HM Inspectorate of Probation

Independent review of the case of Joseph McCann

Contents

1. Foreword

The impact of violent and sexual offences for the victims may be life-long and cannot be underestimated. For the victims of Joseph McCann this impact is worsened by the knowledge he could have been in prison when the offences occurred. If the right actions had been taken by the probation service, he would have been kept in prison until the Parole Board determined he was safe to release.

Joseph McCann was being supervised by the National Probation Service (NPS), following his release on licence from prison, when he committed a series of violent and sexual offences that resulted in him receiving 33 life sentences in December 2019. We have examined in detail the case management and policies in the period leading up to these offences in April and May 2019 and identified significant failings in local supervision but also some issues that need national attention. We make a number of recommendations in relation to these issues.

A primary role of the NPS is public protection. To ensure the public are protected from offenders such as Joseph McCann, who present a high risk of serious harm to other people, the NPS has the authority to recall offenders from the community back to prison when they are in breach of the terms of their release or when it seems that their risk can no longer be managed in the community. Using this authority requires skilled judgement by practitioners and managers to decide when someone can continue to be managed safely in the community or when public safety demands they return to custody.

In this review we found that serious mistakes were made and this judgment was not properly exercised. No fewer than eight opportunities were missed between 2017 and Spring 2019 to ensure Joseph McCann could not be released from prison without a further Parole Board hearing or to recall him to prison. Indeed, on two occasions a decision was taken to revoke his Imprisonment for Public Protection (IPP) licence but for a variety of reasons these were not executed. The individuals responsible for these failures in his supervision have rightly been held to account. We found, however, that their decisions were taken against a national policy context which emphasised that 'alternatives to recall' should be used whenever it was safe to do so, given increasing pressures on prison capacity in 2017 and 2018.

Joseph McCann is a complex, dangerous offender who can be intimidating and controlling, yet was able to present himself positively to staff. Those making the decisions about him should have taken account of his long history of serious offending, his poor compliance with court orders, his behaviour in prison, and indications of his increasing risk. Information and intelligence about his behaviour was available but was spread between various criminal justice recording systems and not easily retrieved. Most worryingly, prison staff did not proactively share information with NPS staff responsible for his management.

As a result, those managing Joseph McCann did not have a clear picture of who they were dealing with. Their decisions and actions were based on inadequate and incomplete assessment, were not scrutinised sufficiently and sometimes not implemented.

Probation staff managing high-risk individuals require well developed skills: to interview effectively; to seek out and analyse information from a range of sources; to see beyond superficial compliance. They also need their managers to provide good oversight, investigative supervision and effective support. The supervision of Joseph McCann took place in an environment where, as we noted in recent previous reports, probation officers

and managers were faced with intolerable workloads and little access to the necessary, high quality professional training.[1] [2]

Individual errors in the case have received appropriate attention. In this report we have highlighted the need for broader changes across the probation system to ensure that staff and managers have both the skills and the resources required to undertake the task of protecting the public from dangerous offenders. We have made a number of recommendations to HM Prison and Probation Service (HMPPS) and the NPS that we believe will improve the ability of the probation service to protect the public.

Justin Russell
HM Chief Inspector of Probation

[1] HM Inspectorate of Probation. (2019). *An inspection of the South East and Eastern Division of the National Probation Service.*

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

2. Background to this review

On 09 December 2019, Joseph McCann (JMc) was sentenced to 33 life sentences for seven counts of rape; rape of a boy under 13; three counts of sexual assault; causing a boy under 13 to engage in sexual activity; seven counts of kidnap; 10 counts of false imprisonment; attempted kidnap; and two counts of offending with the intention of committing a sexual offence. The sentencing judge ordered that he should serve a minimum sentence of 30 years imprisonment before he could be considered for parole. In addition, JMc was sentenced to a 14-year concurrent sentence for causing a boy under 13 to engage in non-penetrative sexual activity and a 10-year concurrent sentence for causing a girl or woman to engage in sexual activity and of multiple offences of kidnap and rape. These offences took place between 21 April 2019 and 05 May 2019.

These were pre-meditated, predatory, violent and sexual offences which were marked out by JMc's cruelty and callousness. Victims unknown to him across England, from the North West to the South East, were targeted regardless of age or gender. JMc subjected them to a series of violent, threatening and humiliating ordeals. A feature of the offences was the absence of any remorse and JMc's relentless desire to bully and control as the offending continued. Indeed, each offence appears to have fuelled further his desire to inflict cruelty and sexual humiliation. Further offences were only prevented by his eventual arrest by the police.

At the time of these offences JMc was subject to supervision by the NPS South East and Eastern Division following his release from prison on licence on 15 February 2019.

The NPS has acknowledged there were serious failings in its supervision of this case. A comprehensive internal Serious Further Offence (SFO) review was undertaken by them, which includes a detailed chronology of the supervision of JMc over a 15-year period and clearly identifies deficits in individual practice of probation staff and their managers. On request, SFO reviews can be disclosed in full to the victims of the offences. This disclosure was undertaken in this case and, exceptionally, the Ministry of Justice produced a review for publication distinct from the redacted review shared with the victims who requested it.[3]

The circumstances of the case caused serious public concern. On publication of the SFO review in March 2020, the Lord Chancellor and Secretary of State for Justice commissioned a separate independent review to be undertaken by HM Inspectorate of Probation.

[3] Ministry of Justice. (March. 2020). *Serious Further offence review in the case of Joseph McCann.*

3. Terms of Reference

This independent review is in two parts: the first part, presented in this report, examines the circumstances leading up to the serious further offences committed by JMc in April and May 2019; the second part, which will be undertaken later in 2020, involves a wider, national thematic review of the 'culture and practice' within the probation service around recall to prison of those released on licence. Part two will be informed by our findings from part one, where we also refer to these broader issues.

The review undertaken by HM Inspectorate of Probation has not sought to replicate the detailed findings of the NPS's own SFO review. We have, however, used the findings of that review to identify lines of enquiry where failures were apparent and to focus on those issues that appeared to be of most direct relevance to the outcome of the case. This approach led us to ask broader questions about policy and practice, and to examine the context and circumstances surrounding the supervision and decision-making in relation to JMc. In doing so, we intend that our findings go beyond the individual case and address areas for improvement across the wider probation system. In addition, we interviewed a range of staff directly involved in the supervision of JMc and reviewed a wide range of documentation relating to the case, including all the relevant case files and policy guidance.

We have also reviewed the sufficiency of actions taken at a local, divisional and national level since May 2019, to address the issues identified in the internal SFO review.

This review primarily covers the management of JMc following the imposition of an indeterminate sentence for public protection in September 2008; his subsequent release in March 2017; his arrest and return to custody for burglary in August 2017; and his re-release in February 2019. During this period of time, two divisions of the NPS were involved in his supervision: the South East and Eastern division where the responsibility for his case was held and the South West South Central division during the periods when he lived in that area.

The detailed scope of this review covers the following:

Failure to recall

- Why was JMc not recalled on his IPP licence between August 2017 and February 2019 to ensure that he could only be re-released from prison after a Parole Board hearing?
- Did the following issues have an impact on the failure to recall: practice guidance; management oversight; policy expectations; staff training and understanding; and operational culture?

Underestimation of risk of harm

- Why was the risk of harm presented by JMc, as evidenced by his previous offending behaviour over a long period of time, not fully recognised at the point when recall on the IPP licence was considered? Earlier assessments contained pertinent information – was this lost or had the significance diminished over time?
- How effectively was information recorded, transmitted and used over a lengthy time period, including transfer of this information between prisons and between probation staff?
- How effectively did agencies work together to share and analyse information and manage risk in relation to JMc?

- How did workload, skills and experience affect the quality of risk of harm analysis by NPS staff?

Lack of appropriate interventions

- Why was there no focus on his reported sexual interests during his IPP sentence and subsequent release on licence?
- Why was a psychopathy assessment not completed during JMC's imprisonment and why was he not referred to the Offender Personality Disorder Pathway[4] prior to his release?
- What issues related to policy, resources and staff skills affected the focus and quality of work undertaken?

Release planning and release

- What were the policy drivers for the release of IPPs and how were these understood by probation staff in this case?
- How effectively did release planning work in this case?
- What were the barriers to effective release planning and how did they affect probation practice?

HMPPS action plan

We have reviewed the action plan prepared following the internal SFO review in 2019. Our lines of enquiry include:

- Do the planned actions sufficiently address deficiencies identified in the review?
- Are there gaps in the actions planned?
- Are there additional gaps identified by HM Inspectorate of Probation's review?
- Have the agreed actions been implemented?
- Have appropriate actions been taken in relation to responsible individuals?

[4] The Offender Personality Disorder Pathway is an initiative jointly commissioned by NHS and HMPPS that provides a pathway of psychologically informed services for complex and challenging offenders who have a severe personality disorder, and who pose a high risk of serious harm.

4. Chronology of key events

This chronology outlines the significant events relating to JMc's offending history, identifying any emerging practice issues while subject to prison and probation supervision.

