interest in him.

Other sections of the report continued to portray DB's version of his substance misuse, health and employment status, without challenge or verification by CO1.

CO1 had easy access to a psychology report written in May 2019 by the prison psychologist, which states: *"DB [has been] persistently returning to violence both in prison and in the community. Thus, attachment experiences and early exposures to violence remain unresolved/unaddressed with no relapse prevent plans in place"*.

Middle and senior leaders acknowledged that time pressures for reports often meant that suitable safeguarding enquiries were not made and that a key gap was when children lived in a different local authority area. We were told that court staff "*just don't know who to go to"*. This is contrary to HMPPS guidance, which states that an adjournment should be requested.[18]

CO1 did not consider all of the available information, so the risk assessment was incomplete and inaccurate. The risk assessment concluded (wrongly): "*There is no evidence or intelligence to suggest that DB currently presents a risk of harm to children, prisoners, known adults, staff or himself at this current time. He is therefore assessed as posing a low risk of serious harm in these areas.*" This assessment was made despite there being previous assessments available, including the most recent assessment in August 2019, which evidenced that DB posed a high risk of serious harm to the public and medium risk of serious harm to partners.

The court report stated that DB was "*suitable for a Curfew Requirement"*. Inspectors found this to be a dangerous and inappropriate assertion in the absence of all relevant

[16] HM Inspectorate of Probation. (2020). *Inspection of probation services: North West NPS division.*
[17] HM Inspectorate of Probation. (2021). *Inspection of probation services: NPS South West.*
[18] HMPPS. (2019). Pre-Sentence Reports: *Interim Guidance on Report Format.*

information. *The Criminal Justice Act 2003* sets out that 'before making a relevant order imposing a curfew requirement, the court must obtain and consider information about the place proposed to be specified in the order (including information as to the attitude of persons likely to be affected by the enforced presence there of the offender)'.

Inspectors found that CO1 took information at face value and did not validate it and that the safety of Ms Harris and her children was not given sufficient consideration.

9.2 The risk of serious harm assessment on OASys

On 10 June 2021, CO1 completed an OASys assessment to accompany the court report. Inspectors found the errors and omissions in the court report were repeated in this assessment.

The report identified the public in the community and staff in custody as being at a medium risk of serious harm from DB. All other groups were identified as being at a low risk of serious harm, which mirrors the risk assessments in the court report. Inspectors found that DB met the criteria for high risk of serious harm to the public and to children, and a medium risk of serious harm to staff and to known adults – who include criminal associates, female members of his family and intimate partners.

9.3 The context in which the court report was completed

Inspectors were advised that CO1 was relatively inexperienced, having transferred from another role in March 2020. During this time there was a lack of quality assurance work being undertaken on court reports. Of the quality assurance court report tool, SPO2 told us: "*we have made it quite clear that we have not been using the QA tool as it is long-winded and takes too much time under pressure".*

Inspectors found that staff and managers reported experiencing work-related stress and associated poor mental and physical health. At the time of our interview with a court SPO in November 2021, they continued to manage 22 members of staff, which is excessive and runs contrary to HMPPS's policy that the aim should be for SPO line management spans of 10 full-time equivalent staff or less. Understandably, their primary concern was that: "*if you know what you're not doing, that can be managed; if you don't know what you're not doing that's the bigger challenge"*.

Senior leaders were aware that the quality assurance tool was not being used, who were *"not confident"* that court work was being quality-assured in the region, but that *"there is a court action plan in place"*.

Senior leaders confirmed that only 60 per cent of staff had completed the online safeguarding training within the last three years. RPD1 noted that *"face-to-face conversations may be more effective"*. RPD1 stated: "*We must get the balance right with quality of training and having the enquiring mind. I am not convinced the current approach to learning and development fosters an enquiring mind"*.

Overall, inspectors found that, during much of 2021, there were no assurances in place that safeguarding work was being undertaken by the court team.

Key findings/missed opportunities

- Despite the significant amount of information held by the Probation Service, CO1 did not read the case records sufficiently. Appropriate enquiries were not made with the police and children's services to inform the court report.
- CO1 appeared to take DB's word without verification. In the McCann review, HM Inspectorate of Probation said that assessment requires resilient staff who are

trained and able to analyse, interpret and challenge difficult behaviour. They need the ability to seek out and synthesise information from different sources and use professional curiosity to question superficial compliance.[19]

- There was no mechanism preventing the CO1 from assessing a curfew as 'suitable' in the absence of domestic abuse checks, child safeguarding checks or any communication with the owner or the lead tenant of the property.
- There was insufficient gatekeeping/oversight to ensure the quality of court work.
- No consideration was given to the impact on Lacey Bennett, John Paul Bennett, and other children in their lives, of being curfewed with DB.

