HM Inspectorate of Probation

Independent serious further offence review of Joshua Jacques

Contents

Acknowledgements

This independent review was led by HM Inspector Hannah Williams and overseen by Simi O'Neill, Head of Probation Inspection at HM Inspectorate of Probation. We would like to thank all those who helped plan and took part in this 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 highlight good and poor practice and use our data and information to encourage high-quality services. 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 April 2022, Joshua Jacques was charged with the murders of a family of four: Denton Burke, Dolet Hill, Tanysha Ofori-Akuffo, and Samantha Drummonds. On 21 December 2023 he was found guilty of murder following trial.

Joshua Jacques was under probation supervision when he was arrested for these offences, having been released from prison on licence in November 2021. Ordinarily, the Probation Service would conduct a review of the management of the case, in the form of a Serious Further Offence (SFO) review. In this case, the Secretary of State for Justice asked HM Inspectorate of Probation to complete an independent review into how the Probation Service managed Joshua Jacques.

The impact of these shocking crimes cannot be underestimated and will have had a profound impact on their family and the wider community. We offer our sincere and heartfelt condolences and recognise that the family need information about how Joshua Jacques was supervised in the community and answers as to whether there were failings in this practice.

This report presents the findings of our independent review and sets out that the practice in this case fell below the expected standards.

As a result of recent recruitment drives and of experienced staff leaving the Probation Service, many probation teams now have large numbers of newly qualified officers (NQO) or recently qualified officers. In the Southwark Probation Delivery Unit (PDU), this situation impacted on the level of experience in the teams available to manage high risk and complex cases, something our core inspections have also routinely found.

We found Joshua Jacques' case was incorrectly allocated to an NQO, and the lack of good quality management oversight of this member of staff impacted on the quality of decisions made. There was a notable absence of professional curiosity[1] across all areas of probation practice from court through to sentence management, and a failure of the probation practitioners overseeing the case and their manager to meet fully their expected responsibilities. As a result, several significant events, such as an arrest for further offences, disclosure of declining mental health, problematic behaviour towards neighbours, a new relationship and use of social media when not permitted to do so, were not responded to sufficiently.

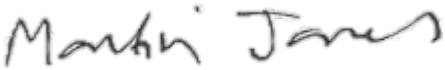
While appropriate referrals were made to Multi Agency Public Protection Arrangements (MAPPA) and to Approved Premises (AP) by the probation practitioner, these critical elements of increased supervision did not fulfil their potential in supporting the management of risk of serious harm posed by Joshua Jacques. An initial OASys assessment was not completed upon his release, which meant that his management in the community was not supported by a robust risk management plan, nor a sentence plan to inform his supervision on licence. The pace and level of engagement of Joshua Jacques with his licence was seemingly determined by him, rather than the probation practitioners, who viewed his engagement and progress too optimistically.

There were concerns Joshua Jacques was not complying with the conditions of his licence and, though this happened repeatedly, they were each dealt with in isolation. Practitioners

[1] Professional curiosity encompasses all aspects of work in probation practice, and is a combination of looking, listening, asking direct questions, and clarifying and reflecting on information received to analyse what it means in context for that individual.

did not see the bigger picture and missed opportunities to respond sufficiently to his concerning behaviours, for example through a recall to prison.

Many of the findings of this review mirror those of our thematic and regional probation inspections. This review makes eight recommendations to His Majesty's Prison and Probation Service which we require implementation of as a matter of urgency to ensure learning is implemented quickly and nationally, not just in the PDU where this case was supervised.



Martin Jones CBE
HM Chief Inspector of Probation

2. Background information

On 25 April 2022, police forced entry to a property in Bermondsey, London, having received reports from neighbours who had heard a prolonged disturbance taking place. Inside the property, the bodies of Denton Burke (aged 68), Dolet Hill (aged 64), Tanysha (also known as Raquel) Ofori-Akuffo (aged 45), and Samantha Drummonds (aged 27) were found. The victims were three generations of the same family: a grandmother, daughter, granddaughter, and Dolet Hill's partner. Joshua Jacques (JJ) was in a relationship with Samantha Drummonds and had been introduced to the family a few days prior. JJ was found by police in the bathroom of the property naked, shouting and appearing to be having a mental health crisis. All four victims had suffered stab wounds and lacerations.

At the time the murders were committed, JJ was supervised by the Probation Service having been released from prison and subject to licence on 11 November 2021. JJ had received a 51-month custodial sentence on 27 November 2019 for offences of supplying Class A drugs and possession of Class B drugs. Upon sentence, the court also imposed a five-year Criminal Behaviour Order (CBO)[2] on him.

On 02 March 2022, whilst still subject to licence, JJ was sentenced to a suspended sentence order (SSO) for offences of failure to give a sample (saliva), failure to provide a specimen of blood for analysis, breach of CBO, and handling stolen goods. The SSO had requirements of rehabilitation activity requirement (RAR) days and the thinking skills accredited programme (TSP). This order was to run alongside the existing licence supervision.

JJ's arrest for four counts of murder constituted a Serious Further Offence (SFO). SFOs are specific violent and sexual offences committed by people who are, or were very recently, under probation supervision at the time of the offence. They are committed by a small proportion of the probation caseload (0.5 per cent)[3] however, while this percentage is small, for the victims and families involved, the impact and consequences are devastating and cannot be underestimated.

An SFO review is triggered when a person is charged and appears in court for a qualifying offence alleged to have been committed while they were under probation supervision or within 28 working days of the supervision period terminating. An internal management report, known as an SFO review, is then commissioned, which aims to provide a robust and transparent analysis of practice. HM Inspectorate of Probation is not responsible for conducting SFO reviews, but does quality assure a sample of reviews to provide independent oversight[4]. Occasionally, the Secretary of State for Justice asks the Inspectorate to review a particular case or aspects of a case; as he has done in this instance, which has been completed instead of the usual internal SFO review. To inform this independent review, HM Inspectorate of Probation has reviewed the quality of the work undertaken by Southwark PDU, within the London probation region, and explored the policies and practice that underpin the management of people on probation more widely.

Probation services underwent a major change in the summer of 2021. In 2014, the government's *Transforming Rehabilitation*[5] programme split probation services into two. Services were then unified in June 2021 into one Probation Service. Preparations for, and

[2] A criminal behaviour order is issued by criminal courts to prevent engagement in anti-social behaviour.
[3] Ministry of Justice and HM Prison and Probation Service. (2021). Notification and Review Procedures for Serious Further Offences Policy Framework.
[4] HM Inspectorate of Probation. (2019). *A thematic inspection of the Serious Further Offences investigation and review process.*
[5] 2010 to 2015 government policy: reoffending and rehabilitation - GOV.UK (www.gov.uk).

the implementation of, this unification took place while services were disrupted by the Covid-19 pandemic. The Probation Service has been operating under a prioritisation framework (PF) delivery model since January 2022, in which PDUs assign themselves a red, amber, or green (RAG) status, with oversight from senior managers. Since the initial Covid-19 lockdowns in March 2020 to January 2022, the Probation Service was operating exceptional delivery models (EDMs), which set out how services would be delivered, taking into account restriction measures, while continuing critical face-to-face delivery of individuals posing the highest risk of serious harm. The PF replaced the EDMs with the different RAG status determining the areas of service delivery that should be prioritised to manage resource and capacity within sentence management teams. The Southwark PDU has been operating under 'green' status since January 2022. This meant that the PDU was required to continue to deliver the following activities:

- all high and very high-risk cases to continue to follow all mandated actions
- Blended Supervision Model operates, including face-to-face contact cases
- complete assessments using the approved OASys tool for all cases
- complete risk management plans for all cases
- review assessments and plans for high and very high risk of serious harm cases
- face-to-face contact with people leaving prison on day of release
- maintain service to the court and complete court reports.

The framework provided authorisation for a decreased frequency of appointments with those cases deemed to pose lower levels of risk of serious harm, cases due to terminate with 12 weeks and cases with no evidence of domestic abuse or child safeguarding concerns.

3. Terms of reference

On 23 June 2022, the Secretary of State for Justice wrote to the Chief Inspector of Probation to ask them to undertake an independent review of the case of Joshua Jacques (JJ).

The lines of enquiry to inform the review were:

- Quality of pre-sentence assessment, court reports and appropriateness of recommendations for sentencing, including the community-based penalty for the breach of the Criminal Behaviour Order (CBO)
- involvement of other agencies including Multi-Agency Public Protection Arrangements (MAPPA), including working with specialist roles such as gangs/serious organised crime probation leads, and police
- management and delivery of sentence/licence requirements, including mental health services and Approved Premises (AP) residency
- quality of management oversight and exploration of enforcement and decision not to recall
- staff training, learning and development and application of professional curiosity
- identify findings and learning at local, regional, and national levels.