A brief chronology	
1998-2003	13 convictions for: burglary, theft, criminal damage, threatening behaviour, escape from lawful custody, aggravated vehicle taking, driving whilst disqualified and handling stolen goods
29 July 2004	Sentenced to 62 months imprisonment for affray, robbery and dangerous driving
13 September 2007	Released from 62-month sentence on licence. Supervised by the NPS
02 November 2007	Recall to prison instigated by the NPS for non-compliance with licence. Warrant for arrest issued
27 December 2007	Commits offence of aggravated burglary
15 January 2008	Arrested for breach of licence and aggravated burglary
26 September 2008	Sentenced to indeterminate sentence for public protection (set minimum tariff of 30 months) for aggravated burglary
July 2010	Parole review – not released
March 2012	Parole review – not released
January 2014	Parole review – not released
April 2015	Parole review – not released
October 2016	Parole review – hearing adjourned to January 2017
January 2017	Parole Board agrees release subject to conditions including residence at an approved premises
28 March 2017	Released from prison on IPP licence
22 July 2017	Commits domestic burglary
18 August 2017	Arrested for dwelling house burglary and remanded into custody
25 January 2018	Sentenced to three years imprisonment for dwelling house burglary
15 February 2019	Automatically released from prison on licence after serving custodial part of three-year determinate sentence. IPP licence had not been revoked and was still in force
04 April 2019	Assistant Chief Officer warning issued for breach of licence following JMc's non-disclosure of a new relationship
23 April 2019	NPS notified by the police that JMc was suspected of sexual offences. Emergency recall instigated
05 May 2019	JMc arrested and charged with a series of sexual and violent offences
09 December 2019	JMc sentenced to 33 life sentences

Terminology used in this review

In our references to probation staff involved in the management of the case we have, for consistency, used the same abbreviations as those used in the SFO review, for example,

OM1, SPO1 etc. Not all personnel referred to in the SFO review are included in this report. For consistency with the published SFO review, we have used the term 'offender manager' instead of the term 'responsible officer' that we adopt in our core inspection reports.

NPS staff involved in the management of JMc's case

Staff member	Role
OM1	Offender manager based in the Watford office responsible for JMc's case from December 2008 until April 2010
OM2	Offender manager based in the Watford office responsible for JMc's case from May 2010 until February 2013
OM3	Offender manager based in the Watford office responsible for JMc's case from January 2013 until March 2015
OM4	Offender manager based in the Watford office responsible for JMc's case from March 2015 until August 2016
OM5	Offender manager based in the Watford office responsible for JMc's case from August 2016 until January 2019
OM6	Offender manager based in the Ipswich office who saw JMc in a caretaking role between March and July 2017 during his period of residence in an approved premises
OM7	Offender manager based in Buckinghamshire who saw JMc in a caretaking role between July and August 2017, following his move to the family home address
OM8	Offender manager based at the Watford office who was responsible for the case between 02 January 2019 and 21 January 2019
OM9	Offender manager based at the Watford office who was responsible for the case after 21 January 2019
OM10	Offender manager based at the Buckinghamshire office who saw JMc in a caretaking role between February and April 2019
SPO3	SPO based in the Watford office and the line manager of the offender managers responsible for JMc's case between January 2013 and October 2018
SPO4	SPO who covered the Watford office and was involved in recall decision in August and September 2017 and March 2019
SPO5	SPO at the Watford office and the line manager of the offender managers responsible for JMc's case at the Watford office between October 2018 and April 2019
ACO1	ACO has been Head of Hertfordshire LDU since March 2017 and was responsible for the line management of SPOs 3,4 and 5

5. Summary of key findings

In sections eight to thirteen of this report we analyse the management of JMc during his IPP sentence and following his release into the community. For a more detailed account, please refer to the published findings of the SFO review.[5]

In section 15 we analyse the wider issues arising from this case.

In this summary we focus on our key lines of enquiry and summarise why, in our view, the failures occurred.

Failure to recall

As he had been sentenced to an IPP sentence, JMc could and should have been recalled when he was arrested for burglary in July 2017 while still on his IPP licence. Between then and his eventual release in February 2019, there were eight separate occasions when probation staff were aware of the possibility of revoking his IPP licence but failed to do so. Taking this action would have ensured he was not released automatically when he completed the determinate sentence imposed for the new burglary offence.

Decisions not to recall JMc were too focussed on his involvement in the further burglary offence and were not based on an analysis of his patterns of behaviour, including his most recent behaviour on licence. A detailed assessment of JMc's behaviour would have identified that his risk of serious harm had increased, and he should have been recalled. This was poor assessment practice and poor operational decision-making.

In our view, the short-term focus of decision-making was influenced by the NPS's Alternatives to Recall guidance[6] and the NPS IPP action plan.[7] These documents directed offender managers to consider alternatives to recall in all cases. The strategy's purpose was to reduce the number of recalled prisoners, and in doing so, reduce overall pressures on a rapidly growing prison population. These were valid aims in the case of offenders who could be managed safely in the community. The written guidance around recall stayed the same, but there was a change in the way the guidance was applied and scrutinised. There was a requirement to consider alternatives to recall in every case before recall could be approved. Areas with 'high' recall rates came under management scrutiny. Together, these changes sent a clear message to frontline staff that recalls were to be avoided where possible.

While the strategic push to reduce recalls in 2017 may have influenced the initial decision not to recall JMc, that decision was later rescinded in October and November 2018. But those later decisions to recall him were never actioned, despite concerns being expressed to those responsible. High workloads and staff turnover were a factor in this inaction, but beyond management oversight, there was no process to ensure recall decisions were implemented. The failure to recall was unacceptable.

Other than senior management sign-off, there is no quality assurance of NPS recall decisions, in particular, decisions not to recall someone on licence. The recall decisions in respect of JMc were, therefore, not reviewed formally. Recall decision-making is a key element of probation public protection practice and yet there is no process to ensure it is undertaken consistently and effectively.

[5] Ministry of Justice. (2020). *Serious Further Offence review in the case of Joseph McCann.*

[6] NPS. (2017). *Alternatives to Recall team briefing pack.*

[7] HMPPS. (2017). *IPP action plan.*

Underestimation of risk of harm

Essential risk and historical information in probation information systems is inconsistent and frequently inaccessible. Practitioners relied on OASys[8] inappropriately as the main source of information. This system was not designed or intended as a repository for all information about a case. Information may be stored elsewhere in different locations on nDelius by different divisions, teams and practitioners.[9] Other information may be on prison systems, or in ViSOR (Violent and Sex Offender Register).[10] As a result, key information can either be lost or very difficult to access.

Assessment practice was too focussed on OASys completion. It did not include a comprehensive review of all key sources of information. The use of the police system (ViSOR) was not central to the assessment of JMc's potential for violent and sexual offences. Consequently, earlier concerns recorded by the police in relation to his sexual behaviour were not identified. Probation assessments did not include the analysis, interrogation and interpretation of key information.

Probation officers and other professionals failed to analyse fully JMc's behaviour in prison and historical patterns of behaviour. Despite the apparently successful completion of programmes, JMc's core behaviour and attitudes had not changed. This was not identified. Professionals responsible for programmes and offender managers relied too heavily on JMc's own self-assessment as evidence of progress. Prison security information was not pro-actively shared and, therefore, risk management decisions and parole reports were based on incomplete information.

Assessments for the Parole Board focussed on justification for release rather than public protection. The quality of reports was poor, but they were still endorsed by managers. During this period, NPS staff were encouraged to progress IPP prisoners through their sentence to their eventual release.

JMc was not managed at MAPPA (Multi-Agency Public Protection Arrangements) Level 2 on his first release in 2017 and should have been. As an IPP prisoner assessed as high risk of harm, he should have been the subject of multi-agency management. MAPPA management does not always equate directly to the level of risk of harm, but this should always be central to the reasons for increased oversight and management. Following his release from prison in February 2019, JMc was managed at MAPPA Level 2 but was moved to Level 1 management 12 days after his release. This was too soon. Multi-agency management at MAPPA Level 2 was still required to manage his assessed high risk of serious harm.

Lack of appropriate interventions

JMc's interpersonal skills and ability to manipulate staff were underestimated. His behaviour and mental health in prison was perceived to improve, based on his immediate presentation. This did not take sufficient account of his previous threatening and violent behaviour. Assessments based on his immediate behaviour and the belief that there were no longer any significant mental health concerns, resulted in no further mental health assessments after 2014. The failure to undertake further mental health assessments meant that a key risk factor identified previously in JMc's sentence was not assessed prior to his release. Nor was he referred to the Offender Personality Disorder Pathway, either in prison or post release.

[8] OASys is a risk assessment tool used by NPS staff to assess all offenders.

[9] NDelius is the case management system used by the NPS to record information and contact with offenders.

[10] ViSOR is the computer system shared by the Police, NPS and Prison service to share information on MAPPA category violent and sexual offenders.

Police intelligence detailing JMc's potential for sexual offences was not analysed fully and incorporated into his overall risk assessment. Later, details that were in the assessment were not used in the risk of harm analysis. As a result, sexual offending was not identified as a potential risk requiring intervention.

The assessment and management of JMc's case after 2015 and until his final release from prison demonstrated poor probation practice. This was undertaken within a context of high staff vacancies and excessive workloads for the offender managers managing the case. The management of complex individuals like JMc requires skilled and experienced practitioners. JMc was managed by an unstable team lacking experienced and skilled practitioners.

Release planning and release

The risk management plan in place at the time of JMc's release in 2019 was insufficient to manage the risk of serious harm he posed. He should have been placed in an approved premises and should not have been allowed to reside with his family. This was further undermined by the premature move to manage JMc through probation-only supervision at MAPPA Level 1, rather than through multi-agency management at MAPPA Level 2.

There is a high demand for beds in approved premises; JMc, as a high risk of harm IPP prisoner being re-released, should have been prioritised. The South East and Eastern approved premises central referral unit (CRU) was not effective in identifying an emergency bed and the responsibility was left with the offender manager to try to locate a space. The lack of a bed for JMc's release meant a key element of the risk management plan was not in place and he returned to wholly inappropriate accommodation.

The sentence and release planning for JMc's release in February 2019 were inadequate. The instability in the South and West Hertfordshire team at the Watford office is demonstrated by the three different offender managers who were responsible for the case in the months before JMc's release. The team suffered from poor management oversight, high workloads, poor performance and high staff turnover. These were central factors in the poor release planning.