[19] HM Inspectorate of Probation. (2020). *Independent review of the case of Joseph McCann.*

10. Case management between 14 June 2021 and 23 August 2021

10.1 Case allocation

DB was sentenced in Swindon and reported living in Derbyshire. As a result, he was automatically allocated to the East Midlands region NPS division. Probation staff were not required to check the address before the case was allocated to the new region. Likewise, direct conversations between regions are not required at this stage. The new region had access to the national systems, NDelius and OASys, the court report completed by CO1, and DB's historical records. This review now looks at the quality of practice of the Derbyshire Probation Delivery Unit.

Inspectors found that DB's case was allocated quickly, partly in order to meet the target for offering a prompt start to the order. The court officer who allocated the case did not provide PSO1 with a summary of the risk indicators of the case, as SPO3 advised us would have been usual practice for a new member of staff.

Inspectors found DB's case was incorrectly assessed as medium risk of serious harm. This meant his case met the criteria for C1 tier[20] and could be held by an unqualified probation practitioner. Had this case been correctly assessed as high risk of serious harm it would have met a higher tiering, ensuring that the case had to be managed by a qualified probation practitioner.

PSO1 had six months' experience of working in the criminal justice system when allocated DB's case in June 2021. Much of PSO1's training had been online, with significant periods of absence from work before this allocation. Limited support was provided, and we heard that there were difficulties in the working relationship with line management. PSO1 is an Asian practitioner and DB had a known history of racially aggravated violence and claimed past membership of a white supremacist organisation. His previous victims were Asian men and, although SPO3 did check PSO1's confidence in managing the case, this was another example of poor allocation practice to add to the other serious issues we have already identified with this case allocation.

We found that the allocation of his case was a missed opportunity for DB's records to be sufficiently scrutinised by an experienced and qualified practitioner, which should have triggered a risk review.

10.2 Checking the allocation

Derbyshire Probation Delivery Unit has a process in place where allocations are checked after three weeks. The Head of Service expected this process to be followed. There was no evidence that there was a review of the suitability of the allocation in this case at any point between June and August 2021. This was a missed opportunity to amend the incorrect risk assessment made at the court stage of this order and ensure the case was allocated to a member of staff with the right grade and experience.

10.3 Case management undertaken by PSO1: assessment

On 16 June 2021, PSO1 initiated a police address check on 54 Chandos Crescent, Killamarsh. A timely response was received and recorded, which stated that there had been no recent domestic abuse incidents recorded at that address. It stated that the last incident

[20] HMPPS. (2021). *Unified Tiering/Case Allocation Framework.*

there was in 2013 and not related to DB; however, there was no further investigation into this by PSO1.

DB failed to attend his initial appointment with PSO1 on 18 June 2021, stating that he felt too unwell after receiving the Covid-19 vaccination and for which he provided evidence. On 22 June 2021, DB attended early for his first appointment with PSO1. This is the start of a pattern by DB of requesting a change of times and/or being very late/early for appointments. Records show that he had attended three appointments in person with PSO1 on 22 June 2021, 30 July 2021 (two hours late) and 02 August 2021 (two hours early) and one in person with PQiP1 on 24 August 2021.

DB complied with three appointments over the phone on 23 June 2021, 07 July 2021 and 16 July 2021, and failed to attend two appointments, on 18 June 2021 (in person) and 10 September 2021 (via telephone).

PSO1 informed inspectors that, in one of their early conversations, DB had given her what felt like a warning: that he had previously been recalled because he did not like his probation practitioner. PSO1 shared that she felt comfortable managing DB, but the implication was that she needed to keep him happy, for example by not challenging him on his lateness.

This is further evidence of DB's propensity to control the direction and pace of his supervision. PSO1's inexperience and her focus on engagement contributed to an unhealthy power imbalance in their working relationship. In such situations, inexperienced practitioners may lack the confidence to challenge unacceptable behaviours and fail to spot signs of false engagement. It is possible that this could have been identified and mitigated had PSO1 been given the opportunity to engage in reflective case discussions with an experienced colleague.

10.4 Unpaid Work requirement

Inspectors found that the Unpaid Work (UPW) requirement of the court was not delivered, i.e. no hours of UPW were undertaken between June 2021 and the date of the serious further offence in September. DB appeared to be able to influence PSO1 into delaying his induction by suggesting that he was too unwell and unable to travel to the prospective work site.