The following staff were interviewed and had direct knowledge of the case:

- Probation officer (PO1) – JJ's case manager from February 2021
- Probation officer (PO2) case manager covering PO1's absence December 2021-March 2022
- Senior probation officer (SPO3) and MAPPA chair
- PSR author (PSR1)
- SPO line manager of PSR author (SPO4)
- Head of Service (HOS1) for the probation delivery unit with oversight for SPO1, SPO2, and SPO3
- Head of Operations (HoOP1)
- Gangs and organised crime probation officer, Serious Group Offending and Organised Crime Unit
- Gang probation officer, Southwark PDU
- MAPPA coordinator London
- Head of Approved Premises London Region (HAP).

We were unable to interview:

- Senior probation officer (SPO1) line manager for PO1 and PO2
- Senior probation officer (SPO2) PO1 line manager March 2022 onwards
- Approved Premises key worker
- Approved Premises Manager.

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

- probation case records, NDelius and OASys – probation case management and assessment systems
- psychiatrist pre-release discharge letter
- recall and related reports following arrest for the murder
- pre-sentence reports
- Multi-Agency Public Protection Arrangements (MAPPA) referral and minutes
- staff supervision notes
- integrated offender management guidance (IOM)– national framework and London IOM framework
- London Newly qualified officer (NQO) induction programme
- His Majesty's Prison and Probation Service (HMPPS) guidance on recording recall decision making and issuing letters
- HMPPS case allocation framework
- MAPPA guidance[6]
- MAPPA quality assurance feedback for Southwark MAPPA
- HM Inspectorate of Probation thematic inspection reports:
  - *A thematic inspection of the Serious Further Offences (SFO) investigation and review process*[7]
  - *Twenty years on, is MAPPA achieving its objectives? A joint thematic inspection of Multi-Agency Public Protection Arrangements*[8]
  - *A joint thematic inspection of community-based drug treatment and recovery work with people on probation*[9]
  - *A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders*[10]
- Approved premises manual
- Practice guidance for national short format reports.

[6] Multi-agency public protection arrangements (MAPPA): Guidance - GOV.UK (www.gov.uk).
[7] A thematic inspection of the Serious Further Offences (SFO) investigation and review process (justiceinspectorates.gov.uk).
[8] Twenty years on, is MAPPA achieving its objectives? A joint thematic inspection of Multi-Agency Public Protection Arrangements (justiceinspectorates.gov.uk).
[9] A joint thematic inspection of community-based drug treatment and recovery work with people on probation (justiceinspectorates.gov.uk).
[10] A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders - HMICFRS (justiceinspectorates.gov.uk).

4. Chronology of events

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

1994	JJ is born.
2011	JJ first appearance before the court for an offence of public order.
July 2012	JJ is sentenced to a community order with a single requirement of a curfew for an offence of possession of an offensive weapon. No probation supervision required.
April 2013	JJ appears before the court for failing to comply with the requirements of the community order. The court determined that the order was to continue, and an additional fine was imposed.
June 2015	JJ received a 20-month custodial sentence for an offence of robbery. JJ was released on licence on 25 September 2015, which expired on 28 July 2016. This was JJ's first contact with the probation service.
April 2016	Appears before the court for offences of criminal damage and failing to provide a sample of fluid for drug testing. JJ received a fine.
April 2016	Appears before the courts for offences of public order and criminal damage. JJ is sentenced to eight weeks imprisonment.
August 2016	JJ appears before the court for an offence of possession of cannabis and received a fine.
March 2017	Sentenced to a community order with a single requirement of 180 hours unpaid work for offences of possession of Class B (cannabis) and driving offences. This order was characterised by non-compliance, and he was deemed to be in breach.
April 2018	Sectioned under Mental Health Act for a period of six months to the Maudsley Hospital.
August 2018	JJ pleads guilty to being in breach of the community order. The order was revoked, and a conditional discharge imposed.
November 2019	Sentenced to 51 months in custody, for offences of supplying Class A (heroin and crack cocaine) and possession of Class B cannabis. A criminal behaviour order (CBO) was also imposed.

February 2021	Allocated from prison probation practitioner (POM) to community probation practitioner (COM) PO1, in preparation for JJ's forthcoming release in November 2021.
April 2021	Prison security information was shared by the POM to PO1. This contained information from 2016 in relation to inappropriate and intimidating behaviour he displayed to staff.
August - October 2021	Two pre-release OASys assessments completed by PO1. Both assessed that JJ posed a high risk of serious harm to the public, and a low risk of serious harm to known adults, children, and staff.
October 2021	MAPPA referral and Approved Premises (AP) referral completed.
21 October 2021	First MAPPA meeting held while JJ was still in custody. Two actions were set for PO1 and POM to gather further case information.
November 2021	Forensic psychiatry discharge letter provided to PO1. Letter sent to registered GP however the GP had retired. POM requested PO1 share this information with a new medical practitioner if JJ was to re-register with a GP elsewhere on release.
11 November 2021	JJ released from prison on licence and directed to an approved premise (AP). The licence and sentence expiry dates are 27 December 2023.
November 2021	OASys initial assessment commenced, however the assessment was electronically locked as incomplete in January 2021, this is an automated process which occurs when an assessment is left open for a period of 45 days.
November 2021	JJ is late for AP curfew two nights in succession, a verbal warning was issued.
November 2021	Second MAPPA Level 2 meeting held. One action was set on information sharing between the AP and PO1.
December 2021	PO1 is absent from work, PO2 assumes responsibility for the case.
December 2021	JJ is found to be in possession of a vehicle and has not informed his probation practitioner. This is a breach of his licence conditions.
December 2021	Breach of AP rules by setting off intruder alarm getting food delivered. AP improvement plan was issued to JJ.
January 2021	JJ breaches AP rules by smoking and setting off fire alarm.

January 2022	Management oversight entry stating in response to JJ being in possession of a vehicle that an enforcement letter called a 'decision not to recall' will be issued. SPO notes that initial sentence plan OASys remains outstanding which will be allocated to a probation practitioner to complete 'asap'. There is no evidence that the letter was issued, nor was the initial sentence plan OASys completed.
11 January 2022	Departs approved premises and moves to privately rented accommodation.
13 January 2022	JJ is arrested for: • failure to give a saliva sample • failure to provide blood specimen for analysis • breach of Criminal Behaviour Order • handling stolen goods. When arrested the vehicle smelt strongly of cannabis. SPO1 decides to issue a 'decision not to recall' letter in response to the further offences, however an incorrect letter was sent. A lower-level enforcement letter called a 'compliance letter' was issued.
20 January 2022	Third MAPPA Level 2 meeting held. Two actions are set, neither of which were completed.
February 2022	Short format pre-sentence report prepared by PSR1 for court appearance in March 2022, relating to 13 January charges. The report states that a custodial sentence would jeopardise his accommodation and education opportunities, and therefore recommends a community penalty with requirements of rehabilitation activity days (RAR) and a thinking skills accredited programme. JJ reported to the report author that he was frustrated by the restrictions of his licence and CBO, stating that they were 'unrealistic'. JJ attributed his further offending to being profiled by police and described that he was experiencing "poor mental health" at the time.
02 March 2022	JJ sentenced to eight weeks imprisonment, suspended for 18 months with 10 days rehabilitation activity requirement (RAR), and requirement to undertake thinking skills programme (TSP). A two-year driving ban was also imposed.
March 2022	PO2 completes an initial OASys assessment following the suspended sentence order. This assessment mirrored the pre-release OASys assessments that JJ posed a high risk of serious harm to the public, and a low risk of serious harm to known adults, children, and staff.

March 2022	PO1 returns to work and resumes responsibility for JJ.
March 2022	Landlord of JJ's accommodation informs PO1 that daily complaints are being received from neighbours regarding loud noise, anti-social behaviour and that JJ has made threats to another resident. JJ was issued with a warning letter by the landlord. Probation practitioner informs landlord this was an accommodation issue and didn't constitute a breach of his licence. Probation practitioner reminds JJ of the importance of maintaining his tenancy. JJ informs PO1 that some of the noise being reported was due to his girlfriend visiting. This is the first refence to JJ having a relationship, and no further detail is gathered by PO1 in relation to the relationship, or the exact nature of the noise being alleged.
March 2022	Fourth MAPPA Level 2 meeting held. JJ is stood down from ongoing Level 2 multi agency MAPPA panel monitoring. The two actions from the previous meeting in January remain outstanding.
March 2022	Home visit completed by probation practitioners PO1 and PO2. JJ's flat is well maintained. A strong smell of cannabis is noted. JJ acknowledged using cannabis daily and was reminded about the potential negative side effects on his mental health.
30 March 2022	PO1 noted that JJ has social media app on his phone, which would place him in breach of his CBO for the second time. JJ was challenged and he admits using the app. The probation practitioner does not report this breach to the police. JJ confirmed to PO1 that he was in a relationship and provides PO1 with her first name, which is different to that of Samantha Drummonds. JJ described the relationship as having a positive impact on him.
20 April 2022	Attended planned appointment late and described cannabis use being at a 'considerable' level. He also tells PO1 that he had been for an expensive meal with his girlfriend and was planning to attend a cannabis rally in Hyde park. Described as being extremely chatty, and often going off on tangents.
22 April 2022	Last contact with the Probation Service – a telephone call from JJ informing his probation practitioner that he has obtained a training placement at a radio station.
25 April 2022	Commits the murders of Denton Burk, Dolet Hill, Tanysha (Raquel) Ofori-Akuffo and Samantha Drummonds.

