HM Inspectorate of Probation

A thematic inspection of work undertaken, and progress made, by the Probation Service to reduce the incidence of domestic abuse and protect victims

An inspection by HM Inspectorate of Probation

July 2023

Acknowledgements

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Foreword

The impact of domestic abuse is significant and far-reaching. An estimated 2.4 million adults were victims[1] of domestic abuse across England and Wales last year, and one in seven children live with domestic abuse at some point in their childhood. Women are disproportionately affected by domestic abuse, with an estimated 1.7 million female victims last year. Those responsible for this abuse account for a very significant part of the Probation Service caseload, with approximately 30 per cent[2] of people on probation identified as current or previous perpetrators of domestic abuse. When we last inspected this topic in 2018, we reported that too many individuals were drifting through their sentences without being challenged or supported to change their abusive behaviours. Very concerningly, despite some positive developments in policy, little appears to have improved in practice, and in some respects, things have deteriorated. Only 28 per cent of the cases we inspected for this review had a sufficient assessment which analysed the risks of further domestic abuse, and only 23 per cent had been reviewed adequately to consider significant changes in the case. This is unacceptable and is leaving far too many potential victims at risk.

People on probation can be offered a range of interventions aimed at helping them make positive changes in their lives and equipping them to have safe and healthy relationships. However, too few people gain access to these interventions; 45 per cent of our case sample should have had access to an intervention but had not. In addition, there is insufficient monitoring of referral, take-up, and completion rates for interventions at a national level to understand the overall picture. It is unacceptable that requirements to undertake a domestic abuse perpetrator programme made as part of sentencing are not delivered, yet this happens in many cases.

Staffing shortages in the Probation Service have led to reductions in expectations around minimum levels of contact with people on probation, partnership working, and the delivery of interventions. In domestic abuse cases, this has led to worrying deficits in the standard of sentence management. Probation staff demonstrate high levels of commitment to their work, often working well over their expected hours, but high caseloads often prohibit them from being able to complete meaningful work. In addition, recent changes in legislation through the *Domestic Abuse Act 2021*, such as the recognition of children affected by domestic abuse as victims in their own right, have not been incorporated into probation practice.

More needs to be done to ensure that there is a shared understanding of roles and responsibilities among agencies working with domestic abuse, and that information is shared to safeguard victims.

In this inspection, we report on similar issues to those we have found in our core inspection programme and to the independent reviews of high-profile Serious Further Offences we have conducted recently. Probation teams are struggling, with too few staff and high numbers of new staff who are yet to gain the necessary experience to work effectively with complex cases and yet are having to do so, in some cases with minimal supervision. Our recommendations, if followed, are designed to improve the quality of domestic abuse work. It is essential that the Service acts on these to improve the assessment and sentence management of this critical and dangerous cohort, and does so urgently.

Justin Russell
HM Chief Inspector of Probation
July 2023

[1] We recognise that people who have been victims of crime, including domestic abuse, may identify either as a 'victim' or as a 'survivor'. Often, criminal justice agencies use 'victim' as it is the legal term. We have adopted this convention in our report, to encompass the actual victims of domestic abuse and potential future victims. We respect that individuals who have experienced domestic abuse can fall into either or both of these categories and may consider that the term 'survivor' better reflects their circumstances.
[2] Caseload data information supplied by the Probation Service.

Contextual facts

Domestic abuse: key statistics

2.4 million	The estimated number of people in England and Wales aged 16 years and over who experienced domestic abuse within the year ending March 2022[3]. 1.7 million women and 699,000 men.
1,500,369	The number of police-recorded domestic abuse-related incidents and crimes in England and Wales within the year ending March 2022[2]
10.4 million	The estimated number of adults aged 16 years and over who have experienced domestic abuse since the age of 16 years[2]
22 in 100	The prevalence of adults in the population who have experienced domestic abuse aged 16 years and over[2]
134	The number of domestic homicides in the year ending March 2022[4]
12	Serious Further Offence notifications received by HM Prison and Probation Service between 01 April 2020 and 31 March 2021 identified as potential domestic homicides[5]
84	Female victims of domestic homicide in the year ending March 2022; 81 were killed by a male suspect[3]

Children and domestic abuse: key statistics

1 in 7	Children and young people under the age of 18 years estimated to have lived with domestic abuse at some point in their childhood[6]

The Probation Service and domestic abuse: key statistics

240, 674	The number of people managed by the Probation Service[7]
74, 996	The number of people managed by the Probation Service identified as a current or former perpetrator of domestic abuse[8]

[3] Office for National Statistics. (2022). https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseprevalenceandtrendsenglandandwales/yearendingmarch2022

[4] Office for National Statistics. (2022). https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/march2022

[5] Information supplied by HM Prison and Probation Service (HMPPS). Serious Further Offence (SFO) notifications are made when an offender is charged. As of 30 September 2022, 10 out of 12 of those notifications had resulted in an offender being convicted for a homicide. For one notification, the offender died prior to conviction, and one was still awaiting an outcome. Figures are based on conviction data that was produced on 30 September 2022. Data is based on the year that the notification of the SFO was received by HMPPS and not the date of conviction. Data was drawn from administrative information technology systems which, as with some large-scale recording systems, are subject to possible errors with data entry and processing. There may be some cases that were not identified as being a domestic homicide due to limited information around the relationship between the perpetrator and the victim.

[6] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/impact-on-children-and-young-people/#:~:text=One%20in%20seven%20(14.2%25),Women's%20Aid%20Annual%20Survey%202017

[7] As of 30 September 2022. https://data.justice.gov.uk/probation

[8] Caseload data information supplied by the Probation Service.

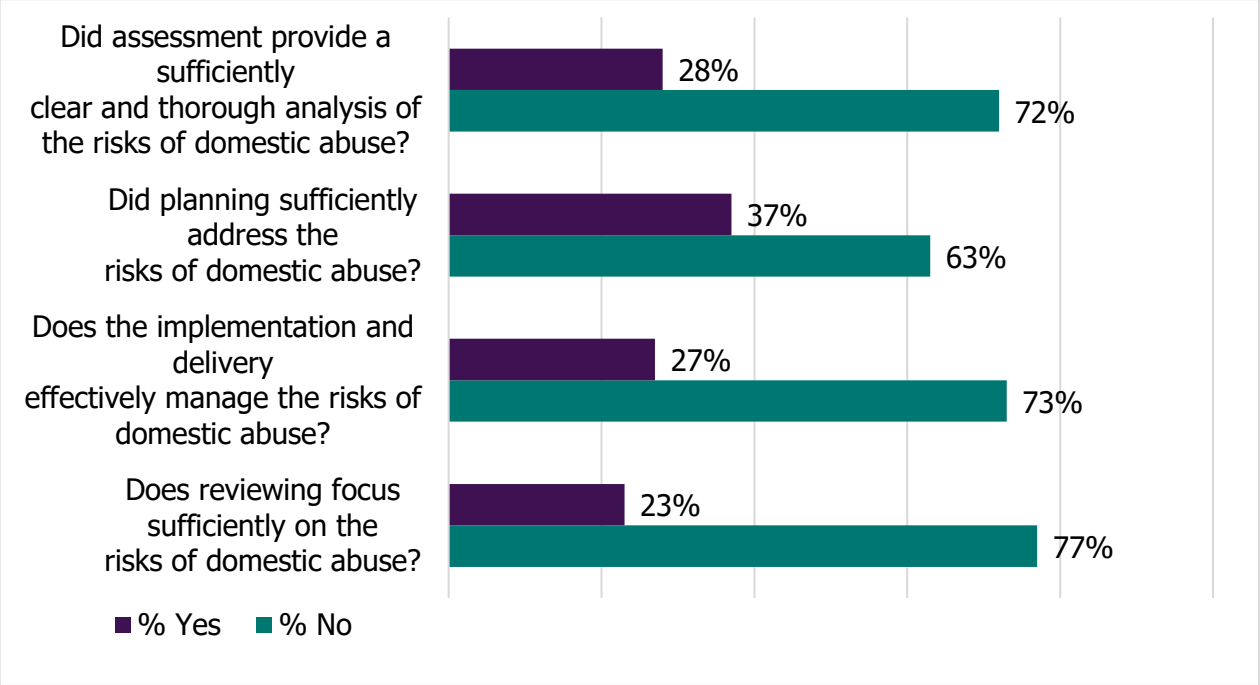
The Probation Service staffing: key statistics[9]

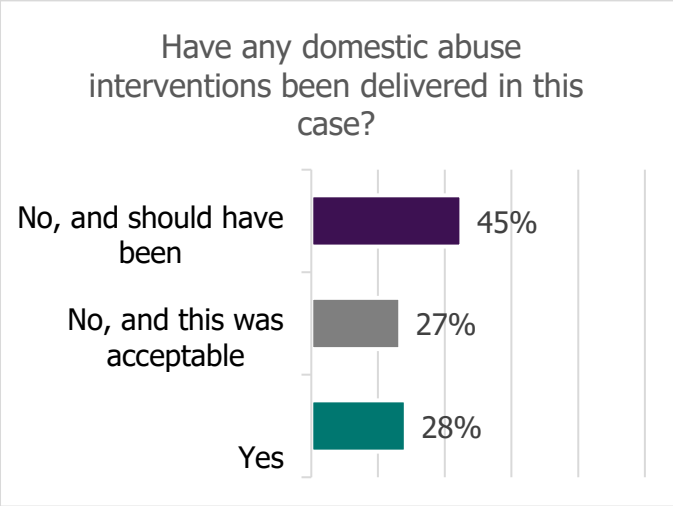
4,464	The number of full-time equivalent (FTE) band 4 probation officers in post. This is a slight decrease of 26 FTE (0.6 per cent) since 31 December 2021
6,209	The number of FTE band 3 probation services officers. This is an increase of 470 FTE (8.2) over the past year
1,794	Shortfall of FTE probation officers in post against the required staffing level of 6,258 (29 per cent) as at December 2022
13.1 per cent	Leavers rate for the band 3 probation services officers for year ending 31 December 2022
7.4 per cent	Leavers rate for the band 4 probation officers for year ending 31 December 2022

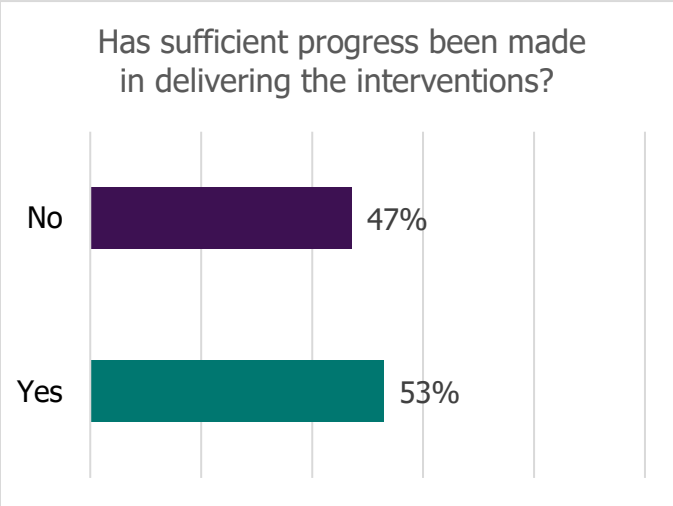
[9] https://www.gov.uk/government/statistics/hm-prison-and-probation-service-workforce-quarterly-december-2022

Key findings

The charts below show key findings from our case inspection work.







Executive summary

Context

Our last inspection of domestic abuse, published in 2018, considered the work of the Community Rehabilitation Companies (CRCs) in delivering domestic abuse work, managing the low and medium risk of harm cases, and the delivery of interventions. Since then, probation services have unified, meaning that the case management of people on probation at all risk levels, and the delivery of accredited programmes and interventions now fall to the Probation Service. In addition, the Covid-19 pandemic has impacted probation practice and necessitated exceptional delivery models, which modified practice expectations in various ways, including reducing face-to-face contact and the delivery of interventions. Staffing shortages in some probation regions have led to continued adaptations to business-as-usual sentence management arrangements under the red-amber-green-rated prioritisation framework for sentence management for sentence management. This adjusts practice expectations to manage demand, including reductions in contact levels and face-to-face appointments, where staffing resources are insufficient to deliver according to the usual guidance.

While domestic abuse perpetrators are not considered as a specific cohort, some aspects of the prioritisation framework for sentence management impact domestic abuse work. Under red status, accredited programme delivery can be paused and staff redirected to sentence management or court work. Under amber status, suggested measures include not providing domestic abuse safety officer (DASO) liaison for new cases, where appropriate, and suspending Building Better Relationships (BBR). For probation delivery units (PDUs) identified as red or amber, face-to-face appointments can be reduced, other than for high- or very high-risk cases, convicted terrorists, people on probation without recourse to a telephone, the first appointment for prison leavers, those assessed as very vulnerable, and those adopted by the integrated offender management scheme. The prioritisation framework for sentence management contains a list of mandated activities, including using the spousal assault risk assessment (SARA[10]) tool at initial or review assessments.

Methodology

Our fieldwork inspected the work of six PDUs and was completed between December 2022 and February 2023, followed by a further week of fieldwork to review arrangements at a national level.

We inspected two samples during the fieldwork; the first was a sample of 60 cases that started an order or licence six to seven months before our fieldwork, with a domestic abuse perpetrator or domestic abuse history flag attached to their record. For these cases, we inspected the quality of the case management work and interviewed the probation practitioner, where possible. In our second sample, we looked at 83 cases where the person on probation was recorded as having started an intervention aimed at preventing further domestic abuse offending seven to nine months before our fieldwork. We explored whether the intervention had been fully delivered and any reasons for non-completion. During each fieldwork week, we held meetings with a range of staff, managers, senior leaders, and operational and strategic partners. We also spoke to a small number of sentencers and four women receiving the services of DASOs. During our final fieldwork week, we met those responsible for domestic abuse policy and strategy at a national level.

We commissioned User Voice to undertake remote semi-structured interviews with people on probation. Consultants with lived experience of the criminal justice system gathered the views of 55 individuals identified as perpetrators of domestic abuse who had been managed by the Probation

[10] The Spousal Assault Risk Assessment (SARA) is a screening tool that assists criminal justice professionals to predict the likelihood of further domestic abuse.

Service. We have included examples of the views gathered from people on probation in the relevant sections of this report, and a copy of the full User Voice report can be found here.

A detailed breakdown of our methodology can be found in Annexe 2.

Policy, strategy, and leadership

Since our last inspection, there have been improvements to the leadership of domestic abuse work at a national level, and clearer policies are now in place to guide this work, although there is room for further improvement. HM Prison and Probation Service (HMPPS) has published a domestic abuse policy framework, which provides comprehensive guidance on managing domestic abuse work. However, this document is not used regularly by frontline staff and managers. The Probation Service is included in the government's overarching Tackling Domestic Abuse Plan (HM Government, 2022). However, it still does not have a specific domestic abuse strategy which sets out its approach to domestic abuse work.

The national domestic abuse reference group (NDARG), chaired by the designated regional probation director lead for domestic abuse, aims to drive improvements in domestic abuse practice. The group is well attended by representatives from each region, usually by the head of public protection and the senior policy leads for domestic abuse, effective probation practice service improvement group (EPSIG) leads, and senior interventions staff. The NDARG monitors regional progress against a range of actions, including the recruitment of additional administrators to support the provision of domestic abuse enquiries and increased use of the SARA tool.

There is a national information-sharing agreement (ISA) in place between probation services and the police which provides a basis upon which local arrangements can be determined. While the spirit of the agreement is positive in recognising the importance of sharing information, there are gaps whereby police forces can reject enquiries if the Probation Service cannot identify any known history of violence. Most forces deliver over and above the provision set out in the national ISA through locally agreed arrangements; however, in some forces, including the Metropolitan Police Service, although they comply with the ISA important information in some cases is still not accessible to probation staff. In our London PDU inspections, 64 per cent of cases were missing domestic abuse enquiries as part of the assessment process. More must be done to ensure that probation staff always request necessary information and that arrangements are in place to provide comprehensive police responses that prevent known domestic abuse issues from remaining hidden from probation practitioners.

In theory, a good range of domestic abuse interventions is available to address different risk and need levels, and cater for all perpetrators of domestic abuse through groupwork or one-to-one delivery. However, in practice, we saw little delivery of structured interventions and practitioner toolkits, and no comprehensive analysis has been completed to understand what delivery volume should be expected. Despite programme managers monitoring BBR delivery at a regional level, at a national level, oversight of the delivery of the BBR accredited programme is inadequate. Consequently, we could not establish the proportion of people who have a requirement to complete BBR who do so.

In too many places, practitioner workloads are excessively high. Two PDUs we inspected were identified as 'red' under the prioritisation framework for sentence management[11], and one was 'amber'. Where PDUs are not operating under business-as-usual arrangements, the guidance often directs staff to reduce intervention delivery and partnership work, which are crucial elements of effective domestic abuse work. Therefore, these measures impact negatively on the quality of work.

Most practitioners feel that they have had sufficient training and development to work effectively with domestic abuse perpetrators; however, our case inspection work raised concerns about the

[11] The prioritisation framework for sentence management is a mechanism which attributes a red-amber-green rating to a PDU based on staffing levels and workloads.

depth of practitioners' understanding in this area. In addition, there are few opportunities for staff to engage in multi-agency training to gain a greater awareness of the complexity of domestic abuse work and understand the roles and responsibilities of other agencies.