The Unpaid Work practitioner (UPW1) conceded that it suited the UPW team to delay DB's start as there was, and remains, a significant UPW backlog as a result of the Covid-19 government restrictions in 2020 and 2021.

It is our view that it was a missed opportunity that DB was not directed to begin his UPW hours. This would have brought him into an induction meeting with UPW1 who could have required evidence from him about his alleged brain mass. UPW1 also had greater experience of probation work, so could have held DB to a greater degree of scrutiny. We find that DB was given too much leniency in the decision on when and how to start this court-ordered requirement.

The NDelius contact log stated that PSO1 would review DB's UPW induction appointment on 27 August 2021. However, there is no evidence that this took place.

10.5 MAPPA Q

Probation case records confirm that a MAPPA Q form had been completed, endorsed and emailed to the MAPPA Unit. The offence of arson (including without intent) under section 1 of the Criminal Damage Act 1971 is included in the list of Schedule 15 offences under the *Criminal Justice Act 2003*.

The main reason for MAPPA consideration is the benefit that a multi-agency approach can bring to risk management.

It is recorded that PSO1 and SPO3 agreed that: "*DB can be managed at level one. He is a medium risk case, category 2, level 1.*[21] *He has been assessed as posing a medium risk of serious harm to the public and to staff. At present he is stable, and the risks are not deemed to be imminent."* Inspectors challenge the assessment that "*at present he is stable"* as lacking evidence or corroboration.

It would have been positive practice for PSO1 and SPO3 to have considered previous MAPPA intervention in this case. Communication by the Probation Service with the police at this stage may have alerted probation to the risk of serious harm that DB posed to girls. There is no evidence that DB's case records were reviewed in order to be able to identify the necessity of a multi-agency approach in this case.

On 30 June 2021, PSO1 held her third supervision meeting with DB, again by phone. They agreed sentence plan objectives, which covered alcohol use, completion of Unpaid Work, health and wellbeing, and victim empathy. Inspectors found no evidence that DB's use of alcohol or drugs was being monitored and there was no discussion about the quality of his relationship with Ms Harris, her health during her pregnancy, or the children with whom he was living and who would shortly be on school holiday.

10.6 Alcohol Treatment Requirement referral

On 06 July 2021, PSO1 records that DB was referred for the Alcohol Treatment Requirement (ATR) to be delivered by the local relapse prevention provider.

The disability section does not note DB's frequent assertions that he has a mass on his brain, despite there being an 'other' section where this could have been recorded. In all other instances the alleged brain mass is accepted as true and even linked to his risk of serious harm to the public. The absence of this information is a striking inconsistency.

The referral form to the treatment agency asks whether the children, Lacey and John Paul Bennett, are involved with children's social care. Although they were not, PSO1 had not checked this and therefore selected 'no' inappropriately.

The form includes DB's disclosure that he had been using alcohol in a problematic way since he was nine years old, that he had continued to binge drink, and that he smoked cannabis as recently as two months ago. Alongside this referral was a risk information-sharing form, which inaccurately stated a low risk of harm to children and known adults and a medium risk of harm to the public and to staff.

On 06 July 2021 the local relapse prevention provider emailed PSO1 to confirm a first appointment with DB on 21 July 2021. DB then contacted the ATR provider to rearrange this appointment, which he then failed to attend. This was not enforced.

10.7 Initial sentence plan

On 07 July 2021 PSO1 completed the initial sentence plan OASys assessment.

Inspectors found that PSO1 had continued with the same errors as the CO1 and failed to take a 'deeper dive' into the recent history of the case. This could have uncovered indicators of high risk of serious harm. This formal assessment was a missed opportunity for PSO1. It could have acted as a prompt to read the detail of DB's previous offences.

[21] HMPPS. (2021). *MAPPA Guidance* document for information on MAPPA levels and Categories (p44).

Although a police check of Terri Harris's address for previous domestic abuse incidents was conducted on 16 June, no other consideration was given to the suitability of the address for the curfew and the safety of the relationship with Ms Harris and the wellbeing of the children were, again, taken for granted. Ms Harris herself was not contacted for her views on this or any other occasion.

Analysis of DB's lifestyle and associates and his thinking and behaviour was superficial and failed to contribute to a broader picture of DB's risks.

Inspectors found several inconsistencies in the assessment that demonstrate DB's ability to obfuscate skilfully when there is an attempt to hold him accountable, and PSO1's own professional optimism and lack of experience in exploring such discrepancies. Contact with local police was included in the planning, but it was unclear whether these other checks were made.

PSO1 noted that she believed DB to have the following support in the community:

- DB's partner, Ms Harris, and her family to provide support for DB and help him stay away from his previous lifestyle
- DB's mother, who provides financial support
- DB's neurologist, to provide support in terms of medication, appointments and assessments for the mass on his head.