5. Summary of Key findings

JJ's supervision was characterised by several practice deficits and missed opportunities which impacted on how JJ was managed on licence. Nine key themes identified from the independent review are outlined below.

Risk of serious harm assessment

In custody, two OASys[11] assessments were completed which concluded that JJ posed a high risk of serious harm to the public, specifically identifying the public to be drug users and peers operating in drug supply. This was an appropriate assessment, however it failed to identify all factors that were linked to the risk of serious harm such as his mental health, substance misuse and current accommodation. JJ was assessed as posing a low risk of serious harm in all other categories,[12] which was an underestimation of the level of risk he posed.

An initial OASys assessment was commenced upon release, however, this was never fully completed and remained an incomplete document. This was poor practice and was not in line with organisational expectations.

The failure to complete an OASys assessment on release resulted in no assessment of risk of serious harm and no risk management plan in the community to inform how the risk posed should be safely managed while on licence. Additionally, there were no sentence plan objectives to support and inform the supervision appointments, which should have been targeted to address those factors most likely to contribute towards further offending. Further reviewing did not take place following MAPPA meetings, nor in response to changes of circumstances and significant events. Completing a review would have enabled the probation practitioner to consider the significance of new information, and review the sentence and risk management plans accordingly, to ensure the necessary arrangements were in place to protect the public.

The pre-sentence report prepared for court, and the OASys completed following sentence to the suspended sentence order, both replicated the pre-release assessment and did not take the opportunity to consider all available information to support an updated and holistic assessment.

MAPPA meetings considered the level of risk of serious harm posed by JJ; however, this did not negate the need for an OASys assessment to be completed. This is essential probation practice to ensure that the management of each case is supported by a robust and defensible assessment of risk of serious harm and need. In the absence of a formal assessment using the OASys tool, inspectors would have expected to see other evidence of assessment and planning within case management records. However, there were no such records to satisfy us that a clear understanding of how to manage the risks posed were in place.

Professional curiosity and optimism bias

PO1 and PO2 put a strong focus on addressing JJ's needs, such as accommodation and employment. Though these were important factors and progress was made, the supervision sessions were not underpinned by a sentence plan and there was no evidence of

[11] OASys is an actuarial risk and need assessment tool used by the probation service to assess a person on probation.
[12] Risk assessment categories in OASys include public, known adult, children, staff, and prisoners.

interventions which focused on offender behaviour being delivered. Inspectors found that this strong emphasis on relationship building and addressing JJ's needs was not balanced against the need to manage risk of serious harm.

Probation practitioners viewed JJ's behaviour on licence through an over optimistic lens[13] and did not fully understand the expectations on them to be professionally curious and proactive.[14] As a result, they did not adequately explore issues such as why he had purchased a vehicle, or his problematic behaviour in his accommodation and they failed to inform police of a second breach of the criminal behaviour order (CBO).

These skills of professional curiosity grow and develop with practitioner confidence and experience, and with the effective support and oversight from peers and managers. There was a lack of experience within the probation practitioner staff group at Southwark PDU and lack of robust management oversight further contributed to this. Where a workforce has limited experience, they need guidance from those with a more established level of knowledge to provide support and oversight to aid their development.

Enforcement

Good probation practice seeks to motivate people on probation to comply and engage positively with the requirements of their sentence. While this should include a focus on desistance from further offending, it should also include appropriate enforcement action being taken when required. Instances of non-compliance should be responded to in a proportionate, fair, and transparent manner.[15]

Enforcement practice in this case was inconsistent, with instances of non-compliance considered in isolation rather than seen in the round. Opportunities to escalate and consult with the delivery unit head (HOS1) were not sought. There was a failure to act upon a pre-release assessment that identified that swift enforcement of the CBO and licence were required to manage the risk of serious harm posed by JJ. Enforcement guidance[16] issued in October 2021 was not followed. Our inspectors felt the decision not to recall JJ following his arrest for further offences was defensible. However, in making the decision, senior manager oversight should have been sought by SPO1 and the failure to do so was against expected practice. The enforcement practice in this case did not analyse the behaviour being displayed by JJ, nor did it explore whether additional supportive or restrictive measures short of recall were needed to manage his licence.

Resourcing and workload

Southwark PDU had been operating under 'green' status under the national prioritising probation framework but had several vacancies, particularly at probation officer and probation service officer grade. Many staff within the PDU were at early stages of their career and there were limited numbers of experienced staff available. The probation practitioners in this case lacked the required experience to respond adequately to the complexity of the case and behaviours being presented. In addition, the pace and volume of work impacted on the quality of work undertaken in this case.

HMPPS's *Tiering framework and case allocation*[17] guidance was not followed, and JJ's case should have been allocated to a more experienced probation practitioner. The allocated

[13] Bias and error in risk assessment and management, Hazel Kemshall, Academic Insights 2021/14 Bias and error in risk assessment and management (justiceinspectorates.gov.uk).
[14] Effective practice guide: Practitioners – professional curiosity insights (adult services) (justiceinspectorates.gov.uk).
[15] Effective practice guide: Adult effective case supervision (justiceinspectorates.gov.uk).
[16] HMPPS guidance *Recording recall decision making and issuing letters.*
[17] HMPPS guidance *Tiering framework and case allocation.*

probation practitioner in this case was within their newly qualified probation officer (NQO) period and in allocating the case, the SPO should have been assured that PO1 had the required knowledge, skill, and experience to manage the case effectively. JJ's tier[18] increased following the initial MAPPA meeting and this should have prompted re-allocation of practitioner in line with the expected practice for NQOs.

Management oversight

Management oversight was of an insufficient standard. Staff reported a lack of confidence in decisions made by their line manager, contributing to a reluctance to seek out further management oversight. When sought, decisions made by the probation practitioners would generally be approved without the necessary discussion or scrutiny needed to ensure that the most appropriate course of action was being taken. Opportunities to escalate to HOS1 were also missed.

Similar to the findings from the Inspectorate's broader local inspection programme, the workload, and responsibilities of line managers in this Probation Delivery Unit were found to be concerning. SPOs were managing large teams and were expected to provide support and oversight of their staff and manage human resource issues, as well as provide oversight and scrutiny of each probation practitioner's caseload. SPOs also have additional lead responsibilities, such as MAPPA, which impact on their ability to perform their role to the expected standards.

Inspectors also found insufficient processes in place to manage staff absence. PO1 was absent from work for a period of three months. While during this time PO2 had maintained contact with JJ on their own initiative, the process for caseload reallocation during an absence was not clear, which resulted in a lack of clear ownership of this case and many of PO1's other cases during this period.

Multi Agency Public Protection Arrangements (MAPPA)

JJ's index offence (the last set of criminal actions that brought him into contact with the criminal justice system) meant that he was not automatically eligible for management under multi agency public protection arrangements (MAPPA). Therefore, it was good practice for JJ to have been referred to MAPPA as a Level 2, Category 3 case. However, there was insufficient evidence that this MAPPA referral positively impacted upon the management of the case.

The MAPPA referral for JJ was completed late, only one month prior to release. To allow effective coordination this should have been done six months prior. In recognition of the complexity of the case and imminency of need, it was positive to see that JJ was listed promptly for discussion once he had been referred. However, the initial delay in referral resulted in little time for MAPPA to effectively contribute to the pre-release planning, with PO1 having already set licence conditions with the prison, without a contribution from the MAPPA panel.

The minutes from each of the four the MAPPA meetings held to discuss JJ were of an insufficient standard, providing limited evidence that partner agencies were active in supporting the management of risk of serious harm he presented.

There were missed opportunities for meaningful actions to be set in response to new information, and a lack of oversight of outstanding actions. JJ was de-registered from

[18] Each person on probation is assigned a tier which informs the level of oversight and resource required and support the allocation process to the probation practitioner.

MAPPA oversight without an adequate rationale, whilst two actions which had already been carried forward remained outstanding.

Approved Premises

The Approved Premises (AP)[19] placement was an opportunity to positively contribute to the management of JJ's risk of serious harm. Key work sessions were held by AP staff which were appropriately focused, with structured sessions on the immediate needs of JJ; exploring issues such as registration with a GP, finance, and education, training, and employment (ETE), which supported his resettlement into the community. However, professional curiosity was not applied during AP staff interactions with JJ. There is no evidence that there was sufficient exploration of his behaviour and movements, which would have aided the probation practitioner's understanding of how JJ was spending his time away from the AP.

AP staff should play a significant role, both in providing relevant risk information to the probation practitioner and in contributing to effective risk management. It is essential that they understand the risk of serious harm presented, are actively involved in the delivery of the risk management plan and are part of MAPPA meetings. An AP representative was not able to engage in pre-release planning due to the delayed referral, and subsequently did not attend the MAPPA meetings held, which impacted on pre-release planning, information exchange and the effective risk management of the case.