The current arrangements for transferring people under supervision between different NPS divisions are applied inconsistently by Local Delivery Units (LDUs) and divisions. They do not always take into account the profile of individuals subject to probation supervision or include regular professionals' meetings attended by the offender managers involved. Cases undergoing temporary transfer for supervision by another NPS division are not prioritised consistently by HMPPS. Their significance and frequent complexity is not recognised by their inclusion in the Workload Measurement Tool.

The arrangements for transferring the supervision of JMc from the responsible team in Watford to a different NPS team in Buckinghamshire did not follow the directed practice in either 2017 or 2019. Insufficient risk information was sent with the request for a temporary transfer and there was inadequate planning for his supervision in a different area. Licence breaches communicated to the responsible offender manager in Watford, were not fully assessed and scrutinised. This meant that the supervision of a high risk of serious harm, manipulative offender was not well coordinated and was not sufficiently robust.

6. Key recommendations

HMPPS should:

1. ensure that probation staff are able to access all relevant information about an individual, including from historical case records
2. ensure prisons comply with the requirement to share all relevant information, including from prison security departments and records of prison behaviour, with the Parole Board
3. require prisons to share all relevant information, including from prison security departments and records of prison behaviour with probation offender managers in prison and in the community to assist with parole reports and recommendations and with planning for release
4. ensure there is sufficient capacity in the approved premises estate to accommodate all high risk of harm offenders who require a placement.

NPS should:

5. ensure that the new recall framework is fully embedded in practice
6. introduce quality assurance processes to review the consistency and outcomes of recall decisions. This should include cases where recall was considered but not instigated as well as cases where it was approved
7. ensure that recall decisions are recorded and implemented regardless of staff absence. A digital prompt should be built into the nDelius system to remind offender managers and their line managers of the need to execute a recall until this action is marked as completed or cancelled by the relevant ACO
8. ensure that probation staff have adequate time to become familiar with complex cases for which they assume responsibility
9. improve the professional training of qualified and experienced probation staff to enhance skills in interviewing; interpretation and analysis of information from different sources; and risk assessment
10. review supervision and contact arrangements for managing the most intimidating, complex and manipulative high risk of harm offenders
11. ensure the implementation of post-release risk management plans presented to the Parole Board, including referral to MAPPA, access to relevant interventions, residence in approved premises, and move on plans
12. review the Probation Instruction for case transfers (PI 07/2014) to ensure the exchange of all risk information; establish an effective communication framework between transferring areas, including clarity about roles and responsibilities; and to ensure cases are prioritised and transfer is expedited
13. ensure there are clear and responsive arrangements for emergency referral to approved premises where required, to manage offenders who present a high risk of serious harm.

7. Legal and professional context

Indeterminate sentences of Imprisonment for Public Protection

The sentence of Imprisonment for Public Protection (IPP) applied to Joseph McCann in 2008 was created by the *Criminal Justice Act 2003* and came into use in April 2005. It was abolished in 2012. These indeterminate sentences were designed to protect the public from serious offenders whose crimes did not, in themselves, merit a life sentence. Offenders sentenced to an IPP were set a minimum term (tariff) which they must serve in prison. Release can only be granted by the Parole Board who consider IPP cases referred to them by the Secretary of State for Justice. The test for release applied by the Parole Board is statutory and laid down by the *Legal Aid, Sentencing and Punishment of Offenders Act 2012* (LASPO). The Parole Board must not give a direction for release unless it is satisfied that it is no longer necessary for the protection of the public that the prisoner should be confined. On release, the individual is subject to supervision by the NPS.

The extensive use of the IPP sentence by the courts following its introduction was not anticipated. By 2012, a total of 8,711 IPP sentences had been given. Public debate about the IPP sentence focussed on two specific areas. There was concern that the sentences were not targeted effectively by the courts and that this resulted in inconsistent and, in some cases, unfair sentencing. In addition, there was concern that IPP prisoners were unable to demonstrate that they were safe for release into the community, resulting in high numbers remaining in prison beyond their tariff date.

The Queen's Bench Division of the High Court in 2007 ruled that after the tariff expiry date, it was unlawful to continue to incarcerate IPP prisoners if they did not have access to appropriate courses and facilities.[11] In 2012, the case against the detention of IPP prisoners beyond their tariff date was heard by the European Court of Human Rights. The Court found that holding IPP prisoners beyond their tariff date without access to relevant courses rendered continued detention arbitrary and a violation of the *Human Rights Act* (Article 5: the right to liberty and security).[12]

The failure to release IPP prisoners post tariff combined with the popularity of the sentence, contributed to an increase in the prison population. A government review into the sentence was announced in 2011; IPP sentences were abolished in 2012. At this stage there were more than 6,000 IPP prisoners in custody, half of whom had passed their minimum tariff date. This included JMc. The changes to the sentencing framework were not applied retrospectively, so IPP prisoners continued to serve their sentences and could still only be released by the Parole Board. The subsequent policy focus on progressing and releasing IPP prisoners is relevant to JMc's case.

The progression of IPP prisoners became a priority for both the prison and probation service. Regimes specifically designed for IPP-sentenced prisoners were set up at prisons such as HMP Warren Hill; JMc resided there between September 2015 and his release on his IPP licence in March 2017. This focus on supporting IPP prisoners to progress through the system was shared by the Parole Board who wrote to ministers in October 2017 setting out options for reducing both the backlog of indeterminate sentenced prisoners due for consideration by the Parole Board and the number of IPP prisoners in the prison population.

[11] Nicholas Wells v The Parole Board and The Secretary of State for Justice. (2007). EWHC 1835 (QB).

[12] James, Wells and Lee v the United Kingdom. (2013). European Court of Human Rights.

The Parole Board included working with its partners to release IPP prisoners safely as one of its strategic targets in 2017-2018.

A judgement by the Supreme Court in 2013 directed that Parole Board oral hearings for prisoners should not be delayed.[13] The Parole Board subsequently prioritised the backlog in IPP hearings. At a national level, the Parole Board sat with the HMPPS on the Indeterminate Sentenced Prisoner progression group through which strategy was agreed and joint activities developed, to help reduce the indeterminate prisoner population. This included a role for forensic psychologists in reviewing cases and advising services on how to progress IPP prisoners.

JMc's minimum tariff was 30 months imprisonment. Following completion of the tariff period of an IPP sentence, a prisoner's continued incarceration can only be on the grounds of public protection. The Parole Board reviewed JMc's case on four occasions and decided that continued imprisonment was necessary for the protection of the public. He was finally assessed as safe for release by the Parole Board, seven years after his tariff had expired.

Licence recall and the prison population

The NPS alternatives to recall initiative[14] was part of the overall Ministry of Justice recall action plan that was implemented 2016-2017. The recalled prisoner population had been identified as the fastest-growing group in the prison population. There was concern about the impact on the number of available prison places, with the prison population rising rapidly by almost 1,500 in the spring and summer of 2017 to almost 86,500 by October of that year. This growth was fuelled partly by the number of recalls of those sentenced following the *Offender Rehabilitation Act* (2014) (ORA) which had extended probation supervision to those serving under 12 months. These are predominantly low and medium risk of harm offenders.

Revised resettlement guidance was issued to probation staff in June 2016 and this directed that offenders should only be recalled where there were no alternatives for safe management in the community.[15] Following pilot work in the NPS, additional advice was also issued in the form of the alternatives to recall guidance in April 2017. This guidance emphasised that recall would continue to be necessary, but outlined the potential use of alternative services and supervision packages to manage released prisoners safely in the community. The alternatives promoted included the use of approved premises, electronic monitoring and additional licence conditions. In November 2017, HMPPS issued the effective licence management plan[16] to help improve rehabilitative outcomes for offenders on licence after release from prison by keeping them under supervision in the community where possible and recalling them only when this was necessary. A key purpose of its implementation was to reduce the use of recall:

"The NPS effective licence management plan is intended to continue building on work to increase the use of alternatives to recall where it is safe to do so, and limit recall action to instances where no other option is appropriate."

[13] Osborn, Booth and Reilly v The Parole Board and The Secretary of State for Justice. (2013). The Supreme Court.

[14] NPS. (2017). *Alternatives to Recall guidance.*

[15] NPS. (2016). *Resettlement guidance.*

[16] NPS. (2017). *Effective licence management plan.*

The impact of the 2016-2017 alternatives to recall initiative on recalls appears to have directly affected the national recall trends in the following years. In the third quarter of 2016-2017, the number of recalls decreased by nine per cent when compared with the same quarter in 2015-2016. This is despite the implementation of ORA increasing the number of offenders being eligible for recall. The number was stable in 2017 before increasing from 2018 onwards by 13 per cent compared to the same quarter in the previous year.

Recall and IPP sentences

In August 2017, HMPPS launched the IPP action plan as part of an overall strategy to reduce the number of IPP prisoners. This established IPP progression panels in each probation LDU to review cases. In addition, it focussed on improving the supervision arrangements for released IPP prisoners in the community to reduce the number being recalled to prison. All IPP prisoners released from prison are the subject of lifetime licence conditions which, if breached, can result in recall. The number of IPP recalls was of concern. In 2016, 481 out of 905 released IPP prisoners had been recalled.[17] The action plan provided a framework for improving the management of IPP prisoners in the community and highlighted the NPS Alternatives to Recall guidance as a means to ensure "increased consistency in the tolerance threshold" when recalling individuals to prison. It specifically identified that 51 per cent of recalls over a 12-month period were due to non-compliance. The action plan was delivered to all NPS divisions. The probation staff that we interviewed said the implicit message was that the number of IPP licence recalls for compliance failures should be reduced.