There are considerable concerns regarding this support section. Inspectors have found that often partners and/or parents are included in the support section without the nature of their relationship being ascertained by the probation practitioner.

Probation did not check with Ms Harris regarding her willingness or ability to financially support and accommodate DB. Similarly, DB's mother was also providing financial support and at this time paying one of DB's fines, which was imposed in 2015 alongside the prison sentence. There was no consideration of whether this was appropriate, whether this arrangement was free of coercion or whether it was affordable for DB's mother. We find it unacceptable to include people in a risk management plan without a better understanding of the dynamics of the relationships.

10.8 Case management undertaken by PSO1: planning

PSO1 included five sentence plan objectives:

- implement Covid-19 contingency arrangements
- improved use of leisure time
- victim awareness
- alcohol misuse
- to keep in touch with GP and neurologist.

Inspectors find these objectives suitable, but there are significant omissions, including substance abuse, racist attitudes, offending behaviour and lifestyle.

10.9 Initial assessment and planning countersigning by SPO3

There is a mechanism in place on OASys that requires a manager's countersignature when an assessment is being completed by an unqualified member of staff. SPO3 initially sent it back without countersignature, with an email setting out the requisite improvements – though, since she did not complete a thorough review of this case, this email failed to cover

several critical points. SPO3 did not, for example, find the contact log from the child sexual exploitation police unit indicating a risk of sexual harm to children, or the 2019 assessment which found that DB posed a high risk of serious harm. Her review did not analyse DB's beliefs, which permitted the use of serious instrumental violence, his entrenched racism, his documented enjoyment of violence and his substance abuse. Most egregiously, there was no exploration of the impact that DB living with two young children might have on them, and the risks inherent in being curfewed with a pregnant partner.

When PSO1 sent the revised version of the OASys to SPO3 for countersignature, SPO3 admitted she did *"not read it in detail… Sometimes I am signing off 16 per week"*.

10.10 Case management undertaken by PSO1: implementation

Following PSO1's assessment, the automatic tiering system in NDelius used the scores from the OASys assessment to increase DB's tier to C2, which made no material difference.

On 06 July 2021, DB had been on his suspended sentence order for a month. He had been seen in person once, and had not started his UPW, his ATR, or completed any offence-focused supervision. Inspectors found it inappropriate that reporting instructions were relaxed at this stage to fortnightly and then shortly afterwards to monthly. Supervision appointments during this time took the form of superficial 'check-ins', which did not focus on risk or progress the sentence plan. There was a missed opportunity for PSO1 to become more investigative about DB's use of alcohol and what was going on at home during the school holidays. Some light work was undertaken regarding victim awareness, but this was marred by PSO1's feeling that she could not challenge DB.

On 02 August 2021, PSO1 recorded: 'he started smoking cannabis again… he smokes in the morning… and then smokes at night when kids are asleep'. DB also disclosed that he was drinking strong alcohol. These are very clear indicators of an escalation in risk of serious harm. Our expectation would have been that PSO1 should have completed a child safeguarding referral, increased reporting to weekly, expedited his ATR appointments, and discussed this matter with a manager. Contact with Ms Harris would also have been appropriate. None of these things happened.

On 13 August 2021, PSO1 sent an informal email to Starting Point, which is the local contact and referral service for children's services, mentioning DB's drug and alcohol use but not making a formal referral. This was a significant missed opportunity for both agencies to examine more closely the impact of DB's substance abuse on the safety and wellbeing of children. This is the end of PSO1's work on DB's case management.

10.11 PSO1 in context

PSO1 had no experience of working in the criminal justice system before starting as a PQiP in January 2021. She completed her initial training entirely online.

The quality and impact of e-learning was commented upon by other people we interviewed. A practice tutor assessor (PTA2) noted that e-learning contributes to a *"lack of exposure for a learner"* and the PTA is left with limited "*oversight of what they have absorbed and consolidated"*. She concluded with *"I would question how much value e-learning would have"*. The Head of Service (HOS2) shared that "*most staff report a disconnect with the training"* and shared his concern that "*I struggle to see impact from much e-learning"*. HOS3 stated "*what we have is okay, but e-learning will never be as good as classroom. It's hard to know how well people have engaged"*. SPO3 stated that "*whilst training has improved slightly it does not meet the gaps needed for operational work"*.