Mental health

JJ had been sectioned previously in 2018 and had informed probation practitioners that feelings of anxiety and paranoia were normal for him. Prior to release, JJ's mental health was described to be stable, and probation practitioners stated that there were no obvious signs of a mental health decline upon release into the community.

However, he was described by PO1 as presenting as 'low' on occasion, which was attributed to boredom and need for structure in the community. Days prior to the SFO, JJ was described as talkative and going off on irrelevant tangents in his conversations with probation staff. Furthermore, JJ informed PSR1 that when committing the further offences on licence, he had been experiencing poor mental health. This was not explored further and there was a lack of significance given to this statement, resulting in no analysis or action.

Probation practitioners were aware of JJ's mental health history but lacked any detailed information. They were also aware that he had behaved violently during a period when his mental health was not stable, and JJ himself had reported that random aggression could be a sign of his mental health declining. However, this was not identified as a factor linked to risk of serious harm within OASys assessments. Additionally, the correlation between his continued use of illegal substances and his mental health was not sufficiently explored or responded to. Prior to JJ's release from custody, information on JJ's mental health was sent by the prison mental health in-reach team to his registered GP, however they were not aware that the GP had retired. Upon registration with a new GP, this prior information on JJ's mental ill health was not passed to them.

There was a reliance on JJ recognising and self-reporting a decline in his mental health and on the one occasion he disclosed such concerns no action was taken. Probation practitioners stated that there was a gap in services available to support those with mental health, particularly if there were also substance misuse concerns. As emphasised by the report published in 2021, *A joint thematic inspection of the criminal justice journey for individuals*

[19] Approved premises (APs) are residential units which offer an enhanced level of public protection in the community and are used primarily for high and very high risk of serious harm individuals released on licence.

with mental health needs and disorders, mental health can present significant challenges for probation practitioners, and is often characterised by insufficient information exchange and the need for better training and support. Inspectors found during this review that staff felt ill equipped to understand and respond to mental health concerns, with limited training and support being available.

Substance misuse

JJ had used cannabis since he was a child and was described to be lacking insight into the harmful effects of his substance misuse. Probation records and a psychiatrist's assessment indicate a link between JJ's substance misuse use and mental health, and that JJ's sectioning in 2018 had been preceded by the consumption of medication, alcohol, and cannabis. Additionally, much of JJ's offending was linked to substance misuse.

Probation case records show that JJ was routinely using cannabis while on licence. He had completed substance misuse intervention programmes in custody and his licence contained a condition to engage in a drug abuse intervention on release from prison. However, such an intervention was not organised by probation practitioners, and we could find no evidence of a referral to a drugs agency.

Inspectors found that probation practitioners did not explore the underlying reasons for JJ's substance misuse, and minimised and tolerated regular use while he was on licence. This was underpinned by a failure to adequately analyse the impact of substance misuse to the risk of serious harm he posed.

6. Recommendations

Between July and October 2022 HM Inspectorate of Probation inspected six PDUs in the London region. Although Southwark PDU was not one of those inspected, many of the findings from this independent review mirror those from the London PDU inspections. The recommendations[20] made were aimed at local PDU, regional, and national levels. They focus on critical concerns such as the quality of work undertaken to assess and manage risk of serious harm, the delivery of interventions to people on probation, information sharing between partner agencies, quality assurance processes and the quality of management oversight, staff training and development, and resourcing and retention of staff. These recommendations are relevant to the practice observed in the case of JJ, and therefore have not been duplicated in this report. It is crucial that the service deals with these broader issues if it is to address the practice deficits and wider systemic issues identified in this independent review.

This independent review makes a further eight recommendations specific to the case of JJ.

HMPPS should:

1. ensure there is consistent practice in the allocation and oversight of caseloads, including explicit reallocation of cases when a probation practitioner is absent from work
2. ensure newly qualified officers are supported to develop their practice and are only allocated suitable caseload volumes and types of case during their post qualification period
3. develop an automated process to alert managers to unsuitable case allocations for practitioners (for example, to prevent unsuitable allocations to NQOs)
4. ensure that referrals, such as to approved premises and MAPPA, are completed sufficiently prior to release, to support the effective management of cases in the community (as suggested in HMMPS guidance).
5. ensure that sufficient staff resources are allocated to the effective oversight, chairing and administration of MAPPA
6. work with local and commissioned providers of drug misuse services to ensure that interventions and training are available to support probation practitioners to properly respond to cannabis dependence and its links to mental ill health
7. ensure that probation practitioners understand their role in supporting the police and courts to monitor compliance with Criminal Behaviour Orders
8. ensure each person on probation has an up to date, timely, appropriate and completed assessment of risk and need which, where required, is quality assured through effective countersigning.

[20] An inspection of probation services in Hammersmith, Fulham, Kensington, Chelsea & Westminster PDU (justiceinspectorates.gov.uk).
An inspection of probation services in Lambeth PDU (justiceinspectorates.gov.uk).
An inspection of probation services in Ealing and Hillingdon PDU (justiceinspectorates.gov.uk).

7. Relevant background information about JJ

JJ first appeared before the courts in June 2011 aged 17 for an offence of public order and had a total of 10 previous convictions for 17 offences. His first period of supervision by the Probation Service was in 2015, when he received 20 months imprisonment for robbery and was released on licence in September 2015. While on licence in April 2016, he received a further custodial sentence for offences of public order and criminal damage and was released at his licence and sentence expiry dates, so was not subject to further licence supervision upon release.

In 2017, JJ was sentenced to a community order with a single requirement of unpaid work for possession of cannabis. This order was characterised by poor compliance and action was taken for his breach of this order. Probation case records state that during this period JJ had presented at an accident and emergency (A&E) department and had made threats to kill staff and appeared to have experienced a drug-induced psychotic episode. He was subsequently admitted to hospital and sectioned on 26 April 2018 for a period of six months. The community order from 2017 was subsequently revoked by the court and was replaced with a conditional discharge for 12 months.

On 27 November 2019, JJ was sentenced to 51 months imprisonment for offences of possession with intent to supply heroin and crack cocaine and possession of cannabis. Documentation from the Crown Prosecution Service described JJ as occupying a leading role in the supply of drugs. There was suspicion at that time that JJ was involved with a local gang, but this was something he denied and was never substantiated during the supervision period. A criminal behaviour order (CBO) was also imposed for a period of five years, which placed several restrictions upon him on release which included:

- an exclusion zone preventing him entering a specified area within the Southwark borough
- restrictions on possession of mobile phones, sim cards, and devices which facilitate instant messaging
- restrictions on possessing drug paraphernalia
- no-contact conditions with named co-defendants.

8. Case management pre-release

Following sentence, JJ had regular contact with his offender management in custody (OMiC) key worker based within the prison and spoke about his wish to pursue a music career upon his release. JJ's mental health in custody was described as stable, and he was not in receipt of prescribed medication. His behaviour was described positively up until August 2021 when there were several failures to comply with prison rules. There were also unsubstantiated concerns that JJ had been involved in the supply of drugs in custody. This behaviour was not sufficiently considered by practitioners involved in the case and was not critically analysed to support an assessment of risk and reoffending.

In February 2021, in preparation for his forthcoming release into the community, JJ was allocated to a community probation officer PO1. The timing of the allocation was in line with OMiC practice guidance and was supported by oversight from a middle manager. However, the Inspectorate found that the allocation to PO1 was inappropriate, and the case should have been given to a more experienced probation officer. PO1 was three months in their newly qualified officer (NQO) period at the point of allocation, which should have afforded protected status in terms of reduced caseload volume and from being allocated higher risk cases of this type. PO1 reported the caseload protection did not happen and described being allocated 25 cases, many of which were complex and manged under MAPPA. JJ's assessed tier should have generated specific consideration by the SPO as to the appropriateness of the allocation to an NQO. The subsequent decision to allocate MAPPA Level 2 status to JJ raised the tier of this case further, to Tier A, and the HMPPS *Tiering framework and case allocation* guidance is clear in stating that 'Newly Qualified Officers in the community must not be allocated Tier A cases in the first 12 months post-qualification'.

Upon allocation, PO1 was prompt in facilitating a meeting between themselves, JJ, and the prison practitioner. A further pre-release meeting was held in October 2021, and a pre-release OASys completed. The pre-release engagement was positive and enabled issues pertinent to JJ's release to be discussed.

In planning for JJ's release, PO1 was supported by the PDU's serious group offending (i.e., gang related offending) expert single point of contact (SGO SPOC) within the locality. These consultations were risk-focused and generated several actions. JJ's age and unconfirmed links to serious group violence resulted in him being ineligible for the two main referral pathways for multi-agency intervention and oversight within the locality, and it was suggested that a MAPPA referral as a Category 3 nominal should be made to provide additional multi-agency oversight upon his release. Inspectors found that consideration of the use of a MAPPA Category 3 to support the management of JJ in the community was good practice.

