

Independent Assurance Report
To the Board of the
Reducing Reoffending Partnership
on 20 February 2015

**Review of the work done by the two CRCs* to
Manage offenders' *Risk of Harm to others (RoH)*
Report of Phase One (as proposed), February 2015**

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Levels One and Two contain the essentials; the remainder covers the supporting materials and detail for those who wish to look into them.

****I could have written two separate reports for each CRC, but found much more in common than is different. Two reports would have made the format more repetitive.***

I apologise, however, to those interested in the detail since some of the (small) differences will this way be less clear than they would have been otherwise.

Level One - Executive Summary of my findings:

1.1. **Main Outcome: Assurance is positive, but inevitably qualified.**

1.2. **The caveat:** The nature of Probation work is that the great majority of the contact with people who have offended is done by individual practitioners 'in private' (not directly observed), and the effect of management action on the detail of that practice is by necessity indirect rather than direct. I am able to make some very positive comments about the arrangements for doing *Risk of Harm* work well in the two CRCs, as always with some areas for potential further improvement, but my assurance has to be limited by the fact that at this stage I have not directly looked at any current work with cases. An additional qualification is that by the date of the Board meeting I have not yet received all the responses from partner agencies I was looking for.

1.3. **Summary:** The arrangements for managing *Risk of Harm to others (RoH)* work across the two CRCs are largely very sound, and a credit to those who have developed them over recent years. Furthermore, the culture of awareness of the importance of *RoH* work, including Child Protection responsibilities, was well understood by almost all the 67 frontline staff I interviewed – and they were also **mainly** sound in their descriptions of how they put this difficult work into practical action. Although I hold to my caveat above, this was still an encouraging picture.

1.4. **Key points:**

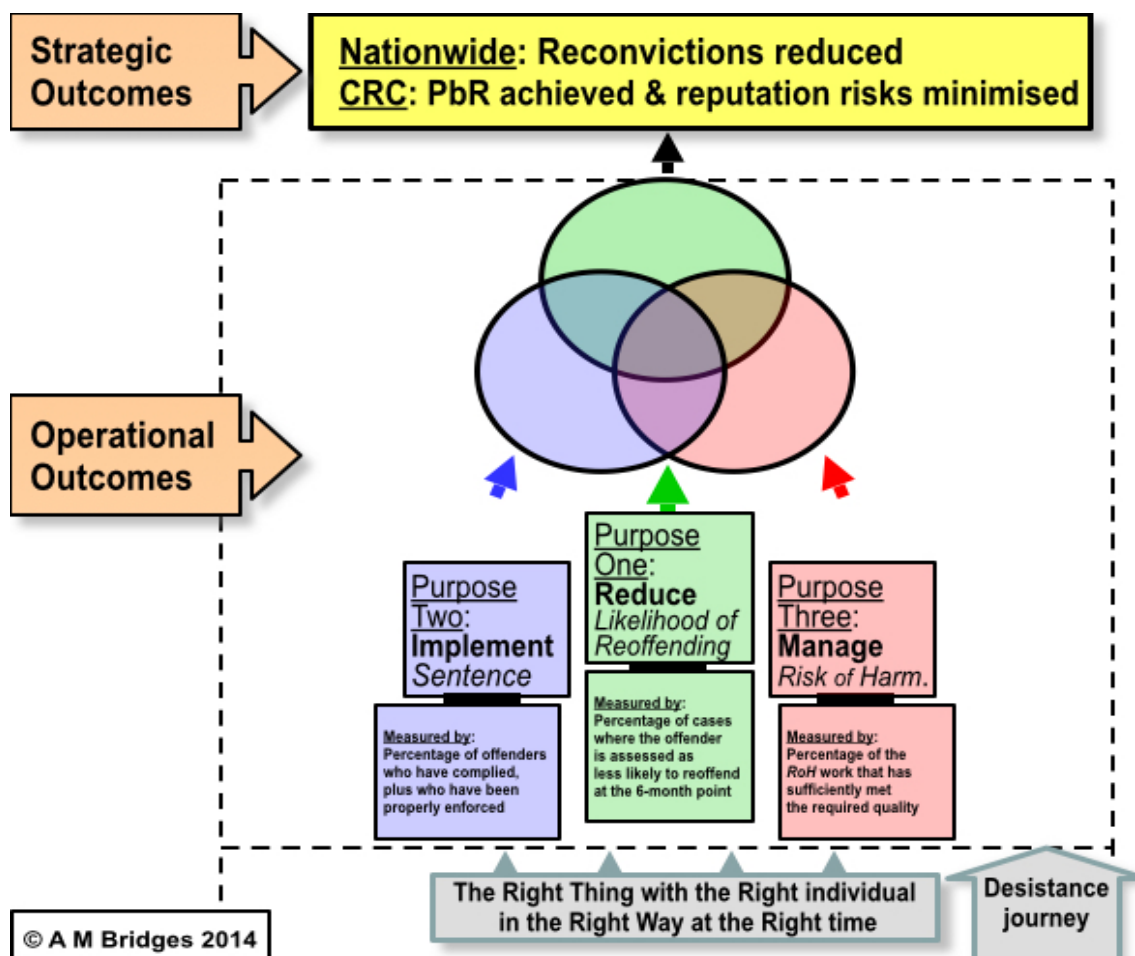
- A strong clear lead has been set from the top of both organisations, with appropriate resource allocations
- Operational senior management(s) have useful – if sometimes wordy - policies and guidance in place, make the right demands on what they want staff to achieve, and in the main set the right tone
- Local operational managers and practitioners are well focused on most of the actions they need to take to achieve this, though I have found one particular strategic *RoH* issue to be resolved - concerning '*Confidentiality v Disclosure*'
- While I can't verify actual achievement, the picture is broadly promising, although some important variations and details are reported further below
- Recommendations from me for further continuing improvement are included, for your consideration, provided from **Page 5 (in Level Two)**.

1.5. The following Levels each go into an increasing layer of detail of my findings, though the consistent thread(s) of my account should remain apparent throughout.

1.6. I invite the Board to consider the potential benefits of proceeding with my proposed Phase Two – the case assessment exercise. It brings with it, not only a more reliable picture of how the work is being done now (see 1.2 above), but also the prospect of directing operational staff towards precisely how you want them to perform in future – if you integrate it with the right **Design**.

Level Two – My findings etc viewed in a wider context

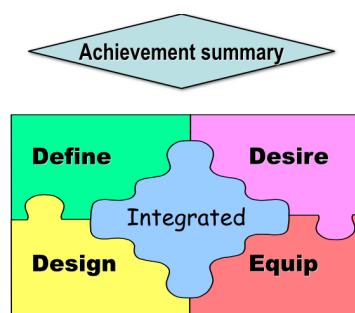
- 2.1. The focus of this report is, as requested by the Board, on a subject that is one of the three core Purposes of Probation supervision. In my own construct, this is what I now call Purpose Three: Managing *Risk of Harm to others*, which is separate from but still overlaps with Purposes One and Two. As this graphic illustrates, achieving Purpose One enables Payment by Results, while achieving Purposes Two and Three means that catastrophic reputational risks to the organisation are kept to a minimum*, in addition to the benefit provided for the public. Within this wider context, the focus of this report is on what one of my Berkshire officers used to call “The Red Box work”.



- 2.2. As in this report, this analysis of how to do Probation work well can be viewed in increasing Levels of complexity and detail, but such material can always be traced consistently and directly back to this clear overall picture at the top Level.

- 2.3. In my *Prescription for Making Probation Work*, I have amongst other points emphasised that Define, Design, Desire and Equip all have to be integrated, both in overall strategy and in detail, into a unified approach in order to be successful.

*The specific ways of measuring these Purposes are set out in my paper, available online.



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2.4. One illustration of what this can mean in practice can be seen within this Summary chart of this report's findings. The topics in the left-hand column cover the areas for analysis that one might expect, but the middle column includes the key success factors above, in what I hope is perceived as plain English.

2.5. **Summary chart of Findings:**

Topic:	What I sought:	What I found:
Strategic lead	Necessary attention and resource allocated	Strong clear message from the top of both CRCs of importance of <i>RoH</i> work, evidenced not only by words, but also by established policy documents and ongoing resourcing of training to support it. Also that a strong 'learning culture' is led from the top.
Operational management: area and team:	Success is Defined ; means are Designed , and practitioners are Equipped , to achieve that success. Practice is sufficiently monitored.	Broadly the right definition is set, with correct messages re some of the key details. Design and tools could be improved, by being made more concise and focused. Monitoring of real cases is inevitably limited; an increase could be designed in and implemented, while retaining learning culture.
Practitioner understanding:	Practitioners understand what they are expected to achieve, and how it will be assessed.	Practitioners mainly show good understanding in interview, with mixed expectations of whether they will be treated fairly in any retrospective case reviews. But see Recommendation 1 at 2.7 below.
Practitioner implementation:	Practitioners Desire to achieve this, and actually do it in practice.	The talk is mainly positive, and when taken alongside recently available evidence, it is probable that most <i>RoH</i> work is Sufficient in quality; an assessment of a representative sample of current cases would be needed to provide proper evidence of this actually being done in practice now.
Partner agency experience	Partners are satisfied that CRCs make their proper contribution to multi-agency work to minimise <i>RoH</i> inc CP.	As of 19 February, the answers are incomplete, though no major operational concerns have been raised so far.

2.6. Furthermore I have identified some emerging issues that are perhaps beyond my immediate brief but will in my view need strategic planning if the Board wishes to pursue an integrated approach to achieving success. Naturally I offer my own recommendations concerning these, based on my own version of such an approach. They all emerge from the fact that Probation is an individualised service: success is when practitioners 'Do the Right Thing with the Right Individual in the Right Way at the Right Time'. My approach aims to make that happen, in the short and long term.

One RoH recommendation, plus some other Strategic Recommendations:

2.7. Recommendation 1 (RoH work):

Domestic Violence - The CRCs' role & responsibility with potential new victims:

One potential but entirely plausible reputational risk to the CRCs is the all-too-possible scene following the violent death of a woman at the hands of her quite-recently established partner. The grieving mother of the victim announces to the media: "My daughter had been living with this man for two months, but **no one told her** that he was a bad man who was actually **currently on Probation** for battering his previous partner" (or words to that effect).

Practitioners across the two CRCs gave varying accounts as to how their practice would – or would not necessarily – prevent that scene occurring by ensuring that the new partner knew at an early stage that the new man in their life was "on Probation" and that he had been violent towards a previous partner. Whereas, without exception, every practitioner was clear what action should be taken in comparable circumstances if the potential victim were a child (e.g. a child of the new partner), there was a wide variety of uncertainty about how far a practitioner could reasonably go to ensure that the new partner was informed, should the person under supervision be obstinately uncooperative.

This scene is a 'Probation-centred' version of what is sometimes called the 'Clare's Law disclosure' issue. It can be seen that although there is strong clarity among practitioners about their role and responsibility with safeguarding children, there is currently much less clarity about their role and responsibility with this other particular type of vulnerable potential victim. No doubt the two managements will want to take steps to ensure that practitioners are as clear about what actions are needed with new partners as they already appear to be in relation to children.

I discuss this further in **paragraphs 3.28-3.38** (in Level Three).