10.12 SPO3 oversight for PSO1

Supervision by SPO3 of PSO1 was of an insufficient standard. Although regular supervision took place and notes were taken, the content of these meetings did not allow for reflective case discussion or a deep dive into cases, as would be appropriate. Notes show that SPO3 managed a significant amount of HR-related work with PSO1 and also tried to support her when she shared feelings of being overwhelmed by the work.

In conversation with inspectors, SPO3 described the summer months of 2021 as a "*frantic period of time"* and "*a vulnerable time for the learners"* because inexperienced trainee officers were routinely being used to "*hold up teams"*.

SPO3 told inspectors: "*I do not think an SPO should have more than 10 members of staff and at one stage I had almost 30. It was difficult to identify which case was going to blow up. I could have 10-12 supervision sessions per week. I had 16 PQiPs to do supervision with but the others… I relied on them to come to me with issues that were of concern to them".* HM Inspectorate of Probation has consistently found that the span of control for SPOs is of concern. They increasingly deal with complex staffing and HR issues, for which some feel ill-equipped. This also reduces the time they have available to provide effective professional oversight of work on individual cases. Most told us that they do not have enough time to supervise all members of their teams to the standard they would wish; when supervision takes place, there is often a focus on managing volumes of work rather than improving quality.[22]

HM Inspectorate of Probation has previously found that the centralised recruitment processes are not sufficiently responsive to local need. While progress has been made in recruiting PQiPs, it will be some time before national gaps in skills and experience are adequately filled. In the meantime, high numbers of PQiPs are being recruited to a service that may not have sufficient capacity to support them.[23]

Key findings/missed opportunities

- There is a 24-hour key performance indicator that encourages the swift allocation of cases. This limits the time taken by allocating managers to read the case, and any errors and omissions in the risk assessment may be missed.
- PSO1 was not sufficiently experienced, supported or qualified to be allocated DB's case.
- The Probation Service's united tiering/case allocation framework (October 2021 version 2.2) states that 'the allocation decision will be based on individual circumstances of the case, and the skills, ability and experience of the individual officers. Cases that are likely to attract manager judgement and thus oversight because there is scope for either a PO or PSO to manage them will, in the main, sit within the C tier… Case allocation decisions will be based on the manager's understanding of the individual circumstances of the case, and the skills, ability and experience of the individual officers.' This is an improved process compared to the one applied in June 2021.
- Probation practitioners continued to accept and repeat DB's unsubstantiated claim that he suffered from a 'mass on his brain'.
- The Probation Service failed to robustly enforce the suspended sentence order, in part due to an unhealthy power imbalance in the relationship between PSO1 and DB.

[22] HM Inspectorate of Probation. (2020). *An inspection of central functions supporting the National Probation Service.*
[23] HM Inspectorate of Probation. (2020). *An inspection of central functions supporting the National Probation Service.*

- The court-ordered requirements of Unpaid Work and Alcohol Treatment Requirements were not commenced or enforced sufficiently.
- MAPPA Q form was not used to achieve its purpose to review the case. Instead it was incorrectly completed by PSO1 without the required discussion with SPO3, and inappropriately countersigned by SPO3.
- The OASys assessment that informed the sentence plan was insufficient. It lacked a depth of understanding of DB's criminal history and risks posed. It did not sufficiently consider the safety of Ms Harris and her children while living with DB.
- Contact between PSO1 and DB lacked appropriate authority, structured intervention or focus on reducing the risk of serious harm and likelihood of reoffending.
- Evidence of escalating risk was not shared with a probation manager or a more experienced probation colleague.

11. Case management between 24 August 2021 and 19 September 2021

11.1 Care-taking appointment by PQiP1

In PSO1's absence, PQiP1 offered to cover an appointment with DB. On 24 August 2021, PQiP1 met DB for a planned office visit and recorded that DB "*presents as well and was engaging*". During the appointment, PQiP1 identified that DB had resumed drinking alcohol and smoking cannabis. Inspectors found that, during this interview, PQiP1 provided more challenge than PSO1. She recognised that DB was using cannabis and alcohol when he committed the arson offence, and this is the first clear offence-focused work undertaken on the sentence.

It was a missed opportunity, however, that PQiP1 did not read the most recent risk management plan, which clearly linked alcohol and cannabis use to an increase in risk of serious harm and related this to his current domestic circumstances. We would have expected to see PQiP1 discuss this case with a manager and complete an urgent child safeguarding referral.

11.2 Case allocation to PQiP1

On 28 August 2021, DB's case was reallocated to PQiP1, and SPO3 approved the move. At the point of allocation, PQiP1 had been in post for six weeks. She had received training on OASys and NDelius but had completed no domestic abuse or child safeguarding training. On the day that PQiP1 was allocated DB's case, she was also allocated four other cases, bringing her total caseload to 10 people on probation. We learned that PQiPs should gradually build up their caseload to 10 during the first six months of the training programme. HM Inspectorate of Probation has consistently found that probation practitioners are allocated too many cases;[24] it is concerning to see that this happened at such an early stage in someone's career.