Upon release, a discharge summary advised that JJ had previously been diagnosed with "Bipolar Affective Disorder, PTSD, and Dissocial Personality Disorder Traits", and that he had been seen regularly by the prison in-reach team, with no concerns raised regarding his mental health during the custodial sentence. Importantly, the letter outlined helpful information which described that indicators of a mental health decline would include reduced sleep, agitation irritability, increased energy levels, incoherent speech, thought disorder and auditory perceptual disturbance, and empathised that substance misuse was a risk factor. The discharge summary states that a re-referral to the community mental health team (CMHT) would be required if JJ's mental health deteriorated upon release. This letter was issued to JJ's GP who had in fact retired, and there was a lack of clarity on how this information should be used in the community. This information was stored on JJ's probation

case record, but not transferred into an OASys assessment, and not passed by PO1 to his new GP following release, with an assumption that this would have been actioned by the National Health Service.

Key findings and missed opportunities

- There was evidence that the probation practitioner was proactive in their pre-release engagement with JJ.
- PO1 sought specialist practitioner advice to support pre-release planning.
- It was positive practice that a MAPPA Category 3 referral was identified as being required to support the management of this case.
- JJ's case was inappropriately allocated to a newly qualified officer, which was not in line with guidance.
- There was a lack of multi-agency provision available for JJ in the community due to him not meeting the eligibility criteria for existing pathways.
- The mental health discharge summary was not issued correctly and there was a lack of clarity around responsibility of this information in the community. This information was not subsequently passed to the new GP and the information was not transferred into an OASys assessment to inform the assessment of JJ's risk and need.

9. Timeliness of pre-release activity

Although PO1 was prompt in pursuing a handover from the prison probation practitioner and active in seeking support and guidance from specialist practitioners, there was a notable delay in the actions required to support JJ's release from prison being completed.

The AP referral was completed in October 2021, one month prior to JJ's release, which was significantly later than required, despite case records referencing the need for the referral from February 2021 onwards. The AP manual states that 'preparation for the future, including a referral to an AP, should start in sufficient time to allow for planned resettlement. This will include referral to MAPPA where appropriate. Ideally, planning should start at least six months in advance of release for long-term prisoners'.

PO1's decision to seek an approved premises placement appropriately identified that an enhanced level of monitoring and oversight was required. The AP referral was accepted but the placement was not confirmed until the day prior to release. Probation practitioners advised that this was routine practice, and on occasion placements can be confirmed as late as the day of release. This practice does not support probation practitioners in developing timely and robust resettlement and risk management plans and does not consider the needs of the person on probation in preparing for their release.

Pre-release information was returned to the prison by PO1 on 18 October 2021, which contained a list of additional conditions to be included on JJ's licence upon release. There was evidence that PO1 received support from the Serious Group Offending expert probation practitioner and appropriately used the effective proposal framework (EPF)[21] tool to develop the list of licence conditions. However, the recommendation of these conditions in advance of the initial MAPPA meeting in October 2021, and without the AP placement having been confirmed, resulted in a missed opportunity for MAPPA and the AP to contribute to the development of the licence conditions.

The MAPPA referral was also not timely against expected practice, with the referral submitted on 05 October 2021 and the first meeting being held on 21 October 2021, only three weeks prior to JJ's release from custody. This impacted on how sufficiently MAPPA could contribute to the development of the resettlement plan, and support PO1 in developing a robust risk management plan.

Following a disagreement with one of the non-contact conditions in the licence requirements by JJ, PO1 contacted the prison to request a change. This action lacked the required oversight and scrutiny at a middle-level management, and there was no evidence that these changes had been discussed in the MAPPA meeting held the day prior.

The licence conditions confirmed on JJ's licence upon release comprised of the seven standard conditions, and several additions:

- to be of good behaviour
- not commit any offence
- keep in touch with supervising officer
- receive visits from supervising officer
- reside permanently at an approved address

[21] The EPF is a digital tool that supports probation practitioners to create shortlists of relevant requirements, interventions, and licence conditions.

- not to undertake work unless approved by supervising officer
- not to travel outside of the United Kingdom/Channel Islands/Isle of Man without prior permission
- attendance at a substance misuse service
- non-contact with index offence co-defendants
- specified exclusion zones
- curfew (not electronically monitored)
- to provide details of vehicles
- restrictions relating to mobile phone/sim card possession
- requirements for the facilitation of drug testing.

Key findings and missed opportunities

- Both the MAPPA and AP referrals were not completed within expected timeframes, impacting on the sufficiency of pre-release planning.
- The confirmation of the AP placement location was received only one day prior to JJ's release, resulting in insufficient time to engage with services within the locality, and prepare JJ for his release.
- Licence conditions were drafted in isolation from the MAPPA process and without AP input.
- Licence conditions were subsequently amended, an action guided by JJ's dissatisfaction, without SPO or MAPPA consultation.

10. Assessment of risk of serious harm and need

Upon release, PO1 started the required initial OASys assessment. However, it was not finalised and was subsequently locked incomplete, which is an automatic process when an assessment remains open for a period of time. Expected practice, in line with national standards[22], is that people on probation have an OASys assessment completed within 15 working days of their first appointment following sentence or release. The failure to complete the assessment was poor practice and resulted in JJ's supervision not being underpinned by a current and comprehensive active assessment of his risk of serious harm and need. It also resulted in no risk management plan being in place to support the management of the case, and no sentence plan to inform how supervision appointments would be structured. PO1 attributed this, as with the earlier delays to pre-release work, to the volume of their work being unmanageable. It is apparent that the lack of effective oversight and support from SPO1 was also a contributory factor.

Prior to JJ's release from custody, PO1 had updated the risk registrations on the probation case management system NDelius, and completed two pre-release OASys assessments, which demonstrated they had some insight into the risk of reoffending and serious harm posed by JJ. The pre-release OASys appropriately assessed that he posed a high risk of serious harm to the public but assessed that a low risk of serious harm was posed in all other categories.[23] This assessment did not adequately reflect that JJ had historically behaved in an aggressive, violent, and inappropriate way to medical and prison staff. Additionally, the assessment of risk of serious harm to children had not sufficiently explored his drug dealing and potential associated exploitative activity, and his behaviour in custody and risk of serious harm posed to other prisoners was not analysed.

The OASys assessments contained reference to JJ's previous sexually inappropriate behaviour to female prison officers, but no further information was available. This brief information was noted in the context of risk to staff but was not analysed against whether it demonstrated a risk towards women more generally. Greater exploration of this was needed for the probation practitioner to understand how to utilise this information to inform the assessment of risk, should JJ commence an intimate relationship.

The two OASys assessments completed prior to release had appropriately identified that there were several criminogenic needs linked to JJ's offending. However, as with the risk assessment, not all pertinent factors had been identified.

In advance of JJ's release, PO1 liaised with several partnership agencies who could provide support to JJ upon release and coordinated their involvement to minimise duplication. This facilitation of support, which specifically focused on JJ's ETE and housing needs, continued throughout the licence supervision period, and reflected PO1's commitment to support him to make positive changes to his lifestyle. However, the focus on meeting JJ's needs was to the detriment of analysis of his behaviour and management of the risk of serious harm he posed. A successfully blended approach to working with people on probation combines the practice of managing the risk of serious harm alongside a focus on desistance.[24]

[22] National standards provide the practice framework for probation practitioners and managers.
[23] Risk assessment categories in OASys include public, known adult, children, staff, and prisoners.
[24] Risk and Desistance: A Blended Approach to Risk Management (justiceinspectorates.gov.uk).

Key findings and missed opportunities

- PO1 coordinated partnership engagement to address housing and employment needs, appropriately identifying these as important factors linked to desistance.
- PO1 did not complete an OASys assessment upon release, and this lack of completion was not monitored or acted on by the senior probation officer.
- The previous OASys assessments underestimated the risk of serious harm posed to others and did not identify all factors linked to risk of reoffending and serious harm.
- There was a failure to analyse all available information relevant to risk of serious harm. JJ's behaviour in custody was not given due regard, and previous concerning behaviour displayed towards female prison officers was not analysed to inform an assessment of the level of risk of serious harm posed to women.

11. Management of Licence

a. Substance misuse

Despite the proactive work to secure partnership agency support for some of JJ's criminogenic needs, provision was not sought for his substance misuse despite this being included as a requirement on JJ's licence. PO1 attributed this to the lack of certainty on the location of the AP placement, which meant they were unable to identify an available intervention. However, upon confirmation of the AP placement and JJ's subsequent move to independent accommodation, a substance misuse intervention was again not sought. During their interviews with inspectors, PO1 and HOS1 told us of a lack of support and intervention available within the locality specifically for cannabis use. A failure to make the necessary referral was compounded by JJ's own lack of motivation to address his substance misuse and PO1's failure to explore and challenge this directly with him.

JJ responded to questions regarding his level of drug use and had openly disclosed regular and significant levels of cannabis use after his release, but there was no evidence that the underlying reasons for this continued use of cannabis was explored in detail or understood or challenged by probation practitioners. The drug testing condition on JJ's licence was appropriate, and some tests were completed whilst at the AP, however they did not take place after JJ vacated the AP and moved to independent accommodation, with the conducting of drug tests having been affected by operating practices during Covid-19.