2.8. Some other Strategic recommendations or suggestions:

Recommendation 2: - see also 3.47-3.53

Concise and focused Design and documentation:

We will want concise and focused individualised service by practitioners in the future, but in the past the Probation world has regularly inflicted on its staff massively comprehensive policies, directions and guidance that have not had the beneficial effects intended. Although done with the best of intentions in these two CRCs as elsewhere – to try to cover for every eventuality in an individualised service – 'comprehensiveness' has shown itself to be an illusory benefit, especially as it carries with it an implied 'counsel of perfection' that often paradoxically has a disabling effect in the minds of staff. In reality, practitioners have about 20-30 hours per year on average for each case (face-to-face AND all other supporting activity), so a more 'fit for purpose' approach is to Prescribe **what** is to be achieved, and to Advise **how** it is to be achieved. Many implications for **Design** follow from such an approach, where success is clearly **Defined** for staff, but they can use their discretion in how to deliver it. This helps to promote the **Desire** to achieve what their managers want them to want to achieve.

Recommendation 3: - see also 3.54-3.60

Equip staff with an ICT Infrastructure that is integrated with the Design:

The user-unfriendly nature of both N-Delius and OASys is well-known, and I summarise this in Level Three, because it dilutes and saps the Desire of operational staff to do well – but a redesigned and integrated approach would match real work processes better and eliminate the need to duplicate data entries and constantly click through screens, thereby making the **Design** more efficient, and also support a performance focus – the **Desire** - in the minds of practitioners.

Recommendation 4: - see also 3.61-3.68

A single Practitioner career path:

The still-current inflexible two-tier grade structure of POs and PSOs that Probation has saddled itself with for too long should be finally replaced with a single Probation Practitioner role, within which a single smooth path of continuous learning and improvement can be progressed without artificial interruptions. Within that single role, there will still need to be careful allocation of each task and case matched to the level of demonstrated ability of each Practitioner, but the progressing of taking on more difficult work, matched to the growth of the Practitioner's workskills (and hence career progression), could be achieved much more flexibly in the future than hitherto.

Recommendation 5:

Effective 'branding' of the new organisation(s):

'Probation', although it no longer means what it meant in 1908, is the internationally recognised term – brand label – used for work with offenders in the community (or to prepare for that work etc); it maintains its currency around the world. 'Community Rehabilitation' is a term that is both inelegant and inaccurate (only partially accurate), and nobody uses it other than in its initials, and risks being the risible equivalent of Royal Mail being briefly renamed Consignia. Furthermore the CRCs are sometimes unfortunately thought to be the 'second class service' after the NPS. Effective branding of the new organisation(s) is in my view an essential strategic matter to get right at an early stage, and the solution must be got right so that it works both externally and internally, and both formally and informally (everyday language):

- a) RRP should grasp ownership of the 'Probation family' – "we are not a second-class alternative to Probation, but an equal-but-different member of the international Probation family, because we aim to achieve similar purposes with a group of individuals who happen to have some differences from the NPS's cases".
- b) When a licensee is required to report on release from custody, is s/he being required to report to a-different-organisation-with-a-funny-name, or simply to the 'X' Probation Office as opposed to the 'Y' Probation Office? – it is the term 'Probation' that has recognition value. Just as the old British Rail logo used to belong to an old nationalised industry, but is now widely used to indicate 'National Rail', whichever private company runs that particular station, so the CJS will need 'Probation' as the term to indicate both the activity and the premises in which different organisations carry out such work with offenders.
- c) Plain English is needed, and its abbreviation must work for its internal users as well as its external users, so three initials maximum. Since 'Midlands Probation' now belongs to the NPS, my suggestion is Heart of England Probation Company, 'initialled' to HPC, or HPC East and HPC West, with logos designed accordingly.

2.9. Recommendations 1-4, plus other points, are discussed further in Level Three.

Level Three – My findings etc expanded

Introduction:

Importance of *RoH* work to the Board - ‘Reputational’ Risk:

- 3.1. The Board is clearly aware that this work is a critical consideration, because when a current case becomes a high profile Serious Further Offence (SFO), in addition to the catastrophe that the victim of an SFO has experienced, the owner experiences a major threat to its reputation. While failure to achieve Payment by Results (PbR) has some financial consequences, a perceived failure after a review of an SFO has resulted in the dismissal of staff at various levels over the years, including the Chief Officer of London after the Dano Sonnex case of 2009. In my view, the new Probation companies will face even greater attention, and potential criticism, from the media and politicians than the former Probation Trusts, which if seen to be justified can lead to long-term reputational damage and a ‘tainted brand’ – such as for G4S currently.
- 3.2. By their nature, these incidents cannot be prevented from occurring: As a very rough average, it can be expected that in any given calendar year for the foreseeable future there will be approximately 35¹ Serious Further Offences per year arising in the RRP combined area, although the figures will in practice prove to be very volatile, because these are rare and almost random events inside a big mass of cases. But while some of these SFOs will inevitably occur, the organisation can prevent them from developing into the consequences of reputational damage.

What the Board can hope and expect to achieve with its *RoH* work

- 3.3. The Outcome that RRP will need from each and every SFO that comes to Review can be worded in a number of ways, depending on the audience, such as “We did our job properly” or “We did all we could” – in short it is about being able to give a credible account. But this must be one that will stand up to scrutiny, remembering that some Reviews of such cases have been published in the past, so a plausible Press Statement won’t do it unless there is substance behind it.
- 3.4. In my former Chief Inspector role I asserted that risk of harm to the public could not be eliminated, but the public is entitled to expect that the authorities will do their job properly, and I note that this is still referenced in some of the NOMS guidance on the subject. I made it more specific for practitioners by stating that they should ensure that they have “taken all reasonable action to keep to a minimum each offender’s *Risk of Harm to others*”. In inspections we ‘operationalised’ this principle by examining representative samples of case files in each area, and made qualitative judgements about how far such “reasonable action” had been put into practice in each of the cases. *If every practitioner achieves the case outcome of “taking all reasonable action” in each of their cases, then when an SFO occurs RRP can achieve its collective outcome of being able to give a credible account and thereby minimise its own reputational damage.* This is therefore a **Defined** outcome for *RoH* work.

¹ MoJ Management Information release of 17/11/14, pp3-4, reports figures for the same 4-month period for the last 3 years of ‘SFO notifications’ that suggest an annual rate of 450-540 per year. The MAPPA Annual Report of 30/10/14 states on p10 that 174 SFO notifications were MAPPA-eligible offenders supervised by Probation Trusts in the year 2013/14, though all these figures bounce around a lot, as relatively rare events inside a big mass of cases. But we can conclude that on a very rough average the CRCs across England & Wales will report around 300 cases per annum in total, though this will fluctuate. Although RRP makes up about 14% of ‘national’ resources, it is about 11% of the total Offences Brought to Justice for year ending June 2014 [MoJ Analytics], so 35 per annum as a ‘ball park’ if volatile average is a reasonable projection for the whole RRP area.

What we know from the past:

- 3.5. In February 2013 HM Inspectorate of Probation published aggregated findings from its 'Offender Management 2' programme of inspections, providing three 'scores' from each area inspected for their achievement of each of the Three Purposes of Probation supervision. (The methodology involved making dozens of qualitative judgements by inspection staff on a representative sample of cases from each area, which were then aggregated quantitatively.) In relation to each of the Three Purposes, all of the four constituent areas scored above or close to the national average for England & Wales. Specifically in relation to the Purpose of minimising *Risk of Harm to others (RoH)*, where the national average was 75% at that time (part of a rising national trend), Derbys scored 80%, Staffs & West Mids and Leics each scored 78%, and Notts 74%. The national average at that time was depressed by the scores from London and most of East of England, so most of the RRP area was fairly typical of England & Wales as a whole, with Notts slightly below.
- 3.6. On a detail, it is worth noting that in the 2012 Inspection in Staffs/West Mids, an inspection conducted after I left, a segmented analysis of the case scores revealed the perhaps surprising result that better scores were achieved on average by PSO case managers than PO case managers. As I will mention again elsewhere, this point might merit some further consideration.
- 3.7. Nevertheless it is at least a broadly encouraging record from the recent past of 'doing *RoH* work well enough' in the two current CRC areas. In that context I now provide an expanded version of the Findings summarised in the chart at 2.5, topic by topic.

My Findings

(A) Strategic lead:

- 3.8. Evidence of a strong lead on RoH work comes from several sources. Policy documents have been well drafted with a clear emphasis on the importance of the work, and what management will look for; learning and development (training) has been making a strong and regular contribution for some time; senior managers have been deployed to see that this is implemented, and in the main staff across both CRCs perceive the demanding requirements being made of them by their leaders as being constructive in tone.
- 3.9. Additional: I believe it is fair comment to say that in the recent past most Chiefs across the country as a whole have been acutely conscious of the reputational damage that can be caused when certain types of catastrophic events occur, typically a child death or a high profile serious crime inflicted by someone under current Probation supervision (the term Serious Further Offence – SFO – is the common shorthand for such catastrophes). Indeed the Chief Officer of London lost his job as a result of the Sonnex case in 2009.
- 3.10. I believe it is also fair comment to say that some Chiefs in some areas reacted rather too strongly after certain notorious cases (even before 2009), and set an oppressive atmosphere in which practitioners feared a witchhunt whenever an SFO occurred. I was conscious of controversies in Nottinghamshire in the past, and I have learned that similar concerns arose in Derbyshire at one time. There was also some hint from the Staffs/WMids interviewees that there had been some comparable experiences there in the past too. Interviewees from a number of levels said that they thought that there had been the occasional example of a SWM staff member being disciplined formally but no one had direct experience of this.

- 3.11. The SWM CEO said that she thought that there had been rather undue emphasis in the recent past on satisfying the 'quality requirements' of the NOMS unit that reviewed all SFO reports received, and this perspective was consistent with a story I heard in an office location of an SFO being amended into a "harsher" judgement as a direct result of being 'sent back' by NOMS for revision. The current CEO had aimed to restore an ethos of 'learning' – to benefit future practice – to SFO reviews.
- 3.12. The practitioner expectation of how SFOs would now be handled, as best as I can ascertain, is currently cautious optimism, broadly speaking. None of the Derbys practitioners I interviewed voiced any concerns that management might treat them unfairly. In Notts two were able to recollect an unpleasant past – I was told that a senior manager had told an officer that he/she "was responsible for" a particular murder - but all were nevertheless cautiously optimistic that in the last two or more years the atmosphere appeared to have changed. An increase in cautious optimism was also now the tone in SWM, and appeared to have been the general expectation of staff in Leics throughout.
- 3.13. In case of doubt I should further add that I found no evidence that management had 'gone soft' on the subject of reviewing SFOs – but the tone for conducting them, set from the top, was a constructive one, in some instances perhaps a much more constructive one than in the recent past, though it might depend on the individual conducting the review. In short, the CEOs had broadly set a **Definition** of 'doing RoH work well' in a tone that enabled most staff to **Desire** to achieve it.