The issue of recalls of IPP prisoners received attention when the-then Chair of the Parole Board and the-then Prison and Probation Minister gave oral evidence to the Justice Committee in October 2017.[18] The-then Chair of the Parole Board stated that more than 50 per cent of IPP prisoners released by the Parole Board were being recalled and suggested that the test for recall was set too low, and that the system was not working effectively. The Prison and Probation Minister spoke about the development of alternatives to recall, including the use of approved premises and electronic monitoring.

JMc was released from his IPP sentence in March 2017. Although some of the initiatives were implemented after this date, the policies highlighted above are directly relevant to the thinking and decision-making in the criminal justice system at the time. Of particular relevance is that the alternatives to recall initiative and the NPS IPP action plan were launched in the period before JMc's court appearance for burglary in August 2017. There was evidently concern at both ministerial level and senior management level at this stage, about both a rapidly-growing prison population more generally and about the number of IPP prisoners who remained in prison past their tariff date or were being recalled more specifically. The clear message of the policy initiatives and action plans to NPS divisions was to continue to supervise offenders in the community where it was assessed this could be done safely. It was within this policy framework that probation managers and operational staff made proposals and took key decisions in relation to release, resettlement, enforcement and recall of JMc in 2017.

We have examined the events in this case within this context. This is not to excuse poor practice. Serious mistakes were clearly made in the management of JMc's case and staff have been held to account. The published SFO review examines in detail the actions of probation staff in relation to practice and procedure. We have analysed the key decisions and practice, and made judgements on the organisational and systemic issues that

[17] Jones, M. (2017). *IPPs, recalls, and the future of parole.*

[18] Justice Committee, House of Commons. (2017). *Oral evidence: work of the Parole Board.*

contributed to the mistakes that were made. Our findings cover practice, policy and inter-agency working. We have made a series of recommendations to improve the current assessment practice, release planning and management of individuals both in prison and the community.

8. Management of JMc's IPP sentence in custody

JMc was 23 years old when, in September 2008, he was sentenced to an IPP with a minimum tariff of 30 months. He already had 17 previous convictions for 34 offences and had previously served nine custodial sentences in either secure accommodation, Young Offender Institutions or adult prison. He is said to have had strong family ties, but this does not seem to have been a positive factor as several of his previous offences had been committed with family members. His criminal history included acquisitive, violent and driving offences. JMc's history of compliance with criminal justice agencies was poor, and when he was 17 he was convicted of "escaping from lawful custody". This offence involved taking a member of security staff hostage to enable his escape. His most serious convictions for violence were for robbery and affray, and were committed with family members. JMc had no previous convictions for sexual offences prior to the offences committed in 2019.

The IPP sentence was imposed following an offence of aggravated burglary committed in December 2007. The victim of the offence was an 85-year-old man. During the course of the burglary, JMc threatened to stab the victim with a knife and demanded money. JMc committed this offence when he was the subject of a prison licence but unlawfully at large. His non-compliance with probation appointments led to the probation service instigating his recall to prison on 02 November 2007. A warrant for his arrest was still to be executed when he committed the aggravated burglary.

Assessment of risk of sexual serious harm

During the initial period in custody, JMc was assessed as presenting a high risk of serious harm to family members. There were concerns about previous domestic abuse incidents and the prison intercepted graphic and detailed letters written by JMc to family members. Letters included threats of sexual violence and referred to wanting a "clean young girl" on release. Significantly, JMc was supported in these threats by other family members who were also making direct threats. In response to the threats, the police and statutory services took appropriate action to protect the threatened members of JMc's family.

The lack of assessment in relation to JMc's sexual behaviour has been highlighted in the SFO review as a failure in the management of this case. As well as the letters written to family members, there were three additional sources of information from which JMc could potentially have been identified as a sexual risk:

- The police had intelligence from 2003 which alleged that JMc, along with another family member, had been involved in the abuse and sexual exploitation of young teenage girls. This information was also discussed at a MAPPA meeting attended by his then offender manager (OM2), who was responsible for JMc's case between May 2010 and February 2013. ViSOR[19] was accessible to the offender managers managing the case, although the relevant police intelligence from 2003 was one of 234 activity log entries and not easily accessible on the shared probation, police and prison system. No other entries until the 2019 offences identified a risk of sexual offending.
- In April 2010, JMc sent a threatening letter which contained a sexual reference to his offender manager (OM1) based in Hertfordshire LDU. The threats contained in the letter were taken seriously and management of the case was transferred to another officer who, on the advice of the police, operated under a pseudonym for their own

[19] ViSOR is the computer system shared by the Police, NPS and Prison service to share information on MAPPA category violent and sexual offenders

protection. Also in 2010 a reference to "young girls" was made in OASys but this was not linked to a risk of sexual offending. The risk of harm JMc presented to any future partners was prioritised.

- In 2013, intelligence received by prison service security again identified that JMc, with the collusion of his family, was attempting to find a "young girl" for his release. This key intelligence was not shared with the NPS and, therefore, did not inform subsequent risk assessments or release planning.

JMc had not been convicted of a sexual offence but the information from these combined sources indicates a potential sexual risk. Failures in information-sharing between the prison service and the NPS, in information retention, and operational procedure and in practice meant that no one individual had the complete picture of JMc. At the early stage of his sentence, JMc's potential risk of sexual offending was recorded in some sections of OASys but was not analysed fully and incorporated into the overall risk assessment and risk management plan. Subsequent risk assessments did not re-assess the historical information, therefore repeating this initial failure.

These failures were compounded by the number of offender managers involved with his case. Leading up to his first release in 2017, JMc had five different offender managers while in custody. As the case was transferred between offender managers, the information was not re-visited or re-assessed. New offender managers based their assessment of risk and progress on the previous assessments included in OASys, their own personal knowledge of JMc and his behaviour in prison. OASys was relied upon as the primary source of information; other historical information was not reviewed routinely.

In our view, this approach undermined the assessment of JMc during his sentence and meant that his potential risk of sexual offending was not recognised fully.

Comprehensive assessments must consider all available information and assess its significance. Offender managers tend to focus on the most recent assessment. This practice can result in key information in earlier assessments being missed. This is highlighted in JMc's case as the OASys completed on his release in 2019 did not contain information in the risk of harm analysis on the threatening and graphic letters sent to family members in 2009.

Information-sharing

MAPPA guidance directs that all prisons should hold regular Inter-departmental Risk Management Team meetings (IRMT) to review high risk of serious harm prisoners and the offender managers involved in the community should be invited. Apart from one meeting at HMP Frankland, there is no evidence of probation offender managers attending these meetings or receiving a copy of the minutes. This is surprising, given the concern expressed at various points about JMc's prison behaviour. More importantly, this omission prevented the sharing of key risk information. In particular, the intelligence in respect of JMc asking his family to find a young girl for him on release was not shared. This pattern of key prison security information not being shared routinely was a critical feature in JMc's case. It prevented offender managers having access to information to inform accurate risk assessment and release planning.

Psychiatric and psychological assessments

JMc's violent and threatening behaviour, including the graphic threats made to family members, prompted OM1 and OM2 to seek a mental health assessment in 2010. To initiate

a full assessment, a Hare P-Scan was completed to identify possible traits of psychopathy.[20] High scores were recorded on all measures which OM2 believed supported the need for a full PCL-R assessment for psychopathy.[21] When the psychological assessment was undertaken in 2012, an assessment for psychopathy was not included because the clinician viewed it as inappropriate to assess behaviour that occurred under the age of 25 for psychopathy. The psychologist's recommendation that JMc should attend a Cognitive Self Change Programme (CSCP) was incorporated into the sentence plan.

The Offender Personality Disorder Pathway programme is jointly commissioned by the Ministry of Justice and NHS England. It aims to provide a pathway of psychologically-informed services in prisons and in the community for offenders who have a personality disorder and are assessed as high risk of serious harm. In 2013, JMc was screened for the Offender Personality Disorder Pathway and the pathway team agreed to review JMc following his completion of the Healthy Relationships Programme. This did not happen and there is no obvious reason why.

In 2014 a psychiatric assessment was completed at the direction of the Parole Board. The psychiatrist concluded that JMc had anti-social personality disorder traits but not mental illness. He recommended a further International Personality Disorder Examination (IPDE), before any assessment of psychopathy. This examination was not subsequently undertaken and no further psychiatric or psychological reports were completed prior to his release.

There is no evidence that the pathway team at HMP Garth followed up their initial agreement to review JMc's case, although a psychiatric assessment did take place early in 2014. OM3 who managed the case during this period, recalls that access to prison mental health services was inconsistent and varied between establishments. The initial concerns about JMc's mental health receded as he progressed through his sentence. He was initially reluctant to engage with mental health services and his agreement to do so only occurred after his first parole hearing in July 2010. His motivation to engage appears solely focussed on achieving release. The initial P-Scan screening highlighted his interpersonal skills. These skills may have masked mental health problems.

The personality disorder assessment recommended in 2014 should have been prioritised by both prison healthcare and the supervising offender manager before any release. We were unable to identify the reason why this did not happen.

The offender managers responsible for JMc in 2013 and 2014, were concerned that the two mental health assessments did not include or recommend a full assessment for psychopathy. However, they felt unable to challenge the clinical judgements. Elements of the recommendations made were incorporated into sentence planning but no-one appears to have had a full understanding of JMc's mental health and presentation. As a result, the relevant issues could not be incorporated into either risk assessment or release planning.

When JMc was released in 2017, there was no focus on his mental health and he had not been re-referred for a mental health assessment or to the Offender Personality Disorder Pathway. In the light of the earlier mental health assessments, this was a serious oversight. It again demonstrates the necessity that assessments should take into consideration relevant historical reports and information. Assessment of JMc became short-sighted and focussed on his perceived progress in prison.

[20] Hare, RD. and Herve, H. (1998). *Hare P-Scan.* Multi-Health Systems.

[21] Hare, RD. (1998). *The Hare PCL-R.* Multi-Health Systems.