Inspectors conclude that this was an unsuitable allocation and, with hindsight, senior leaders have concurred.

Inspectors found that PQiPs were regularly holding large numbers of complex cases. SPO3, who allocated cases to PQiPs, told inspectors: "*all staff are placed under impossible pressure. We did not have any PSOs [in their local office], the only one we had went off with stress two months ago*". It was clear that general staff shortages had the impact of putting additional pressure on trainees, increasing their exposure to risk.

11.3 Case management undertaken by PQiP1

On 04 September 2021, PQiP1 recorded that she sent a text to DB stating that the appointment on 10 September 2021 would need to be conducted by telephone. We found that there were no cover arrangements agreed to ensure someone was able to have face-to-face contact with DB. On 10 September 2021, DB failed to answer the telephone call from PQiP1 and she issued a final warning letter, the first piece of enforcement during his sentence. The letter included the next appointment, which was for 20 September 2021, the Monday after the weekend the SFOs were committed.

[24] HM Inspection of Probation. (2020). *An inspection of central functions supporting the National Probation Service*.

11.4 The span of control for SPOs

Inspectors learned that, at the time DB's case was reallocated to PQiP1, SPO3 had asked for a change of role because she felt her workload "*was becoming unmanageable".* She reported that, of the learners she was managing at that time, "*10 or 11 were going through [complex] HR processes".* She reported that, when new learners start with the Probation Service, the PQiPs' SPO is not given any information about diversity issues, including any reasonable adjustments that may be required for them to do their jobs. Additionally, all learners are in post before the ViSOR[25] vetting process has been concluded. We understand, however, that this is about to change.

SPO3 had worked in probation for 34 years, and she told inspectors that she is "*used to change but I think over the last 12 months, it has not been manageable for anybody".*

The SPO role is widely recognised by senior leaders we interviewed as the "squeezed middle" grade. HM Inspectorate of Probation found that SPOs managing too many staff and holding multiple responsibilities are unable to support frontline staff sufficiently.

The Head of Service (HOS3) has been the line manager for SPO3 since the unification of probation services on 25 June 2021. He conceded that, between June and September: "*I didn't look at her work in detail at that time".* HOS3 stated that: "*we don't have a particular [quality assurance] method that gives visibility to SPO's practice"* and that, as a legacy manager from the Community Rehabilitation Company, he spent these initial months learning the policies and procedures of the new organisation.

The Head of Operations (HoOp2) for the Probation Service – East Midlands region explained that they agreed to assign a dedicated SPO to the PQiPs after the increase in PQiP recruitment. HoOP2 also voiced her concern about the "*churn in those teams, new PQiPs with every cohort and changing every 15 to 21 months"* and suggested that the model potentially "*warrants another look".*

SPOs who manage teams of PQiPs should have the opportunity to have their work scrutinised. The usual pathway to case discussions between SPOs and their head of service is through instances of extraordinary risk, requiring additional funding or an urgent issue with a high-risk release plan. These conversations are less likely to emerge from a PQiP's workload. However, this should not mean that the quality of work by the PQiP SPOs should receive less attention. Indeed, as the overseer of the standard to which future qualified probation practitioners will work, it is a business imperative.

Inspectors found that middle and senior managers in both regions experienced their workloads as unmanageable.

Key findings/missed opportunities

- SPO3 did not allocate this case to a qualified practitioner because insufficient consideration was given to risk indicators and DB's use of drugs and alcohol.
- PQiP1 did not have the experience, qualifications, or training to manage this case.
- PQiP1 did not adequately understand the risks in this case prior to meeting DB for their only supervision appointment.
- PQiP1 displayed positive practice when she challenged DB on his use of alcohol and cannabis and when she sent an enforcement letter to mark his failure to comply with a telephone appointment.

[25] ViSOR is a police information system that requires security clearance to access.

12. A summary of the Suspended Sentence Order

Six weeks into DB's 24-month suspended sentence order, he had not commenced the Unpaid Work or Alcohol Treatment Requirements. Records show that he attended three appointments in person with PSO1 on 22 June 2021, 30 July 2021 (two hours late) and 02 August 2021 (two hours early), and one appointment in person with PQiP1 on 24 August 2021.

DB complied with three appointments over the phone on 23 June 2021, 07 July 2021 and 16 July 2021, and failed to attend two appointments on 18 June 2021 (in person) and 10 September 2021 (via telephone).