(B) Operational management: area and team:

- 3.14. Senior managers immediately below the CEOs have a variety of job titles, while typically the front-line managers who directly manage practitioners are usually called Senior Probation Officers – I shall refer to them collectively here as SMs and SPOs.
- 3.15. SMs in both areas felt directed and equipped by their CEO to organise arrangements in their respective 'sub-areas' to ensure good quality RoH work. Training programmes, and the training materials supporting those programmes, were of good quality, and supported the policy and practice directives from NOMS and from the local CRC. There are some details I could quibble with – some of the criteria could be simpler, and the guidance material more concise – but the overall thrust of the content of them is along the right lines.
- 3.16. Also in both areas SMs expressed high expectations of what practitioners should be doing in Child Protection cases, and cases where safeguarding children generally (SG work) was a consideration. Two spoke of the need for "monthly" home visits (HVs), though there was doubt about whether this was achieved - indeed, by self-report practitioners were strong on getting an early HV in at start of supervision but vaguer about HVs after that, although in every other respect they displayed acute awareness of their responsibilities to make their proper contribution to SG work.
- 3.17. As described above, most practitioners have expressed to me reasonable confidence that they would be dealt with fairly should they have a case reviewed after an SFO has taken place, even though they are sometimes aware of colleagues who have been either disciplined or dismissed following such a review. Although any practitioner will always want to offer human support to a colleague who is experiencing a hard time, most have a sense of when a colleague has probably failed to do what they should have done, and understand that everyone has to be

accountable for their performance. But a few felt that it might depend on the individual reviewer of the case as to whether you would be treated fairly.

- 3.18. As for the documents I have received and read, some are current from the period of the new CRCs, while others are from the predecessor Trusts. On one level the older documents are informative and full of positive intent, and their content is full of items that I would expect to see; on another level I am conscious that they are lengthy and well intentioned – full of noble aspirations and detailed prescriptions of how to do the job properly. The problem is that for the majority of practitioners, who are dealing with 30+ to 70+ cases each at any one time, it is difficult to see the wood for the trees.
- 3.19. It was clear from my discussions with practitioners that they valued the short, graphic ‘step-by-step’ guides that enabled them to complete a specific task at the moment they needed it, while the large well-intentioned guidance manuals were in reality rarely touched. The ‘step-by-step’ guides were examples of **Designing** a work process, and **Equipping** staff to implement it, so that they could get on and achieve the **Desired** and **Defined** outcomes.
- 3.20. A useful example of **Defining** the required outcome appears in Paragraph 21 of the 2012 Leics DV policy statement which states that:
“The key [desired] results are: -
 - Repeat incidents of domestic violence reduce year on year
 - Target for IDAP completions is met
 - Number of SFOs where deficiencies in relation to the assessment or management of domestic violence decreases.”
- 3.21. I might quibble with some of the detail of this paragraph, but I strongly support the principle of senior managers seeking to steer practice by Defining *what practitioners are required to achieve* (but maybe more prominently, in a different document?).
- 3.22. Some other more recent guidance documents are also more useful to practitioners – such as the worksheets – but I think that the strategic route to guiding successful practice in future will be one that is still more concise and focused on the Defined outcomes, being clear that **what** outcomes to be achieved are Prescribed, while **how** they are achieved is Advised.

(C) Practitioner understanding:

- 3.23. Despite my reservations about some of the management’s documents, as above, it is only fair for me to record that the majority of practitioners I interviewed showed a good understanding of what their managers expected of them. They worded it differently – for example, with Derbys respondents all citing correctly that “more SFOs come from Medium/Low cases than from High RoH cases”, while Notts respondents referred to making defensible decisions – but the broad thrust of their understanding was correct. The appreciation of the importance of protecting children, and how to do it in practice, came over particularly strongly in Notts, while what was required to protect potential victims of Domestic Violence was strongest in Leics.
- 3.24. In Staffs/West Mids, the comment was frequently that “Risk of Harm can change rapidly” or “Our task is to manage **dynamic** RoH”. Meanwhile, staff of Unpaid Work tended to talk about Safety – and made it clear that this included ‘Safety of the public’ – and illustrated how they took, correctly, a wide view of this responsibility. However, the differences in language on this point were not significant in my view, reflecting the different ways different practitioners discuss their everyday work with each other, and on this particular matter the important thing was that there was very strong

understanding among staff across the two areas that *RoH* work continued to be a very important consideration in their CRC duties.

- 3.25. Almost without exception, practitioners across both areas were able to list the things that they expected managers to look for in the event of a Review following an SFO, and some could also make the more general point that there would need to be defensible decision-making, and as a whole the case would have to stand up to scrutiny. Although some of the practitioners in Notts referred to a recent past period when there had been a general concern that managers were expected to conduct a witchhunt when an SFO was being reviewed, and there was vague mention of a similar view in SWM in the past, the widely expressed current expectation was that managers were now likely to treat practitioners fairly and constructively during such an eventuality, even though they would still be asking some hard questions.
- 3.26. More generally, it was noticeable to me that although there has been extensive publicity about the fears that many practitioners have about the approaching future following the Transforming Rehabilitation (TR) change, I found a strong element of optimism, or at least a constructive attitude, by the great majority of the staff I met. Several said of their own volition that they hoped that they would have the opportunity to work more creatively within the new arrangements.
- 3.27. Having said all that, I now have to add that as my interviews with practitioners and front-line managers progressed I started to note what seemed to me to be a curious anomaly within the understanding of some operational staff of their *RoH* role and responsibilities in certain circumstances – so in my later interviews I pursued the subject more directly. It concerns an aspect of work in Domestic Violence² cases, and it contrasts interestingly with how ‘Probation’ helps to ‘Safeguard’ children.
‘Confidentiality’ v Disclosure to new partners – see Recommendation 1 at para 2.7:
- 3.28. Solidly, across the two areas, practitioners expressed a clear focus on the priority of their duty to help protect children from potential harm, whether or not the person directly under their supervision agreed with their actions. For example, if a person with a DV history starts a relationship with a ‘new’ woman who happens to have children at home already, there was unanimity among my respondents that there was a clear duty to refer the matter to statutory social services³ (SSD) who as a last resort might even intervene to take the children away – and they would do this even if the person under supervision objected.
- 3.29. Yet among my respondents, both practitioners and managers, there was much less unanimity about what their responsibilities would be if the prospective new partner did not have children. There were some practitioners, in all the constituent areas, who were clear that, having first done their level best to secure the cooperation and consent of the offender for his supervising officer to meet his new partner, would nevertheless as a last resort arrange to see her whether he liked it or not. There were others who were much less clear about this, and who expressed concern about breaching confidentiality or potential comeback on the new partner.
- 3.30. I put it to these respondents that the same arguments could be made concerning children, and yet all practitioners seemed clear about their role with children. Why not

² Terminology: a SWM circular cogently argues that Domestic Abuse is a more appropriate name for this subject; but while I have no personal preference myself, I note that currently everyone seems to say “Domestic Violence” or “DV”, and I’ve gone with that usage here throughout.

³ Terminology: each local authority now has its own name for the department whose job it is to safeguard children, so for simple consistent clarity I’ve used ‘social services’ department (SSD) throughout.

be equally clear concerning an (arguably) vulnerable woman who might not have realised what she was letting herself in for? As stated earlier, the worst eventuality is a future dead body and a grieving mother who wants to know why “nobody warned my daughter that her new boyfriend was currently on Probation for battering his previous partner.”

- 3.31. Although the figures on the two databases show broadly that a fifth or a quarter of current cases are ‘flagged’ as DV (see Appendix), almost all Probation Officer case managers reported much higher proportions of DV cases among their own – this could largely be explained by the fact that, since there should be very few DV cases held by their PSO colleagues, POs would be holding a higher ‘share’ of the numbers held within each team as a whole. In any event DV appears to be by far and away the single most prominent issue that each PO has to deal with, and even for PSOs, the issue must be just as relevant to them as Safeguarding (SG) Children is already.
- 3.32. This all makes it important at a strategic level – not just as an operational detail – that practitioners and their immediate managers should be as clear about their role ‘in the last resort’ in a DV case with a new partner who has no children as with one who does. As an external reviewer I don’t like to make recommendations to managers about *how* they should do their job – my preference is simply to recommend that a certain outcome be achieved, as above – but I will offer some observations about methods for consideration:
- 3.33. To take SWM as an illustration: There is an April 2013 Policy and Procedure Implementation Circular with Practice Guidance for Domestic Abuse cases, 54 pages long, which as far as I can tell nobody has read. (If they wanted to read it its filename of “10-2013” might not make it particularly easy to identify.) In any case its section on Victims is all about past victims and not about potential new victims and certainly not about ‘disclosure’ to them – or I missed it if it was there. In any case I very much doubt whether a longer version of a document of this nature is the answer to this problem – see also Recommendation 2 at 2.8 above.
- 3.34. Instead, experience tells me that practice becomes ingrained with practitioners through its prominence in training arrangements, linked with the ‘social’ importance it grows among groups of practitioners who then reinforce its development together, supported by genuinely workable ‘enablers’ provided by managers such as the concise worksheets to stimulate sessions and step-by-step guides for getting procedures done smoothly – both of which I’ve seen good examples of here. One step worth considering is that if we want people to be as clear about disclosure in DV cases as they are with SG cases, then perhaps a thorough and persistently scheduled and structured series of training programmes should be devised and implemented for DV as they already are for SG⁴.

Other potential Disclosure issues:

- 3.35. I would add as a further point that there are other potential ‘Disclosure’ issues that can also arise in a practitioner’s *RoH* work with cases. In my own time as Chief Probation Officer prior to 2001 two cases came to me about disclosure to a potential employer. One was a drugs offender who the Community Service (now Unpaid Work)

⁴ Related point: Three practitioners in SWM said things like “We don’t talk to victims”, or expressed doubts about doing so. When pressed on the subject, one said “I think we were told in our original PO training that contacting victims was a problem and could be a conflict of interest.” They knew things had changed since then, but were unclear where expectations lay now.

officer had learned had just got a job in pharmaceutical lab – “Should I tell the lab that this is a drugs offender?” – and the other was a man who had made a series of calculated thefts from a previous employer for whom he had been a live-in helper, and who had now got a job offer from a retirement home. In the latter case he was already threatening my officer with a suit for breach of confidentiality should he make contact with the retirement home⁵. On both occasions I advised to ‘go for it’, a view that I think would be shared now by a number of staff in the two CRCs, but which might well not be shared at all by others. It appears to me that there is among many staff considerable caution, for understandable reasons, concerning ‘confidentiality’.

‘Confidentiality’:

- 3.36. Of course it is right and proper that personal confidentiality should be respected most of the time. But it has become well established, even in European law, that it can be put in second place in certain circumstances if there are considerations of public safety, and when it comes to protection of children this point is well established and understood. Yet, although some staff were confident and (relatively) comfortable with a wider interpretation of their potential duty to disclose, some others expressed great concern about where they might stand should they ‘breach confidentiality’ in other respects. One SWM officer told me that “Head Office” had advised him that he couldn’t tell the mother of a dead probationer what her son had been ‘on Probation’ for before he died, for reasons of “confidentiality”, while others expressed concern about potential legal action. On the other hand, also with SWM, I was helpfully shown the Induction form in which a new person under supervision signs to say that they understand that their personal information may be shared with others “if there is a risk of me causing harm to myself or others” (though the subsequent qualifier reintroduces an element of doubt).
- 3.37. From my perspective the Induction form is interesting but not ultimately the key point. The view I took in 2000 was that I would welcome Court action by an offender who sought to sue us for advising his potential employer that his previous conviction was for a breach of trust theft – a substantial one – from his previous employer when acting in a comparable role. While I was only 90% confident at the time that we would win such a potential Court action I was very confident that in the event of publicity the media and public would be on our side. (There was no Court case.) All this was at the time when I was nationally an enthusiastic national Lead Officer for getting offenders into jobs! – but only ‘safely’ into jobs.
- 3.38. My point here is that the issue of Confidentiality v Disclosure may need to be looked at in the round, beyond simply the DV new partner instance, to develop a shared understanding in *RoH* practice generally within both the two CRCs – and not to try and achieve this shared understanding by writing a lengthy manual about it.