Progress in prison

JMc's initial behaviour in prison following his IPP sentence was poor. He was involved in violence and intimidation, and he failed mandatory drug tests. His behaviour resulted in adjudications and periods in the segregation unit. He was resistant to sentence planning although he applied for and completed an Enhanced Thinking Skills (ETS) programme in November 2009. The programme report was positive, although within days of its completion he was transferred to a Category A prison following a planned escape attempt from HMP Wellingborough.

The discrepancy between JMc's completion of prison programmes and his presenting behaviour continued throughout his time in custody. In Section 7 we note that IPP prisoners were prioritised for access to appropriate programmes, in order to demonstrate their progress and to work towards their eventual release. JMc undertook the programmes indicated in his sentence plan throughout his sentence. There was, however, a recurring overestimation of his improved behaviour resulting from these programmes and an underestimation of his risk of serious harm.

JMc undertook several vocational courses and offending behaviour programmes during his sentence. The key programmes identified in his sentence plan were the 62-session Healthy Relationships Programme (HRP) that he completed in 2013 and the Cognitive Self Change Programme (CSCP) that he completed in 2014. Both programmes were completed at HMP Garth. HRP is aimed at perpetrators of domestic abuse. Although JMc had no convictions in respect of domestic violence it became part of his sentence plan following the threatening letters he had sent to family members. CSCP is aimed at reducing violence in prisoners assessed as high risk of serious harm. Both post-programme reports are positive in respect of both JMc's engagement and his progress on the programmes.

On the basis of JMc's engagement with the sentence planning and offending behaviour programmes, OM3's OASys review in 2014 reduced his assessed risk of serious harm to staff and the public from high to medium, but he continued to be assessed as high risk of serious harm to family members. OM3, a probation officer based in the Watford office, described JMc as motivated to engage with the programmes. In assessing JMc, OM3 did not have the benefit of the information that had been received by the prison security department in 2013. The contrast of this intelligence with the reports of his apparent engagement on HRP are stark. Without the full picture, OM3's assessment of JM's risk was incomplete.

In recognition of the perceived progress JMc was making, he was moved to the Psychologically Informed Planned Environment (PIPE) at HMP Wymott in 2015. All staff working in PIPEs are trained in psychologically-informed ways to improve their understanding of prisoners' behaviour and to develop positive working relationships. Following security information in relation to JMc bullying other prisoners to obtain medication, he was transferred to HMP Warren Hill after nine months. This information was shared with OM4 but did not result in a questioning of JMc's previous progress in prison. This was an oversight and demonstrates a lack of professional curiosity. JMc's core behaviour at the start of sentence included threats and intimidation. This indicates that controlling and intimidating behaviour continued to be key elements of his core behaviour.

JMc's use of medication should have resulted in further analysis. There is frequent reference in reports and case management records to JMc's conflict with prison healthcare departments and this continued at GP surgeries following his release. Given his history of Class A drugs use and his insistence on the need for powerful painkilling drugs, there should have been inquiry and assessment into whether JMc was using medication to maintain an addiction. Such an assessment would have given greater insight into his risk of serious harm and the extent to which he had genuinely changed his behaviour.

HMP Warren Hill has been set up as a progressive regime in order to facilitate the progress of IPP prisoners who are past their tariff dates towards release. These regimes are designed to test responsibility, and improve behaviour and compliance. This was JMc's final prison before his initial release on IPP licence. His management during his residence at HMP Warren Hill was again characterised by a failure of information-sharing which contributed to the underestimation of his risk of serious harm. The prison offender supervisor reported to OM4, who was based at the Watford office and who now held the case, that JMc was making good progress. JMc completed the 12-week independent living course and was a prison hub council representative offering advice to fellow prisoners.

Prison intelligence reports, on the other hand, painted a very different picture. They had reports that JMc was bullying prisoners for medication, dealing in psychoactive substances, and was using a weapon to threaten and intimidate. There was no evidence that this information was shared with either OM4 or subsequently OM5 or with the prison's own offender management unit which liaises with probation staff in the community.

The effective risk assessment of someone of JMc's complexity and violence requires that all relevant information is considered. In this case it was not, and this allowed him to be perceived as making progress when in fact his core attitudes and behaviours did not change throughout his prison sentence. The sentence planning process itself contributed to this view. Far too much emphasis was placed on the completion of programmes and the meaning of his wider prison behaviour was not analysed.

Early in his sentence JMc's interpersonal skills were highlighted as part of the P-Scan. JMc's manipulation of staff was identified in his general prison behaviour, but his motivation to change through the completion of programmes was not questioned or analysed. In our view, the emphasis on the completion of programmes and sentence plan objectives was a reductive approach to a complex individual. In the context of his previous offending, compliance and prison behaviour, his presumed progress should have been questioned more rigorously. In our view, the policy drive to progress IPP prisoners influenced the over-optimistic assessment of JMc's attitudes and behaviour. This confirmatory bias was a factor in his risk of serious risk of harm being underestimated.

Key findings

- The probation assessment did not include a comprehensive review of all key sources of information. OASys was used as a source of information and not as a tool to guide assessment and judgement.
- The probation assessment did not include the analysis, interrogation and interpretation of key information and behaviour from his time in custody.
- Professionals and offender managers were too optimistic in their assessment of JMc's ability to change his behaviour. His core presenting behaviours in the prisons had not changed.
- Intelligence available to probation staff from the police was not used to assess JMc's potential for violent and sexual offences.
- The assessment of JMc's progress in prison put too much emphasis on the completion of programmes. Prison security information was not routinely shared with probation offender managers within the prison and in the community undermining their ability to assess his risk of serious harm and progress on his sentence.
- JMc's interpersonal skills and ability to manipulate staff were underestimated. His behaviour and mental health in prison was perceived to improve. This perception was based on his immediate presentation. After 2014, further mental health assessments

were not requested. The IPDE assessment recommended in 2014 did not take place. JMc's mental health was, therefore, not fully assessed before his release. This should have been central to his risk assessment.

9. Planning for release

The minimum tariff for JMc's IPP sentence was 30 months; the earliest date the Parole Board could have directed his release was August 2010. A parole hearing took place in July 2010 and the recommendation by OM1, based in Watford, and other prison-based professionals was that JMc should remain in custody. Although he had completed the ETS programme, the parole reports highlighted his controlling and manipulative behaviour towards staff and there had also been a serious escape attempt.

Further parole reports were prepared by OM2, OM3 and OM4 for hearings in March 2012, January 2014 and April 2015. These reports also recommended that JMc should not be released. The reports detail the threats JMc made to his offender manager, to family members and to prison staff in the early years of his sentence, but note that his prison behaviour had improved after 2012. His compliance with his sentence plan and attendance on programmes were highlighted as examples of this improved behaviour. The parole report completed in January 2014 details his engagement and progress on the HRP and provided examples of his ability to use the learning to change his behaviour. Significantly, however, the examples were based on JMc's self-disclosure. Similarly, the parole report in 2015, described the "significant improvement" in JMc's behaviour and referred positively to the offending behaviour programmes and vocational courses he had completed. The negative prison intelligence about his behaviour during this period did not inform this report.

Offender managers should have questioned JMc's perceived motivation and improved behaviour, given his history of intimidating and manipulative behaviour, and interpersonal skills. However, probation offender managers in the community were not party to all the information available to the prison authorities. His completion of and learning from the HRP, for example, would not have been viewed positively had they been aware of the prison intelligence from 2013.

JMc was aware that completing programmes was necessary to progress and achieve his release from prison. This was reinforced by the sentence planning process which identified specific interventions to address factors relating to his offending. This is understandable and to some extent appropriate. JMc, however, was a complex individual and it was far too simplistic to assume that the completion of the programmes and his own self-disclosed evidence of progress meant that core attitudes and behaviour had changed. It was not only offender managers who described this progress; accredited programme facilitators working with forensic psychologists assessed his progress in the same way.

The message that JMc should complete programmes in order to progress to release was reinforced in a letter from the Public Protection Casework Section (PPCS) following a Parole Board review in 2012. This stated there would be a further review in two years and JMc should achieve the following to "help him reduce his risks":

- to undertake the high intensity Healthy Relationships Programme (HRP) which is anticipated to commence in October 2012
- to be assessed for, and if found suitable, complete any further offending behaviour interventions that may be identified
- to allow for a forensic psychiatric assessment to take place which may help establish whether any mental health considerations are relevant to your risk assessment.

This emphasis on programme completions as a means of informing risk assessment needs to be set within the overall IPP context. The Queen's Bench Division of the High Court ruling in

2007 specifically stated that IPP prisoners should have access to programmes and interventions to allow them to demonstrate they are no longer an unmanageable risk to the public. Subsequently, enabling IPP prisoners to access offending behaviour programmes became a priority as a means of measuring progress through the sentence. In our view, however, there is evidence that in JMc's case, other sources of information were not given equal weight. For example, in September 2015, JMc was removed from the PIPE at HMP Wymott following allegations of bullying and moved to the progression unit at HMP Warren Hill. There is no evidence that this incident was assessed fully to inform a review of his behaviour and progress.

The key parole hearings in relation to JMc's release from his IPP sentence occurred in October 2016 and January 2017. Two parole reports were prepared in 2016, one by OM4 and one by OM5. Both offender managers were based in the Hertfordshire LDU. OM5 had only recently taken over JMc's case when the parole report was prepared in September 2016 and relied heavily on OM4's report for information. OM4 was employed on a temporary contract and was responsible for the case between March 2015 and August 2016. Neither report made a clear recommendation and they did not recommend JMc's immediate release. The focus of both reports was the apparent progress he had made at HMP Warren Hill. This assessment was almost entirely based on JMc's completion of programmes. His removal from the PIPE at HMP Wymott was referred to but not analysed. Good progress at HMP Warren Hill was reported by the prison offender supervisor. This is surprising as prison security had intelligence during this period that JMc was bullying prisoners and carrying a weapon. This information was not made available to the offender manager and so did not inform the report and, therefore, the Parole Board itself. This is further evidence that vital information was not shared between the prisons and the NPS during the custodial term of JMc's IPP sentence. It may explain why his risk of serious harm was underestimated consistently after 2013.