Assessment and planning

Many of our findings in this inspection mirror those in our recent core inspection programme. Too often, we found poor-quality risk assessments concerning domestic abuse that missed out on essential details or failed to provide a sufficient analysis of the case. Not enough use was made of information from other agencies or previous probation assessments, even though over half of our sample had been identified as being at risk of domestic abuse for more than four years. We concluded that only 28 per cent of assessments in our sample provided a sufficiently clear and thorough analysis of the risks of domestic abuse. While the volume of completions of the SARA has increased, they often lacked sufficient analysis to provide a meaningful assessment of the likelihood of further domestically abusive behaviour. Probation practitioners do not value the tool, and as it sits outside the primary offender assessment system (OASys) risk and needs assessment tool, it is not seen as a priority. Yet, the SARA is a key determining factor in access to domestic abuse interventions; if not completed accurately, it can lead to inappropriate intervention referrals.

Pre-release work to address domestic abuse issues was only sufficient in half of the licence cases we inspected. In two-thirds of cases, there were appropriate licence conditions in place to manage the risks of domestic abuse. In almost three-quarters of cases where it was necessary, planning set out restrictions and measures to protect victims, such as restraining orders; however, constructive activities to address domestic abuse were included less often. Contingency planning was sufficient in less than half of the cases we inspected. Overall, we concluded that planning sufficiently addressed the risks of domestic abuse in only 37 per cent of cases.

High-quality sentence management relies on effective information sharing with other agencies, such as the police and children's social care services. Unfortunately, in too many cases where it was necessary, there had not been appropriate information sharing with other agencies involved in managing the risks of domestic abuse. Nevertheless, some probation areas have developed impressive arrangements with local forces, allowing them to receive daily information about incidents or arrests for people on their caseload, which allowed practitioners to make informed decisions about case management.

Sentence and intervention delivery

Some PDUs were experiencing significant staffing shortages; in one PDU, they had only half of the practitioner-grade staff they should have had. As a result, there were nationally agreed arrangements in place to manage resources, but these were having a negative impact on the quality of sentence management. For example, people on probation were seen too infrequently, and too many appointments offered no meaningful intervention to reduce the risks of further domestic abuse. Overall, we concluded that the implementation and delivery of sentences managed the risks of domestic abuse effectively in only 27 per cent of the cases we inspected. Too few enquiries had been made with children's social care services and the police to inform sentence management, leading to gaps in the practitioner's knowledge about the risks in the case. In cases where information had been gathered, it was not analysed or used sufficiently to inform case management. Many probation practitioners knew little about specialist domestic abuse services that could support them in their work. Reviews of cases often failed to address changes in factors linked to domestic abuse or make adjustments to ongoing work. In over half of the cases where it was necessary, information had not been gathered from other agencies to inform reviewing. Overall, we assessed that reviewing focused adequately on the risks of domestic abuse in only 23 per cent of cases.

Notwithstanding our concerns about the general quality of practice concerning domestic abuse, we found some examples of impressive practice. Where specialist multidisciplinary teams were in place, this enabled practitioners to work collaboratively with police and other services. Practitioners in

these teams demonstrated a better understanding of the complexity of domestic abuse. As they usually had smaller caseloads, they had the time to work more effectively with people on probation. Joint work with other specialist organisations, such as through the Drive project, also led to effective work to reduce domestic abuse.

Practice around making disclosures about domestic abuse to new partners when a perpetrator started a new relationship varied significantly, and in some cases we assessed it to increase risks. Where decisions were not made as part of multi-agency meetings or through the domestic violence disclosure scheme (often called Clare's Law), we found no evidence of a systematic approach to considering the risks around disclosures. The national guidance in place at the time was insufficient to support decisions or delivery adequately. Practitioners expressed a range of views about disclosure, with some stating clearly that they did not feel it was part of their role, and others telling us that they gave information routinely to new partners of perpetrators without consulting managers about the content of this information or how it could be shared safely. When probation staff made disclosures, we found little evidence that consideration had been given to the potential vulnerabilities of the person receiving the information, nor any effort to engage the services that might support them.

Opportunities to support victims are sometimes missed through late referrals to the DASO service or failure to liaise with independent domestic violence advisers (IDVAs). The DASO service offers valuable support to victims and partners of people on probation completing BBR and other domestic abuse groupwork interventions. The guidance manuals for the service are being reviewed currently as they are significantly out of date, and this has resulted in variable delivery of the scheme across the country and a need for a more consistent approach to be put into place.

Recommendations

HM Prison and Probation Service should:

1. publish a domestic abuse strategy for the Probation Service and review progress against it regularly. The strategy should be gender and culturally informed, and ensure that the voice of the victim is fully considered and that probation leaders are fully engaged in local multi-agency responses to domestic abuse
2. ensure that all people on probation who require an intervention receive one in a timely way and clearly record any rationale for not delivering if plans change, monitor the delivery of all interventions, and analyse attrition rates and shortfalls against potential need
3. ensure that all actual and potential future adult and child victims of domestic abuse are identified accurately and work with other agencies, such as the police, children's social care services, and specialist domestic abuse services, to ensure that victims are protected and informed at each stage of the sentence management process
4. ensure that all probation practitioners and managers are familiar with and work in accordance with the domestic abuse policy framework
5. ensure that decisions taken under the prioritisation framework for sentence management for red or amber status maintain partnership working and intervention delivery to protect domestic abuse victims
6. develop a comprehensive system to manage requests for disclosures of past perpetrator behaviour to new partners in relation to domestic abuse, including decision-making, delivery, and recording, through a route which provides appropriate support and safeguarding for those receiving information
7. review its national information-sharing agreement with the National Police Chiefs' Council, to ensure that it closes the current loophole that allows police forces to refuse probation staff enquiries about information on domestic abuse incidents (for example, past callouts) involving a person under probation supervision
8. ensure that all DASOs are fully equipped for their role and trained to a high standard, using nationally recognised inter-agency training.

The Probation Service should:

9. engage in local multi-agency training and awareness-raising events with partner agencies. This should support probation practitioners and managers to develop their understanding of the complexity of domestic abuse, the roles of other agencies that can offer support and information in managing domestic abuse cases, and the changes introduced under the Domestic Abuse Act 2021, which recognise children affected by domestic abuse as victims
10. ensure that timely and accurate exchanges of information are supported through local agreements and active relationship management with the police, children's social care services, perpetrator services, specialist domestic abuse services, and other relevant organisations
11. ensure that all practitioners complete high-quality assessments and reviews in domestic abuse cases that fully analyse information from specialist assessment tools, such as the spousal assault risk assessment (SARA), and all available information from other agencies
12. ensure that sentence delivery in all relevant domestic abuse cases includes an active role in multi-agency forums and draws on specialist domestic abuse services to ensure that the victim voice is considered fully
13. ensure that the respective roles and responsibilities of sentence management and programme teams, including domestic abuse safety officers, are clear. This should include the responsibility to prepare people on probation to attend programmes, to share information and to support risk management throughout sentence delivery.

1. Introduction

1.1 Why this thematic?

Domestic abuse is widespread. The Crime Survey for England and Wales estimates that 1.7 million women and 699,000 men aged over 16 years experienced domestic abuse in the year ending March 2022.[12] SafeLives[13] reports that an estimated 4.6 million women (28 per cent of the adult population) have experienced domestic abuse at some point since the age of 16. In approximately 40 per cent of cases inspected by HM Inspectorate of Probation in our core inspection programme in 2022 and 2023 (1,248), there was a concern about the person on probation being a perpetrator of domestic abuse.

Our last inspection of domestic abuse (HM Inspectorate of Probation, 2018) considered the work of the CRCs in delivering domestic abuse work and managing low and medium risk of harm cases. Several concerns were identified. In 2021, probation services unified, meaning that the case management of people on probation at all risk levels, and the delivery of accredited programmes and interventions, now sit with the Probation Service. As part of the unification process, new interventions, including toolkits to be delivered by probation practitioners, have been rolled out.

Our overall findings in PDU inspections have also raised concerns about the quality of risk assessment and management, and a lack of effective sentence delivery to keep people safe. This inspection allowed us to examine the unified Probation Service and assess the progress made since 2018 in relation to domestic abuse work.

1.2 Background

The *Domestic Abuse Act 2021* provided an updated definition of domestic abuse as follows:

Behaviour of a person ('A') towards another person ('B') is 'domestic abuse' if:

a) A and B are each aged 16 or over and are personally connected[14] to each other, and
b) the behaviour is abusive.

Behaviour is 'abusive' if it consists of any of the following:

a) physical or sexual abuse;
b) violent or threatening behaviour;
c) controlling or coercive behaviour;
d) economic abuse; or
e) psychological, emotional, or other abuse.

It does not matter whether the behaviour consists of a single incident or a course of conduct.

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[12] Office for National Statistics. (2022) https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2022

[13] A UK-wide charity dedicated to ending domestic abuse. https://safelives.org.uk/policy-evidence/about-domestic-abuse#facts%20and%20stats

[14] For the purposes of this Act, two people are 'personally connected' to each other if any of the following applies:
(a) they are, or have been, married to each other;
(b) they are, or have been, civil partners of each other;
(c) they have agreed to marry one another (whether or not the agreement has been terminated);
(d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);
(e) they are, or have been, in an intimate personal relationship with each other;
(f) they each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2));
(g) they are relatives.

Key statistics

Domestic abuse is often a hidden crime that is not reported to the police. Therefore, data held by the police can only provide a partial picture of the actual level of domestic abuse experienced.

However, the number of police-recorded domestic abuse-related crimes in England and Wales in the year ending March 2022 rose 7.7 per cent, to 910,980.[15] This follows increases seen in previous years and may reflect improved recording by police, alongside increased reporting by victims.

There were 134 domestic homicides recorded by the police in the year ending March 2022. This represents 19 per cent of all homicides where the victim was aged 16 years and over during this period. Of the 134 domestic homicides, 78 victims were killed by a partner or ex-partner, 40 were killed by a parent, son, or daughter, and 16 were killed by another family member. Almost half (46 per cent) of all adult female homicide victims were killed in a domestic homicide. Of the 84 female victims, 81 were killed by a male suspect.[16]

Previous inspections and independent reviews

Our last inspection on this topic (HM Inspectorate of Probation, 2018) examined the work of the CRCs, which were responsible for delivering domestic abuse interventions and managing low- and medium-risk individuals. The inspection found that domestic abuse work was nowhere near good enough, with insufficient work being done with people identified as perpetrators of domestic abuse, leaving victims at risk of further harm. The report highlighted concerns that interventions were not all evidence based and that too few individuals were completing the BBR accredited programme. Probation practitioner workloads were also problematic and too many staff were managing complex cases without the knowledge and experience to do so effectively. Joint targeted area inspections of the multi-agency response to safeguarding children living with domestic abuse indicated that probation services did not always contribute effectively to child safeguarding processes; there were delays, some considerable, in BBR start dates; staff were not being empowered to manage domestic abuse cases; and not enough was being done by CRCs to protect victims. In addition, inspectors saw significant differences in how well these systems worked in different local authority areas (Ofsted et al., 2017).

Our 2022 inspection of the use of electronic monitoring by the Probation Service (HM Inspectorate of Probation, 2022) highlighted concerns that domestic abuse and safeguarding checks were not always being made before recommending a sentence or release on electronically monitored curfew, and called for changes to this practice, to ensure that this could no longer happen.

In our core inspection programme, we consider the quality of work done by PDUs, and a large number of the cases we inspect include concerns about domestic abuse. Through this programme, we have made recommendations regularly, calling for improvements in the quality of assessment and management of risks.

Following our thematic inspection of Serious Further Offence (SFO) reviews in May 2020 (HM Inspectorate of Probation, 2020), we were asked by the previous Secretary of State for Justice to take on a new quality assurance process. From April 2021, we have been responsible for examining and rating the quality of a sample of 20 per cent of all SFO reviews undertaken by the Probation Service in England and Wales. From April 2022 to February 2023, 49 out of the 73 reviews we have quality assured involved a perpetrator with an identified domestic abuse risk. Our independent SFO review into the case of Damien Bendall, convicted of murdering his partner and three children, published in 2023 (HM Inspectorate of Probation, 2023), identified that inaccurate assessments had

[15] Office for National Statistics. (2022). https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseprevalenceandtrendsenglandandwales/yearendingmarch2022#crime-survey-for-england-and-wales

[16] Office for National Statistics. (2022). https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/march2022#the-relationship-between-victims-and-suspects

been made about the risks that Mr Bendall posed in a domestic setting, and made further recommendations aimed at improving the assessment and management of domestic abuse risks. It also recommended that mandatory domestic enquiries with the police should be undertaken before any curfew order can be made in court or before any home detention curfew release from custody. In this review, the Chief Inspector stated:

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

We also identified concerns about how risks to children were assessed and made the following recommendations that HMPPS should:

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

HMPPS agreed all recommendations made in this review.

1.3 Interventions

There are three types of intervention delivered by the Probation Service: accredited programmes, structured interventions, and practitioner toolkits. Accredited programmes have been reviewed by the correctional services advice and accreditation panel (CSAAP). They are higher-intensity groupwork programmes. Structured interventions are shorter in duration than accredited programmes, and aimed at those with a lower risk classification; they are also usually delivered via groupwork sessions. Decisions about appropriate proposals in reports to court or initial sentence plans are made based on the assessed risks of the person on probation and their suitability for different methods of delivery. Finally, practitioner toolkits are designed for use by probation practitioners on a one-to-one basis. They are, therefore, more flexible and able to be adapted to suit the individual needs of the person on probation. All of the domestic abuse interventions share the same evidence base and have complementary delivery methods, which means that the transition should be smooth if someone has to move from one to another.

Accredited programmes

The only accredited programme delivered in the community that is specifically aimed at domestic abuse is Building Better Relationships (BBR). This is suitable for men convicted of intimate violence against a female partner who present a moderate or high risk of further similar offences, as assessed using the SARA. It is delivered via 24 groupwork and five individual sessions. During the Covid-19 pandemic, alternative delivery formats were used – for example, to allow one-to-one delivery – and these are still being used in some cases, to support delivery and meet the specific needs of some people on probation, enabling them to complete the programme when it would not be possible under the standard groupwork arrangements. For a programme to be accredited for use by HMPPS, it has to be approved by the CSAAP, which reviews programme design, quality assurance procedures and findings, and programme evaluations. To remain accredited for use, programmes must be reviewed periodically by the panel; for BBR, an extension to accreditation was granted in November 2022. HMMPS has still not completed an outcome evaluation of BBR and has no plans to do so.

As reported in 2018 (HM Inspectorate of Probation, 2018), assessing the effectiveness of interventions to reduce domestic abuse is difficult. Measuring the impact of interventions is complex, not least due to the hidden nature of domestic abuse, which does not always result in incidents being reported or perpetrators disclosing their actions. Renehan (2020) summarises:

'In short, we do not yet know what works, for whom, and under what circumstances. Consequentially, the effectiveness of both accredited voluntary and statutory programmes unfortunately remains in doubt.'

Studies focused on the delivery of BBR have highlighted concerns about the ability of those delivering the programme to manage the sometimes-traumatic disclosures, which underlie their offending, that men may make in the group. Renehan (2020) fears that BBR may:

'…teach men to control their emotions rather than to fully understand them.'

Hughes (2017) also found that the effectiveness of BBR may not be fully realised, as:

'While BBR contains many therapeutic elements, its structured nature risks diverting attention away from developing skilled staff practice.'

1.4 Aims and objectives

In addition to following up on the progress made on recommendations from previous inspections and reviews, this inspection sought to answer the following questions:

- Does leadership support and promote the delivery of a high-quality, personalised, and responsive service for all perpetrators and victims of domestic abuse?
- Are staff within the Probation Service empowered to deliver a high-quality service for all perpetrators and victims of domestic abuse?
- Is a comprehensive range of services and interventions in place to undertake work with domestic abuse cases?
- How well do practitioners support desistance from domestic abuse behaviour?
- How are victims and their children supported and protected?
- Are arrangements with statutory partners, providers, and other agencies established, maintained, and used effectively to deliver high-quality services?

1.5 Report outline

Chapter	Content
2. Policy, strategy, and leadership	This chapter considers the national leadership and governance arrangements that oversee domestic abuse work within the Probation Service, including the provision and oversight of domestic abuse interventions available to people on probation. It describes how domestic abuse work is driven regionally and within PDUs. Finally, it reports on the domestic abuse training and support arrangements for probation staff.
3. Assessment and planning	This chapter reports on the work of the Probation Service in providing advice to court to support sentencing, the quality of pre-release work, and planning for release for people serving custodial sentences. Next, it describes the quality of assessments and plans for individuals who commit domestic abuse, and the effectiveness of information sharing with other agencies.
4. Sentence and intervention delivery	This chapter considers how effectively sentences are delivered, including the views of people on probation about their experiences and intervention delivery. It reports our findings about the enforcement of sentences when people on probation do not comply and how well reviewing activity is completed., It also describes how the Probation Service supports victims of domestic abuse.

2. Policy, strategy, and leadership

In this chapter, we report on the national leadership and governance arrangements that oversee domestic abuse work within the Probation Service, including the provision and oversight of domestic abuse interventions available to people on probation. We consider how domestic abuse work is driven regionally and within PDUs. Finally, we explore the training and support arrangements aimed at equipping probation staff to work with domestic abuse.

2.1 Policy and strategy

In our 2018 domestic abuse inspection (HM Inspectorate of Probation, 2018), we were concerned that HMPPS lacked an overarching strategy to drive domestic abuse work. We recommended that it should identify and disseminate an effective, integrated pathway for working with domestic abuse that takes account of the full range of domestic abuse contexts and the need to protect victims and children. Since then, the government has published the Tackling Domestic Abuse Plan (HM Government, 2022), which includes some high-level references to probation work. However, there is still no Probation Service-specific domestic abuse strategy against which progress can be measured. In March 2020, HMPPS launched the domestic abuse policy framework.[17] This document sets out HMPPS expectations and provides comprehensive guidance on all aspects of managing domestic abuse work. However, the rollout of this document has not reached all necessary staff, and, disappointingly, during our fieldwork we found that many practitioners, some managers, and even some senior leaders were unaware of the policy framework and did not use it regularly to direct their work.