(D) Practitioner Implementation:

- 3.39. Moving from Practitioner Understanding to practitioner implementation, as already stated the evidence for it is by necessity very finite at this stage. The way almost all practitioners talk about their practice gives a positive picture – in the main they are able to describe the practical actions they take to ensure that they can demonstrate that their work with a case would ‘stand up to’ an SFO Review should one become

⁵ Both of these episodes did of course arise before Criminal Records Bureau (CRB) checks were introduced, but even now comparable dilemmas could still arise in the real world.

necessary. When this is taken alongside recently available evidence, it is reasonable to infer that most *RoH* work is indeed probably Sufficient in quality in both CRCs.

3.40. I am very aware that academic researchers and management consultants rarely conclude a report without recommending that 'further work needs to be done', and so it is not lightly that I pursue a similar course at this point – at least I indicated before I started that a Phase Two would be advisable. Naturally the Board will want to be very prudent about how it spends its money, as I would in its place. So for the Board's careful consideration the points I will make about the potential Phase Two are:

- An independent assessment of a representative sample of cases would inform the Board about the extent to which the work was actually being done well, rather than just being self-reported as being done well
- A number of my interviewees of all grades have voiced, without any prompting from me, their hope that the case assessment exercise takes place, as it would be seen as helpful and informative for them
- If its design is integrated with the prescribed Definition of the outcomes to be achieved, and the Design of the work processes to enable it – which it would be – it provides an immediate stimulus to steer practice in the direction of the concise and focused approach needed in the future, i.e. it would not just be passively 'looking back' but actively 'directing forward'. (The arrival of the contracted Service Level targets would need to be taken into consideration.)

(E) Partner agency experience: [not yet complete]

- 3.41. I discuss briefly the experience of the CRCs' staff of other agencies further below, in Level Four, while the purpose of this section is to consider how the CRCs are currently perceived and experienced by their partners. At the time of writing, the letters sent on my behalf to the various partners only started going out on 13th February, so many replies are still awaited.
- 3.42. At the current early stage, a Police reply, from an Integrated Offender Management (IOM) perspective, has been very positive about the benefits of co-working based on co-location, confirming benefits I outline elsewhere, with the main negative comment on operations being about "Reduction in information sharing as CRCs no longer have access to all cases" – which as we know is a matter outside the CRCs' control. (When a case is closed, the access to the information in that file, other than the very top line, is also closed to the CRC. The Police then have to refer to the NPS, who retain access to information on closed cases.)
- 3.43. I will offer an updated version of this report when a good proportion of replies have been received.

Overall: Strategies for *Making Probation work*:

- 3.44. If effective practice is Doing the Right Thing with the Right Individual in the Right Way at the Right Time, why has it been so difficult until now to promote such practice, even allowing for the fact that case numbers per practitioner are far higher for Probation than for their counterparts in Youth Offending Teams? I have written elsewhere about the general need for managers to Define success, Design work process, promote Desire by operational staff, and Equip them properly to do the job; there are implications for making that work effectively in reality.

Accommodating the NOMS-contracted Service Levels:

- 3.45. To be frank, the list of required Service Levels has the potential to cut right across the crisp concept of Defined success that I believe is necessary. However, from my brief discussions with the two CEOs I foresee that they will be able to convey the message to staff that the Service Levels are details that the CRCs will have to accommodate within the wider strategy of the organisation. The danger they know they must avoid is allowing the staff to gain the impression that these Service Levels are simply the latest list of unshaped prescribed targets that will now be the primary drivers for the organisation for a while until NOMS changes its mind (again) – the usual demotivating cycle. Instead, your people should be able to set their sights on a more concise and focused (and shaped) Definition of success, and treat these SLs as simply something that you collectively will arrange to ‘accommodate on the way’.
- 3.46. Moving on from that, it may be useful here to look at some of the specific current arrangements that sometimes do, and sometimes don’t, promote effective practice.

Policies, Manuals, Guidance and Training:

- 3.47. Because providing an individualised service is complicated, Probation has maintained a knack of making much of its management and training materials complicated, often because the focus is on the actions that might have to be done rather than on what achievement is wanted. The supreme example was the introduction of very hefty National Standards in the early 2000s, followed a few years later by their demise because they were unworkable in practice, however well intended. I found, and prompted the speedy abandonment of, similarly huge practice manuals in the New Zealand Community Probation Service. (Of course, now the emergence of the contracted Service Levels looks like a partial return for them.)
- 3.48. With both CRCs I have in my swift perusal of materials sent to me found a mixture of both useful focused materials like one-page worksheets and graphic flowchart-style step-by-step guides, and some of the old-style well-intended hefty guidance documents. Clearly I cannot claim that my sample of interviewees was representative but of those I did ask only one spoke with any familiarity with – for example – the local guidance on Domestic Violence/Abuse. They did speak more positively about the training they’d received, and some of the worksheets they were able to access, but given that DV is such a large part of the workload of almost every Probation Officer it might seem surprising that the informative guidance is not referred to much.
- 3.49. I feel reluctant to sound unkind and critical of documents that have been devised with the very best of intentions, but experience demonstrates that they just don’t work. As always, because every individual and every circumstance is different there is an attempt to cover for every eventuality, and when the document is drafted by a group a lot of possible eventualities are thought of. The aim is to be comprehensive, but this

cannot be achieved; gaps like the SWM Domestic Abuse guidance not including the problem of the new partner become a problematic area of doubt, while if comprehensiveness is perceived as achieved, this benefit turns out to be an illusion, because it is too weighty for most staff to use. There is also the problem that it conveys an implied 'counsel of perfection', by appearing to spell out every detail of what 'perfect practice' would look like at every stage of any case.

- 3.50. This can have the paradoxical effect of making busy and pressured staff feel dispirited that such implied perfection seems impossible for them. It should be remembered that in reality, practitioners have about 20-30 hours per year on average for each case (face-to-face AND all other supporting activity), or maybe 30-40 minutes a week per case – in a year's time it may well be less. It would be better to be clear and straightforward in the giving of operational directions: "We know you've only got this much time per case per year on average, so please focus your efforts on achieving the following Three Purposes [or whatever], and this is how we Define whether those Purposes are being achieved: [etc]"
- 3.51. In other words you Prescribe what is to be achieved, and there is no choice about that – though well-chosen prescribed outcomes will *both* achieve the organisations' objectives, including PbR, in time, *and* also inspire the Desire of practitioners to deliver them. As for the How they are achieved, this is where the worksheets, guidance and training come in – but explicitly as Advice. Practitioners can and should exercise their discretion – and be accountable for doing that – and they can also look to their management for relevant support, materials, and training to help them achieve. With increased responsibility and discretion comes increased accountability, so there is both a cost and a benefit with this approach for practitioners, but the more skilled, confident and creative ones will prefer it, as they did in New Zealand. The one key thing they are especially accountable for is demonstrating that their work is firmly focused on aiming to achieve the Prescribed outcomes (the Three Purposes in my approach). Well-Designed work processes will also be necessary to support this – but again the requirement for contracted Service Levels adds a most unwelcome complication to the approach I am advocating.
- 3.52. In my opinion the reason why practitioners value the training and the worksheets is that these usually already fit the role of Advising the staff rather than directing them. What the materials often lack, however, is sufficient focus – because both the subject matter and the required outcome have not been defined clearly enough in advance. To take as an example the SWM training on Risk Assessment, which I have to be mainly complimentary about because it draws on a lot of material I once produced, I noted that a lot of time was spent clarifying what the course was about, and the desired outcome, whereas in a future world those definitions would be clearer throughout the organisation already and need occupy much less time on the course.
- 3.53. Hence my Recommendation 2 – at 2.8 above – that concise and focused documents are desirable, and would be consistent with promoting concise and focused practice.

ICT Infrastructure and software:

- 3.54. I asked almost every member of operational staff about their usage of N-Delius and OASys, and it is important to note that there were some variations in the comments made. I believe that perception is strongly influenced by the individual's expectations (which have in turn grown out of personal experience), and this may account for elements of disparity. For example, the staff that tended to be most critical of

N-Delius were those from the old West Midlands area of SWM – they had previously had a version of Delius, which people now refer to as “Legacy Delius”, that they unfailingly described as far better than the national version that replaced it. The criticism of N-Delius from the staff of the other areas was less strong, although only a very few simply said that they could ‘get by’ with it. If you’ve never known anything better then your expectations are not as high as those who have known better.

3.55. I noted a large number of criticisms, but the ones that most struck me were the ones that made everyday (or every-minute!) work actions unnecessarily irritatingly onerous – although I have not of course been able to verify these in person:

- Number of clicks: All reported that you have to click through numerous screens to do the job at hand; a PO stated that it was six clicks just to get to the Contact log to make an entry. Another said that it was 24 just to write a letter.
- To prepare a breach report to take someone back to Court involved going in and out of the case record several times in order to attach the related reports to the application. (Some said that the ability to attach documents to the case record was a step forward compared with the past, but the interaction between them and the record was so unwieldy that even writing a simple letter became a trial to do, as above.)
- For SPOs, the simple-sounding task of entering a Countersignature on a Recall report involved numerous clicking backwards and forwards to add the necessary comments and then sign off. Since the report then had to go to a senior manager one SPO got round this by printing the document off, making his brief entries, and then the senior manager’s secretary put the SPO’s and the SM’s entries on together.
- The most utterly frustrating feature (in my opinion) has to be that the system ‘times out’ but does not tell the user it has timed out until you press ‘Save’ for the entry you have just made; only at that point does it say timed out and your entry is lost and has to be redone. Given that the job is full of interruptions, timing out is a constant hazard, but unless you take precautions you risk losing your current work since don’t know you’ve timed out until it’s too late. The ‘precaution’ one user said he always took was to make a copy of his entry before pressing ‘Save’ – a good workaround, but hardly the efficient work process one would want for staff. Needless to say, since ‘demonstrating you’ve done your job properly’ (paraphrase) is the key performance measure for RoH work, the current system is poor at assisting staff to achieve that.

3.56. The position with OASys was more nuanced. At one extreme there were a couple of practitioners who said that they simply hoped that RRP would ‘do away’ with OASys altogether, and clearly saw it as serving no useful purpose. But for most of the operational staff there was a clear recognition that either OASys was useful or it ought to be useful, and tended to speak of it needing to be shorter, less “repetitive” and less time-consuming:

- Length: A common suggestion was to ditch the 11 sections concerning the ‘criminogenic needs’, i.e. the factors that might lead an individual to be more likely to reoffend. These respondents would like just to do ‘basic Layer One’ OASys. Other ideas were less drastic.
- Repetitive: Whereas OASys rightly seeks to get the officer to assess ‘what the problem is’ and also plan ‘what I’m going to try to do about it’ the separation and sequencing is all wrong. It was rightly pointed out to me that you shouldn’t have to go through each of the 11 sections one by one *twice* in order to do this. Instead, under each of the sections that apply to that individual, you should be able to do both your assessment and your plan in one go.
- Time-consuming: When asked how long to do an OASys from scratch – not always but quite often necessary – the responses varied from a firm definite “a whole day” to about one hour, with three to four hours being a common answer. Two former secretaries separately

said to me firmly that the issue was not about keyboard skills; it was about collecting the necessary information and deciding on each entry. From my own previous experience I have sat alongside a particularly able practitioner who showed me on the screen how she could and did enter concise, focused, pertinent, and sufficient entries and complete an OASys in about 40 minutes – but I don't think that such speed and quality of practice could be readily made universal!