There was no clarity within the probation records or MAPPA meeting minutes as to whether there was a consistent understanding of what constituted problematic cannabis use on licence and what the proposed contingency plan action was if the use reached this level. JJ's use of cannabis was considered in isolation and the impact of it was minimised and not sufficiently responded to.

b. Approved Premises (AP)

The delayed referral and late notification of the location of the AP placement for JJ did not allow sufficient time for pre-release planning, coordination of services or engagement with him to support compliance. The head of approved premises (HAP) described long-standing practice within the Probation Service, London region, of referrals being completed outside of the expected timeframes, which impacted on the timeliness of placement confirmation and the ability of the AP staff to support pre-release planning.

JJ spent regular periods away from approved premises during the daytime. Whilst permitted to do so, this impacted on the opportunity for staff to monitor and engage with him meaningfully. There is no evidence that consideration was given to how the AP could support the risk management plan aside from providing accommodation. Additional sign in times throughout the daytime were not utilised. AP staff were not professionally curious in their approach and did not engage with JJ to explore who he was associating with or how he was spending his time.

Positively, key work sessions in the AP were delivered as expected and were appropriately focused on JJ's resettlement needs. There is no evidence of purposeful activity being delivered within the AP, however Covid-19 operating arrangements did adversely impact on this. During the AP placement, JJ had declined to take some of the required drug and alcohol tests, citing ill health. This rationale was accepted and there was a missed opportunity to have considered this as admittance of use and a further example of non-compliance with his licence.

c. Cover arrangements

PO1 was absent from work for three months from December 2021 and had provided a caseload handover note to SPO1 to support covering arrangements. However, JJ's case was not formally reallocated, with PO2 describing that they had decided to maintain contact with JJ on their own initiative while PO1 was off sick.

The length of PO1's absence from work should have prompted SPO1 to reallocate cases to other practitioners to ensure that there was absolute clarity on case responsibility in PO1's absence. PO2 stated that while they oversaw the case in PO1's absence, they did not feel that they had full ownership of the case, instead seeing their role as offering JJ appointments and providing a point of contact.

In March 2022, PO1 described that they had an unsupported transition back to work, whereby they resumed responsibility for most of their previous caseload, which felt unmanageable. They had to regain oversight and re-establish contact with many cases that had not been managed during the absence period. Although PO1 was subject to a reduced caseload during a return to work, their perception suggests that it did not comply with the expected standard of return-to-work practice following a lengthy period away from work.

d. Enforcement and engagement

The AP placement was characterised by several breaches of hostel rules, two within the initial days of the placement, whereby JJ was late for his curfew and received a verbal warning. The HM Inspectorate of Probation report: *A thematic review of probation recall culture and practice* emphasised the limited effectiveness of issuing warnings; finding that there was inconsistent practice across probation regions when issuing and communicating warnings. In response to these findings, His Majesty's Prison and Probation Service (HMPPS) issued guidance,[25] which required practitioners to stop using warnings and to respond to licence non-compliance in three ways; a compliance letter, a decision not to recall letter, or recall to custody.

The breaches of the AP rules represented an early compliance concern and, therefore, a compliance letter was required instead of a verbal warning. Later into the AP placement, JJ also received an approved premises improvement plan which required him to consider the impact of his behaviour and agree to make improvements.

In December 2021, it was established that JJ had purchased a car and had not informed his probation practitioner. This was a breach of a licence condition to provide details of any vehicle owned, hired, or which he had use of, in advance of such use. Case records note that when considering the circumstances of JJ's failure to inform him of the purchase, PO2 believed something *"didn't add up",* demonstrating they knew more information was required, however this was not acted upon further. There is no evidence that professional curiosity was extended beyond that of basic questioning, with the response taken at face value and no further verification sought. An entry by SPO1 was placed on NDelius, stating a decision not to recall letter would be issued but we found no evidence that the letter was actioned.

Throughout the management of the case, responses to poor compliance and licence breach were considered without accessing all available information, and without analysis of the behaviour in the context of the risk of serious harm and reoffending posed by JJ.

In January 2022, JJ's AP placement was extended by one week to support his move into independent accommodation. During this period there were two further breaches of his curfew, although by small amounts of time. Southwark PDU case records do not show that

[25] HMPPS Recording recall decision making and issuing letters guidance, issued October 2021.

action was taken in response to these, and they appeared to be viewed as insignificant in the context that JJ was imminently leaving the AP for independent accommodation. This demonstrates further that compliance concerns were not viewed or analysed cumulatively.

JJ attended 25 of the 38 routine appointments offered to him by the AP or with his supervising probation officer, and probation practitioners felt that he engaged well and had become increasingly more open with them. Probation case records show that JJ responded positively to PO1 and PO2, providing enough information to satisfy the practitioners. This contributed to PO1 and PO2 viewing the level of attendance and progress made with an optimism bias, impacting on the level of professional curiosity they exercised. There was a clear pattern of low-level non-compliance which was not analysed, both in custody and the community, with JJ openly expressing that he felt his CBO and licence conditions were excessive.

Probation practitioners acknowledged that they had been pleased with JJ's response to supervision. We asked PO1 and PO2 about this when we interviewed them for this report. On reflection, both acknowledged that had they been more professionally challenging, and asked more probing questions, this would most likely have been met with resistance from JJ. Focusing on his needs during the supervision sessions had maintained positive engagement, but at the expensive of challenging underlying risks.

In January 2022, JJ moved into his own independent accommodation, which was out of the borough of Southwark and should have prompted a transfer to a different PDU. This would have prompted revision of the sentence and risk management plan, and scoping of what partnership services were available within the locality to support their implementation. This inaction was reflective of the lack of ownership of the case during this period, whereby oversight of the case was reactive, rather than planned and sequenced.

In March 2021 and following his move to a new address, JJ's curfew, which had been in place since his release from prison, was changed from a 9pm start to 10pm. The curfew was not electronically monitored and was therefore dependent on oversight by police. However, probation records do not show an agreement was in place with the police to support active monitoring of the curfew or engagement with them to seek feedback on JJ's compliance.

Complaints from neighbours were received regularly from March 2022, including loud noise, anti-social behaviour, and allegations that JJ had made threats toward a neighbour. Requests were made for PO1, who had recently returned to work, to support the landlord in responding to the concerns raised. While the need for JJ to maintain his tenancy was reinforced, PO1 stated that the behaviour was an accommodation issue and not deemed to be pertinent to the management of his licence. This was a missed opportunity to explore this behaviour, and glean information into JJ's lifestyle, relevant to his assessment of risk of reoffending and serious harm. The threats made to neighbours prompted no reflection on the imminency of risk of serious harm, which was particularly pertinent given the high risk of serious harm to the public assessment. There is also no evidence that management oversight was sought to discuss the concerns and explore whether eviction from the tenancy would constitute a breach of his licence.

In discussing the tenancy concerns, JJ had disclosed that a girlfriend was visiting his flat. This was the first time JJ had mentioned having a girlfriend. PO1 later asked JJ for more details of the relationship, and he disclosed her first name and was described to have spoken positively about their relationship and the positive impact it was having on him. No other detail was provided or asked for at that stage, and the name he provided was different to that of Samantha Drummonds, one of the murder victims described to have been his girlfriend. Had there been a sufficient analysis of the risk of serious harm posed by JJ, particularly considering the risk of serious harm to women, this could have supported

PO1 in responding proactively to this new and significant piece of information enabling them to understand what additional information needed to be sourced to support safeguarding enquiries (such as full name, address and whether she had children).

At the end of March 2022, PO1 noted that JJ was using the social media application WhatsApp and appropriately questioned JJ about this. JJ admitted he was regularly using the application and was aware this represented a breach of his Criminal Behaviour Order (CBO). This should have been reported to police and escalated for management oversight, but PO1 told us they did not feel this was part of their role. This is incorrect and a critical omission in the management of this case. Probation practitioners must do all they can to support the management of risk of reoffending and serious harm in the community. This omission is further representative of an absence of professional curiosity, whereby information was not explored in full nor analysed to understand its significance. It is likely that had PO1 informed police of his use of the social media application, it would have constituted a further breach of the CBO and thus also placed him in breach of the suspended sentence order and licence, and therefore at the threshold for recall to custody.

Inspectors found that although the probation practitioners in this case were motivated to work to a high standard, they did not fully perform their role which impacted on the management of this case. Caseload volumes, and the pace of work further impacted on each probation practitioner's ability to perform their duties to a sufficient standard. Southwark PDU, whilst operating as 'green' under the prioritising probation framework, still had several vacancies: including approximately three probation officers, 10 probation service officers, one senior probation officer and five administrators, not including sickness or maternity absences[26] and teams consisted of disproportionate numbers of newly qualified and trainee officers. These pressures were compounded by the changes and challenges posed by the unification of probation services in July 2021.