Within the HMPPS public protection group, the risk and domestic abuse team focuses on domestic abuse policy and how this is implemented in operational teams. It also ensures that appropriate links exist between domestic abuse and other policy areas, such as sexual offending and Multi-Agency Public Protection Arrangements (MAPPA). This team has also contributed to the development of updated training around domestic abuse. It works closely with the national OASys team, and together they have provided guidance on incorporating risk factors from the SARA into OASys assessments. In our independent review of the case of Damien Bendall (HM Inspectorate of Probation, 2023), we recommended that HMPPS improves risk assessments, to ensure that children's safety and wellbeing are considered fully. In response, changes are being made to the OASys assessment, to support this work and promote a fuller consideration of the impact on children. However, our case inspections show that probation practitioners and managers need to develop this area of practice further, to ensure that the impact of domestic abuse on children is always considered fully.

Information sharing

The government Tackling Domestic Abuse Plan identifies a need for greater collaboration and coordination between and within organisations because:

'Research has shown this is crucial to reducing the prevalence of domestic abuse. When organisations do not collaborate and coordinate internally and externally, opportunities are missed to identify victims and survivors and perpetrators sooner. This also helps to curtail abuse. Plus, sharing crucial information about victims and survivors can help tailor and improve the support they receive.'

[17] HM Prison and Probation Service. (2022). Domestic abuse policy framework. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1106675/domestic-abuse-pf.pdf

To support the flow of information between the police and probation services, a national ISA18 has been negotiated between the Probation Service and the National Police Chiefs' Council which provides a basis for defining arrangements between local probation services and police forces. While the spirit of the agreement is positive in recognising the importance of sharing information, there are gaps, whereby police forces can reject enquiries if the Probation Service cannot identify any known history of violence. Most police forces deliver over and above the provision set out in the ISA; however, the Metropolitan Police Service will reject such enquiries, in order to manage the resource burdens involved. While this has improved recently for domestic abuse checks around electronically monitored curfews, it remains unacceptable that requests to the police for information relating to the risks of people being supervised by the Probation Service in other cases can be rejected.

Given the widespread and often hidden nature of domestic abuse, we expect the Probation Service to make enquiries with the police in all cases, to ensure that every opportunity is taken to identify domestic abuse, and we have made recommendations in previous inspections and independent reviews to this effect. The Probation Service guidance relating to enquiries that should be made at court are currently less stringent and require that:

'Where domestic abuse is a feature of current or previous behaviour, seek information from key agencies such as the police, Children's Services, and any other partnership agencies in contact with and relevant to the individual and victim, where the information is not already known.'

HMPPS domestic abuse policy framework[19]

The Probation Service acknowledges that further improvements are needed to ensure that its standard is met consistently. Once this is achieved routinely, it aims to raise expectations to seek checks in every case. The Probation Service has provided probation regions with extra funding to recruit additional administration staff, to drive improvement in obtaining information from the police and children's social care services. Regional leaders can determine how best to deploy this resource following negotiations with local police forces and children's social care services. Most aim to train staff to use police intelligence systems and, therefore, be able to complete enquiries without adding workload pressure to police forces. Recruitment of staff has been slow in some regions, but most are now starting to fill these roles.

Multi-Agency Public Protection Arrangements

The Tackling Domestic Abuse plan identifies MAPPA as a crucial mechanism for managing domestic abuse perpetrators. However, many dangerous and repeat domestic abuse perpetrators do not receive sufficiently long sentences to qualify them automatically for MAPPA management via category 1 or 2 MAPPA management. In our 2022 thematic inspection of MAPPA (HM Inspectorate of Probation et al., 2022), we considered how category 3 was used to manage high-risk domestic abuse perpetrators. We found that it was underused, and recommended that category 3 MAPPA referrals should be made to manage individuals who present a high risk of domestic abuse where formal multi-agency management and oversight through MAPPA would add value to the risk management plan. As a result, the national MAPPA team has published an updated thresholding document which directs practitioners to consider domestic abuse alongside terrorism, sexual offending, and violence when considering MAPPA management, and provides helpful case scenarios to support practitioners. The HMPPS MAPPA team recently surveyed MAPPA coordinators, and 62 per cent indicated that they had seen an increase in category 3 referrals since the guidance was updated. In addition, a new specific domestic abuse and stalking chapter has been included in the MAPPA guidance. This states, firstly, that all automatic MAPPA cases where domestic abuse or stalking may be an issue should be identified, and, secondly, that all other instances in which domestic abuse or stalking may be an issue should be considered for referral to MAPPA category 3

[18] At the time of writing, the existing ISA was under review.
[19] HM Prison and Probation Service. (2022). Domestic abuse policy framework. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1106675/domestic-abuse-pf.pdf.

by the lead agency, especially where an offence of coercive control has been committed or breach of a civil order (such as a restraining order) has taken place.

2.2 National leadership

When we last inspected domestic abuse in 2018 (HM Inspectorate of Probation, 2018), we found that there was no coordinated leadership directing domestic abuse work. Positive improvements have been made, largely through the National Domestic Abuse Reference Group, chaired by the designated regional probation director lead for domestic abuse. The terms of reference set out the aim of the group as follows:

'…to improve practice in relation to domestic abuse […] by identifying key priorities, supporting implementation of the Policy Framework, establishing the best practice, procedures, and learning from across the country, and publishing processes and documents on Equip to promote consistency in the way domestic abuse is assessed, managed, and recorded across probation regions.'

The group is well attended by representatives from each region, usually by the head of public protection, as well as the national senior policy leads for domestic abuse from the public protection group, EPSIG leads, the business strategy and change team, and senior interventions staff. Bringing together those responsible for policy and operational delivery provides a productive forum which is used to consult on any planned changes in domestic abuse policy and allows operational leaders to feed back concerns about policy.

The group holds regions to account for their progress against actions relating to domestic abuse – for example, by monitoring the use of the SARA tool, which has driven completions from 49.6 per cent to 67 per cent for current perpetrators. In addition, the NDARG has commissioned a domestic abuse dashboard which, when completed, will allow helpful performance information such as the completion rates of SARA and police enquiries to be tracked and progress against aims measured more easily. Another key focus for the NDARG has been to drive progress on the recruitment of additional administrator resources, to support domestic abuse enquiries with the police and children's social care services, and to allow regions to share their approaches to this piece of work and how they have overcome potential barriers.

Regional leads for domestic abuse spoke positively about the group. They valued the opportunity to hear about potential changes and offer their feedback, as well as being able to ask questions of policy leads and hear from other regions about their work. The group provides a strong network to share best practice and ideas around delivering domestic abuse work. The designated lead regional probation director also works closely with the designated EPSIG lead for domestic abuse, and this has led to improvements in the recording of domestic abuse enquiries, to enable data to be produced showing requests made and responses received.

The resources allocated to domestic abuse at a national level are relatively small, considering the high prevalence of domestic this issue within the probation caseload. Nevertheless, the multidisciplinary group that comes together through the NDARG takes a collaborative approach and works hard to drive positive changes.

2.3 Interventions

Effective proposal framework

In 2018, the National Probation Service rolled out the effective proposal framework (EPF) digital platform, to improve consistency and effective intervention proposals in court. Probation practitioners working in court input an individual's details, including gender, age, geographical location, offending-related needs, and offence seriousness, and the tool provides a list of interventions which would be suitable and available to them. Most court-based probation staff told

us that they value the EPF, particularly when completing assessments on people who live outside the local area; however, they said that it takes a long time to complete – time which they struggle to find, given the fast-paced environment of court work. Court staff identified that there had been some glitches within the tool, which could have led to inappropriate proposals, but the team responsible for the tool had made swift adjustments once issues were identified. A further version of the tool, known as EPF2, is now available to support decision-making on conditions that may be attached to a licence following release from prison. Some aspects of the tool need updating, to ensure that the language used fits with the HMPPS domestic abuse policy framework – for example, using the term 'domestic abuse' rather than 'domestic violence', to support practitioner understanding that there does not have to be physical harm involved to be viewed in this category. Within EPF2, the addition of further questions on whether safeguarding and domestic abuse enquiries have been completed on the potential release address would mirror the similar question in the original court-based tool. Both versions of the EPF tool rely on the accuracy of the information that the probation practitioner adds. If relevant information is not included, the tool will not identify the most suitable sentence requirements or licence conditions.

Accredited programmes

Through our fieldwork, we tried to establish the proportion of men given a sentence requirement or licence condition to complete BBR who start the programme, and how many then go on to complete it. Regional programme managers monitor programme completions, but no national data is available. Senior leaders have recognised that this is unacceptable and are working on addressing this gap as part of a broader focus on changes to the national interventions team arrangements. To gain some understanding of this topic, we asked for details of all BBR requirements and conditions made between 21 June 2021 and 30 September 2022, which showed that a total of 6,723 requirements or conditions for BBR were made. At the time that this information was drawn (09 November 2022), a total of 3,287 requirements were recorded as commenced, with the remaining waiting list comprising 2,757, as 679 had been terminated for other reasons. Of these, 489 (18 per cent) had already waited over 52 weeks to start the programme. By 09 November 2022, a total of 594 of the BBR requirements which had started had been terminated – 187 (31 per cent) because they had successfully completed the requirement, and 407 for a range of other reasons, including revocation of their order or licence (245) or activation of a suspended sentence order (95). Due to a backlog of BBR cases resulting from the Covid-19 pandemic and staffing shortages in some regions, the Probation Service was operating a demand management process for BBR. This prioritised high-risk cases over those with lower risk and meant that not all who were given a BBR requirement would be offered the chance to complete it, instead being offered an alternative either through a structured intervention or delivery of the individual Skills for Relationships Toolkit (SRT). Again, no national data was available to give assurance that alternative interventions have been delivered in all cases where BBR would was not available.

The lack of oversight and scrutiny of BRR nationally is highly concerning and provides little assurance that people on probation are being offered the opportunity to complete necessary interventions or fulfil the orders of the court.

Structured interventions

Following the unification of probation services, HMPPS undertook to rationalise the suite of interventions on offer. Before probation services were unified, CRCs had developed numerous lower-intensity interventions that could be delivered during rehabilitation activity requirement (RAR) days. In our previous inspection, we expressed concern that not all of these interventions were evidence based. During the current inspection, we were pleased to see that each of the approved structured interventions had been tested against the principles used by the CSAAP. HMPPS had also convened the national effective interventions panel (NEIP) to assess what are now called 'structured

interventions'. The three structured interventions available which specifically target domestic abuse were Stepwise Relationships, Positive Pathways Plus and Help. Stepwise Relationships and Positive Pathways Plus both consist of 10 sessions in total and are available for both men and women, who have been in either heterosexual or same sex relationships. Help has 15 sessions and is only available for men. In addition, Developing Assertiveness for Women in Relationships is available for women. The guidance for determining appropriate interventions indicates that the target group for structured interventions comprises people assessed as low risk according to their SARA. Where the risk is medium or higher according to SARA, BBR should be the preferred option. However, if the person is not suitable for BBR, the structured intervention can be considered if other criteria are met. There has been no analysis nationally to determine the proportion of the probation caseload that would be expected to be referred to BBR or to structured interventions. While data is available that could be used as a starting point for this work, we were told that the complexity of recording systems used by the Probation Service means that it cannot be identified with any certainty whether someone has already completed an intervention or if they are unsuitable for any reason. Table 1 shows data provided by the Probation Service, detailing the number of referrals to each of the domestic abuse structured interventions since 01 April 2022 (as of 13 February 2023) and the number of recorded completions.

Table 1

	Help	Positive Pathways Plus	Stepwise Relationships
Number referred	249	210	1,696
Number recorded as completed	71	07	199

Toolkits

The SRT was updated and relaunched in May 2022. It has been approved by the NEIP. It had previously been made available for use as the Covid-19 pandemic started. The materials from the toolkit are aligned with the structured interventions and BBR. Therefore, if the circumstances of a person on probation change during the delivery of one type of intervention and they have to be changed to another, this should not mean that a new approach has to be taken with them, and learning already completed would be complementary. There are 35 exercises within the toolkit, with animated video materials to support the learning points of sessions. Those responsible for the toolkit acknowledge that the lack of reliable Wi-Fi in all probation offices has been a barrier to use, although there are workarounds available. Developers of the toolkit are working towards making the toolkit accessible via a mobile phone application, which would negate the need for Wi-Fi and provide more reliable data on usage. The complex recording arrangements within the nDelius case management system means that it is not possible to determine reliably how many people on probation are benefiting from the SRT.

This toolkit is designed for practitioners to select sessions to meet the needs of the person on probation; therefore, there is no set number of sessions and decisions about whether the intervention is complete are at the discretion of the probation practitioner. Data supplied to us as part of this inspection showed that, as of 11 November 2022, there were 3,724 cases where the practitioner had raised a referral for the SRT between 21 September 2021 and 30 September 2022. At the time of the reporting, 2,862 cases were marked as 'active' for the SRT, 554 of which had had no sessions recorded, and 589 only one, in many cases taking place many months earlier, which did not indicate currently active delivery. A total of 149 had the SRT recorded as completed. However, of these, 26 had no sessions recorded against the delivery, and 22 had only one session, which did not suggest

comprehensive intervention delivery. A further 56 had between two and five sessions recorded, 36 had between six and 10, and nine had more than 10 sessions. There is no formal quality assurance for the SRT; it is expected that managers will consider this in their routine supervision.

At the time of the original launch of the SRT, there was no available resource to deliver training to support practitioners to use the materials; there have since been national briefings delivered and the recordings of these are available.

Commissioned rehabilitative services (CRSs)

Under CRS provision, probation practitioners can refer individuals through the 'personal wellbeing - family and significant others' pathway to commissioned providers, to support them to develop or maintain positive family relationships and avoid harmful relationships. Guidance for referrals suggests that this can be used to support compliance with voluntary or mandatory family- or relationship-focused programmes, although we did not see them being used in this way. The available data from regions we visited shows low numbers being referred to these services, and we found only one case that had been referred from our main sample of 60 cases.

2.4 Regional and PDU leadership

Regional probation directors determine the governance arrangements for domestic abuse work in their region. In most areas, responsibility for domestic abuse sits with the head of public protection. Structures within regions vary; some hold a specific domestic abuse board or public protection vulnerabilities group, which drives practice in the region, disseminates any changes, and considers training issues. There was no specific domestic abuse forum in other areas, and the regional leadership team shared practice expectations with the PDU heads to disseminate them, and this also worked well. The particular model employed did not impact the quality of domestic abuse practice in the region. The critical factor was whether domestic abuse was being scrutinised and approached strategically, whether this was through a dedicated domestic abuse meeting or a component of the regional senior leadership team. In regions where we found clear governance, no matter what the structure, we usually found that practitioners were more informed and up to date. Conversely, in areas where we found the poorest-quality practice, we found no evidence of a strategic approach to improving domestic abuse work. Often, these were also the places most severely impacted by staffing shortages, which undoubtedly took up much of the focus of senior leaders.

Good practice example – Wales

The Wales domestic abuse board was launched in 2022. The group aims to set the direction of domestic abuse work in Wales and deliver on the domestic abuse strategy. It reviews communications and actions from the NDARG and the Welsh Government blueprint on violence against women, domestic abuse, and serious violence (VAWDASV). The terms of reference for the board include audit work to ensure that PDUs are implementing the domestic abuse policy framework. The governance for the group is clear, with the head of operations chairing the group and feeding back to the Wales senior leadership team and the head of public protection linking to the NDARG, to ensure that regional and national links are strong. The board's membership includes leads for learning and development, interventions, psychology services, the regional quality and performance team, and the senior operational support manager from each PDU, which means that all aspects of domestic abuse work are represented in the group. The design of this group ensures that there is a clear focus on domestic abuse in the Wales, and the minutes and actions from meetings show that the group looks consistently for opportunities to understand the quality of domestic abuse delivery and identify areas for improvement.

The government Tackling Domestic Abuse Plan (HM Government, 2022) sets out that:

'Local areas should have the right interventions in place for perpetrators. One way we will ensure this is through empowering local areas to develop their own perpetrator strategies and needs assessments for interventions.'

We would expect probation senior leaders to be at the heart of these discussions, to support multi-agency collaboration and the development of local plans to address domestic abuse. We found that all the PDUs we inspected were involved in local partnership meetings about domestic abuse. However, in some, which had been identified as red sites due to low staffing numbers, in order to manage resources, they were only engaging actively in those they had a statutory duty to attend, which impacted the effectiveness of some multi-agency initiatives. In addition, some PDUs span multiple local authorities and therefore have to service meetings in each; in Hereford, Shropshire and Telford, for example, leaders have three sets of meetings to attend, which places high demands on their time.

Strategic leaders responsible for determining local authority approaches to addressing domestic abuse told us that contributions from the Probation Service were essential in developing robust arrangements. Most strategic partners felt that engagement with the Probation Service had been more straightforward since the unification of services. However, many commented that they were aware of the demands on senior probation leaders due to shortages in staffing. Partners spoke highly of probation leaders' contributions by chairing important groups or subgroups, or providing data and information. Representation at partnership meetings was generally at the right level to enable decisions to be made. Some local authorities acknowledged that the local meeting structures placed heavy demands on probation services and that, in some cases, it would be beneficial to merge or streamline meetings to maximise attendance from partner agencies. We were told that, when probation representatives had had to withdraw from non-statutory meetings due to workload capacity, the reasons had been communicated; nonetheless, partners had felt the loss of their input.