- Also time-consuming: I heard a range of accounts about 'updating' an OASys entry, and without going into too much detail the issue was whether you had to go through the form in every detail in every section just to update the perhaps one section where you wanted to note an important change, or whether you just clicked through those other sections and risked being criticised later for 'doing an inadequate OASys review'. This was an effect of OASys requiring one single 'sign-off' date at the end of the document, implying confirmation that every entry was up to date for that single date. In contrast, Asset, the system for Youth Offending Teams, is more flexible in allowing individual sections to be individually dated.

- 3.57. OASys ought to have been the most important single step in supporting effective Probation practice for decades, but its weakness is caused by exactly the same syndrome that I described earlier about Probation's traditional bulky guidance documents and manuals. It tries to allow for every eventuality, and aims for comprehensiveness, and there was clearly a fear that anything less would risk seeming incomplete. Once again there was an implied counsel of perfection, that leads some officers to spend hours trying to achieve it, and others feeling disabled and wishing it would go away. Either way it certainly does not promote the Desire by practitioners to deliver what their managers require of them.
- 3.58. When designing the Offender Management Inspection programme, I stopped my inspectors from criticising assessments and plans for not being "comprehensive", and in this and all other inspection criteria what we sought was 'sufficiency'. While excellent practice was to be noted and celebrated when we found it, the 'pass mark' was in plain English to be 'good enough' or 'fit for purpose' – *Sufficient*, we said. In the future Design of the work process, and in the ICT infrastructure provided to enable that to operate, it is when it is concise and focused on the Defined outcomes that staff can get away from the pressure to be perfect and instead focus also on achieving those outcomes.
- 3.59. Clearly, in principle one would want a successor to OASys integrated into a more user-friendly successor to N-Delius. Both would be constantly pointing the user towards the required outcomes, as Defined, although the specific detail of what would be needed to do that with my Purposes One and Two would be where most of the effort to achieve an integrated Design would need to go. But in principle staff should be required to record actions and decisions that are about the planning and achieving (and progress towards achieving) the required outcomes, while any additional recording should in principle be optional – there for whatever that practitioner finds useful. I could discuss what this might mean in practice for a radically streamlined concise and focused successor to OASys another time.
- 3.60. In Recommendation 3 I have said that staff should be Equipped with an ICT infrastructure that is integrated with the Design. In relation to the *RoH* work of the two CRCs that would include among other things the ability to scan easily the officer's plan to keep the offender's *RoH* to a minimum, and the recent actions taken to carry that out, and the pattern of recent contacts and events that indicate how well that is going in practice – currently OASys and N-Delius only do that through disproportionately laborious effort.

The career path for practitioners:

- 3.61. There is no doubt in my mind that some practitioners are – and need to be – more skilled than others, and solely for the purpose of this section in this report I could temporarily refer to them as the Higher and the Lower practitioners. Undoubtedly CRCs will continue to need Higher practitioners for some of their work. No doubt some people will still argue that *all* cases should be managed by such Higher practitioners, though for a combination of reasons I think that that argument is in reality now long gone. Most now accept – some more happily than others – that there are many cases that can be managed effectively by Lower practitioners, and many benefits have been gained because of this. A key question that this raises, however, is whether you keep these two groups of practitioners in inflexible watertight compartments, with a highly regulated doorway between them - which over the years has had pernicious effects on Probation both in its operation and its consequences.
- 3.62. If you argue for a single Probation Practitioner grade, as I do here, you risk being accused of wanting to dumb down the skills of the Probation Officer grade or reduce practitioners to a low common denominator. My point however is that while I do want only one single grade for Probation Practitioners I do also recognise and want to retain the concept of different levels of skill/ability. The key difference would be how each member of staff moves through (or not) the career path in front of them.
- 3.63. It might also be worth a moment to reflect on the Inspectorate finding I mentioned in para 3.6, that the sample of cases inspected in 2012 showed more work achieving the Sufficient level of quality where the case manager was a PSO than where the case manager was a PO. Since the inspection test was always 'Sufficient for that case' this would not have been reflection of managing 'easier cases', and was anyway not a finding in other areas. It would be entirely wrong to draw dramatic conclusions from this already-historic finding, but I also think it wrong to make assumptions about what a PSO might be capable of achieving over time.
- 3.64. For over forty years the title of Probation Officer has been reserved for those who have a particular qualification, the name of and arrangements for which have changed a number of times, but have always involved a formal period – usually two years until recently – in the post of Trainee Probation Officer. Until the very recent past it always involved resigning any existing post, taking up the TPO post, and taking a substantial drop in salary/income. If you had come into Probation as a PSO, worked a number of years in that role, and were considering becoming a PO, the practical disincentives were massive, especially if you had dependants: a drop in income, plus potential pension and continuity issues, and the uncertainty of getting a job with one's preferred employer on return.
- 3.65. My interviews with staff revealed in passing – as ever – the personal experiences of officers who were either PSOs now or had been at some point earlier in their career, and they confirm this perverse picture – see the footnote further below. One current PO additionally spoke about her own experience of being made to feel very 'second class' in her office when she had been a PSO – and she aimed to be very different in how she treated her PSO colleagues now.
- 3.66. With current PSOs one can normally identify – and I did again in these interviews – two broad syndromes. Some actually like being 'protected', that is to say that they enjoy working with the cases they have but would not like to have to deal with the more difficult cases where the responsibilities may well be greater. They welcome the

'rules' in allocating work that 'protect' them from being given those difficult cases. But there are also some, as ever, who find such 'rules' irksome and demeaning to them as practitioners who are trying to learn and develop their skills. With the path to becoming a Probation Officer now becoming even more unclear yet again in the new world, the prospects look discouraging for such PSOs.⁶

- 3.67. I would be perfectly content to see the job titles Probation Officer and Probation Service Officer retained, provided that they were re-established within a single Probation Practitioner grade for career structure purposes. The doorway between them should thereby be far more flexible than it is now, but should still be properly managed – no competent manager should allow a difficult case to be managed by a member of staff who does not have skills for that task. But those PSOs who are looking to be stretched as part of their development could build their practical skills by taking on gradually more difficult cases within a managed programme that could include theoretical study as part of a vocational qualification.
- 3.68. The approach advocated above is particularly relevant to the issue of RoH work, since currently PSOs across the organisations, from Unpaid Work staff to drug workers, other specialist providers, and practitioners managing cases, all have to be able identify potential concerns with cases, and changes in current circumstances, and then 'know enough to know' that at the very least they should notify their manager for possible action – and all I met did seem to know this. But the career path forward, for those who wish to pursue it, could be greatly improved, and would embed long-term skills and experience into the future of both CRCs.

Front-line management of practice:

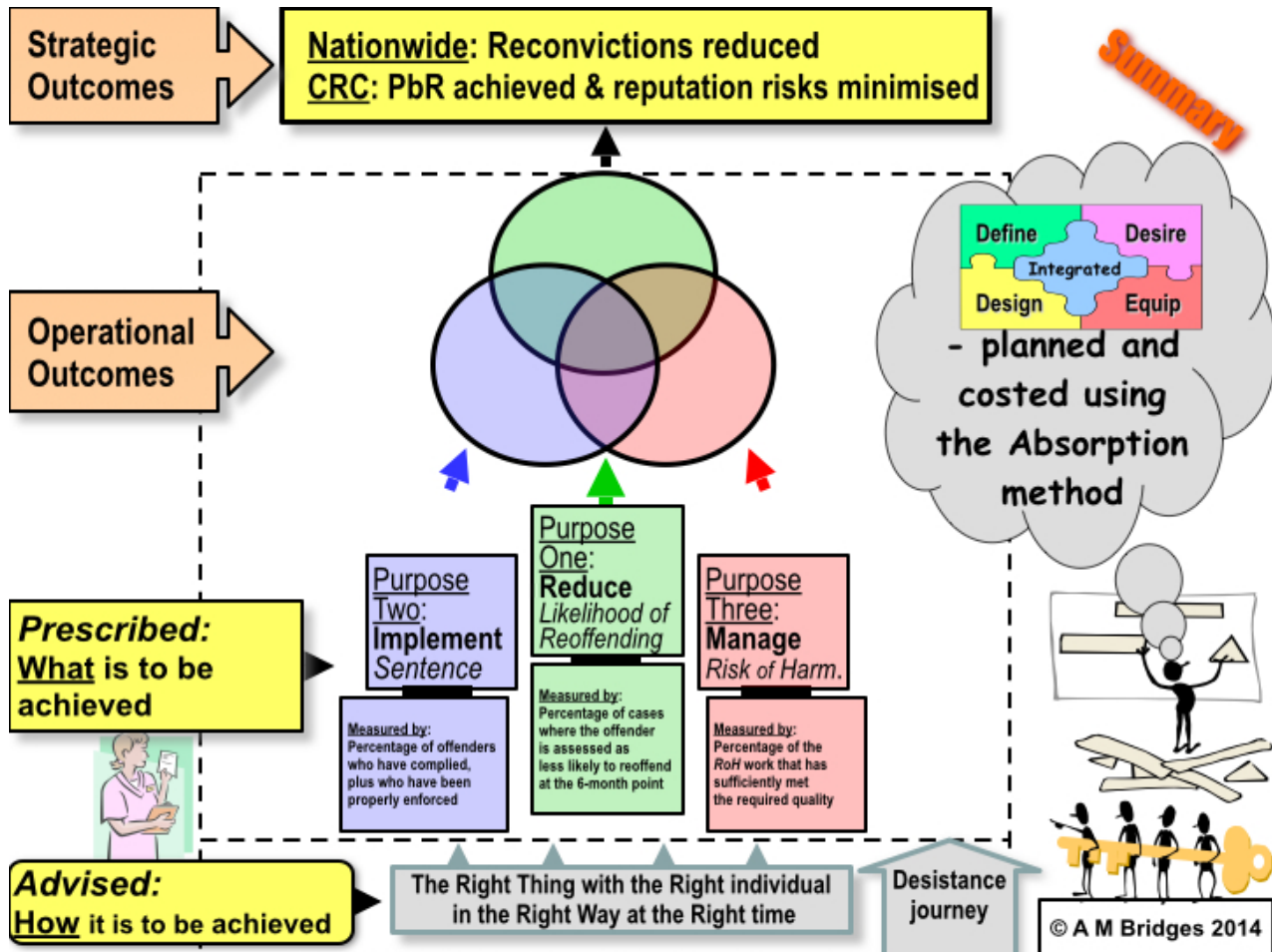
- 3.69. I doubt if it will be a surprise if I say that the particular upheavals of the last year or so may have had some impact on the nature of how front-line practice is managed. On the positive side there is much to be commended, based on the oral accounts I have received from a wide range of practitioners across both areas, as well of course as the self-reports by the front-line managers – SPOs usually – themselves. From all the interviews there were only two instances where the practitioner hinted that their SPO might be doing little more than passively responding to requests for help. Most were very positive about the accessibility of support and advice from their SPO (and often from other SPOs when their own was unavailable), informally through the proverbial 'open door' in addition to formal one-to-one meetings, "supervision sessions". I found virtually no sign of the complacent 'I'm too experienced to need to bother the Senior' syndrome that I have experienced directly in other organisations in the past. There was a strong vote of confidence by practitioners in the support they were receiving from their Seniors, especially at this time of anxious upheaval, and in terms of keeping the core work of the CRCs going this achievement should be noted.
- 3.70. Respondent almost invariably reported that formal sessions were held "monthly" or thereabouts, though it might be interesting to verify at some point how many are actually recorded over the course of a year. My own past practice showed me that –