Both parole reports are of poor quality. The analysis of JMc is superficial and there is little attempt to explore his behaviour beyond the completion of programmes and sentence plan objectives. Of particular concern is the fact his previous behaviour was not analysed to understand his current presentation. Bullying and intimidation had been key characteristics of JMc's behaviour throughout his time in prison and directly linked to his criminal behaviour. When continued evidence of this materialised at HMP Wymott, this should have resulted in a detailed re-assessment of his progress and an assessment of the risk of serious harm.

The Parole Board hearing in October 2016 was deferred until January 2017. The Board had heard concerns about his relationships with staff in the prison and particularly the healthcare department. These centred on JMc's belief that his medication was being mismanaged and his resulting attitude and behaviour. The reason for deferral was to establish whether he could be transferred to an open prison, which in the event was not allowed due to his previous escape attempt.[22] The report submitted by OM5 for the October 2016 hearing did not make a recommendation. The addendum report, again prepared by OM 5 for the deferred hearing in January 2017, recommended release and for JMc to reside initially in a probation approved premises. The basis for this recommendation was that JMc had completed the offending behaviour programmes in his sentence plan and this had improved his attitude and behaviour. The analysis was superficial and the evidence of progress – self-reported by JMc – was accepted uncritically. The previous concerns about his relationships with staff in prison healthcare departments were not analysed; JMc's denial of any responsibility for conflict with the medical staff was not challenged.

[22] HM Prison Service. (2014). *PSI 37/2014.*

The Parole Board panel that sat on 23 January 2017 decided to release JMc subject to a place being available at an approved premises. Their decision letter makes clear their understanding that JMc would be managed by the Multi-Agency Public Protection Arrangements (MAPPA) at Level 2 on release[23] and would be referred to the Offender Personality Disorder Pathway. In the event neither referral was made. The risk management plan presented to the Parole Board was not fully implemented after his release. This is clearly unacceptable practice.

IPP prisoners should only be recommended for release when they have demonstrated they can be managed safely in the community. In our view there was enough information to cast doubt on whether this was the case with JMc. The assessments completed by OM4 and OM5 were inadequate. It is clear they did not have all the relevant information. Nevertheless, where there were clear concerns in relation to JMc's behaviour, they did not demonstrate the necessary professional curiosity or seek to get a more rounded picture of his behaviour over the longer term. The parole reports completed during 2016 and 2017 were countersigned by the same Senior Probation Officer (SPO3) who must share the responsibility for this poor practice.

While there were clear failures in practice and oversight, the recommendation for release took place within the overall context of concerns relating to the numbers of IPP prisoners in prison past their minimum tariff date. The focus of prison and probation policy had been to enable such prisoners access to programmes to demonstrate a reduced risk of harm. By January 2017, JMc was 60 months past his tariff and had completed programmes recommended for him by psychologists, sentence planning boards and the PPCS. In our view, his programme completion was not subject to sufficient scrutiny to assess whether it had had a positive impact on his behaviour, or whether it indicated that he could be managed safely in the community.

Key findings

- The prison service and NPS prioritised access to programmes for IPP prisoners. The assessment of JMc's progress on his sentence was too focussed on programme completion and did not scrutinise sufficiently his wider prison behaviour in reaching an overall view on his risk.
- Professionals running programmes and offender managers relied too heavily on JMc's self-disclosure as evidence of progress.
- Information was analysed superficially and key events were not investigated. This resulted in poor assessment, decision making and reports.
- Referral to MAPPA Level 2 was not made prior to release as required by the Parole Board. He was not referred to the Offender Personality Disorder Pathway.
- Poor quality reports and assessments were endorsed by managers.
- Security information was not pro-actively shared by the prison service with probation and, therefore, risk management decisions were based on incomplete information.

[23] High risk of harm offenders managed at MAPPA Level 2 are the subject of formal multi-agency meetings aimed at developing and implementing effective risk management plans. See: HMPPS MAPPA guidance (version 4.5, 2012 updated July 2019).

10. Management on first release

Multi-Agency Public Protection Arrangements (MAPPA)

JMc's conviction for aggravated burglary meant that he was automatically subject to MAPPA when he was released in March 2017. The level of management would normally be set six months before release. In 2008, 2010 and 2015 the threats made to family members and his former offender manager earlier in his sentence, and his upcoming parole hearings, had prompted previous offender managers to note that JMc would be referred for MAPPA Level 2 management.

The OASys risk management plan prepared for his release, and provided for his parole hearing, stated that he would be managed at MAPPA Level 2. However, the necessary referral was not made by OM5 and he was managed at Level 1. This failure to implement an agreed plan was very poor practice. It meant that JMc was not the subject of multi-agency meetings, including the involvement of the police, pre and post release. Level 2 management would have ensured that key information was shared between agencies and a coordinated approach taken to decision-making. A previous HM Inspectorate of Probation independent review[24] in 2018 raised concerns about the absence of a formal decision-making process for deciding whether cases should be managed at MAPPA Level 1 or 2. The NPS has has since introduced MAPPA screening processes for prisoners to take place six months prior to release. These were not in place at the time of planning JMc's release in 2017.

A MAPPA serious case review is being undertaken to consider the effectiveness of MAPPA in JMc's case, and is due for completion in July 2020.

Case management on release

Following his release on 28 March 2017, JMc remained in the community until his arrest and remand into custody for a domestic burglary on 18 August 2017. The probation offender manager responsible for his case (OM5) was based in the Watford office; JMc had lived with his family in the area prior to his IPP sentence. There are no approved premises in Hertfordshire, so on release he was placed in one in Suffolk. A local probation officer (OM6) was designated to meet with him during his residence in Suffolk, with responsibility for the case remaining with OM5 in the NPS Watford office.

The demand for beds in approved premises for released high risk of harm prisoners far exceeds their capacity across the NPS. A placement system operates to manage this high demand. JMc's placement was confirmed on 15 March 2017 and was for a maximum of three months. It was envisaged that he would then move on to independent accommodation in Hertfordshire.

This arrangement whereby an offender is placed in an approved premises outside the supervising area and is seen on a "caretaking" basis by a local offender manager is not unusual given the pressure on approved premises beds. In well-managed cases these arrangements will be characterised by regular contact between the offender manager responsible for the case and the offender manager performing the caretaking role. The caretaking offender manager should be given a clear plan by the offender manager holding the case, in relation to reporting frequency and interventions. Such arrangements were only

[24] High risk of harm offenders managed at MAPPA Level 2 are the subject of formal multi-agency meetings aimed at developing and implementing effective risk management plans. See: HMPPS MAPPA guidance (version 4.5, 2012 updated July 2019).

partially evident in JMc's case and were hampered by the late notice of the approved premises placement.

The approved premises received clear directions from OM5 in relation to curfew, alcohol and drug testing. These actions were undertaken by approved premises staff as requested and JMc had regular meetings with the onsite keyworker. Communication with OM6 was less well planned. The case record has no evidence of any discussion between OM5 and OM6, particularly in relation to planning JMc's move on from the approved premises. The NPS Practice Framework[25] does not mandate the level of contact offender managers should have with offenders on release. It is, however, accepted good practice that an individual presenting a high risk of serious harm should be seen weekly. JMc had daily contact with the NPS staff in the approved premises but his contact with the caretaking probation officer in Suffolk (OM6) was irregular and unstructured.

During his three months at the approved premises, JMc generally complied with the rules and conditions of his licence. His move on from the approved premises on 24 June 2017 was not well planned. A lack of suitable accommodation meant that the approved premises placement was extended for a week. This allowed time for OM5 in the Watford office, who retained responsibility for the case, to contact the NPS team in Buckinghamshire and confirm that JMc could reside at his family's address. Buckinghamshire is located in a different NPS division to Hertfordshire (South West South Central division). A Buckinghamshire offender manager visited the family address and undertook police domestic abuse checks before agreeing to JMc's move to the area. The final assessment of the suitability of the address remained with OM5 who held responsibility for the case.

Prior to being given permission by OM5 to reside at the family address, JMc is recorded as being in bed and breakfast accommodation in Buckinghamshire for a short time. Securing suitable independent accommodation for complex individuals like JMc is frequently difficult, but the lack of planning contributed to the confusion about his move on plans. OM5 was clearly under pressure from approved premises managers in Suffolk to move JMc on and this does lead to concerns about approved premises placement policy. JMc was the subject of an IPP sentence and assessed as a high risk of serious harm. In our view, he should not have left the approved premises until suitable accommodation was available. It is clear that OM5 approved the family address for residence as it was the only option available for him upon leaving the approved premises. Decisions in relation to public protection should not be made on that basis.

JMc's residence at the family address was unsuitable from a risk management standpoint. Much of his previous offending had been with other family members and there had been intra-family threats and disputes. Allowing JMc to return to this environment increased his risk of reoffending. As JMc was residing away from Watford, another Buckinghamshire probation officer (OM7) was assigned the task of seeing JMc. OM5 continued to be formally responsible for the case, for example in relation to decisions about recall.