Within most PDUs, we found that there was a senior probation officer (SPO) with responsibility for domestic abuse; in others, there was one for each office. The expectations of this lead role varied depending on arrangements within the PDU or the region. For example, some were expected to account for performance data in relation to domestic abuse, while others did not have this expectation and felt that the role was more aimed at being a point of contact for staff queries. In some areas, the SPO lead attended external partnership meetings, such as local authority domestic abuse subgroups; in others, almost all partnership meetings were attended by the PDU head. Due to the lack of SPOs in post, in some PDUs there was no designated domestic abuse lead as there was no capacity to undertake anything other than core tasks, but the PDU head expected that all SPOs were responsible for domestic abuse and safeguarding matters.

2.5 Equipping staff to work with domestic abuse

Probation practitioners

As we have found in many recent inspections, practitioner workloads are excessively high in too many places. For example, 19 out of the 45 practitioners we spoke to had workloads of over 131 per cent of target levels, according to the service's own workload management tool, and many told us that they also had additional tasks covering work for colleagues who were off sick. Probation practitioners showed a firm commitment to reducing domestic abuse, but many did not know how best to go about it or could not work as they would like due to heavy workloads. The significant pressures upon them were apparent in many cases.

Most probation practitioners told us that they had received sufficient training and development to work effectively with domestic abuse perpetrators. However, our case inspection work raised

concerns about practitioners' depth of understanding about domestic abuse work. Although, in general, staff had completed the mandatory e-learning relating to domestic abuse, only three had attended any local face-to-face multi-agency training since the unification of probation services. Many staff told us that they gained little from e-learning or online delivery and would often be distracted by other tasks while undertaking training in this way. They felt that the most effective training would be face to face, with opportunities to discuss cases and learn about updates to legislation and available resources to support them to work with domestic abuse cases. Most practitioners had heard of the Domestic Abuse Act 2021, but few had received specific guidance on what the legislation meant for their practice. For example, when asked what they knew about this Act, a few practitioners were aware that it had introduced the offence of non-fatal strangulation and that there were changes relating to the recognition of children as victims in their own right; however, almost half told us that they knew nothing, or little, about what the Act had changed. Practitioners in some areas were better informed as local briefings on the topic had been delivered during team meetings.

Too often, practitioners lacked knowledge about other organisations involved in domestic abuse work; 41 per cent of practitioners we spoke to told us that they did not know about local support services for domestic abuse. When we asked probation practitioners if they ever had the opportunity to attend training with other organisations in their local area, to share information about their work and find out about other services, few could give examples, and if they could, they related to pre-Covid-19 events. Most local authorities advertise training on safeguarding and domestic abuse, and welcome attendance from partner agencies; however, this was not well known among probation staff. Working with domestic abuse cases inevitably requires liaison and partnership working. To be effective, agencies need to understand each other's roles and thresholds. Therefore, there would be clear benefits to probation staff engaging in multi-agency training and awareness raising, to support their knowledge and understanding of domestic abuse and available services, as well as sharing information about the work that probation services do to increase knowledge within partner agencies.

The majority of practitioners (41 out of 44) had completed SARA training; however, 22 told us that they found the tool 'not very' (20) or 'not at all' (two) useful. The only available training for SARA is a digital online course, which most staff told us was not equipping them to understand or value the tool fully. Some managers and senior leaders were under the impression that for those undertaking the Professional Qualification in Probation (PQiP) or new practitioners using SARA for the first time, a fuller face-to-face option would be available, but this was not the case. Prior to the unification of probation services, some CRCs had adopted an updated version of the SARA tool, and practitioners who had used it were more positive about the value of that assessment, and reported being disappointed at having to return to the previous version in use within the unified Probation Service. Following consideration, the Probation Service has no plans to roll out the newer version of the tool, although is looking at alternative risk assessment tools.

Heavy workloads also had a negative impact on practitioners' ability to familiarise themselves with new materials such as the SRT; many told us that they needed more time or capacity to explore the materials and therefore had yet to use it. In addition, few seemed aware of the national briefings that had been delivered on the SRT, or that they could access recordings of them. In some PDUs, programme facilitators and quality development officers provided briefings to increase familiarity with the materials and build practitioner confidence, which were well received. In addition, some staff told us that they would value the opportunity to shadow more experienced colleagues delivering the SRT, to learn from them; however, this had yet to be offered. Finally, due to the lack of knowledge about the SRT, some practitioners had formed negative views about the materials, based on

misunderstandings; for example, some had determined to refrain from using the toolkit as they felt that the video animations were patronising, but were not aware that viewing these was optional.

Practitioners were not always clear on what was expected of them when working with domestic abuse cases. Where measures were in place under the prioritisation framework for sentence management, the guidance often directed staff to stop intervention delivery and partnership work, to manage resources. However, the adaptations only applied to some staff, as those undertaking the PQiP training were expected to continue operating under usual practice guidance, which caused confusion as they would ask longer-standing colleagues for advice, and they were operating under different rules. Some practitioners were concerned about failing to deliver offence-focused work, and expressed concerns about how their practice would be viewed if the person on probation committed an SFO. Practitioners in areas where measures resulting from the prioritisation framework for sentence management had been in place for some time and had been reviewed and changed were not always clear on the current expectations and had decided to do what they felt was correct, rather than what their managers directed. Where PDUs are significantly understaffed, it is clear that action has to be taken to manage resources; however, interventions and partnership work are crucial elements of effective domestic abuse work. Therefore, these decisions were having a negative impact on the quality of case management. Furthermore, in some cases the support of partner agencies could have relieved the probation practitioner of some tasks.

The HMPPS domestic abuse policy framework sets out provisions available to support staff in working with domestic abuse, and we wanted to explore the effectiveness of these measures. We asked practitioners if they had sufficient management oversight and support with domestic abuse cases, and 38 of the 45 said that they did. However, few said that the emotional labour of working with domestic abuse was addressed with them explicitly. Some practitioners described concerns about the emotional impact of working with domestic abuse cases due to their own lived experiences. Given the prevalence of domestic abuse in the general population, it is likely that many staff will have been affected by this issue in their personal lives. Ministry of Justice guidance is available to support employees experiencing domestic abuse, which includes advice for managers, and some staff were aware of this. Most staff knew about the employee assistance scheme that was available to them, and some reported positive experiences with this. Managers told us that they ask staff about their wellbeing during formal supervision, but also described multiple expectations about what is covered during supervision. Practitioners sometimes felt that supervision is process driven, and one told us:

> *"It doesn't make me feel safe; I always feel like I have missed something."*

Few managers felt able to deliver reflective sessions, allowing practitioners to consider their feelings about their work thoroughly. In addition, we met newly appointed managers who had received no training to support the staff they managed; they reported drawing as best they could on their experience as practitioners but had no other input to equip them. In one area, managers told us that they felt that senior leaders prioritise performance targets over staff wellbeing.

Domestic abuse safety officers

We found the training and support of DASOs to present a mixed picture. For example, in some regions they are required to complete training which qualifies them as IDVAs; in others, there is no specific role-based training, and new staff learn only by shadowing colleagues. Line management arrangements also vary, with some regions having a dedicated manager but others being supervised by managers who also oversee accredited programmes. DASOs in some areas are expected to attend externally delivered clinical supervision, whereas others are not. At the time of our inspection, the DASO role and supporting guidance manuals were under review as they had been published in 2015 and were out of date. As a result, DASOs had insufficient formal guidance

on their work, besides learning from their colleagues. We found the most confident practitioners to be those who had undertaken the IDVA training, which gave them a formal qualification and status, and was particularly helpful in working with other agencies. These staff had the knowledge and ability to provide tangible support to those they worked with, underpinned by research and theory. We heard examples where DASOs with this qualification had been able to apply for civil injunctions and non-molestation orders, which would otherwise cost thousands of pounds through a solicitor. In some areas where DASOs were not IDVA trained, we found some well-intentioned staff in the role who were delivering what they felt was best, rather than working to recognised standards.

Programme facilitators

Academic research (Renehen, 2020) has highlighted that some programme staff feel devalued by the decision not to award BBR facilitators the same pay grade as those who deliver sexual offending treatment programmes. We also heard this concern from programme facilitators, who told us that BBR delivery used to be a specialism which facilitators took on once they were experienced in general offending programme delivery.

While some facilitators did not see a problem in going straight into BBR delivery, as it made the role more varied and interesting, many we spoke to did. They expressed concern that facilitators need to build their resilience first and learn the craft of groupwork delivery before taking on the complex and demanding topic of domestic abuse. Training to deliver accredited programmes was comprehensive, including groupwork skills training and specific training for each programme. The intervention delivery structures give facilitators a range of opportunities to talk about their work, including immediate debriefing with co-facilitators after programme sessions, feedback from treatment management, and supervision with their line manager. As with DASOs, we found a mixed picture concerning clinical supervision, which is no longer routine in all areas but remains mandatory in some. In Cardiff, facilitators told us that they have mandatory counselling twice a year, provided by external facilitators, and supervision with their line manager every four to six weeks, in addition to their programme delivery being monitored by a treatment manager to ensure that the programme is delivered correctly. Facilitators in Cardiff were very positive about the support they received. In some other areas, the process was less clear; although we were told that staff have access to external support, arrangements were less definite.

2.6 Conclusions and implications

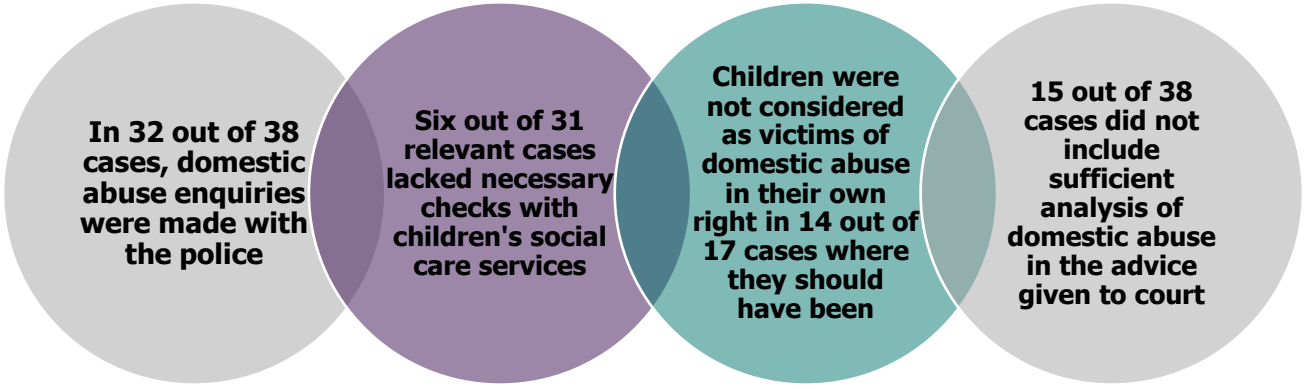
National leadership on domestic abuse has improved since our last inspection. There is now a focused drive to make improvements through the NDARG and an opportunity for policy and strategy leaders to come together with those responsible for operational delivery. A clear domestic abuse strategy for the Probation Service would focus efforts further and provide a mechanism to test progress. Senior leaders need to review national ISAs, to ensure that there are no barriers to obtaining information from police forces, in line with the spirit of the government's overarching plans to tackle domestic abuse. Processes in place to monitor the use of interventions are ineffective and need to be overhauled radically, to ensure that the proportions of people being offered and completing each intervention are known and analysed, to check that they meet the needs profile of domestic abuse cases within the probation caseload. Every effort should be taken to enable people on probation to complete work aimed at reducing their risk of further domestic abuse incidents.

Frontline practitioners are unfamiliar with national guidance and products that could support them with domestic abuse work. More needs to be done within regions and PDUs to ensure that these are used and that practitioners understand what their service expects from them. In addition, the training needs of probation practitioners are not being met, and too many are unfamiliar with the broader domestic abuse landscape and the work of other organisations that they could be working alongside to support victims better and reduce domestic abuse. Those employed in the DASO role must be equipped appropriately to deliver the role. The existing IDVA training offers the best opportunity to achieve this and also provides a qualification recognised by other organisations, which gives confidence in the service being provided.

3. Assessment and planning

In this chapter, we report on the work of the Probation Service in providing advice to court to support sentencing for domestic abuse perpetrators. We then consider the quality of pre-release work and planning for release for people serving custodial sentences. Next, we report on the quality of assessments and plans for individuals who commit domestic abuse. Finally, we comment on the quality of information sharing with other agencies.

3.1 Advice to court



Probation staff have an essential role in supporting courts to make appropriate decisions about sentencing and suitability for the range of interventions available to promote change and desistance from offending. In our core programme of adult probation inspections, we have inspected 140 cases where advice was given to the court regarding concerns about the defendant being a perpetrator of domestic abuse. Overall, we found the quality of advice to courts for this cohort to be similar to the overall quality of court reports. While an appropriate proposal was provided to the court in 83 per cent of cases, only 44 per cent provided sufficiently analytical pre-sentence information to support the court's decision-making. Not all available sources of information, including child safeguarding and domestic abuse, had been used, leading to gaps in understanding who was, or might be, at risk from the individual.

In 32 of the 38 cases we reviewed in this inspection where advice was given to court, court staff either had made necessary enquiries with the police to find out about any history of domestic abuse or already had sufficient information to make an informed assessment of the risk; however, in three cases there no was evidence that a response to the enquiries had been received. In addition to police enquiries, we found that, in 31 cases where information was needed from children's social care services, appropriate enquiries had been made in 25 cases, or sufficient information was already known, leaving six cases where necessary checks had not been made. In four cases, there was no record that a response to the enquiries had been received. The section of the Domestic Abuse Act 2021 that recognises children affected by domestic abuse as victims in their own right came into force on 30 January 2022. However, for 14 of the 17 cases where this had not been considered, reports for court had been written after this date, indicating that probation court staff were not yet fully considering the changes.

In 15 out of the 38 cases, there had not been a sufficient analysis in relation to the risk of domestic abuse. Deficits we identified included failures to analyse previous domestically abusive behaviours or patterns of behaviour. In some cases, there was a failure to recognise the offending as domestic abuse, mainly where the victim was a family member rather than an intimate partner. In 16 of the 26 cases where a SARA should have been completed, it had not been. In a further three, it had been

completed but not accurately, leading to an inappropriately low risk level being assigned. The quality of the SARA assessments was generally poor, with little analysis to support the scoring provided.

Poor practice example

Arnold was sentenced to a 12-month community order with 15 RAR days following an offence of harassing his ex-partner after their relationship ended. The pre-sentence report author did not identify the offending as domestic abuse. Consequently, no enquiries were made with the police to enable consideration of any patterns in relationships or behaviours, and no registrations were added to the nDelius case management system to flag domestic abuse as a concern. No SARA was completed, and the EPF tool was not used.

Our inspection evidenced that, more often than not, courts follow the probation sentencing proposals; in our sample, 24 were followed fully and a further six partially. Sentencers told us that they valued the work of probation staff in the court and were generally satisfied with the quality of the information provided. However, some sentencers raised a concern that sometimes too much information was included in reports, which they felt was more for the benefit of the future probation practitioner who would manage the case, rather than the court. In addition, in some courts, a four-week adjournment was requested to provide a sentencing report. Sentencers felt that this was too long, and concerned them, given their focus on progressing domestic abuse cases swiftly through the courts, in the interests of victims.

The best examples of advice to the court were those that used all available information, including previous responses to supervision, to make a fully informed, realistic proposal. An example is provided below.

Good practice example

Chris was sentenced to 16 months' imprisonment after breaching a restraining order. His conviction history showed numerous offences against the same victim for more than 12 years. The pre-sentence report written for this offence used all available sources of information, including previous assessments and information from the police and children's social care services. It gave appropriate information about Chris's own vulnerability, substance misuse, and negative peer group. The author clearly set out the impact of Chris's offending on the victim. Chris had a history of poor compliance with previous sentences, and this was taken into account when considering how effective potential sentencing options would be in offering opportunities for rehabilitation and protection of the victim.

3.2 Pre-release

Preparation for release from prison is crucial to ensuring that plans are in place to support the individual and protect victims. We have recently reported concerns about pre-release activity, in our joint thematic inspection of offender management in custody (HM Inspectorates of Probation and Prison, 2023), where we found a lack of preparation work for individuals being released from custody. In this inspection, we inspected 28 post-release cases and found that only half had had sufficient pre-release work undertaken. We found instances where there had been little consideration or planning for release. In nine cases, this had resulted in essential licence conditions being missed. Reallocating the case to a new practitioner close to release dates had had a negative impact on some individuals' pre-release planning. We also saw instances where pre-release planning had taken place but focused only on risks related to the index offence, overlooking concerns about domestic abuse. The case outlined below was representative of some of the issues we found in pre-release practice.

Poor practice example

Ed was given a 14-week prison sentence for breaching a restraining order against his ex-partner. He shared children with the victim and had a history of offences against her, and had been supervised by the Probation Service as a result of those offences. He was assessed as posing a high risk of serious harm to the victim and future partners. Ed's case was allocated swiftly, but the probation practitioner made no contact with him before release. Little was done to plan for release, other than a referral for housing support. A screening completed in custody suggested that he was in a new relationship, but the probation practitioner did not pick up on this, and therefore no enquiries were made with the police or children's social care services about his new partner. Ed's offences were alcohol related, but this was not considered in his release plan. Once released, Ed moved his home address several times without permission, and no checks were made concerning the suitability of the addresses. He reported that he was using alcohol regularly, and despite the links to his previous offending, this did not prompt a review. Ed's licence was allowed to drift, with little meaningful activity taking place to reduce the risks of further similar offending.

Overall, we found that planning addressed the risks of domestic abuse sufficiently in only 12 of the 28 licence cases we inspected. The best examples we saw considered all available information about the individual fully and made use of all applicable opportunities to safeguard victims and prevent further offending. A positive case example is shared below.