⁶ Three practitioners had been PSOs for over a dozen years each. A remarkable combination of personal and organisational circumstances had resulted in two of them never getting onto a TPO course despite strong endeavours, although other qualifications had been achieved in 'own time' to date during the full time career of one of them – and currently the new requirement for a previous 'relevant' degree was now blocking the path for both of them. The other had felt it necessary to decline applying for a TPO post in c2004 solely because of the potential cut in income at that time (personal circumstances).

because of leave etc – if you get ten sessions in over a year in a big team you are doing really well. And it was in the discussions of where ‘responsive support for the practitioner’ crosses over into ‘management monitoring and oversight of practice’ that a more mixed picture emerged. More than one senior manager (SM) expressed the hope that SPOs directly observed practice and conducted regular audits of the cases of their team members, in particular checking the cases with ‘Risk Flags’. No one mentioned having had their practice directly observed by their Senior recently, as part of how their SPO managed them, although one reported that such a session was now planned in the diary, and a new SPO described plans to do so, and the story was very mixed in terms of how far their manager scrutinised the cases **other than** the ones ‘brought up’ by the practitioner. One felt that previous SPOs had been “nice” but frankly ineffective, but was very complimentary about the current one, including saying, “I feel monitored”.

- 3.71. Many said that their SPO ‘went through’ the list of their cases, especially those ‘flagged’, during their formal sessions, and there is some value in that – but it won’t tell the Senior what might be being missed, if the practitioner does not mention it. There were some who said that their SPO picked cases at random to read and discuss, and a few who said that they occasionally found that a ‘management oversight’ entry had appeared on their case file. Mention was made of ‘OASys Quality Audits, though current implementation of it was unclear, and in SWM there were two ‘Risk Review’ checklists, one of which had been introduced in 2010 for SPOs to use when checking Risk Flag cases periodically. Also in SWM I am aware that there were three Safeguarding audits (i.e. in three Local Delivery Units LDUs), and a partially completed internal Inspection and Audit programme.
- 3.72. One practitioner had felt thrown in the deep end in the summer of 2014, without SPO supervision at all, but this was now being picked up with a proper programme of sessions by the incoming Senior. From this and my not-necessarily-representative other interviews it appears to me that the scrutiny aspect of the work of SPOs may well have diminished during the recent considerable upheavals. While I would be reluctant to recommend a specific regime of routine excessive ‘case checking’, which can easily turn into a bureaucratic burden that squeezes the life out the practice one is trying to improve, I think that both CRCs may benefit from giving attention to how SPOs find a (new) balance between their support and their scrutiny roles.
- 3.73. Conclusion to the Level Three report:
- 3.74. The strategic point I’m making at the end of my Level Three report is that a number of key long-term considerations need to be integrated – made consistent with each other – if effective *Risk of Harm* work is to be promoted, and if that *RoH* work is to be promoted within the bigger picture of Making Probation work. That overall picture is summarised in the graphic that follows on the next page.

A summary picture of what Makes Probation work:



My approach to allocating resources (the Absorption method), and my detailed discussion of the measuring of the achievement of the Defined outcomes is beyond my present brief, but is available on my website, and of course I would be happy to discuss with anyone interested.

Level Four – Additional observations + a recommendation

- 4.1. During the course of this review a number of points of interest struck me, some but not all of which were very directly related to the subject of *RoH* work, but I felt that I would report a number of them here for the potential consideration of the operational managers and staff of the two companies.
- 4.2. I start with a recommendation about operational strategy. It's in this Level Four report as it is an operational matter that is not directly about *RoH* work, but it emerged out of the process of conducting this review.
- 4.3. **Recommendation 6:**
Stop 'normalising' Unemployment; arrange to make Employment the norm
- 4.4. I realised, as I spoke with practitioners and managers across both areas, that more often than not it was still the case that induction groups and work groups and other organised activities were being organised for during the day – 'office hours'. Yes, alternative arrangements could be made for the people who 'inconveniently' happen to be in work, but this made Employment the exception instead of the norm.
- 4.5. The alternative is to make arrangements so that the 'normal' position is that they are designed for people who are Employed, i.e. the main induction groups, accredited programmes, work groups etc are in the evenings and weekends. This may well involve a major strategic – and perhaps cultural - rethink, because a number of the offices I visited had just one 'late evening' per week, often only until 7.00pm.
- 4.6. Some background: In the late 1990s I was the national Lead Officer for promoting offender employment for the then Association of Chief Officers, and when I was Chief Probation Officer for Berkshire the national movement towards running accredited groupwork programmes was in full swing. To the dismay of my groupwork team, I insisted that they ran their programmes in the evenings, and arrange for the Reading office to be open for three evenings a week to accommodate this. I did not like the previous arrangement whereby if someone started a programme – in the daytime - and then gained employment he was then obliged to come off the group, and a special arrangement had to be made to accommodate him. I wanted the message to be that the organisation treats being employed as 'normal', not as an exception that we would have to find some way of working around.
- 4.7. When I came into the Inspectorate I was astonished to find that when we visited various Probation areas it was often still the norm for most groups to be daytime, with the typical provision that "If they do get a job, we move them onto the evening group – we'll have a problem if too many of them get a job!" - I heard similar light-hearted comments during this review. There have often been similar issues for Unpaid Work (Community Payback). It arises, of course, because most offenders under supervision are indeed unemployed (typically 50-60%), and it suits us to accept this as the norm. But perhaps we should want that to change?
- 4.8. In relation to those on Jobseeker's Allowance there is a further growing consideration – that increasingly they are being required by Jobcentre to undertake structured activities, whether jobseeking or 'job-substitute' activities. It was a growing problem even 15 years ago that certain daytime Probation activities such as groupwork were sometimes cited by Jobcentre staff as meaning that the person might therefore be 'unavailable for work' and therefore no longer eligible for JSA, and whether or not that is still a specific issue it seems to me unnecessary for jobseeking and Probation activities to compete for time in this way.

4.9. Clearly this point was not my main subject-matter in this review, and therefore I have not conducted an audit of office opening hours or organised activities. But it would not be difficult for CRC managers to review this themselves. But I would suggest that the question should not just be 'Can we just about manage to deal with the cases where the person is employed?' but 'What implicit messages are we giving to those individuals who either are in work, or who want to be in work?' and 'Could we organise ourselves in future so that our arrangements for seeing them regularly make being in employment the norm rather than the exception?'

4.10. The implication of this is of course more 'normal' working at evenings and weekends. I recommend such considerations.

4.11. I return at this point to other additional observations:

RoH-related matters:

i) The danger of 'dropping the baton' at the point of transfer:

4.12. I will outline further below that only a few cases came to my notice where there was an issue of transferring a case to the NPS due to new and rising RoH concerns. But there is a real danger to be considered when that rare need does arise. It is well known that a mistake in managing RoH is more likely to happen just at the point when a case is being transferred. Often in the past this has been about when a prisoner changes his release plan at the last minute, going to a completely different area, and suddenly a new case manager has to be identified who needs to pick up the case quickly. Now we have in addition the possibility of a transfer to the NPS just at the point when a case is becoming volatile. In both instances the perpetual problem is how to ensure that a grip is maintained on the management of the case. Taking a relay race as my analogy, I call this 'not dropping the baton'. While this is less likely to be critical concern if the relevant offender is in custody at the time, it is potentially a highly risky period if the person is at liberty during this handover period.

4.13. Many efforts have been made in the past, always well-intentioned, to write reams of instructions to ensure that the baton does not get dropped, but as any professional relay team can testify, you can't legislate against anyone ever making a mistake. Such errors can be minimised but never eliminated, if both the relevant practitioners are reminded to be clear at every point as to who is 'holding the baton'⁷.

ii) Emailing local authority social services departments:

4.14. I again cover the main matter – relations with social services – further below, but there was this one specific issue that might bear attention at higher management level. A number of practitioners mentioned freely to me that often email was the best way to get a message through to a particular social worker about a current shared case. But a higher number of interviewees told me that "Unfortunately we can't email social workers because their email system is not secure". And there were variations on this theme: some said that those who had a 'gsx' address were OK, and others who said it was OK if you kept any personal information in the form of an agreed 'code' – this latter idea seemed to have some merit to me.

4.15. It was a very useful step forward in those locations where a 'Safeguarding Hub' had been established that this brought with it a secure 'single point of contact' email

⁷ I'm afraid that the image of the Chuckle Brothers always comes to my mind at this point, although the consequences of the fiasco will be considerably less funny if and when there is an SFO.

address, and this was much valued by those who had it. The dilemma over 'insecure' email addressed arose when wishing to communicate effectively over time with a named social worker regarding a shared piece of work.

- 4.16. Email seems such an essential tool nowadays for contacting busy colleagues or partners in other locations who may often be out or on the phone when you call – so to find a practical way forward, while not falling foul of Data Protection, would seem highly desirable. I invite the relevant managers to consider this matter.