12.1 Court risk assessment and initial OASys assessment

Children: the assessment of risk of serious harm to children as low in the pre-sentence report failed to consider the impact that such a man would have on the lives of young children. DB is an unpredictable and chaotic man, with a history of substance abuse, serious violence and extremist views. He reported that he had childcare responsibilities, including picking children up from school. It is implausible that DB had no negative effects on two children aged 11 and 13 years old. If records had been explored correctly, this assessment would have included police intelligence from March 2020 that DB posed a risk of sexual harm to girls. Inspectors find that at the start of this order the correct risk assessment of DB's risk of serious harm to children should have been 'high'.

Partners: the assessment of risk of serious harm to known adults (which includes partners) was low. A previous OASys assessment outlines how DB had lived a lifestyle that involved moving between the women in his life, such as his mother and grandmother, and stealing from them or otherwise using their money to pay his fines and accommodate him more generally. If the information provided by his previous partner in 2016 had been explored and recorded appropriately, this would have helped to inform this assessment. Inspectors found that the available evidence showed a medium risk of serious harm to a partner at the initial sentence planning stages.

Public: the risk assessment stated that DB posed a medium risk of serious harm to the public. DB had a known history of violence against Asian men (robbery in 2010, attempted robbery with a knife in 2015 and arson in 2020). He had been explicit about his previous use of violence as a member of a white extremist organisation. He had been recalled to prison previously for his reckless and unpredictable behaviour, and this was exacerbated by substance abuse. At the time of this order, there was no evidence of stability or sobriety in DB's life. He was known to be callous, to enjoy violence and to use it in a controlled and instrumental manner. There were unanswered questions about a potential brain injury, which is a significant unknown in this case. Inspectors found that at sentencing DB posed a high risk of serious harm to the public.

Staff: in 2016 DB planned an attack on three prison officers, causing injuries which amounted to grievous bodily harm and two counts of assault occasioning actual bodily harm. He told PO2 he felt his use of violence was acceptable because he had wanted a prison transfer and had been denied one. Previous probation officers and approved premises staff had recorded their discomfort in working with DB and found him to be intimidating and manipulative. Inspectors find that DB posed a high risk of serious harm to staff in custody and a medium risk of serious harm to staff in the community.

12.2 Risk management

DB's admission that he had resumed drinking alcohol and smoking cannabis did not trigger either PSO1 or PQiP1 to activate the actions in the contingency plan that had been written recently. It is our view that evidence of substance abuse in conjunction with being under curfew with his pregnant partner increased the risk of serious harm at this time.

Probation practitioners did not contact Ms Harris or take the appropriate time to consider the risk of serious harm DB posed to John Paul Bennett and Lacey Bennett. The safety of Ms Harris and her children was not a feature in the Probation Service's supervision of DB.

When inspectors asked HOS2 whether he was assured that all current curfew addresses are safe he replied: "*Clearly not. We are now, on the back of this SFO, ensuring that we have [completed safeguarding checks]. Locally we have put PSOs in court to conduct enquiries and we are confident, that those checks will be completed before they go to court*."

Probation practitioners did not conduct a home visit in this case and there was no evidence that this was considered. HoOp2 said that the probation guidance on home visits is new and that: *"We have not fully implemented the policy due to resource constraints."*

HoOP2 acknowledges that local safeguarding boards and policies are built on the basis that every child has the right to a safe and nurturing environment and anything less is a concern. However, the Probation Service does not currently have the processes or resources to catch every case. She noted: "*We have some really positive practice around child safeguarding that would provide some assurance that child wellbeing is in people's minds*." However, she recognised that probation practitioners do not run domestic abuse checks currently if there is no indication of risk or other behaviours that compromise child welfare.

By 17 September 2021, probation practitioners had evidence that DB was capable of committing serious harm and that this was potentially imminent. At this time, he was being managed by an inexperienced probation practitioner who could not identify this risk. On the weekend of 18 to 20 September 2021 DB remained under curfew at an address where a pregnant Ms Harris and her two young children lived and where a young friend was staying for a sleepover. He murdered them all and then raped Lacey Bennett, the weekend before his next probation appointment. RPD2 concluded: "*We expect people [probation practitioners] to prioritise risk. This SFO suggests that is not the case"*.

12.3 The impact of Covid-19

Inspectors found that the exceptional delivery model (EDM) operated by the Probation Service from March 2020, as a result of the Covid-19 pandemic and still in place in September 2021, did not directly impact the management of this order. DB's most recent sentence, imposed in June 2021, did not take place during a national Covid-19 lockdown. While some restrictions remained, had DB's risk been correctly assessed as high, he would still have been directed to attend weekly probation appointments in person.