Good practice example

Brendan was sentenced to custody for serious violence against his wife. His probation practitioner was changed three months before release, and although this took place later than would be ideal, there was a good focus on planning for release. The prison offender manager and community offender manager had a comprehensive handover meeting, and pre-release visits with Brendan took place. The probation practitioner liaised with the victim liaison officer (VLO), to ensure that they considered the victim's needs thoroughly. In addition, they made enquiries via the multi-agency safeguarding hub, to find out information about children that Brendan might have contact with and ensure that appropriate safeguards were in place. Brendan's case was referred to multi-agency risk assessment conferencing, to ensure that all relevant agencies considered the victim's safety. The practitioner assessed that an approved premises placement was needed and that Brendan's case should also be discussed under MAPPA, and completed referrals for both. A professionals meeting and MAPPA level 3 meeting were held before release, ensuring that appropriate licence conditions were set and that protections were in place for the victim. The probation practitioner consulted the personality disorder pathway team to establish the most effective ways to engage with Brendan. They used the guidance provided and discussed plans for release with Brendan, to set expectations, and explained his licence conditions fully. Brendan was referred for support with substance misuse and housing services. Despite the late reallocation of Brendan's case, all appropriate steps were taken to manage the risks he posed and support him to have a successful licence period.

3.3 Assessment

A comprehensive assessment that considers all relevant information about the person on probation is essential to effective planning to reduce the risk of further domestic abuse. In our core inspections, we have regularly been concerned about the quality of assessments. In our current local PDU inspection programme, only 34 per cent of all cases have had an assessment that focused sufficiently on keeping people safe. There is little difference between the quality of assessments for individuals with domestic abuse concerns and those where this is not a feature. In our previous thematic inspection of domestic abuse (HM Inspectorate of Probation, 2018), we found that assessments focused sufficiently on keeping victims safe in 58 per cent of cases. Concerningly, in this thematic inspection, we found that only 28 per cent of cases had an assessment that provided a sufficiently clear analysis of the risks of domestic abuse.

Assessments generally considered the personal circumstances of the person on probation and how these affected the individual's ability to comply with their sentence, although the impact of protected characteristics was less well considered. We found little evidence that race, ethnicity, gender, or culture were being taken into account routinely in considering how an individual might engage with their sentence. In some cases, people on probation had identified that they were a carer, sometimes for their victim, and the implications of this were not always fully considered.

The domestic abuse policy framework sets out that a SARA should be completed in every case where intimate partner abuse has been identified within current or previous behaviour, to assess the likelihood of further domestic abuse-related offending, and is therefore a key component of assessments. Table 2 shows our findings about SARA completions in the 60 cases we inspected.

Table 2

Was a SARA completed as part of assessment?	Number	%
Already completed and up to date	4	7%
Yes, and it is accurate	24	40%
Yes, but not accurate	10	17%
No, and should have been	13	22%
No, not required	9	15%

While SARA assessments usually identified the correct risk level, most we inspected had insufficient analysis to make the assessment meaningful. The inaccuracies we identified often involved previous

domestically abusive behaviours not being included and incorrect details about the individual's current relationship status. Probation practitioners we met were sometimes unclear about whether the SARA tool was suitable for use with women who commit domestic abuse, and this was the case for some of the missing assessments; in others, the assessment had been marked to say that there was no suitable assessor available, although nine were qualified probation officers who could reasonably be expected to have undertaken the appropriate training. As the SARA is used to determine appropriate interventions, it is unacceptable that it is completed poorly in so many cases.

Over half (57 per cent) of OASys assessments did not analyse specific concerns about actual and potential adult victims sufficiently. Only 43 per cent drew sufficiently on all available sources of information. In some cases, while enquiries had been made with the police to understand any previous domestic abuse, the information had not been included in the assessment. In too many cases, the full range of victims or potential victims had not been considered. Where offences had been committed against family members, not within an intimate relationship, the broader risks that the individual posed were not always considered. An example is provided below.

Poor practice example

Dev was given a 12-month community order for a violent offence against his father, which took place in the family home, where he lived with his parents and vulnerable adult siblings. Dev moved out of the family home following the offence. An initial assessment was not completed until four months after his sentence, by which time Dev had returned to the family home. Enquiries were made with the police and children's social care services; however, there was no liaison with adult social care services, despite Dev reporting that he was a carer for his brother. Triggers for offending were identified as the pressures in the family home and alcohol use. There was a history of domestic abuse, and a domestic violence prevention order had also been made. Dev had a partner, and no assessment of risks to her was made.

Probation practitioners sometimes appeared to pigeonhole individuals into one type of offending and failed to draw parallels between different types of domestically abusive behaviour. For example, where abuse had originally been against a family member within the family home, insufficient consideration was paid to risks that might have increased when the perpetrator moved in with an intimate partner. Similarly, some practitioners considered the abuse to be isolated to one relationship and failed to consider the potential for further abuse in new relationships. Practice guidance may be unintentionally contributing to this. Within the OASys tool, when assessing risk, practitioners are required to set a level in four categories: known adults, children, the public, and staff. Current Probation Service guidance directs that:

'A "future partner" (in other words a person in the future with whom they form a relationship) is not a known adult because that relationship is yet to happen and they are not identifiable. You should capture that group under risk to the public.' [20]

(Assessing Domestic Abuse within OASys Guidance, March 2022)

Through discussions with probation practitioners and managers, we concluded that this guidance is not helpful and dilutes the assessment of domestic abuse. Identifying the individual as a risk to the public indicates that they pose a more indiscriminate than specific risk when forming a new intimate relationship. An alternative definition of a known adult, as someone known to them at the point that risk exists, would provide a more precise assessment and might support them in identifying that a new relationship (at which point, the adult becomes known) is a trigger for risk, and that some action is needed.

[20] Assessing Domestic Abuse within OASys Guidance, March 2022 linked via the HMPPS Domestic Abuse Policy Framework 2020.

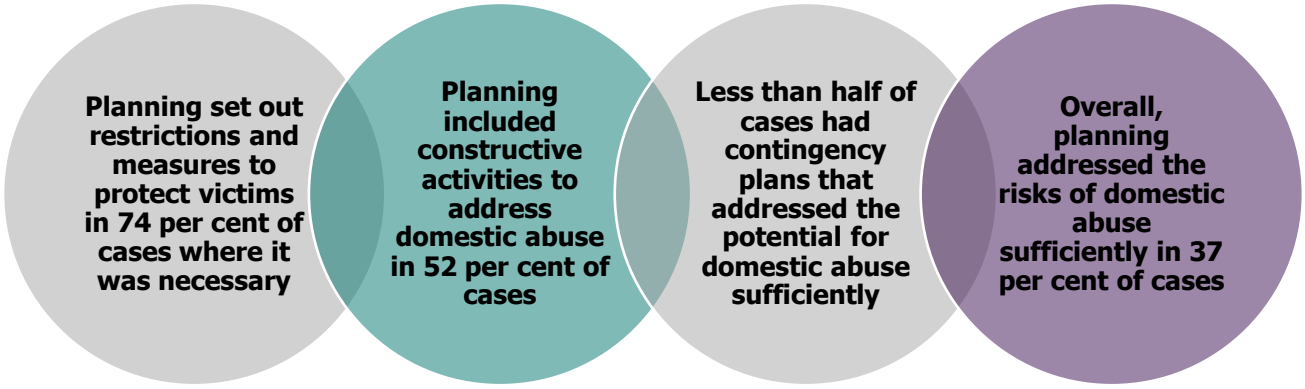
We assessed that the overall level of risk assigned to the cases we inspected was correct in 82 per cent of the cases we reviewed; in one assessment, it was too high, and in 10 cases, too low. Themes among the assessments where risk had been underestimated included a failure to consider previous domestically abusive behaviours and not seeking important information. In addition, some cases did not include actual or potential victims in the assessment. Often, there was an underestimation of imminence; for example, the perpetrator was still living with the victim and little had changed from the circumstances of the index offence.

Assessing risks to children

The welfare of children is affected by domestic abuse, whether they witness incidents directly or live with adults who are victims or perpetrators. In recognition of this, from 30 January 2022, the *Domestic Abuse Act 2021* requires children who experience the effects of domestic abuse to be regarded as victims in their own right, and we hoped to see probation practice taking this into account when assessing risks to children. In our previous inspection, we found that 43 per cent of assessments, where it was required, focused sufficiently on keeping children safe. In the current inspection, we considered whether the assessment analysed specific concerns about actual and potential child victims adequately, and found that it did so in only 45 per cent of relevant cases. Given the recent legislative focus on recognising the need to consider children, we found this extremely concerning.

The practice we have seen does not offer assurance that every opportunity is being taken to safeguard children from the risks of domestic abuse. Probation practitioners are not yet recognising children as victims in their own right or considering consistently their role in the welfare of children connected to individuals who commit domestic abuse.

3.4 Planning



We expect that people on probation have comprehensive plans in place which address the identified risks in the case. Our findings that the assessment of the risk of domestic abuse was insufficient in too many cases clearly linked to the quality of planning, although some aspects of planning were more positive. The views of the person on probation were taken into account in planning in nearly three-quarters of the cases we inspected, and plans usually set out a pattern and type of contact that were sufficient to support planned interventions

Risk management plans were more likely to set out restrictions and measures to protect victims than to include constructive activities. Overall, in 74 per cent of cases where it was necessary, planning set out restrictions and measures to protect victims. In 52 per cent of cases, planning included constructive activities to address domestic abuse. An example of good-quality planning is included below.

Good practice example

Greg received a community order for criminal damage committed at his partner's home address in the presence of their young child. He had no previous convictions, but police had attended the address on previous occasions due to reports of domestic abuse. Following the assessment, a robust plan was created, with Greg's input. Recognising that Greg's upbringing had been difficult, and that he had experienced time in the care system, sources of support were identified to help him. The plan included relevant details of children's social care service activities and actions for the probation practitioner and Greg to undertake, including appointments and meetings. The plan outlined the intervention work that Greg was expected to complete, and it was clear that this had been discussed with him. His work and other commitments had been considered with the planned timescales. The contingency plan included actions that would be taken in the event of known risks re-emerging – for example, new relationships or the resumption of a relationship with the victim, loss of accommodation, or unemployment. The plan provided a sound basis for Greg to work with his probation practitioner, knowing what was expected of him. It also allowed the probation practitioner a solid foundation against which to review progress and consider whether risks had increased or decreased during his sentence.

Domestic abuse work almost always requires probation practitioners to work with other agencies, such as the police or children's social care services, to ensure that victims are protected. Of 55 cases where we expected planning to set out the actions and timescales of the work of other agencies, in six cases this was fully included, in 24 partially included, and in a further 25 cases this was missing. In 42 per cent of the cases we inspected, we assessed that there should have been a reference to some form of multi-agency forum, but this was not included. We were unsure in some cases if this related to a lack of planning to include such forums or if this was a recording issue. Although more recent guidance has confirmed that the multi-agency risk assessment conference (MARAC) should not be referenced in an OASYs assessment (for example, in case the person on probation were to request access to their records, which could unintentionally disclose information about a victim), such activity should be recorded in nDelius, using appropriate recording conventions to safeguard the information. Probation practitioners were aware that they needed to be cautious about including references to MARAC, but this led to some practitioners not recording important information. In addition, we found nine cases where we assessed that MAPPA management would have added value in the case, but this had not been considered.

Risk management plans should include a contingency plan that provides for foreseeable risks that, while not present currently, may arise in the future. However, we found that less than half of the cases we inspected had contingency plans that addressed the potential for domestic abuse sufficiently.

We concluded that planning addressed the risks of domestic abuse sufficiently in only 37 per cent of inspected cases.

3.5 Information sharing

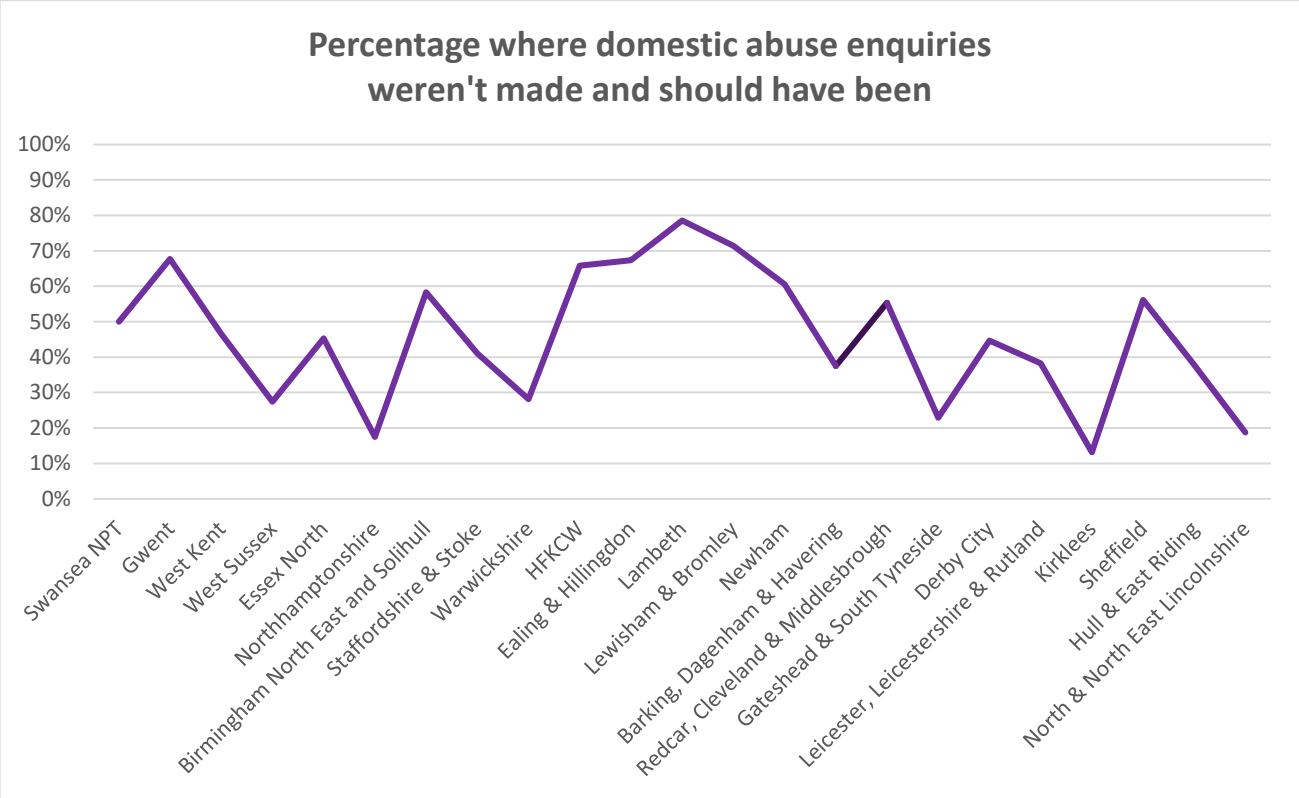
Overall, we found a worrying lack of effective information sharing between probation services and other agencies. This had been done well enough to manage the risk of domestic abuse in only 34 per cent of cases.

There is an ISA in place between the National Police Chiefs' Council and HMPPS[21] to support information sharing between the police and probation services. However, local arrangements to facilitate this vary across England and Wales, and most police forces rightly provide information

[21] At the time of writing, the ISA was being reviewed.

over and above what is set out in that document. We have previously reported[22] on problems experienced in the Metropolitan Police Force area, where information is provided by the police only when the probation practitioner can evidence a known history of violence. We found that probation practitioners in London have a varied understanding of the current criteria. Therefore, they do not always request information when they anticipate that this will be rejected, and do not challenge or escalate rejected requests as they feel that this will not be successful. Figure 1 shows the proportion of cases in our PDU inspection reports published between January 2022 and March 2023 where domestic abuse enquiries should have been made but had not taken place.

Figure 1



Elsewhere, some probation areas have developed highly effective arrangements with local forces, allowing them to receive daily or weekly information about incidents or arrests for people on their caseload. In Hereford, Shropshire and Telford PDU, probation practitioners are able to share the list of cases they are concerned about with West Mercia Police and they will then be provided with any arrest or incident information about those individuals. The most comprehensive example we found was in Cardiff, as detailed below.

[22] Our inspections of six London PDUs completed in 2022 are available on our website: https://www.justiceinspectorates.gov.uk/hmiprobation/inspections/.

Good practice example – Cardiff

The probation service and the police forces in Wales have an agreed semi-automated reportable incidents process for exchanging probation caseload and police incident data. The aim is to ensure that the police force is notified of all offenders under the statutory supervision of the Probation Service in Wales, and that information is transferred from the police force to the Probation Service in respect of offenders involved in a reportable incident. This model supports the proactive sharing of information and intelligence. It aims to ensure that probation staff know relevant risk information and can take appropriate actions to manage that risk. Case administrators receive information and transfer it to the probation case management system. Probation practitioners are then expected to take action concerning the incident in consultation with their managers, and record decisions resulting from it.

In addition to any proactive exchange of information, probation practitioners can make enquiries with police forces periodically throughout the sentence when reviewing risks or when they have a concern that risks are escalating. In some PDUs, we found local agreements in place to facilitate regular enquiries at an agreed interval – for example, every 12 weeks. However, in some instances this led to enquiries being refused between these times, despite concerns having arisen, such as a new partner or increased substance misuse. Not all problems with information exchange were escalated to managers to address.