Continuity of case management:

- 4.17. There are several issues that I have included under this heading, and they all relate to the (now) widely-held belief – currently evidenced too - that it is generally considered that individuals under supervision are likely to benefit from retaining the same supervising officer throughout their experience. The messiness of real life does however mean that, for many reasons that are hard to avoid, a number of cases will undergo a change of officer; my focus with each of the issues that follow is on whether certain case transfers really are unavoidable, and I invite consideration of whether more could be done to keep 'unavoidable transfers' to the absolute minimum. This is all the more worth reviewing because the new arrangements now force a break anyway between the report-writer and the supervisor in CRC cases.
- 4.18. There is a separate but linked point here. Although the person under supervision is not a 'client' or 'customer' – Probation works **with** the individual **for** the community, **not for** that individual – the perspective of that person is still important. If he or she gains the early impression that this is an organisation that doesn't seem very clear what it is doing or how to do it their consequent low respect will make positive engagement in the work less likely. Instead it would help if from the very start the organisation conveyed to the offender that this is a competent organisation that knows what it's doing.

a) Process for starting a new Order:

- 4.19. So it often interests me to consider how a newly sentenced or released person might be experiencing the organisation at the very start of the Order or Licence. I noticed that in some locations there was a strong system whereby the NPS officer in Court would be provided with a set of 'diary slots' so that he or she could give a specific appointment to the person straight after Court with a minimum of fuss. In most of these instances the appointment was with a duty officer at the specified time, who did the induction interview but who might – or sometimes might not – be able to make the next appointment for the individual with his 'real' supervising officer. This would of course be the third different Probation practitioner that the individual will have to have met in the first two weeks. The first change was a necessary consequence of the new TR arrangements – but the second? A Stoke officer told me that they were planning to see if they could organise the diary slots so that the induction interview would be almost always with the person's planned supervising officer.
- 4.20. In some other offices, for example Walsall, the arrangements seemed much more precarious. Either limited diary slots were offered – necessitating an urgent phone call from the NPS officer at Court when the slots were full – or none at all, in which case the NPS officer would be keeping hold of the newly sentenced offender and making the urgent phone call in every case. This does not make the organisation look like a competent one, and slows the start of the supervision process – operational managers might wish to consider options for dealing with this.

b) Transfers within a location for geographical reasons:

- 4.21. When a change of address is going to mean a change of location (office) which the person under supervision must attend – or in the old days when there were legal issues of presiding petty sessional areas – it was inevitable that such a change of address would lead to a change of supervising officer. It is much more common now for a single large office to cover a whole city. There might be a need to divide the work among teams, and sometimes it's useful if the leading criterion for allocating a new case is a geographical subdivision of the city. But when this is applied too inflexibly it can result in an apparent inability of managers to keep workloads fairly balanced between teams in that office, and more importantly here the practice of moving a case from one team to another in the same office solely for that geographical reason – in my book an 'avoidable transfer'.
- 4.22. Two practitioners mentioned this to me as a current undesirable practice, and on further enquiry my information – though not confirmed – is that, for example, Stoke-on-Trent no longer does this, but Leicester does. My observation here is that again this might be something that local operational managers might wish to look at.

c) 'Escalation of cases':

- 4.23. I found two issues here. First was the expected problem of needing to 'escalate' a case from the CRC to the NPS owing either to an original classification error or to new circumstances – typically a new offence that put the case into the 'NPS box'. I asked a lot of managers and practitioners for their experience of needing to escalate a case, and to be frank I rather expected this to be quite a problem. So although I readily acknowledge that my 'sample' may not have been typical, the overall problems reported to me were much less than I had expected. Cases that possibly required 'escalating' were mainly reported in single figures by both SPOs and POs, and the great majority of those apparently went through without fuss, although the paperwork was sometimes a bit of a sweat.
- 4.24. However, there was a total 'hard core' of about five difficult cases reported to me, which were not straightforward to resolve, and which presented ongoing problems. Although in different locations, in each case the problem was where the offender's periodic explosive behaviour, often linked to volatile mental health, was leading an otherwise-correctly-classified Medium *RoH* case to be viewed by the CRC officers as a High *RoH* case. In two of the cases the best available solution had been for the CRC officer to continue to manage the case, but handling it as a High *RoH* case for the time being. As one of the officers pointed out to me, this was good in terms of case continuity anyway – though I don't know whether this will cause the CRC organisational or contractual problems at some point.
- 4.25. The second related 'escalation' issue is when a case being managed by a PSO becomes a more serious matter, and should be taken over by a PO. I was pleased to find that in the instances reported to me the solution was a measure of co-working, whereby the PO took over the responsibility and some of the contact with the case, while the PSO continued some of the contact in person and thereby maintained some case continuity. Of course I don't know how typical this practice was.

General PO / PSO arrangements:

- 4.26. This leads on to the wider question of the management arrangements for practitioners. Leics has established for some time now the arrangement of the PSOs being line managed by the POs, an arrangement that on paper does not immediately appeal to me. Most staff in other areas who expressed a view were not sure either.
- 4.27. But I have to report that the system was described within Leics as very positive in practice, though it should be noted that there were few PSOs in my Leics sample. Respondents added – and this made sense to me – that the arrangement was assisted by the ‘pod’ system of having two POs, two PSOs and an admin person working closely together as a mini-team, as a sub-unit within larger teams (in the City at least). There were similar arrangements starting in some of the SWM teams, as some staff described that very recently in their team the PSOs now each had a named PO for ‘practice oversight’ purposes, though the SPO continued to be the formal line manager. This sounded like local experimentation.
- 4.28. Often it’s not what you do, it’s the way that you do it, and my emerging theory is this: It wouldn’t be a good arrangement if it encouraged hierarchical diminishing of team colleagues, but if the ethos is instead to use this structure to encourage a team spirit among colleagues that are ‘equal in team value though different in learning’ then it clearly brings some benefit. I don’t offer a dogmatic view on this matter, but it clearly merits consideration across both CRCs. Much will of course depend on the future deployment of POs and PSOs across the two areas in reality, with some teams already having fewer POs than PSOs.

Working relations with other agencies:

a) National Probation Service:

- 4.29. Although I have outlined the issue of ‘case escalation’ further above, there are some other potential areas of interface with the NPS that might need attention.
- 4.30. The topic of Pre-sentence reports (PSRs) may continue to grow as a potential bone of contention for CRC staff. It is widely believed that the NPS now has a target of producing 80% of its PSRs as ‘same day’ reports, either same-day Fast Delivery Reports (FDRs) or Oral reports. Whether or not this is a formal target, many cases are determined on the day, and many CRC staff complained to me that this means that they now have minimal information in many cases, and often the OASys has not been started at all. Most people recognise that the NPS has its own pressures, but one way or another this matter may need some attention.
- 4.31. Peculiarly, in the event of a breach of an Order the CRC officer can provide information for the Court but not advice or a proposal, and formally this goes ‘through the NPS’. This arrangement has the potential to impact on Service Level Measure 8 – on so-called “successful completions” – since the CRC capacity to propose that an Order should continue after a penalty for a breach does not formally exist. (By the way, an electronic Curfew is in my view an underused option on such occasions.)
- 4.32. Although this can’t be helped now, it is also worth noting that this all also plays into that emotional agenda that some CRC officers definitely feel, which is that in some implicit way the NPS is the ‘first class’ service, with the CRC in subordinate role. One said “I’ve been told that I’m now not able to report to the Court”; the officer knew rationally that the message was really “It’s no longer your role”, but emotionally that’s not how it felt. This is just one of the reasons why I feel strongly that the CRCs would

be wise to grasp ownership of the Probation brand name, claiming to be an equal-but-different Probation, not a second-class pale imitation of it.

b) 'Social services' (named differently in different local authorities):

- 4.33. Having outlined the 'secure email' issue further above, there are some other general findings I can now report under this heading. I have reported earlier that practitioners across both areas expressed a strong understanding of the need to check information with other key agencies, notably police and social services, and to liaise with them closely on current cases. Here I expand briefly on their perceptions of working with social services.
- 4.34. Perhaps unsurprisingly, there was a wide range of perspectives. As one of the POs said to me, "They would probably say much the same about us – it often depends on the individual worker". Without attempting to itemise too many individual local authority departments – which I couldn't anyway at present – the general pattern was that there were often close working relations in the smaller towns, where individual staff of both agencies were more likely to know each other personally anyway. Meanwhile in the larger cities the basic arrangements for doing the 'initial checks' at the start of the case worked OK in most instances – especially with the new MASHs (Multi-Agency Safeguarding Hubs) but if there was a need for a follow-up this was much less reliable. Liaison over an individual shared current case depended on the individual social worker, and a comment made a number of times – justifiably or not – was that "they are fine when *they* want something, but not when *you* want something".
- 4.35. There is probably also a 'threshold' factor here. For Probation, there is a 'threshold' – a point at which one should alert social services to consider taking action in relation to, say, a child; but for social services the circumstances notified might well not be high enough to merit immediate action compared with other cases they may have on. If they are indeed hard pressed with work, as they probably are, then their 'threshold' for taking action may well be higher than Probation's, and lots of examples were cited to me where this seemed to be a factor. This often meant, for example, that if a man with a violent record was not actually currently formally living at the same address as an apparently vulnerable woman and child it might not qualify for current intervention. The frustration for the CRC practitioner was that he or she might want the assessment **before** they move in together, and often this did not prove possible. One can of course see the point of view of both agencies.

c) Police:

- 4.36. With some very rare exceptions and qualifications, there were positive reports of working with the police, notably with the Domestic Violence units, which constituted much of the contact needed by practitioners. In addition, particularly in the smaller towns away from the bigger cities, practitioners also spoke of working with local beat officers and intelligence staff. The relatively minor quibbles were about the limitations of the information sometimes (and one said it was often inaccurate) and some of the bureaucracy of securing the information. The most positive reports consistently came from the officers working in the Integrated Offender Management teams inside their local police stations, not surprisingly, a topic I return to further below.

MARACs (Multi-agency Risk Assessment Conferences):

- 4.37. This particular multi-agency forum regularly features in the life of most practitioners one way or another across both CRCs. Normally chaired and administered by the

police, and usually covering the equivalent of a unitary or upper tier local authority area (or part), they meet to discuss what actions can be taken to protect a series of named potential victims, either usually or always domestic violence victims. The specific arrangements for how the relevant CRC makes its contribution to the local MARACs varies by MARAC. I have heard of meetings where the CRC representative attends the whole meeting, typically a half-day, and others where they only attend for the cases where the CRC has had a known case identified for discussion. Perhaps noteworthy was one instance where last June an officer was initially refused entry because the police officer thought that the CRC was not an eligible agency – swiftly resolved though.

- 4.38. The two issues are, first, to decide how much time and resource to devote to supporting these key meetings, and the second is to resolve the relationship with the NPS in each of these forums. I was told of instances where the NPS and the CRC both attend, and attend throughout, and I was told of others where the agreement locally was that the CRC would ‘also represent’ the NPS. While the latter arrangement might sound more efficient – and MARACs perhaps come some way down the NPS agenda compared with MAPPA etc – the drawback comes with obtaining information from the NPS before a meeting, and implementing any action points by the NPS after the meeting. I was told of NPS not providing such information beforehand, and ambiguity about implementing action afterwards - there could be future problems for the CRC if they in effect become accountable for perceived shortcomings by the NPS.
- 4.39. I’m uncertain how important this may be in reality, since I was also told that the main ‘flow’ of work for MARAC was information **from** Probation (CRC) into the meeting, for the benefit of partner agencies attending, and it was rare for work to flow back to Probation in the form of action points required. But clearly the two CRCs have a stake in being seen as a good partner in this valued forum, and managers may wish to consider what line to take in providing representation in each MARAC.

Integrated Offender Management units:

- 4.40. Across both CRCs there were accounts of units, usually located in a local Police station, where Probation and Police officers worked together on managing a range of cases, the specific details of which might vary by location. The core principle of all these units – at one time called Prolific & other Priority Offender (PPO) units - is that at any one time about 3% of offenders are committing about 60% of offences, mainly theft, and so special attention should be given to managing this group of high-volume acquisitive-crime offenders. NB This “3%” is a demographic ripple – the individuals who make up these prolific offenders change every year or so, since in broad terms they move through this phase in their individual lives. But while they are in this phase it has proved enormously useful for Police and Probation to work together to exercise close supervision of many of them.
- 4.41. The points to note here are:
- Most of these offenders are high-volume offenders, but not usually High Risk of Harm – but some are High RoH.
 - Sometimes, but not always, the IOM cases include ‘drug-driven’ offenders, and the unit will therefore include other specialist staff

- Therefore IOM units were originally ‘profiled’ as CRC business, but in practice there has been a need to reinsert a couple of NPS officers into each unit, to deal with the small group of High RoH cases
- Informal reporting suggests that this initially left police staff somewhat bemused by the arrangement of having in their location two separate groups of Probation staff, with separate computer terminals – though probably getting used to it now
- Key point 1: This way of working, which parallels the shared working in some Public Protection units now staffed by NPS and Police officers, is usually described very warmly by all participants – co-location is seen as the key driver of effectiveness here.
- Key point 2: Even these IOM units, though not principally about *RoH* work, carry out a number of actions that restrict the opportunity for offenders to reoffend. The individual gains certain services (benefits) if he/she consents to one or more of the ‘containment’ provisions, under the IOM ‘carrot and stick’ method: The persons signs to comply with the package, including non-association with named individuals, and/or with an Exclusion zone, or use of one numbered mobile phone only (for drug dealers). Some units have, say, 5 GPS units, so that the offender consents to have all his movements ‘tracked’ every day – an expensive but valuable resource for use with an individual who wants to demonstrate that he is now leading a law-abiding life.