OM7 was pro-active in overseeing the case in Buckinghamshire. They undertook a visit to the family home and initiated a police domestic abuse check on the address. OM7 also arranged regular appointments with JMc. As part of the transfer discussions with the local SPO covering the Buckinghamshire office, OM5 agreed to refer the case to MAPPA Level 2 but this referral was not made. As with OM6 in Suffolk, the communication OM5 had with OM7 was limited and there were no direct meetings to discuss the case. OM7 had access to the case records and OASys but had not noted the previous threats made by family members or the threats that JMc had made to a previous OM. These were not specifically

[25] Ministry of Justice. (2015). *Practice Framework: National standards for the management of offenders for England and Wales.*

pointed out to OM7 when arrangements were made for oversight of the case. Consequently, OM7 made and arranged home visits alone. The short notice transfer arrangements in this case were not comprehensive. The request for transfer to Buckinghamshire should have included all the relevant risk information particularly in relation to JMc's family and his risk to staff. In our view, the lack of information potentially put OM7 at risk of serious harm.

Probation staff who manage transfer arrangements are often dealing with unstable offenders; they have to be responsive and make quick decisions. Good practice in these cases should include ensuring that professionals' meetings always take place at the start of the process and at least monthly thereafter, until the full transfer is finalised.

JMc's compliance with his licence deteriorated shortly after his move to Buckinghamshire. OM7 arranged regular meetings and undertook home visits but JMc's attendance declined. Areas of concern emerged. He attended one appointment with bruised arms and attributed this to boxing with a family member. This contradicted his earlier assertions that he had a serious back injury that required strong medication. Of more concern, was his failure to keep appointments on the basis he was in Manchester, caring for an elderly relative. There is no evidence that JMc travelled to Manchester, although OM7 had sent details of the address to OM5 so this could be verified. It was OM5's responsibility to liaise with NPS colleagues and the police in Manchester to verify the circumstances of the address. Other concerns that had emerged included his use of dating websites and his attendance at a meeting with a sprained ankle which he attributed to being in a road accident with a family member. OM7 spoke to the elderly relative he claimed to be caring for and concluded she was a much younger person than expected.

Failing to keep appointments and moving address without permission were breaches of licence conditions and OM5 was kept informed by OM7 of all the relevant information. OM7 was the primary contact with JMc at this stage but responsibility for enforcement remained with OM5. Communication was electronic but, due to these licence breaches, there should have been a professionals' discussion to review the concerning developments in the case.

On the basis that JMc had remained in contact with OM7, OM5 decided a verbal warning was appropriate for the licence breaches. This decision was taken on the basis of JMc's explanations for his absences. It did not identify the pattern of unrealistic explanations that were being given. In addition, there was no consideration given to his history of non-compliance. His index offence of aggravated burglary, committed in December 2007, was a serious further offence committed on licence and this was evidently not considered as JMc's compliance deteriorated. On 18 August 2017, 14 days after the warning was given to JMc, he was arrested and remanded in custody for a domestic burglary in Bedford. Following his arrest, JMc informed OM7 in a phone call on 21 August 2017 that he had been in a relationship with a woman prior to his remand in custody. This constituted a further breach of his IPP licence which stated that he should disclose all developing relationships to his offender manager.

Key findings

- JMc was not managed at MAPPA Level 2 on release and should have been. MAPPA procedures did not ensure that a case designated to be managed at Level 2 was then managed at that level on release.
- The pressures on offender managers resulting from the approved premises placement policy contributed to a high risk of serious harm IPP sentenced individual being moved to accommodation that, in our view, increased his risk of reoffending. The pressure on beds is acknowledged but for placements to end before there is

confidence that the risk of harm and reoffending can be managed safely is not satisfactory.

- The transfer arrangements for the supervision of JMc in Buckinghamshire, away from the responsible team in Hertfordshire, did not follow the directed practice. Insufficient risk information was sent with the request for temporary transfer and there was a lack of proactive planning of JMc's supervision in Buckinghamshire. Deterioration in JM's compliance and behaviour was not the subject of effective review and action.

11. Further offence of burglary and recall decision[26]

Domestic burglary is a serious offence and was a repeat of JMc's previous pattern of behaviour. Although McCann was remanded in custody, he should have had his IPP licence formally revoked due to this offence, his behaviour since release, and his previous pattern of offending on licence. The reasons this did not happen are rooted in policy, procedure and decision-making based on inadequate information.

SPO4, who was temporarily covering the Watford office, took the initial decision not to revoke JMc's IPP licence in August 2017. This decision was taken on the basis that he had been arrested but had not yet appeared in court; more information about the charges was required. SPO4 did not have background knowledge of JMc's case and was covering the office for SPO3, who was not in work. The recording of the decision in nDelius sets out the consideration of alternatives to recall but states that a remand in custody "should see the recall progress". In the event of JMc's remand into custody on 19 August 2017, no further action in relation to revoking JMc's IPP licence was taken. SPO4's initial decision not to recall was based on the knowledge of the arrest for burglary and did not take into consideration JMc's previous patterns of behaviour.

SPO4 reviewed the initial decision not to recall JMc's IPP licence seven days later with the Assistant Chief Officer (ACO1) responsible for Hertfordshire LDU who was the line manager. Recall was again not instigated. The decision not to recall was taken partly on the grounds that as JMc was subject to an IPP sentence, revocation of his licence would mean that he would not be released from custody immediately if he was acquitted of the burglary. The decision was taken to wait for the outcome of the court case. The recording of this decision again focussed on the circumstances of the new offence of burglary and did not include any reference to previous patterns of behaviour and non-compliance. Alternatives to recall, such as GPS tagging and an approved premises placement, were referred to as suitable contingencies if JMc was bailed before any trial.

NPS recall policy at this time was contained in PI 27/2014.[27] It details the test for recall for both determinate and indeterminate sentenced prisoners. For determinate sentenced prisoners there must be "indications" of an increased risk of harm to the public. For indeterminate sentenced prisoners there must be "evidence" of an increased risk of harm. For indeterminate sentenced prisoners, it specifically states that where there is a clear causal link to previous offending patterns, consideration must also be given to whether this behaviour increases the risk of sexual or violent offending. This difference in threshold was justified on the basis that a recall for an indeterminate sentence prisoner has the potential consequence of no future release from custody.

The burglary committed by JMc had been of an unoccupied residence. ACO1 and SPO4 did not believe the circumstances of the new offence met the necessary risk increase threshold for recall as his index offence was for aggravated burglary. This was flawed thinking. Any

[26] Following his arrest JMc was remanded into prison custody and subsequently sentenced to three years imprisonment for the further offence of burglary. The "recall" decision in this section relates to the original IPP sentence and licence. In view of the further offence and sentence, the NPS had to decide whether to revoke the IPP licence and technically recall JMc to prison on that sentence. As this was an indeterminate sentence, this would have meant that he would not be automatically released from prison at the end of his determinate sentence for burglary but would have to go back in front of the Parole Board.

[27] HMPPS. (2014). *Recall, review and re-release of recalled prisoners policy framework*.

burglary is a serious offence and could, through unforeseen circumstances become aggravated (for example, if someone had been at home at the time).

PI 27/2014 makes clear that a conviction is not necessary for a recall, but they decided to recall JMc only in the event of conviction. They directed there should be regular case reviews, but the decision to consider recall again in the event of conviction was not recorded on the case management system. This poor recording practice meant that ACO1's view that JMc's recall on his IPP licence should be reconsidered if he was convicted of the burglary was not accessible to SPOs and offender managers responsible for the case. In our view the decision to recall JMc should have been taken on the basis of the evident increase in his risk of harm and this did not require a conviction.

The focus of the decision-making on the circumstances of the burglary runs counter to the process guidance set out in EQuiP, the database of NPS processes and procedures. The recall decision tree directs that relevant information should be gathered and assessed to inform the recall decision. In JMc's case this was not done and SPO4 only had limited evidence from nDelius and OASys when the case was discussed with ACO1. The normal process for recall decisions is for information and analysis to be undertaken by the supervising OM. There is no evidence that OM5 discussed the recall decision either with OM7 or with line managers. The absence of discussion with OM7 – who had been the offender manager meeting with JMc – again demonstrates the flaws in implementing the transfer arrangements.

In the absence of detailed information about JMc to help them make the decision, further information should have been requested by the managers. An analysis of JMc's behaviour preceding his arrest would have identified clear discrepancies in his behaviour and breaches of licence. It would have shown that he had returned to previous patterns of behaviour and his risk of harm had increased. OM7 had established that he had been in an undisclosed relationship prior to his arrest. His previous behaviour in relationships meant his situation prior to arrest should have raised serious risk concerns, as well as being highlighted as another breach of licence conditions. Finally, the recall decision should have been informed by the fact that JMc committed the original aggravated burglary in December 2007 when a warrant for breach of licence was outstanding. We earlier noted that OASys was used by the offender managers as the primary source of information; it is significant, therefore, that this information had not been recorded in OASys assessments and so was not immediately accessible. SPO4 and ACO1 made their decision purely on the circumstances of JMc's arrest. This was poor practice and the decision should have been based on wider information including JMc's recent behaviour under supervision.

Recall decisions are not quality assured and the decision in JMc's case was not subsequently scrutinised. ACOs sign off all the recalls in their LDU. The process is, therefore, reliant on the quality of information submitted to ACOs by the supervising OM and SPO. ACO1 signed off 60 recalls in the Hertfordshire LDU during 2017-2018. Twelve of these were in August and September during the period when JMc's initial recall was being considered. The role of the ACO in the recall procedure is to confirm both the decision and the quality of the recall report. In our view, the absence of a separate quality assurance framework for recall decisions is both poor policy and practice. This issue needs to be addressed urgently at a national level. The lack of a quality assurance framework has implications not just in this case, but for all cases where recall is considered.

The case reviews directed by SPO4 and ACO1 did not take place before JMc's trial in January 2018. This was another example of the management of JMc's case being impeded by a failure to identify and share key actions and information. The initial recall decision did not take into account patterns of behaviour, but key parts of information were in any case not readily accessible.