Despite the high volume and pace of work, the office culture at Southwark PDU was referred to positively by staff. Good communication from the wider management team and from the HOS1 was also described, alongside a supportive team environment. It was apparent that the HOS1 is a responsive leader, who is aware of the challenges the PDU faced, and is proactive in responding to issues that are within their control. Staff vacancies and a reliance on large numbers of recently qualified and trainee officers is of concern, and an issue that has been found in our core inspections across all probation regions. This staffing dynamic is resulting in inexperienced officers holding inappropriate caseloads and reducing the opportunity for peer-led growth and development.

Key findings and missed opportunities

- Probation practitioners minimised JJ's use of cannabis and did not challenge this use or motivate him to engage with an intervention to support him in addressing it.
- There were no formal cover arrangements put in place during PO1's three-month absence from work, and PO1's return to work did not generate an appropriately phased allocation of work or consideration of the appropriateness of caseload type.
- Enforcement practice was inconsistent and was not in line with expected practice guidance. Poor compliance and licence breaches were viewed in isolation and without a holistic understanding of the behaviour being presented and the risk of serious harm posed.
- Probation practitioners focused on meeting the needs of JJ without balancing this with the need for clear and consistent enforcement.

[26] Figures as of July 2022, provided by HMPPS.

- A lack of professional curiosity was demonstrated by probation practitioners, including AP staff, throughout licence supervision.
- JJ's level of engagement and compliance was viewed with optimism bias.
- Complaints regarding JJ's behaviour in his tenancy were not explored, not viewed as being significant to his assessment of risk of serious harm and were not sufficiently responded to.
- Transfer to the appropriate PDU was not sought upon JJ securing independent accommodation in a different area.
- JJ's accessing of WhatsApp was not reported to police as a breach of criminal behaviour order (CBO), with PO1 not displaying confidence and understanding of her responsibilities in relation to managing JJ's licence in the community.
- High workloads, large numbers of newly qualified officers, and a lack of experience in staff affected the ability of probation practitioners to undertake work to a sufficient standard.
- Insufficient management oversight resulted in a lack of support for practitioners and lack of monitoring of timeliness and quality of expected tasks.

12. Further offending and suspended sentence order

In March 2022, JJ received a suspended sentence order (SSO) with requirements of a rehabilitation activity requirement (RAR) and an accredited programme, which would run alongside his licence supervision in the community. The order was imposed for further offences of failure to give a sample, failure to provide a specimen for analysis, breach of CBO, and handling stolen goods in January 2022.

These offences were committed three days following his departure from the AP and represented a breach of licence. An entry recorded on the case management system showed that enforcement action was discussed between PO2 and SPO1, who determined that the recall threshold had not been met as the further offending was 'not of a violent nature' and did not 'indicate an escalation in the imminence of risk'. A decision not to recall letter was agreed. However, an incorrect compliance letter was then issued, which was not representative of the level of enforcement agreed.

At all points in the supervision of a licence, changes in behaviour or circumstances need to be considered in the light of both the risk of serious harm and the presence of risk factors. Alongside whether enforcement action is necessary, consideration is also needed as to whether more support or further restrictive measures should be added to the licence and risk management plan to support the effective management of the individual on licence. Although the risk of serious harm posed by JJ had been specifically linked to drug supply and potential associated violence, it was simplistic to consider that the further offences did not represent an escalating concern. In doing this, the probation practitioners failed to consider that JJ was already assessed as posing a high risk of serious harm and had previous convictions for violence. He was also subject to a CBO, demonstrating a level of offending and antisocial behaviour which required close monitoring, and factors identified as being linked to the risk of serious harm were present in JJ's lifestyle. There was an over reliance on the presence of protective factors like accommodation and the prospect of training, which were not sufficiently stabilising at this point.

HMPPS guidance on *Recording recall decision making and issuing letters* stipulates that a PDU Head as a minimum 'must endorse any second and subsequent decisions not to recall'. Given that JJ should have previously received a decision not to recall letter (for possession of the vehicle) and had been charged with several further offences, oversight of the enforcement decision in March 2022 was required at a senior level. Although inspectors felt that the decision not to recall JJ was defensible, senior management oversight should have been sought to facilitate a discussion on the robustness of the existing risk management plan, and what additional restrictive and rehabilitative factors should be implemented and attached to the licence to increase its sufficiency.

Prior to sentencing JJ in March 2022, the court had adjourned for a pre-sentence report (PSR), which was completed by PSR1. PSR1 gathered available information on JJ, but this work was guided heavily by the incomplete OASys assessment in place and PO2's knowledge on the case, which was limited by their role and level of oversight of JJ. In doing this, the pre-sentence assessment lacked ownership by PSR1 and failed to apply the level of critical analysis and professional curiosity required, reiterating the pre-release assessment that JJ posed a high risk of serious harm to the public in the context of violence linked to drug supply. This did not analyse all his behaviour, which limited the breadth and quality of the assessment. The pre-sentence report emphasised that a further custodial sentence would separate JJ from his family and jeopardise his education and accommodation,

suggesting an over reliance on the presence of protective factors and a failure to adequately assess how robust they were, and how prevalent risk factors were in the community.

When interviewed to inform the PSR, JJ stated to PSR1 that he was experiencing *"some poor mental health"* when he committed the further offences. This significant disclosure by JJ was not expanded upon and no further detail of the symptoms he was experiencing was provided. Nor was this information analysed to understand how it should inform the assessment of risk of serious harm and offending he posed. This was a missed opportunity to explore a pertinent factor linked to risk and consider the intervention required. Furthermore, this disclosure did not impact on PO1 or PO2's practice whereby it would have been expected this information would have been used to inform the continued management of the case in the community.

The court working environment was described by PSR1 and SPO4 as fast paced and demanding. As such, there was an expectation that requests from the court would be responded to and delivered quickly to support the 'Transforming Summary Justice' [27] programme. SPO4 confirmed that when cases already known to probation required a pre-sentence report, court officers could end up being reliant on information from the existing supervising practitioner to inform their assessment and report, to support the prompt delivery of information to the court. While the gathering of all available information is important, there is a risk of over-reliance on pre-existing information, resulting in a lack of ownership of the assessment by the court officer. Furthermore, a professionally curious approach is essential to the court officer role, and this can be impacted by this lack of ownership and reliance on the provision of information from colleagues.

The recommendation to the court suggested that as JJ was on licence, no further restrictive measures were required, and a proposal of rehabilitation activity days (RAR) and a thinking skills accredited programme was made. This recommendation was limited and should have considered how additional restrictive measures, such as location monitoring (GPS-tagged curfew), could have supported the management of the case in the community alongside the rehabilitative elements. Furthermore, had the assessment been supported by a current and robust holistic assessment, which included analysis of JJ's poor compliance with existing restrictive CBO and licence conditions in the community, it may have impacted on the sentencing decision of the court.

Key findings and missed opportunities

- There was a missed opportunity to escalate and seek senior manager oversight following JJ's arrest for further offences, this would have supported a discussion on whether the threshold to recall to custody had been met or whether the risk management plan in the community was sufficient.
- An OASys assessment was not completed following changes to JJ's circumstances or following significant events, such as his arrest. This was a missed opportunity to review the risk management plan, and available interventions and restrictions in the community.
- The pre-sentence report was not based on all available information and was informed by a previous and insufficient assessment of risk of serious harm and need.
- The sentence proposal made to the court did not consider all available sentencing options.

[27] The Transforming Summary Justice programme is a criminal justice system wide programme to improve how cases are dealt with in the magistrates' courts.

- There was an over-reliance on the presence of protective factors without analysis as to whether they were effective and the impact they were having on JJ's behaviour in the community.
- The disclosure made by JJ that he was experiencing poor mental health was not responded to sufficiently and should have generated further analysis and action at PSR stage and post sentence.

13. MAPPA and information exchange

Multi Agency Public Protection Arrangements (MAPPA) are expected to contribute as much as possible to support the management of risk. The four MAPPA meetings held on this case did not demonstrate robust oversight or meaningful contribution to the management of risk of serious harm posed. The minutes were of an insufficient standard and lacked evidence that there was collective oversight of the case or that there was an active contribution to the development of the risk management plan. A MAPPA meeting is expected to collectively devise the risk management plan (RMP) with the lead agency, however the RMP contained within the minutes was copied from the pre-release OASys assessment and was not updated to reflect the fact that JJ was in the community.

Despite good attendance from a core panel of partnership agencies, there were notable absences. A representative from the AP did not attend, and a representative from the Department of Work and Pensions (DWP) was not invited to the meetings. Attendance and contributions from both could have provided specific information relevant to JJ's behaviour and circumstances in the community. This demonstrated a clear example of how the MAPPA failed to utilise all opportunities to access information potentially relevant to risk.

Each MAPPA meeting received updated information from the probation practitioner, with the minutes reflecting tacit agreement from the partner agencies, with limited evidence of active consideration of risk management activity or scrutiny of case management decisions in response to significant events. The knowledge of a new intimate partner should have prompted rapid vulnerability and safeguarding enquiries, but there was no evidence that consideration was given to the impact of this and other changes upon the assessment and imminence of risk of serious harm.