As part of the inspection, through our second case sample, we sought police intelligence on the individuals, to understand if they had come to police attention since starting a probation intervention. In addition, we wanted to understand if probation practitioners were aware of whether there had been any further domestic abuse or other concerns. In 61 per cent of cases where there had been some police involvement, the probation practitioner was aware of this, in 10 per cent they were not and in 29 per cent it was unclear from the case file whether they knew about it or not. Where proactive systems were in place, such as in the Wales example, practitioners usually received details of any incident swiftly. In other cases, they found out details of an incident some weeks after it had occurred, which meant that opportunities to take action were lost. When probation practitioners made enquiries with the police, it was usually only the local force intelligence system that was checked. The implications of this are that if the individual were to come to the attention of police in a neighbouring force, local checks would not reveal this. The case below demonstrates this issue.

Poor practice example

Logan was given a community order with a requirement to complete BBR following assaults on his partner. Part-way through his sentence, he disclosed that he had started a new relationship. The probation practitioner did not make any enquiries with the police or other agencies about his new partner or refer her to the DASO, who could have provided support. One month after he disclosed the relationship, he was arrested and charged with offences of non-fatal strangulation and other assaults against his new partner. At this point, the probation practitioner made an information request to the local police force which was returned, indicating that they had not had contact with Logan. Further investigation revealed that his new partner lived in a different police force area and therefore checks against the local force intelligence system alone would not have revealed this incident.

The Police National Database (PND) is a national data store of operational policing information and intelligence provided by individual forces. It contains copies of locally held police records, including intelligence about domestic abuse and child safeguarding. If responses to probation requests for

information included checks against the PND, this would reduce the risk of missing crucial information.

When requesting information from the police, probation practitioners were not always clear about what was needed. As the case below demonstrates, we saw some examples of practitioners requesting that case administrators carry out the enquiry without providing sufficient direction about what was required.

Poor practice example

Fraser was sentenced to an 18-month community order with a requirement to complete unpaid work and RAR days, following the breach of a previous order. His original offence was an assault on his mother while she was holding her one-year-old son; her other young child was also present and witnessed the assault. It was unclear from the case records if these children had been referred to children's social care services, and Fraser continued to have contact with his mother and young siblings. During the community order, Fraser disclosed that he had started 'seeing someone' but said that it was 'not yet a relationship'. The probation practitioner accepted this description and did not press for details about the woman or whether she had children. A short time later, Fraser told his probation practitioner that his partner had children and that they were subject to a child protection plan. Fraser's partner lived in a different local authority area, and the practitioner requested that a case administrator submitted an enquiry form to children's social care services; however, they only provided Fraser's details, and not those of his partner or her children. Fraser had never had any connection to his partner's local area, so the response to the enquiry was that he was not known. No further enquiries were made to rectify this error and ask about his partner and her children. In addition, multiple police enquiry forms were submitted, but none contained a clear request or explained the rationale for it. Consequently, the responses did not provide clear information or add value to the risk assessment.

In many PDUs, operational relationships with children's social care services were not working well. Where multi-agency safeguarding hubs included probation staff, working relationships were better and information was shared more effectively. However, there remained room for improvement to ensure that probation staff used the resources available to share information on all children in contact with individuals known to pose a risk of domestic abuse. In too many cases, there was an overreliance on the self-report of the person on probation – for example, the individual telling their practitioner that they did not have contact with their own or a new partner's children – and no enquiries were made to investigate if this was true. In addition, we found cases where, despite clear indications that the perpetrator was in contact with children, this was not investigated to understand whether the children in question were already subject to the involvement of children's social care services or if the contact had been assessed to consider their safety. An example is provided below.

Poor practice example

Ellen was convicted of an affray; details of the offence included an attempt to stab her two adult sons within the family home. Ellen was intoxicated at the time of the offence and reported not coping due to the stress in the family home. At the court stage, Ellen said that she had no contact with any children, so no enquiries were made with children's social care services. At the start of her supervision, Ellen told her probation practitioner that she looked after two of her grandchildren during the week and found this stressful. The probation practitioner submitted this information to children's social care services but did not ask for an assessment, and no follow-up discussion took place to assess the safety or suitability of this arrangement. During her supervision, Ellen reported that her relationship with her husband was abusive and that she was

also a victim of domestic abuse; although support for her was sought through third-sector organisations, there was still no exploration of the safety of the children who were being looked after in the home.

Probation practitioners in some areas told us that their relationships with children's social care services were poor, characterised by not being invited to strategy meetings or child protection conferences, despite their involvement with the relevant child's parent. In one PDU, probation practitioners described the relationship as:

> *"Shocking. We are never invited to meetings and we rarely hear back from them."*

In some PDUs, we found positive attempts to build a shared understanding between probation and children's social care services – for example, by completing a monthly audit of cases referred, to consider the quality of the information provided and the response received. However, we saw little evidence that important issues were being escalated to managers, and even when they were, a resolution was not reached. In one area, we had grave concerns that children were not being referred to children's social care services because the local authority required the consent of both parents to accept a referral. In many domestic abuse cases, one parent may be under the supervision of the Probation Service, and the other might be the victim of the index offence. In such cases, it would be wholly inappropriate for the probation practitioner to contact the victim; however, without this, the referral would be rejected. In this area, some practitioners had stopped making referrals, potentially leaving children at risk. The staff here told us that the situation had been ongoing for over five years. Senior leaders told us that they were aware that it had been an issue in the past, but thought that it had been resolved; they undertook to address it again. In other areas, due to the poor quality of responses when probation practitioners were making enquiries to establish if a child was already known to children's social care services, probation managers were instead advising practitioners to make a full referral about the case, to ensure that probation services had adequately discharged their responsibility to protect children. This could lead to unnecessary work, and a better solution would be for leaders to agree the most effective way of sharing information and therefore resolve the underlying issue.

We heard from a senior probation officer that:

> *"Information is only exchanged after a battle, especially if it is historical information. Possibly, they do not understand the Probation Service's role, but it hinders their, and our, ability to manage risk."*

3.6 Conclusions and implications

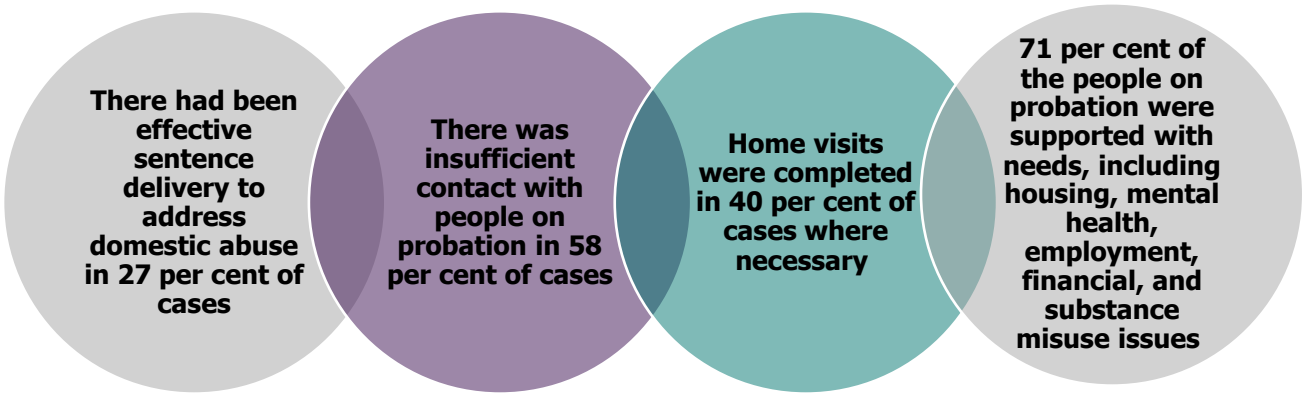
Too often, probation practitioners do not consider important information fully when assessing individuals' risks concerning domestic abuse. Analysis of the critical factors is often insufficient, and these omissions lead to less effective plans which do not address the full range of risks to all potential victims, or mitigate them. Quality assurance and countersigning processes are doing little to address the deficits. Assessing risk to children is an important area that is underdeveloped in probation practice. These findings indicate that probation practitioners need to understand the complex nature of domestic abuse and the factors contributing to such behaviours, in order to assess and plan accurately, and thereby reduce the potential for further incidents.

ISAs with the police do not always ensure that probation practitioners know about new incidents. In addition, arrangements for information sharing with children's social care services are problematic in many areas, characterised by the lack of a shared understanding of each other's roles and responsibilities. As a result, there is an urgent need for probation services to engage in multi-agency training and awareness-raising, to promote a more cohesive approach to managing domestic abuse.

4. Sentence and intervention delivery

In this chapter, we consider how effectively sentences are delivered, including the views of people on probation about their experiences. We then examine the delivery of domestic abuse interventions within the cases we inspected. Further, we report on our findings about the enforcement of sentences when people on probation do not comply, and how well reviewing activity is completed. Finally, we review how the Probation Service supports victims of domestic abuse.

4.1 Sentence delivery



Our overarching question about sentence delivery was whether the implementation of the order or licence managed the risks of domestic abuse effectively. The Probation Service can never eliminate the risks posed by people on probation, but we expect that practitioners take all reasonable steps to manage risks and protect victims. Concerningly, we concluded that there had been sufficiently effective sentence delivery in only 27 per cent of the 60 cases we inspected.

In too many cases, there was simply not enough attention paid to, or engagement in, the case. As reported earlier, some PDUs had significant staffing problems, with correspondingly high caseloads. Measures were in place to manage demand, which led to people on probation being seen less often and with less purpose in some cases. The two PDUs where we found more consistently effective sentence management had better staffing levels.

In 58 per cent of the cases, there had not been sufficient contact with the person on probation to provide effective oversight. The need for consistent, meaningful engagement from the probation practitioner was also a theme in the views expressed by people on probation. One person said:

> *"I've had about 10 to 12 probation officers in a year. When I turn up there I just say 'hello' and I'm out of there within six minutes. I got to travel eight miles to go and say 'hello' and then go."*

Domestic abuse is a sensitive topic; many convicted people feel shame about their actions and are reluctant to open up and speak honestly about the reasons for their behaviour. Building a working relationship with a probation practitioner can make a material difference to an individual's progress in their sentence. In some cases, this had been achieved, as the comment below demonstrates:

> *"Early in the beginning of my sentence I was having issues with my ex, and a lot of the info I was getting from my ex I was feeding into my PO, and she was helping me […] 14 months on probation, with the same officer throughout, it helped a lot, I get on really well with my PO."*

In other cases, individuals lacked confidence in their practitioner, did not feel safe due to changes in the practitioner, and lacked faith in their practitioner's ability to support them. The comments below summarise some of the views that were expressed:

"Unfortunately, the probation officer does not know how to help with the opened-up feelings and thoughts, and you are left for a week or so until your next appointment, trying to deal with those thoughts that are not beneficial to your overall wellbeing. Probation officers need to be able to help put those emotions back in working order. Had four different probation officers in six months, which leaves you very distressed and anxious, and it's not easy. There has to be a way to have the same probation officer consistently. Probation should be trained up more efficiently in mental health – if they are going to discuss it, they should be able to support it."

"Every time I go there, I go and it's like the person you're dealing with is pretending to care about what's going on in your life. They sit there, and they get you to re-answer questions, like re-do worksheets to catch out if you're lying. I had to put a smile on my face but thinking 'this job isn't being done properly'. They are supportive people in general, but they sit down and seem like they want to get deep but they're asking me basic stuff, so you sit down, and the rapport is already broken anyway."

"I come out of there thinking 'what was the point of that'? For instance, two weeks ago I was there, it was the same questions, literally I was there for 10 minutes. She asks what I've been up to, how are things between me and my partner, how I've been coping; she just repeats the same questions over and over. It's like she's reading out of a book. In a sense, the appointments feel rushed, I only have seen her twice because she was not able to attend, and her colleague asks such basic questions. Feels like I'm going around in circles and are more likely to reoffend."

Earlier in this report, we described that most practitioners felt confident in talking about domestic abuse to people on probation. However, our findings indicate that this may be based on too superficial an understanding of the topic. In our previous thematic inspection of domestic abuse (HM Inspectorate of Probation, 2018), we reported:

"There was little assessment and planning to understand and mitigate the effects of previous traumatic events for the service user, such as their own experiences as a victim of domestic abuse or bereavement."

Disappointingly, we saw little evidence that this has improved. Domestic abuse is a complicated multi-faceted area of work, but many practitioners seemed ill-equipped to understand or work with this complexity. For example, we found some cases where the person on probation was both a perpetrator and a victim of domestic abuse. Practitioners sometimes struggled to work with that duality and focused on them being one or the other in managing the sentence, leading to underestimated risks. The example below demonstrates this point.

Poor practice example

Helen was sentenced to a community order with RAR days, a period of unpaid work, and an alcohol abstinence monitoring requirement following an assault on her young daughter. Her children were removed from her and placed in the care of their grandmother. Helen was permitted daily telephone calls with her children, and supervised face-to-face contact once a week. Helen had also been the victim of domestic abuse. Supervision appointments focused almost exclusively on her experiences as a victim, at the expense of addressing her behaviours and the risks she posed to her children. As a result, there was a lack of contact with children's social care services, an underestimation of the risks posed to children, and little thought to how risks would be managed in the future. The practitioner in the case described that she lacked confidence in knowing how to approach a case of this nature.

The HMPPS home visit policy framework[23] evidences the value of visiting people on probation in their own homes and advocates using this as an aid to managing risk. The domestic abuse policy framework confirms that in cases where there are domestic abuse concerns, a home visit should be undertaken within 15 working days from the start of supervision for individuals assessed as presenting a high or very high risk of serious harm, and within six weeks from the beginning of supervision for all other cases. Further, where concerns are escalating, or new domestic abuse concerns arise, a visit should be completed within 10 days. However, we found that only 40 per cent of cases had received home visits where necessary. They tended to be used more regularly in the PDUs with better staffing levels, although use was still below what we would expect.

In addition to managing the requirements of an order or licence conditions, probation practitioners should also be alert to ancillary orders to which an individual may be subject. We found that when a restraining order was made as part of the sentencing for the index offence, the practitioner usually knew about the details of the order. However, too frequently there was little evidence that they were monitoring adherence to the restrictions. The details of orders made in family court proceedings were less often known. There is no central database to check against, making it hard for practitioners to gain details unless orders have been brought to their attention by an IDVA or DASO, for example.

While under supervision, 71 per cent of the people on probation whose cases we reviewed were being supported with a range of needs, including housing, mental health, employment, financial, and substance misuse issues. We saw good work being undertaken in some cases to develop social skills, reduce isolation, and promote pro-social activities through community-based ventures.

4.2 Intervention delivery

As with sentence management, the lack of resources was having an impact on the delivery of probation interventions. People on probation were being prioritised according to risk, to determine when, or if, they started accredited programmes; consequently, some people assessed as posing a low or medium risk of harm sentenced to a BBR would not be offered it. However, according to the framework, they should be given an alternative intervention through a structured intervention or the SRT.

In our main sample, 28 per cent of cases had received a domestic abuse intervention delivered by the Probation Service, and two had been engaged in the externally delivered Drive programme. Table 3 shows the types of intervention delivered in these cases.

Table 3

Type of intervention	Number
Building Better Relationships accredited programme	7
Structured intervention	1
Skills for Relationships Toolkit	6
Other (including workbooks used prior to the unification of services)	3

In a further 27 per cent of cases, there had not yet been any intervention; however, this was appropriate – for example, because other support needs were being met first, or motivational or preparatory work was being completed ahead of the intervention. In 45 per cent of cases, however, we assessed that an intervention should have been delivered but had not been.

[23] HM Prison and Probation Service. Home Visit Policy Framework 2021. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1034080/home-visit-pf.pdf

Of the 17 cases that had started an intervention, we assessed that nine had made sufficient progress and eight had not; for example, there had been delays in delivery which could have been avoided. In almost all cases where the intervention was being delivered by someone other than the probation practitioner, they had maintained a good level of contact with the programme facilitators. In three-quarters of cases, they had supported compliance with the intervention delivery.

Completion rates for those known to have been offered a domestic abuse intervention

We also inspected a second sample of 83 people on probation whose records indicated that they had started a domestic abuse intervention; in most cases, this was BBR. The aim of reviewing this sample was to understand more about the proportion of people who complete interventions, any barriers to progress, and how successful the intervention had been in preventing further domestic abuse incidents. As a result of inadequate recording practices for interventions, it is not always possible to understand the progress made by an individual.

Table 4 shows the intervention status of the sample.

Table 4

Intervention status	Number	%
Complete	26	31%
Ongoing	32	39%
Failed to complete due to non-compliance	10	12%
Failed to complete as intervention not available/delivered	1	1%
Withdrawn – unsuitable	2	2%
Unclear	7	8%
Other (for example, sentence revoked/now in custody)	5	6%

Twelve cases in this sample of 83 were recorded as having started a second intervention; however, none of the sample had fully completed two interventions; more typically, they had been moved from one to another or had been recorded as having started but had not actually done so. We assessed that delivery had been timely in just under half of cases; 21 people in this sample had waited over a year to start an intervention.

Approximately half of the people in this sample had not come to the attention of the police in the period since beginning an intervention; however, 37 per cent (31 cases) had been linked to further domestic abuse, and 14 for other types of offending. Three people had been convicted of further domestic abuse in the same period. The views of people on probation varied, but more were positive about their intervention than not. Of the 20 people from this sample who agreed to discuss their experience, four said that the intervention they attended was not at all or not very helpful in avoiding further domestic abuse incidents, four gave a neutral response, and 12 said that it had been quite or very useful.