Inspectors heard that the requirement for people to isolate due to the Covid-19 pandemic contributed to PSO1 having significant periods of absence from work. We were told that the responsibility for middle and senior leaders to be proactive about the wellbeing of staff, and to ensure that the transition to remote working and the implementation of the EDM was successful, created additional pressure on their workloads. The anxiety and uncertainty created by the Covid-19 pandemic had a detrimental effect on staff resilience. This was heightened during the unification period, which introduced another significant national change at an already challenging time.

13. HMPPS's early look report

In line with HMPPS guidance on serious further offences, an 'early look' report was completed. The remit of this report was to rapidly identify issues with practice from the start of the most recent sentence until the commission of the SFO. This is in order for senior leaders to review, at the earliest opportunity, potentially dangerous processes or to begin appropriate learning, development and any necessary HR processes regarding the staff involved in the case.

In the case of DB, the early look author (EL1) was given five working days to complete this early look report, instead of the usual 20 days. We understand that this was due to the very high-profile nature of these offences. EL1 told inspectors she was unable to access OASys for two of these five days due to limited access restrictions.

The early look process has identified some immediate actions. Inspectors found the quality of this early look report to be good. We agreed with many of the findings, but some of these are not exhaustive. EL1 was unable to read the case files thoroughly and was unaware of the March 2020 contact from the police child sexual exploitation unit and the intelligence of a high risk of serious harm to girls. In the early look report, EL1 references the allegations made in 2016: 'In 2016, in the OASys "not to be disclosed section", it was detailed that DB's ex-partner CG contacted his Offender Manager to request details of his release date, which was not provided, but she reported that she was requesting a Non-Molestation Order. This also suggested concerns in relation to domestic abuse. The reviewing manager identified that in relation to DB's release on licence on the 31st October 2018, there was a licence condition added regarding disclosing intimate relationships which once again confirmed concerns in this area.'

The actions from the report are summarised below:

1. Management oversight: case allocation

- The Head of Service to discuss case allocation with SPO3.
- All cases held by trainee probation officers and probation services officers under SPO1's line management to be audited to ensure that they are appropriate allocations.
- Any identified concerns to be addressed through a tailored improvement plan.

To be completed by 30 November 2021.

2. Risk assessment

- SPO3 to discuss risk assessment in line management supervision with PSO1 with reference to HMPPS's Risk of Serious Harm Guidance (2020).
- SPO3 to complete a full quality assurance audit on five of PSO1's OASys assessments/cases to ensure that they were completed to a sufficient standard.
- SPO3 to discuss risk assessment in line management supervision with CO1 with reference to the Risk of Serious Harm Guidance (2020).
- SPO3 to audit five of CO1's court reports and OASys assessments to ensure that the risk assessment is completed to a sufficient standard with reference to the OASys quality assurance tool and the written short format report and standard delivery report quality development tool (March 2021).

- Any identified concerns to be addressed through a tailored improvement plan, for example referral to a quality development officer to complete specific pieces of work and the completion of relevant training courses.

To be completed by 30 November 2021 or within eight weeks of CO1's return to work.

3. Child safeguarding and domestic abuse

- CO1, PSO1 and PQiP1 to demonstrate improved practice in relation to domestic abuse and child safeguarding.
- If a person on probation is living at an address with children or having regular contact with an identified child, then safeguarding checks should be completed. A safeguarding referral should be completed if lifestyle choices/identified concerns could impact on a specific child. Safeguarding referrals must contain an accurate risk assessment and be informed by different sources of information. Police domestic abuse checks should include previous addresses and other relevant locations to ensure a holistic assessment.
- SPO1 and SPO2 to discuss safeguarding practice in line management supervision with CO1, PSO1 and PQiP1 with reference to the document 'Working together to safeguard children – a guide to multi-agency working to safeguard and promote the welfare of children' (July 2018) and the aide memoir to assessing and managing risk in domestic abuse cases.
- SPO4 to audit five of CO1's court reports/OASys assessments to ensure that appropriate safeguarding checks were completed.
- SPO3 to audit PSO1's and PQiP1's caseload to check that safeguarding concerns are being managed effectively. The audits to be completed in supervision to facilitate learning. Any identified concerns as a result of the audit are to be addressed through a tailored improvement plan.

To be completed by 30 November 2021 or within eight weeks of CO1's return to work.

HM Inspectorate of Probation's recommendations in this report complement and strengthen the findings in the early look report and have national implications.