Following the fourth meeting in March 2022, JJ was exited from MAPPA oversight without adequate rationale and with actions, which had already been carried forward from a previous meeting, remaining as outstanding. There was no evidence of a process in place to ensure continued oversight of these actions.

This poor practice is in line with the findings from a joint thematic inspection on MAPPA which found that information is not always updated within the meeting minutes, as well as poor quality of information within risk management plans. It also highlighted that 'too often, late referrals hamper pre-release planning for individuals being released from prison and mean that important arrangements, such as accommodation, are not in place sufficiently early. Last-minute arrangements do little to ensure that individuals being released are informed about what is expected from them on release or to encourage compliance with licence conditions. The thematic also emphasised that 'areas would benefit from reviewing the resources available for MAPPA and considering whether the staffing, roles, and responsibilities meet the need and volume of work appropriately'.

The SPO with lead responsibility for MAPPA (SPO3) in Southwark PDU spoke positively of the partnership arrangements in place and was found to be motivated to support the delivery of good quality MAPPA oversight. But they are not enabled to do so due to insufficient workload capacity. Their primary role is to manage a generic offender management team, with MAPPA as an additional specialist role. MAPPA meetings had up to 12 cases each day for discussion and review which, on average, allowed only a maximum 30 minutes of discussion per case. This is insufficient time to enable the MAPPA panel to contribute added value and places pressure on administration arrangements to support.

A quality assurance assessment of the MAPPA meetings in the Southwark area was completed in August 2022, which consisted of observations from a member of the strategic

management board (SMB)[28] It was positive that the SMB member noted strong contingency planning, and professional and constructive chairing. However, importantly, it was also noted that the risks needing to be managed through the MAPPA meeting were not always clear to the observer, and constructive feedback was provided as to how this could be enhanced. The feedback from these observations provides some assurance as to the quality of the MAPPA arrangements in place, and places further emphasis on the importance of the minutes providing an accurate reflection of the discussions held. The current quality-assurance process does not include consideration of the minutes subsequently produced, which would support a more comprehensive quality assurance process.

Probation practitioners reported a lack of confidence in the information exchange processes in place within the PDU, which impacted on their ability to gather information from partner agencies, in particular the police. MAPPA was at times viewed as a forum to compensate for this difficulty and used to secure approval of case management decisions to provide defensible decision making, rather than as a forum to actively manage the risk of serious harm being presented by a case.

It was confirmed by the HOS1 and HoOP1 that processes were in place to facilitate the exchange of information outside of MAPPA, however improvements were required. They also noted that they were pleased with the number of Category 3 MAPPA referrals within Southwark PDU, and that there were aspirations to move to this level across the London probation region. Inspectors found the level of resource for MAPPA was insufficient to support the numbers currently being discussed. To maintain this level of use, and deal with possible further increases, adequate resourcing allocation is required to ensure that capacity is given to staff to implement the MAPPA meaningfully. Having recognised the need to increase the resourcing available to MAPPA, HOS1 had recently increased the administration support in place and had one further SPO trained in MAPPA chairing, with the intention of having all four SPOs trained in time. However, how the increased SPO resourcing will impact on MAPPA delivery within the PDU had not been finalised, and assurance is required as to how this will positively impact on the quality of MAPPA oversight and delivery.

Key findings and missed opportunities

- The MAPPA minutes were of insufficient quality and did not evidence that MAPPA made a meaningful contribution to the management of risk of serious harm.
- The decision to exit JJ from MAPPA failed to consider the outstanding actions or the lack of a current and robust risk management plan.
- The MAPPA meetings were not attended by an approved premises representative, and attendance from DWP was not requested.
- The quality assurance process does not provide a comprehensive overview of the quality of MAPPA and should also consider the quality of the minutes produced.

[28]The SMB is the means by which the responsible authority fulfils its duties to keep the MAPPA arrangements under review, and is responsible for the implementation of MAPPA guidance in its area.

14. Early look SFO review and immediate actions

Following JJ's arrest for murder, an 'early look' SFO review was completed by the Probation Service – London region in April 2022 in line with HMPPS expected practice. The purpose of an 'early look' is to quickly review the practice in the case and promptly identify to senior leaders within HMPPS any practice and training deficits that require immediate attention and to begin appropriate actions, and human resource (HR) processes if assessed as being necessary.

Inspectors found the quality of the 'early look' to be of a sufficient standard which met its objectives. We were largely in agreement with many of the findings, however, this was not exhaustive, with our independent review finding several additional areas for learning. Of note, the early look assessed that the MAPPA practice in this case was good, which was not in line with the findings of this independent review.

The learning points from the early look report are summarised below, and are deemed to be appropriate areas to have been actioned immediately:

- PO1s application of the four pillars[29] approach to risk management planning
- PO1's recording practice
- SPO1's recording practice
- cover arrangements for absences and countersigning OASys assessments.

In addition to the activity generated from the early look, the HOS1 took forward several actions. Firstly, they commissioned specialist trauma-informed supervisions sessions for staff within the PDU. This is for a limited time and, ordinarily, clinical supervision sessions such as this are not routine for probation practitioners. This initiative has been well received, with positive feedback as to the impact it has had on practitioners. Secondly, HOS1 has worked with the local drug services to commission an intervention focused on cannabis use. Thirdly, they have arranged a briefing for probation practitioners on Criminal Behaviour Orders. Inspectors found that these actions were responsive and appropriate.

The HoOP1 stated that in recognition of the high numbers of NQOs within many of the London probation officer teams, a development plan had been implemented, delivering group briefings on specific areas of probation practice during an officer's post qualification period. Inspectors found this to be an encouraging approach which will provide some additional support to the continued development of practice. However, this does not take away from the concerns we have raised regarding the appropriateness of case allocation to newly qualified officers, the need for a balance of experience within teams, and the need for robust management oversight and support.

[29] The four Pillars of risk Management is an approach to the planning and delivery of risk management developed by Professor Hazel Kemshall at De Montfort University. The model is based on the four pillars of Supervision, Monitoring & Control, Interventions and Treatment and Victim Safety Planning.

15. Conclusion

Inspectors found that overall, the supervision of JJ's case fell below the required standard. PO1 was a newly qualified officer, and a case of this complexity should have been allocated to a more experienced qualified probation officer. Furthermore, there should have been absolute clarity on who had case responsibility during PO1's absence from work.

Appropriately, a referral to MAPPA and approved premises were made. However, significantly, both actions were completed late against expected deadlines which impacted on the sufficiency of pre-release planning.

Upon release, the management of JJ was not supported by an up-to-date assessment of risk of serious harm and need. Critically, substance misuse and mental health – key factors linked to reoffending and harm – were not sufficiently understood and were not adequately monitored and responded to.

Neither the approved premises placement nor MAPPA fulfilled their potential in supporting the management of risk of serious harm posed by JJ in the community. JJ's superficial presentation and level of engagement contributed to the progress made being viewed over-optimistically by practitioners, which impacted on the way breaches of the terms of his licence and the presence of risk factors were viewed and responded to. Practitioners were not professionally curious in their approach, resulting in a failure to investigate and manage the ongoing risks he presented to the public, including potential partners. Enforcement practice in this case was insufficient, with missed opportunities to apply HMPPS guidance consistently to support the management of JJ.

Several key events are deemed to be missed opportunities in this case. Firstly, a failure to respond adequately to the further offences JJ committed in January 2022. While the decision not to instigate recall is defensible, the response of the practitioner and manager in the absence of recall were insufficient and they should have sought senior manager oversight, which would have supported revision of the risk management plan and licence conditions in place. Secondly, the insufficient response by PO1 to the behaviour being displayed by JJ towards his neighbours reported by his landlord in March 2022. Thirdly, a failure to respond to the disclosure to probation court staff in February 2022 that JJ was experiencing a decline in mental health. Fourth, and finally, a critical failure by PO1 in March 2022 to inform police JJ was accessing WhatsApp and was therefore in breach of his CBO for a second time.

Inspectors found probation practitioners to be overwhelmed by the pace of work, and volume and complexity of their caseload, which in the case of PO1 was compounded by their recently qualified status and lack of experience. Ineffective SPO oversight further exacerbated this, with practitioners not receiving good quality support and oversight, and not actively seeking such support anticipating that it would be unhelpful. The quality of MAPPA delivery was also affected by insufficient resourcing and poor-quality administration.

There have been long-standing concerns regarding the lack of training and interventions available for probation practitioners working with people on probation requiring support for their mental health. Similarly, support and interventions for cannabis use were lacking in Southwark PDU, with practitioners citing this to be a recurring barrier to managing people on probation effectively.

Our core inspections of probation regions, and our quality assurance of serious further offence reviews, are highlighting consistent themes at individual, regional, and national levels which include the quality of risk of serious harm assessment and management,

delivery of interventions, the quality of management oversight, and resourcing and retention of staff – impacting on the volume and pace of work. More needs to be done by HMPPS to address these recurring themes to enable probation practitioners to do all they can to deliver high quality probation work in the community.