Building Better Relationships

In our main sample of 60 cases, 16 had BBR attached to their order or licence, and seven had started this at the time we inspected their case. Waiting times varied: one person started the programme within one to five weeks, four people within 11 to 20 weeks, and two people within 21 to 25 weeks. Relationships between probation practitioners and intervention teams were not always collaborative and, in some cases, obstructed people on probation from gaining access to BBR. We saw delays in probation practitioners completing the paperwork necessary to allow an individual to start the programme. As programme facilitators often work during the evenings, and in some areas from different offices, there was a lack of familiarity between teams. In some cases, unhelpful

assumptions were made about each other's workloads, which led to resentment. Some probation practitioners told us that they referred to programmes and heard nothing back. Expectations were not always clear about what should occur before an individual starts BBR, and there is not always a shared understanding of what it means to be ready for a programme. One programme facilitator summed things up by saying:

> *"We aren't always singing from the same hymn sheet when we put people on programmes."*

In some PDUs, we heard about better collaboration and joint working; usually, this was supported by working from the same offices and having regular opportunities to discuss their cases. Some practitioners lacked general awareness about accredited programmes and what people on probation would experience when they attended. Practitioners undertaking PQiP receive some input about accredited programmes. However, they are no longer required to train to deliver them and therefore have limited opportunity to gain an in-depth understanding of this area of work. Programme facilitators told us that people on probation who have had a comprehensive induction as part of their order or licence from a practitioner who is familiar with the requirements of accredited programmes are better prepared and more likely to complete BBR.

We had some concerns about people with diverse needs being placed on BBR without sufficient consideration being paid to their ability to engage – for example, where English was not their first language. We saw two cases where it appeared that individuals did not have adequate use of English to be able to engage meaningfully in BBR but had been assessed as suitable for it.

Some people who attended BBR described positive changes they had made as a result of the programme. Some examples are provided below.

> *"Before going on the course my mind set was one way and after the course it was another. It made me take a step back and realise I was in the wrong. So, taking that forward it will help me. Stop me from going to prison. By realising my way of thinking may not have been the right way."*

> *"The way my tutor explained things was brilliant. The way he talked to the group was very clear. The coping mechanisms were spot on. Had I learnt this sooner I wouldn't have been in this position. He also let me speak and have an opinion, which is important. He was brilliant."*

Other participants were less positive about their experiences and some found it uncomfortable to share details of their personal lives in a group setting. The comments below reflect the negative views that were expressed.

> *"Boring, it's weird the way they word it out, it's a bit childish. They need to make it grown up a bit."*

> *"…a load of rubbish. […] I'm shy and I don't want other people knowing my business. My business is my business, it's confidential at the end of the day. I know they said it's confidential in that room between us all but at the end of the day I don't want them other 10 lads knowing my s***."*

Some people on probation and programme facilitators expressed concerns about a lack of support after people completed BBR. While there is an expectation that probation practitioners complete post-programme work to reinforce learning, we saw little evidence that this takes place routinely. In too many cases, after BBR was completed, practitioners reduced reporting frequency, and appointments were little more than check-ins. One group member had taken it upon himself to support other group members, and told us:

> *"The only problem I would say is that some people could benefit from help afterwards you know. I personally cope with a lot of things but there was a few of the boys who were on the course with me who actually took my number. They kept contact with me, and they were asking me for help and stuff. I just advised them as best as I could."*

Structured interventions

In our main sample, we found only one case where any structured intervention had been delivered; this had involved only two sessions, and then they had commenced BBR. Many probation practitioners were unclear about which people on probation were eligible for domestic abuse structured interventions, as the criterion states that this should be those who are assessed as low risk according to the SARA tool. Practitioners told us that this was rare among people flagged as perpetrators or former perpetrators of domestic abuse. In most PDUs, structured interventions had only recently become available; in others, there had been no delivery. In London, we were told that all cases on waiting lists for accredited programmes were screened for suitability for structured interventions. As a result, 500 referrals (across all structured interventions, not just domestic abuse related) were generated. However, while some cases we saw had been referred, none had started, as they had begun BBR in the intervening period.

Skills for Relationship Toolkit

We found six cases in our main sample where sessions from the SRT had been delivered. Of these, there was only one where there had been consistent, meaningful use of the toolkit; in most others, there had been only one or two sessions delivered and there were no indications that further sessions were planned. In one case, the practitioner had delivered four sessions but told us that they intended to stop delivering them as they found the materials patronising. Despite the availability of national briefings on the SRT, many practitioners told us that they were not confident or familiar with the materials and therefore had not attempted delivery, despite having suitable cases on their caseload. In recognition, several regions had started briefing sessions to support staff, often led by programme facilitators and quality development officers, which practitioners spoke highly of.

Some practitioners felt uncomfortable about the directions given not to deliver interventions under the prioritisation framework for sentence management arrangements. One told us:

> *"We are not supposed to deliver the toolkit due to workloads, but I do. I'm worried how it would look if there was an SFO and I had not done anything."*

4.3 Enforcement

In our case inspections, we found that probation practitioners, in general, tried to support compliance with interventions, and enforcement was used in 70 per cent of the cases where it was needed. We saw examples where cases were allowed to drift, with too many absences being accepted with no valid reason. In some cases, this became a pattern that diluted the purpose of the sentence. The case below is an example.

Poor practice example

Karol was sentenced to an 18-month community order with requirements to engage in alcohol treatment and attend BBR. Karol had limited understanding of English. There had been many police call-outs to domestic incidents before he was convicted of harassing his ex-partner in the presence of their young child. Planning in the case failed to provide clear timelines for actions and did not indicate how he would be supported on the programme, given his limited understanding of English. There was a long delay in completing the referral to the DASO, which meant that opportunities to support his ex-partner were missed. Of 19 appointments offered to him, Karol only attended five. Ten absences were recorded as acceptable, most without a clear rationale for the decision, and one attendance had no outcome recorded. Karol was subsequently arrested for further offences against the same partner.

We heard about tensions between programme facilitators and probation practitioners over the way they handled the absences of participants. Probation practitioners told us that they find programme rules inflexible; for example, if a person on probation misses more than two programme sessions through genuine illness, they are removed from the group. However, as participants are often expected to attend twice a week, this can occur due to a short period of illness. Where BBR is being run as a rolling programme, participants can rejoin the group at the next module; however, there can be significant delays if it is a closed group. We also heard concerns from sentencers about whether enforcement was being used appropriately. They sometimes saw cases eventually being returned to court when their view was that action should have been taken much sooner and in line with the expectations they had set when passing sentences.

4.4 Reviewing

Reviewing practice was poor overall, too often failing to address changes in factors linked to domestic abuse or to make adjustments to ongoing work. The case below provides an example where the receipt of important information should have led to a comprehensive review, but this did not take place.

Poor practice example

Jay was convicted of breaching a non-molestation order and sentenced to an 18-month community order with requirements to complete RAR days and unpaid work. He had previous convictions for other domestic abuse offences against the same partner. Some of his previous offending had been triggered when his partner became pregnant, which he was unhappy about. Part-way through his sentence, Jay informed his probation practitioner that his new partner was pregnant, and he was not happy about the situation. This information did not prompt any reviewing of his case or any activity to assess the safety of his new partner. Some weeks later, Jay reported that his partner had terminated her pregnancy. No enquiries were made to check on her welfare.

In over half of the cases where it was necessary, information had not been gathered from other agencies to inform reviewing. We found that risk registrations on nDelius were not up to date or appropriate in 35 per cent of cases. In several instances where the probation practitioner had assessed that risks were no longer current, the domestic abuse perpetrator registration had been removed, but not replaced with the appropriate domestic abuse history marker.

Too few enquiries had been made with children's social care services and the police to inform reviews of cases. In some instances where information had been gathered, it was not analysed sufficiently or used to inform sentence management. In over half of our case sample, there was no review of the risk of serious harm classification where this was needed. In six cases, the risk level was changed for no apparent reason; in one case, the risk level was reduced when the person on probation was part-way through BBR. Overall, we assessed that reviewing focused adequately on the risk of domestic abuse in only 23 per cent of cases.

4.5 Managing disclosures

The HMPPS domestic abuse policy framework sets out that in all cases where domestic abuse has been identified as a relevant factor, practitioners must:

'…consider disclosure in all cases where a person convicted of domestic abuse begins a new relationship, including while in custody.'

The policy framework goes on to say that probation practitioners must decide whether disclosure is needed, and this will be when the need to inform and protect a potential victim outweighs the perpetrator's right to privacy. Further guidance requires practitioners to consider the risks of not disclosing and the harm that may arise from the disclosure. It encourages practitioners to seek advice from their line manager when unsure. Once it is decided that disclosure should occur, the

policy framework provides methods that may be used, including an informal conversation, using the domestic violence disclosure scheme, or an immediate disclosure where there is an imminent risk. The document also emphasises that it is important that those receiving disclosure have access to specialist advice and support, which may include a referral to the DASO if the person on probation is attending BBR. Finally, the policy framework states that the decision-making and any disclosure should be recorded in the nDelius case management system.

Practice around disclosure varied significantly, and in some cases we assessed it to be dangerous. Where cases were current to MAPPA or MARAC, or referred to the local domestic violence disclosure scheme, multi-agency decisions were made about whether disclosure was needed and, if so, what the content should be. Where disclosures were made outside of those forums, we found no evidence of a systematic approach to consider disclosures. We heard examples where practitioners had provided information to new partners during telephone calls where the person on probation was present, and unable to manage the aftermath. In other instances, practitioners told us that they had shared police intelligence with new partners without consulting police colleagues to gain permission. The national guidance provided was insufficient to support decisions or delivery adequately. Practitioners expressed a range of views about disclosure, with some stating clearly that they did not feel it was part of their role, and others telling us that they gave information to new partners of perpetrators routinely, without consulting managers about the content of this information or how it could be shared safely. In some cases where probation staff made disclosures, we found little evidence that the potential vulnerabilities of the person receiving the information had been considered or that services that could support them had been engaged.

Where known perpetrators of domestic abuse start new relationships, efforts should be made to safeguard their partners; however, this needs to be considered carefully, to ensure that the information shared is proportionate to the risks and does not increase the risk of harm unintentionally. In our view, except in exceptional circumstances, probation practitioners should not make decisions about making a disclosure, or the content of the disclosure itself, without the input of the police and other specialist services.

Since our inspection fieldwork, new guidance has been issued to probation staff, to clarify that they should not be making disclosures themselves but should be working with the police and children's social care services to ensure that information is given to those who need it, with appropriate measures in place to support them.

4.6 Supporting victims

In addition to sentence management, the Probation Service is responsible for two services to support victims: the victim contact scheme, delivered by VLOs, and the DASO service. VLOs offer a contact service to victims where the perpetrator of their offence is sentenced to a prison sentence of 12 months or more for specified violent or sexual offences. They can provide updates on key stages of the prisoner's sentence and refer victims to sources of emotional support. DASOs offer support to victims or new partners of men undertaking the BBR programme or people completing some domestic abuse-related structured interventions. In addition to the services delivered by the Probation Service, victims deemed at high risk of harm and discussed at the MARAC may also be supported by an IDVA, whose role is to support the victim and develop safety plans. IDVAs are employed by third-sector organisations independent of statutory agencies, to provide risk assessments to identify a victim's level of risk of abuse, represent their voice, and act as their advocate. Other third-sector services also support victims not assessed as being at high risk. In our case inspection work, we found that in eight of nine cases where a VLO was involved in the case, the probation practitioner was in sufficient contact throughout the sentence to ensure that information was shared about changes in the case – for example, to allow the victim to request that specific conditions were added to release licences, to offer them protection. Only 15 of the cases we

inspected met the criteria for the DASO service;24 of these, one declined to engage with the service. Of the 14 cases where victims or new partners were open to DASOs, we assessed that contact between the practitioner and the DASO during the period of supervision had been sufficient in only six cases; in some, the probation practitioner had had no contact at all. Timely referrals were not always made to the DASO service, which led to missed opportunities to offer support and safety planning earlier on. When contacted long after the perpetrators had been sentenced, DASOs told us that victims were more likely to decline the service as they had tried to move on. We also saw cases where important, relevant relationship changes had been missed due to insufficient contact. The case below is an example of this.

Poor practice example

Ian received a suspended sentence order with BBR and RAR days following an assault on his partner and the police officers who attended to intervene. A restraining order was issued at the time of sentence, preventing Ian from contacting his partner. Their case had been discussed at the MARAC. Ian and his partner had been together for seven years, and there had been reports of abuse throughout the relationship. Ian's partner engaged with the DASO service; however, there was no contact between the DASO and the probation practitioner for some months, during which time Ian's partner had applied to have the restraining order revoked, which the probation practitioner was not aware of. Ian was having contact with his partner and her children. As the practitioner did not know about these developments, no enquiries were made to the police or children's social care services. Contact with the DASO was later established, once Ian started BBR, which allowed information to be shared and a fuller understanding of Ian's circumstances to be gained, so that they could be monitored appropriately.

Probation practitioners had little contact with IDVAs. In 12 out of 15 of our sample cases where an IDVA was involved, there had not been sufficient contact with them, and in seven cases it was unclear if there had been any liaison. Some practitioners lacked knowledge about the IDVA service and were unclear on the boundaries or appropriateness of sharing information. In each PDU, we met those providing the IDVA services, and they had had mixed experiences concerning contact with probation practitioners. Some told us that they rarely had contact with probation practitioners other than at MARAC meetings; there was regular communication in other areas. Similarly, in some areas, contact between DASOs and IDVAs was rare, whereas it was better in others, and in some cases handover took place between the two services. We heard from some victim support services that they were working with the victims of perpetrators who were on probation, and struggled to obtain information to support them in their work.

We spoke to four people who had been supported by the DASO service, and each spoke positively about their experience. The key factors that had led to their positive views were being given information and options but being allowed to come to their own decisions about what actions they wanted to take, without any sense of being judged. In one case, after the perpetrator had completed intervention work, the victim had decided to resume her relationship and told us:

> *"They supported me to have the restraining order amended to enable the relationship to be rebuilt. [DASO] didn't judge but supported me to have appropriate safeguards in place. They gave me the confidence to know I'm not alone. They have never given an opinion or judged but validated my feelings, let me make my own choices but gave me support."*

What people want from the DASO services varies; some only want information about BBR, and others value the safety planning aspect of the role. In addition, the DASO service is delivered differently across England and Wales, with some areas only offering telephone contact. By contrast,

[24] Originally 17 in our sample had a requirement or condition for BBR but two had been removed.

others meet face to face; this usually depends on the geographical area they have to cover and the resources available.

4.7 Multi-agency work

Probation practitioners engage in a range of multi-agency forums that support managing domestic abuse. In most PDUs, designated MARAC representatives attend meetings on behalf of their colleagues. This role is usually fulfilled by probation practitioners, although SPOs attend in Wales. In most cases, partner agencies who chair the MARAC meetings were positive about the contributions of probation staff. However, in some cases, there had been gaps in attendance or representatives had attended without full information about the case. Where the Probation Service was the referring agency, MARAC chairs reported that it was beneficial for the referring practitioner to present that case, but this did not always happen. Probation practitioners were not always clear about how to record MARAC information in their case records, which sometimes led to a lack of clarity about whether cases had been discussed, particularly when they had been transferred between practitioners.

In our joint thematic inspection of MAPPA (HM Inspectorate of Probation, et al., 2022), we found that not all cases that should have been referred into MAPPA as discretionary cases were treated in this way. In this inspection, we found that practitioners were more aware of this pathway, and saw some evidence of domestic abuse cases benefiting from MAPPA management, although we still identified nine cases where a referral to MAPPA would have added value but had not taken place.

In some PDUs where domestic abuse was identified as a local priority, perpetrators fell under the integrated offender management (IOM) arrangements and were managed jointly by the police and probation services, which provided good-quality sentence management. We were particularly impressed with the work of the Wisdom team in Cardiff, where police and probation staff work in collaboration with forensic psychologists and other local partners to manage a high-risk cohort which includes high-priority domestic abuse cases. The team is co-located, which ensures good communication and a joined-up approach across each agency. In recognition of the risk and complexity of the cases it manages, the Wisdom team usually has a smaller caseload than most probation practitioners. We have highlighted the work of this team in the Effective Practice Guide that is published alongside this report. The case below is a positive case example managed by this team.

Good practice example

Nigel was sentenced to 10 months in custody for offences of coercive and controlling behaviour, assaults, and criminal damage against his partner. The offences had taken place over an extended period during their year-long relationship. A full assessment of the case was provided, which detailed previous concerns about domestic abuse. Due to the level of risk he posed, Nigel was identified as suitable for management by the Wisdom team. The forensic psychology service informed the approach of all agencies through a detailed case formulation which informed how offence-focused work could be adapted to suit Nigel's needs. Appointments with his probation practitioner included focused work on relationships, decision-making, and attitudes. All agencies involved monitored Nigel's behaviour closely, and swift action was taken to issue warnings against his licence when he was found to be breaching a condition restricting access to social media. Nigel was supported in finding ways to reduce his social isolation and to find employment. He was also given opportunities to engage in pro-social activities to reduce stress and provide relaxation. After a period of sustained progress, Nigel's risk level was reduced to medium risk of harm, and his appointment frequency was reduced. However, a robust contingency plan remained in place, setting out actions to be taken if risks increased.

We also saw an example of advice provided by the Metropolitan Police's Stalking Threat Assessment Centre, which supported the probation practitioner in how to work with a challenging case and identified additional sources of support. This service is commissioned by the Mayor's Office for Policing and Crime and is run as a partnership by the Metropolitan Police Service, the Probation Service, and the Suzy Lamplugh Trust.