4.42. Effect of Offender Rehabilitation Act:

- 4.43. The only issue to raise here is that there was some doubt in the minds of some interviewees – though not others – about the capacity to require appointments over and above the ‘activity days’ in the new sentences. Some people were clear in their own minds that if, for example, the officer wanted to insist on weekly appointments – perhaps for monitoring purposes over and above the attendances on activity days – this was perfectly possible under the new arrangements. Others were doubtful – indeed some had raised it with me as a concern for the future. To be candid, on my reading of the Act at present I don’t feel absolutely sure. I would prefer to be clear – and I’m sure that the CRCs’ staff would too – that the new provisions will not be restricting their abilities to carry out some of the *RoH* work they do.

A final ‘RoH v RoSH’ footnote - some reflections:

- 4.44. This final section is perhaps for purists only, those who can remember the heated debates that I had with NOMS over their insistence on referring to Risk of Serious Harm in OASys and elsewhere, and my own insistence as Chief Inspector on saying Risk of Harm.
- 4.45. In brief, there is agreement on all sides that risk of anything can on an initial level be usefully analysed by referencing a classic two-by-two box:

		PROBABILITY of event occurring	
		HIGH	LOW
IMPACT of event, should it occur	HIGH		
	LOW		

- 4.46. It can be seen that if you apply this to 'Harm to others', you can plot any case into any one of four combinations on this Table: e.g. High-Probability with High-Impact, or three other combinations. However, if you insert the qualifier 'Serious' before you start then it makes it ambiguous whether you are even including the option of considering the two Low Impact options. This is especially the case if you take earnestly the cited definition of 'Serious Harm' in OASys and elsewhere:

Serious harm – an event which is life-threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible. As defined in the OASys risk assessment tool.

- 4.47. The consequence of this seemed to me at the time to be potentially very problematic. In particular my concern was that with a large proportion of DV cases the practitioner might say, "The harm that this individual might cause does not come into the 'Serious Harm' definition and therefore this is not a case that qualifies for any further public protection considerations, since the harm he might cause again won't be Serious by this definition." Candidly I feared that some DV cases (and some others) might not get the attention they needed.
- 4.48. However, what I started to discover before I left the Inspectorate in 2011 was that to my great relief the problem I had feared did not seem to be happening in practice. Despite the high level at which the official definition is set, most practitioners seem to take a more pragmatic interpretation, and indeed find it more useful to take into account a more flexible definition of the potential harm that a former offender might inflict on others. In practice, despite that 'high definition', most people use the terms Risk of Harm and Risk of Serious Harm more or less interchangeably and focus on the proper job of doing all they reasonably can to protect potential victims.
- 4.49. So I continue to feel relieved that in my discussions with practitioners and their managers across both CRCs this seems to continue to be the case - so I can now regard the whole debate of RoH v RoSH as an issue that I need no longer worry about in practice. But it was interesting for me personally to come across one practitioner who continued to find it difficult to decide on how to classify many cases for exactly the reason I had originally anticipated. This practitioner was certainly not seeking to evade any aspect of work with a case; far from it, the problem was conscientiousness – the officer correctly saw the conflict between the 'eligibility for consideration' definition of 'Serious Harm' and the need in many instances to consider where there might be high probability of less-than-'Serious' harm. This practitioner seemed to choose the right course in practice, but this conflict of terminology continued to be a cause of conflict in decision-making.
- 4.50. But I am very content to find that my original fears can now be largely set aside – the terminology problem does not in itself seem to be having a detrimental effect on the RoH work of the two CRCs in practice.
- 4.51. A final footnote to the footnote: I cannot help but continue to feel irritated that the reason NOMS gave – formally - for insisting on retaining the term 'Serious Harm' was that without limiting the scope to 'Serious Harm', as defined, there would be too wide a demand on the resources of the probation and other services. The explanation sounded plausible, but in practice it was nonsense strategically, implying further that NOMS did not expect staff to trouble themselves with the 'High-Probability-but-less-than-Serious-Impact' cases. I can therefore commend the practitioners across the country who have at least aimed to work with such cases in practice, many of which are the troubling DV cases discussed earlier.

Andrew Bridges
19 February 2015

Appendix 1: Evidence for this Review

- 5.1. Although I do of course have some historic knowledge of Probation practice in these two areas, I have not relied on any of it to form my judgements in this report. My 42 years in and around the Probation world have demonstrated clearly to me that good practice is grown over time, but can be wrecked quite quickly (like a garden, one might think). So while I place no reliance on the continued validity of past assessments I do nevertheless find that they can provide useful reference points or pointers towards making assessments now.
- 5.2. I read or at least scanned the large number of documents provided to me by both CRCs, and much of that was familiar material, albeit suitably updated. I list that at the foot of this Appendix. As for my staff interviews, I had previously had little personal contact with either of the two current CEOs, and similarly little with almost all the other staff I met. Although I was keen to talk with a relatively strong cross-section of staff from across the two areas, it would be a fair criticism to point out that I am not able to know how far it was a sample that impartially represents wider opinions and abilities within their respective staff groupings.
- 5.3. Nevertheless, in the short notice available, local organisers fitted available staff into the available 84 interview slots as best they could. I visited ten different locations, and in the end interviewed a total of 76 staff, from the two CEOs and seven senior managers through to 17 SPOs and a range of 13 PSO and 37 PO practitioners, almost all of them for at least an hour each. As a cross section, that does not seem too bad, even though it is still only a small percentage of the total staff group.
- 5.4. I have also made contact, through the good offices of RRP, with a range of partner agencies. I have offered the opportunity for them to give feedback on their experience of the work of the two CRCs either in direct writing to me, or if they wish by arranging to meet me face to face. At the time of writing the responses to my invitation are not complete, and I will of course update the Board should significant information come in.
- 5.5. **Core figures re RoH classifications, incidence of DV and Safeguarding cases:**

Numbers of CRC Cases by Risk of Harm	SWM		DLNR	
	Number	% of Total	Number	% of Total
Overall High RoH Cases	22	0.2%		
Overall Medium RoH Cases	6224	53.4%	4154	60.4%
Overall Low RoH Cases	4394	37.7%	2625	38.2%
'No Risk Entered' Cases	1019	8.7%	94	1.4%
Total Number of Current CRC Cases	11659	100.0%	6873	100.0%
Numbers of CRC Flagged DV Cases				
Domestic Violence Perp	1706	14.6%		
Domestic Abuse History	287	2.5%		
Total Number of Current DV Cases	1993	17.1%	1828	26.6%
Numbers of Safeguarding Cases with Lone Flag				
Child Concern Flag only (CC)	1000	8.6%		
Child Protection Flag only (CP)	278	2.4%	282	4.1%
Risk To Children Flag only (RC)	345	3.0%	402	5.8%
Looked After Child Flag only (LA)	10	0.1%		
Total Number Safeguarding Cases w Lone Flag	1633	14.0%	684	10.0%

Sourced from the two CRCs end Jan 2015

5.6. **List of documents received:**

- DLNR: Draft Interface Protocol DLNR CRC & NPS Midlands
- DLNR: Process for tracking Internal Management Reviews in Child Safeguarding cases 2014
- DLNR: Plans for Training sessions on Safeguarding Children and Vulnerable Adults
- DLNR: Procedure for SFO Reviews and Victim Summary Reports 2014
- DLNR: Leadership Forum presentations: Safeguarding Children, Safeguarding Vulnerable Adults
- DLNR: Domestic Homicide Reviews – Lessons Learned – Nov 2014 presentation
- DLNR: Step-by-step Instructions for Enforcement (taking Breach action) – 14 pages!
- DLNR: Step-by-step Instructions for Escalating a case to NPS (has become High RoH) – 12 pages! – plus graphical chart to summarise. The NOMS Instructions are 49 pages...
- Ex-Derbys docs on: Risk Review guidance – similar topic to escalation, but one page only – 2013 Practice instructions – comparable with old National Standards for managers and practitioners;
2008 Guidance on completing OASys “How to Learn to Love OASys”;
2014 OASys process map;
2014 Recall process map; undated (but probably 2014) and unsourced ‘RSR User Guidance 1.0’ – 9 pages plus 15 pages of lookup references.
- Ex-Leics docs on: 2012 Risk assessment etc guide for CJ Drugs Team; 2012 Domestic Violence policy; 2013 Management of High RoH cases
- Ex-Notts docs on: Victim Contact, undated; 2010 Risk of Harm Manual – 41 pages
- Ex WMids docs on: 2009 Practice Guidelines for working with Older Prisoners;
- SWM: April 2013 Practice Guidance: Working with Victims & Perpetrators of Domestic Abuse – and Summary sheet
- SWM: 2010 Compliance Workbook for Female Offenders
- SWM: June 2013 Implementation Circular on EM Curfewed Offenders
- SWM: 2014 Draft Handbook for Unpaid Work supervisors
- SWM: 2014 Drug Rehabilitation Requirement Good Practice Guidelines
- SWM: Undated Guidance Note On Dealing With Suicide And Self Harm
- SWM: 2013 Implementation Circular on protecting & Safeguarding Children – & Summary sheet
- SWM: 2013 Learning lessons from SFOs re Safeguarding.
- SWM: 2015 Lead responsibilities document.
- SWM: 2011 Maintaining a focus on safeguarding document –
- SWM: 2013 Management Oversight of Public Protection matters.
- SWM: 2010 OASys Risk Management Plan Headings and Guidance
- SWM: 2014 Structured Intervention to Address Domestic Abuse workbook
- SWM: 2010 SPO Case File review checklist – good on items, but how do overview?
- SWM: 2013 Implementation Circular - Domestic Abuse Practice Guidance
- SWM: 2013 Implementation Circular – Safeguarding Children
- SWM et al: 2010 Anger Management workbook
- SWM: 2012 ‘Thinking about Children’ summary
- SWM: 2008 Workbook on Victim Awareness
- SWM: 2014 Safeguarding Refresher Training
- SWM: 2014 Safeguarding Children Training
- SWM: 2011 Safeguarding Adults for PSOs Training
- SWM: Risk Revised Training
- SWM: Domestic Violence Training
- Women’s Aid: 2014 Women’s safety plan
- MoJ Risk review and escalation guidance.
- MoJ 2014 Risk escalation and transfer process map
- MoJ / NOMS ROSH guidance
- MoJ Community Payback operating manual
- Numerous NOMS Probation Instructions and Prison Service Orders, Manuals.
- HM Inspectorate of Probation, Dec 2012: *Some key principles for the effective management oversight of Risk of Harm to others and Safeguarding/ Child Protection*

END