4.8 Use of community resources

The Probation Service manages people with complex lives who have often experienced a range of traumatic events. Some people on probation for matters unrelated to domestic abuse will have experienced this issue, and some people will have been identified as both victims and perpetrators. Alongside national helplines, there are organisations in local communities offering expert and specialist support services to people experiencing domestic abuse. As part of this inspection, we wanted to understand how probation staff engaged with these services and if they used them to good effect to support people on probation. In our interviews with probation practitioners, 41 per cent said that they did not know about local support services for domestic abuse. Even among those who felt that they had a good awareness, many did not know about specialist services for minoritised individuals. Most PDUs had a directory of services available, but staff were unfamiliar with the work of many organisations listed. Through partnership meetings, we heard from some organisations that they receive referrals from probation practitioners rarely; one service providing support for medium-risk victims of domestic abuse said that, at most, they receive one referral every three months but more often they receive none.

We inspected three PDUs where the Drive project[25] was being delivered. Drive was developed in 2015 by Respect, SafeLives, and Social Finance to address a gap in work with high-harm perpetrators of domestic abuse. The project was developed out of a need to address the many perpetrators who were repeatedly offending with either the same or new victims. Eligibility for Drive is identified through the MARAC or, in some cases, a domestic abuse perpetrator panel. If an individual is assessed as eligible, Drive takes a multi-agency approach to addressing the risks in the case, including support for victims and focused police disruption activity, as well as intervention with the perpetrator. Evaluation of Drive has shown promising results. The Tackling Domestic Abuse Plan (HM Government, 2022) states:

'An evaluation of the Drive Project indicates that participation resulted in reductions in abuse and risk amongst users of the service, with physical abuse reduced by 82 per cent and jealous and controlling behaviours reduced by 73 per cent. The cost of delivering Drive, estimated at £2,400 per perpetrator, compares favourably to the social and economic cost to society of high-risk perpetrators, at £63,000 per perpetrator.'

In the sites where Drive was active, we found good collaboration with probation staff and appropriate exchange of risk information. An example of a positive case is highlighted below.

Good practice example – Hereford, Shropshire and Telford PDU

Russ was sentenced to an 18-month community order with RAR days and unpaid work following offences of criminal damage and stalking. He had also committed domestically abusive offences against a family member. His initial engagement with his sentence was poor, and he expressed rigid views and discriminatory attitudes towards women, minority ethnic groups, and the LGBTQ+ community. These views initially prompted his probation practitioner to refer him to the Prevent team. Although Russ did not meet the criteria for that intervention, some helpful actions and guidance were provided, including consultation with the offender personality disorder pathway, an autism screening, and liaison with children's social care services, to obtain information about

[25] Further information about the Drive project is available at: http://driveproject.org.uk/.

Russ's experiences as a child. Through these activities, the practitioner had a better understanding of Russ's behaviour and gained insight into his offending. Russ was adopted onto the local IOM scheme, and, following guidance from the psychology input, the practitioner adopted a different approach with him, to develop a better rapport. As a result, Russ agreed to work voluntarily with the Drive programme to address his domestic abuse offending behaviour. Regular information was shared between Drive and the probation practitioner. Drive offered intervention in a flexible way that responded to Russ's needs, allowing the probation practitioner to coordinate activities and focus on risk management. The change in approach resulted in him becoming more respectful and not displaying negative attitudes and beliefs. In addition, the controls and monitoring via the IOM scheme and the Drive programme supported additional risk management and constructive activities.

In Croydon, and Hereford, Shropshire and Telford PDUs, participants had to engage voluntarily in the Drive intervention, although police disruption activity would be applied even if individuals chose not to engage. However, in Cardiff, a different approach was taken and the project there collaborated to use RAR days for Drive activity, which they described as giving the initial lever for individuals to engage. Those responsible for delivering Drive in Cardiff spoke positively about relationships with probation staff, developed over the seven years they have operated. We have highlighted further examples of the work of Drive in our Effective Practice Guide.

4.9 Conclusions and implications

In too many cases, sentence delivery is not focused sufficiently on the risks of domestic abuse. In many cases, probation appointments are too infrequent and do not offer meaningful work to reduce further offending. Changes in probation officers impact the willingness of some people on probation to trust their supervising officer. Overall, too few people on probation are engaged in domestic abuse interventions and often wait too long to start. While structured interventions and practitioner toolkits have been through a process to approve their content, we saw little evidence that their use was making a positive difference.

There are too many missed opportunities to protect victims and potential victims of domestic abuse. Arrangements for making disclosures to new partners of domestic abuse perpetrators lack the necessary rigour to ensure that appropriate information is shared safely. Access to the support on offer for victims and partners of perpetrators is sometimes delayed due to late referrals to the DASO scheme and the lack of awareness of community resources. In addition, probation practitioners rarely liaise with IDVAs, who often hold important risk management information which could make a material difference to risk assessments. However, where probation practitioners work in specialist multidisciplinary teams with smaller caseloads, the quality of domestic abuse work is dramatically improved.

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Annexe 1: Glossary

Accredited programme	A programme of work delivered to offenders in groups or individually through a requirement in a community order or a suspended sentence order, or part of a custodial sentence or a condition in a prison licence. Accredited programmes are accredited by the correctional services accredited panel as being effective in reducing the likelihood of reoffending.
Building Better Relationships (BBR)	BBR is a nationally accredited groupwork programme designed to reduce reoffending by adult male perpetrators of intimate partner violence.
Child protection	Work to make sure that that all reasonable action has been taken to keep to a minimum the risk of a child coming to harm.
CRC	Community Rehabilitation Company. These organisations held contracts to deliver some probation services, including managing people assessed as posing a low or medium risk of harm, and the delivery of accredited programmes and unpaid work. CRCs operated between June 2014 and June 2021, when probation services were unified into the Probation Service.
HM Prison and Probation Service (HMPPS)	The single agency responsible for both prisons and probation services. See note below on NOMS.
IDVA	Independent domestic violence advisers: provide support to survivors of domestic abuse living in the community and assessed as being at high risk of further domestic abuse.
Integrated offender management (IOM)	Integrated offender management brings a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together.
MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison, and other agencies work together locally to manage offenders who pose a higher risk of harm to others. Level 1 is ordinary agency management where the risks posed by the offender can be managed by the agency responsible for the supervision or case management of the offender. This compares with levels 2 and 3, which require active multi-agency. management
Multi-agency safeguarding hub	Multi-agency safeguarding hubs act as the first point of contact for new safeguarding concerns or enquiries. They usually include representatives from the local authority (children and adult social care services), the police, health bodies, probation services, and other agencies.

Ministry of Justice	Responsible for major parts of the criminal justice system in England and Wales, including courts, prisons, probation services, and attendance centres.
nDelius	National Delius: the approved case management system used by the Probation Service in England and Wales.
NOMS	National Offender Management Service: until April 2017, the single agency responsible for both prisons and probation services, now known as HM Prison and Probation Service (HMPPS).
National Probation Service	A single national service which existed between June 2014 and June 2021. Its role was to deliver services to courts and to manage specific groups of offenders, including those presenting a high or very high risk of serious harm and those subject to MAPPA.
OASys	Offender assessment system currently used in England and Wales by the Probation Service to measure the risks and needs of offenders under supervision.
Partners	Partners include statutory and non-statutory organisations, working with the participant/offender through a partnership agreement with the Probation Service.
PDU	Probation delivery unit.
Providers	Providers deliver a service or input commissioned by and provided under contract to the Probation Service.
Pre-sentence report	This refers to any report prepared for a court, whether delivered orally or in a written format.
Probation Officer	This is the term for a 'qualified' responsible officer who has undertaken a higher education-based course and achieved the relevant qualification. The name of the qualification and content of the training varies, depending on when it was undertaken. They manage more complex cases.
Probation Services Officer (PSO)	This is the term for a responsible officer who was originally recruited with no qualification. They may access locally determined training to 'qualify' as a probation services officer or to build on this to qualify as a probation officer. They may manage all but the most complex cases depending on their level of training and experience. Some PSOs work within the court setting, where their duties include the writing of pre-sentence reports.
Rehabilitation Activity Requirement (RAR)	From February 2015, when the Offender Rehabilitation Act was implemented, courts can specify a number of RAR days within an order; it is for probation services to decide on the precise work to be done during the RAR days awarded.

SARA	Spousal Assault Risk Assessment, to be used where intimate partner abuse has been identified in current or previous behaviours. SARA can be used to assess men and women involved in heterosexual, same-sex, and transgender intimate partner relationships.

Annexe 2: Methodology

This inspection sought to answer the following questions:

Does leadership support and promote the delivery of a high-quality, personalised, and responsive service for all perpetrators and victims of domestic abuse?

- Does strategic decision-making enhance and enable effective practice?
- Do structures and operating models support effective practice?
- Are appropriate information-sharing agreements in place with all relevant agencies to inform domestic abuse work?
- Are the plans for monitoring, assurance, and evaluation of interventions sufficient?

Are staff within the Probation Service empowered to deliver a high-quality service for all perpetrators and victims of domestic abuse?

- Do staffing and workload levels support the delivery of a high-quality domestic abuse service?
- Are domestic abuse cases managed by practitioners with the right level of knowledge and skill?
- Are practitioners provided with the right guidance, development, support, and oversight to manage domestic abuse cases ably?

Is a comprehensive range of services and interventions in place to undertake work with domestic abuse cases?

- What analysis does the Probation Service undertake to identify and provide an appropriate range of interventions?
- Does the Probation Service provide the volume, range, and quality of services to meet the identified need?
- Are there appropriate interventions available to cater for the diverse needs of service users?
- Are the domestic abuse interventions sufficiently aligned to the current evidence base?
- Are there appropriate quality assurance measures in place for all domestic abuse interventions?

How well do practitioners support desistance from domestic abuse behaviour?

- Do practitioners engage the person on probation sufficiently at each stage of a case?
- Are assessment, planning, and review good enough to support the delivery of good-quality, personalised, well-coordinated interventions?
- Do service users participate in and complete appropriate and timely interventions?
- Is enough attention given to preparing service users for interventions and managing progress and compliance throughout the sentence?

How are victims and their children supported and protected?

- Is there appropriate information exchange, where required, with victims or their advocates at relevant stages in a case?
- Are the needs of victims given sufficient priority at a strategic and practice level?
- How well do practitioners monitor non-harassment, restraining orders, and other orders?
- Do practitioners use disclosure appropriately and have a good understanding of the domestic violence disclosure scheme (DVDS; often referred to as Clare's Law)?

Are arrangements with statutory partners, providers, and other agencies established, maintained, and used effectively to deliver high-quality services?

- How well does the Probation Service participate in strategic partnership initiatives, agreements, and policies relating to domestic abuse?
- Does the Probation Service contribute effectively to multi-agency arrangements (e.g. (MARAC)/multi-agency tasking and coordination (MATAC), child protection conferences)?
- Do practitioners work effectively with other agencies to protect and support victims, and aid the desistance of perpetrators?
- Is information about domestic abuse gathered and shared with all relevant agencies, including police and children's social care services, in timely way at appropriate points of assessment, sentence delivery, and review?

Expert Reference Group

An expert reference group contributed to this report by advising on strategic and operational issues associated with domestic abuse work. The group represented stakeholder perspectives and commented on emerging findings and final recommendations. Group membership included:

Rachel Nicholas – Head of Service, Victim Support
Nicole Jacobs – Domestic Abuse Commissioner
Jessica Eagleton – Policy and Public Affairs Manager, Refuge
Jo Todd CBE – Chief Executive Officer, Respect
Suzanne Jacob OBE – Chief Executive, SafeLives
Rosie Jarvis – Head of Programme and Practice, Respect
Sara Kirkpatrick – Chief Executive Officer, Welsh Women's Aid
Farah Nazeer – Chief Executive Officer, Women's Aid England
Paul d'Inverno – HMI Specialist Adviser, Child Protection, Ofsted
Stephen Thomas – Deputy Portfolio Director, Joint and National Police Inspections Portfolio, HM Inspectorate of Constabulary and Fire & Rescue Services
Professor Marianne Hester OBE FAcSS, Bristol University
Suki Binning – Executive Director of Justice and Social Care, Interventions Alliance
Assistant Commissioner Louisa Rolfe OBE – Lead for Domestic Abuse, National Police Chiefs' Council
DCC Maggie Blyth – Violence Against Women and Girls National Lead, National Police Chiefs' Council
Davina James-Hanman – Associate at Supporting Justice
Professor Gail Gilchrist, King's College London
Professor David Gadd, Manchester University
Professor Elizabeth Gilchrist, Edinburgh University

Fieldwork

Our fieldwork inspected the work of six probation delivery units (PDUs): East Lancashire, Surrey, Croydon, Cardiff and The Vale, Hereford, Shropshire and Telford, and Oxfordshire. Our fieldwork sites included metropolitan and more rural areas, to ensure that we gained a rounded picture. Fieldwork was completed between December 2022 and February 2023, followed by a further week to consider arrangements at a national level.

We inspected two samples during the fieldwork; the first was a sample of 60 cases that started an order or licence six to seven months before our fieldwork, with a domestic abuse perpetrator or domestic abuse history flag attached to their record. For these cases, we inspected the quality of the case management work and interviewed the probation practitioner where possible.

In our second sample, we looked at 83 cases where the person on probation was recorded as having started an intervention seven to nine months before our fieldwork. We explored whether the intervention had been fully delivered and any reasons for non-completion. During each fieldwork week, we held meetings with a range of staff, managers, senior leaders, and operational and strategic partners. We also spoke to a small number of sentencers and four women receiving the services of domestic abuse safety officers (DASOs).

In each fieldwork area, we held meetings and focus groups, including: probation practitioners, senior probation officers (SPOs), programme facilitators and treatment managers, strategic and operational partners, PDU heads, and domestic abuse safety officers (DASOs). Additionally, we were able to observe MARAC meetings in one PDU and a recording of a Building Better Relationships session. We also spoke to four people who were being supported by the DASO service.

During our final fieldwork week, we met those responsible for domestic abuse policy and strategy at a national level.

We commissioned User Voice to undertake remote semi-structured interviews with people on probation. Consultants with lived experience of the criminal justice system gathered the views of 55 individuals identified as perpetrators of domestic abuse who had been managed by the Probation Service.

Characteristics of main case sample

Sex	Number	%
Male	54	90%
Female	6	10%
Race and ethnic category	**Number**	**%**
White	50	83%
Black and minority ethnic	10	17%
Not clearly recorded	0	0%

Sentence	Number	%
Community order	22	37%
Suspended sentence order	10	17%
Licence	28	47%

Grade of current or last probation practitioner	Number	%
Probation officer (member of staff with a recognised probation qualification)	40	67%
Trainee (member of staff currently on a formal training programme to achieve a probation officer qualification)	7	12%
Probation service officer (member of staff working directly with service users, without a recognised probation officer qualification)	13	22%

How many victims of domestic abuse has the perpetrator had?	Number	%
1	25	42%
2	20	33%

3	10	17%
4	2	3%
5	0	0%
6 or more	3	5%

For how many years has the person on probation been identified as presenting a risk of domestic abuse?	Number	%
<01	4	7%
1 – 3	20	33%
4 – 6	14	23%
7 – 9	12	20%
10+	10	17%

Annexe 3: Data tables[26]

The tables below show data from some of our key questions and summary judgements.

Court work

Did the pre-sentence information to court sufficiently analyse the risk factors linked to domestic abuse to facilitate safe sentencing?	Number	%
Yes	17	45%
No	21	55%

Assessment

Does assessment analyse protected characteristics and the impact these may have on engagement?	Number	%
Yes	38	63%
No	22	37%
Does assessment draw sufficiently on all available sources of information?	**Number**	**%**
Yes	26	43%
No	34	57%
Overall, did assessment provide a sufficiently clear and thorough analysis of the risks of domestic abuse?	**Number**	**%**
Yes	17	28%
No	43	72%

Planning

Does planning set out constructive activities aimed at addressing domestic abuse, including timescales?	Number	%
Yes	31	52%
No, and should have done	29	48%
Does planning set out restrictions and measures in place to protect victims?	**Number**	**%**
Yes	34	74%
No, and should have done	12	26%
There were no restrictions required in the case	14	–
Overall, did planning sufficiently address the risks of domestic abuse?	**Number**	**%**
Yes	22	37%
No	38	63%

[26] Due to rounding, percentages may not sum to 100 per cent.

Implementation and delivery

Have any domestic abuse interventions been delivered in this case?	Number	%
Yes	17	28%
No, and this was acceptable	16	27%
No, and should have been	27	45%
Throughout the sentence, was information shared sufficiently with other agencies involved with managing the risk of domestic abuse?	**Number**	**%**
Yes	18	34%
No	35	66%
Not applicable, no other agency involved	7	–
Was the nature and level of contact sufficient to support the management of the case overall?	**Number**	**%**
Yes	25	42%
No	35	58%
Overall, does the implementation and delivery effectively manage the risks of domestic abuse?	**Number**	**%**
Yes	16	27%
No	44	73%

Reviewing

Does reviewing identify and address changes in factors linked to domestic abuse, with the necessary adjustments being made to the ongoing plan of work?	Number	%
Yes	26	49%
No	27	51%
Not applicable, no adjustments required	7	–
Was information from other agencies involved in the case gathered and used to inform reviewing?	**Number**	**%**
Yes	28	48%
No	30	52%
Not applicable, no other agencies involved	2	–
Were child safeguarding enquiries made as needed throughout the sentence?	**Number**	**%**
Yes	19	36%
No	34	64%
Not applicable, not required	7	–

Were domestic abuse enquiries made as needed throughout the sentence?	Number	%
Yes	26	44%
No, and should have been	33	56%
No, not required	1	–
Was information from other agencies involved in the case gathered and used to inform reviewing?	**Number**	**%**
Yes	28	48%
No	30	52%
Not applicable, no other agencies involved	2	–
Overall, does reviewing focus sufficiently on the risks of domestic abuse?	**Number**	**%**
Yes	14	23%
No	46	77%