On 25 January 2018, JMc was sentenced to three years imprisonment for domestic burglary. On 26 January, SPO3 – who was familiar with the case – reviewed the recall decision with a duty offender manager. The previous senior management view, that JMc should be recalled if he was convicted, had not been entered on nDelius, the case recording system. SPO3 did not consult ACO1 directly. SPO3 decided that because the burglary was not aggravated, it did not constitute evidence of an increased risk of sexual or violent behaviour and, therefore, recall was not warranted. This decision did not take into consideration the sentencing remarks of the judge, which clearly indicated he believed that JMc would be recalled upon conviction.

In our view this is the point when the need to revoke JMc's IPP licence was incontrovertible. It was a further offence, in clear breach of the licence, and there had been indications of poor compliance and increased risk.

Key findings

- Recall decisions in 2017 and early 2018 were too focussed on the circumstances of the domestic burglary and did not consider patterns of previous behaviour and compliance. The potential seriousness of the dwelling house burglary was underestimated, and the immediate consideration was the alternatives to recall strategy rather than public protection considerations.
- Key information, necessary for JMc's assessment and management, was stored in different locations on nDelius and not immediately accessible. Offender managers relied on OASys as the primary source of information as well as a risk assessment tool.
- Managers were influenced by the alternatives to recall strategy in their decision-making. The initial consideration following JMc's arrest was focussed on continued management in the community rather than public protection.
- Managers were confused by the directions in PI 27/2014 that to recall individuals on IPP licence, there must be evidence of an increased risk of violent or sexual harm. This resulted in them focussing inappropriately on whether the further dwelling house burglary constituted evidence of an increase in risk of serious harm.
- Poor recording practice resulted in a lack of clarity about recall decisions. A decision in August 2017 to recall JMc in the event of his conviction was not recorded; the recall was not executed in January 2018 following his conviction.
- Decisions were made without a detailed consideration of the available information including JMc's most recent behaviour on licence.

12. Determinate sentence and preparation for release

JMc's three-year determinate sentence for burglary in January 2018 meant that, taking into account his time in custody on remand from August 2017, he would spend a further 12 months in prison. At the half-way point in his sentence, in February 2019, he would be automatically released. Had his IPP licence been revoked at any time during his period in prison from August 2017 to February 2019, however, he would not have been released until the Parole Board agreed his re-release.

During his determinate sentence there were repeated requests by prison authorities for the responsible NPS offender managers and SPOs to consider JMc's recall status in relation to his IPP licence. The first two occasions were in February 2018 and August 2018. OM5, who continued to manage the case after his sentence, dealt with the first query. OM5 responded that it had been decided JMc would not be recalled. Although the recording indicates the contrary, our view is that this decision was not discussed with ACO1. In August 2018, SPO3 who line managed OM5, was contacted directly by the prison and asked to consider recall. SPO3 discussed the case with ACO1 and spoke to the national HMPPS Public Protection and Casework Section (PPCS) to take advice on whether the recall threshold had been met. SPO3 did not discuss the case further with ACO1. In her interview with us it was maintained that the intention was to recall JMc and that it was the subsequent absence from work that prevented this task being completed.There is no record of these discussions on nDelius but entries on C-Nomis,[28] the prison case recording system, on 11 October 2018, confirm that SPO3 informed JMc's prison offender supervisor at HMP Mount that JMc would be recalled. SPO3's absence from work commenced in October 2018, several weeks after the conversations with the prison and ACO1 in August. It is evident that the decision to recall was not prioritised or communicated to other managers or operational staff. This was unacceptable management practice resulting in JMc's recall not being processed.

SPO5 was moved to the Hertfordshire office in June 2018 to share the management of the team and became responsible for OM5's line management in October. Following an audit of OM5's caseload, SPO5 directed OM5 to recall JMc on 07 November due to his conviction for burglary. OM5 was subsequently absent from work and SPO5 discovered the recall had not been processed in early December. The case was discussed with ACO1 and they made the decision not to recall JMc. Their reasoning was that such a late recall decision in JMc's determinate sentence, would not be in line with the principles of procedural justice highlighted in the NPS IPP action plan. They were also concerned about the potential for a legal challenge to the revocation of JMc's IPP licence at such a late stage in the three-year determinate sentence for burglary. They decided that if JMc was placed in an approved premises on release and managed at MAPPA Level 2, he could be managed safely in the community.

It is evident that this decision was taken without full knowledge of the case and, in particular, an analysis of JMc's previous behaviour on licence. The fact that JMc was close to release should not have influenced the decision-making. A full risk assessment, including JMc's recent behaviour, should have been the basis of the decision. The lack of assessment and planning undertaken since JMc's sentence meant that information on his recent prison behaviour was not recorded on nDelius. A full review of his case would have revealed that JMc's violence and intimidation had continued since his return to custody.

[28] C-Nomis is the prison case recording system which prison staff use to record their contact with prisoners. Since the implementation of Offender Management in Custody (OMiC) in October 2019, these entries are available on NDelius.

Until January 2019, there had been minimal planning for JMc's release, which was due to take place the following month. We noted earlier in this report the instability of the South and West Hertfordshire team which held JMc's case. It was experiencing both staffing and performance problems. All offender managers in the team were recorded as working at over 100 per cent capacity on the Workload Management Tool in September 2018. Staff turnover in the preceding 12 months also meant that the team was very inexperienced. In addition, SPO5 was in the process of addressing entrenched performance and practice problems.

In the six weeks prior to his release, JMc had two offender managers. OM8 held the case very briefly and OM9 became responsible for the case three weeks before his release. New to the team, on the day of taking on JMc's case, OM9 also took responsibility for another 44 cases. This is an excessive workload of new cases and is evidence of the workload pressure affecting the team. JMc was one of numerous cases in the team that caused immediate practice and risk management concerns.

This context does not excuse what was evidently an expedient and poor decision, but it was one taken in the face of a very demanding situation. Previous HM Inspectorate of Probation reports[29] have highlighted our view that SPOs have too many responsibilities and do not have the capacity to provide the necessary casework oversight to offender managers. SPO5's workload during this period was excessive and, in our view, was a significant factor in the poor decision-making. Nevertheless, subsequent requests by the prison prior to JMc's release combined with a request from another SPO, should have alerted SPO5 to the need to further review the recall decision.

OM9 was well supported by SPO5 who had already ensured JMc was managed at MAPPA Level 2. The focus of OM9's work was to acquire an approved premises bed at very short notice. This was achieved only for it to be withdrawn due to legitimate risk issues, eight days before JMc's release. No alternative beds at NPS South East and Eastern approved premises were made available. The pressure on bed spaces in approved premises has been documented but this was unacceptable in our view. JMc was the subject of an IPP sentence and assessed as high risk of serious harm. Re-release should only have been to an approved premises. Although central referral units have been implemented for approved premises beds in all NPS divisions, following the withdrawal of the original bed, OM9 was still expected to contact alternative approved premises to seek a placement. Probation staff told us that the central referral system is only effective for planned admissions. In exceptional circumstances ACOs will direct admission, but for emergency referrals it is common practice for offender managers to make direct contact themselves and request an offender's admission to an approved premises.They do not have the authority to direct admission and this can mean that beds are not consistently secured. The management of high risk of harm individuals requires a consistent process to ensure access to emergency placements.

Key findings

- On two occasions, August and November 2018, NPS staff took the decision to revoke JMc's IPP licence but did not action either decision. The managers involved should have ensured their decisions were implemented. In JMc's case the decisions and actions were lost due to workload pressure and staff absence. Recall is a key public protection decision and when it is directed there should be a formal process beyond management oversight to ensure it is instigated.
- Recall decisions focussed on the further offence of burglary and were not based on an analysis of JMc's behaviour and risk of harm. The fact that JMc was close to his

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

release date should not have been a factor in the decision-making nor should the fact that previous inaction meant the recall had not taken place.

- The sentence and release planning was inadequate until OM9 became responsible for the case three weeks before JMc's release. The instability in the South and West Hertfordshire team is demonstrated by the number of offender managers who were responsible for the case in the months before JMc's release. The team was characterised by poor management oversight, high workloads, poor performance and high staff turnover. They were key factors in the poor management of JMc's case.
- There is a high demand for approved premises beds but JMc, as a high risk of harm IPP prisoner being re-released, should have been prioritised. The South East and Eastern approved premises CRU was not effective in identifying an emergency placement for JMc and the offender manager was expected to try to locate a bed. The lack of availability of a bed for JMc's release meant a key element of the risk management plan was not in place and he returned to wholly inappropriate accommodation.

13. Release from determinate sentence

An approved premises bed was not available on JMc's release from prison on 15 February 2019. Again, he resided at the family address in Buckinghamshire. For the second time an offender manager in the Buckinghamshire office was allocated the case at short notice, to see JMc on release. Despite the absence of an approved premises bed, a key element of the risk management plan, OM9 in Watford and OM10 in Buckinghamshire, worked hard to manage JMc effectively following his re-release. He was seen weekly and OM9 arranged on two occasions to see JMc at the Watford office. This was good practice. These were the only occasions during JMc's two licence periods that he actually met the offender manager responsible for making decisions on his case. The late decision to allow JMc to reside at the family address meant that transfer of JMc's case was not agreed prior to his release.

MAPPA Level 2 meetings were held on 30 January 2019 and 27 February 2019 when it was decided that further multi-agency meetings were not necessary and he could be managed at Level 1. A separate MAPPA serious case review will review the effectiveness of the MAPPA arrangements in overseeing JMc's case.

In our view, JMc's management should not have been moved to MAPPA Level 1 management less than two weeks after release from prison. The basis for the decision to remove JMc from Level 2 management was his apparent compliance and the belief that an appropriate risk management plan was in place. This was not the case. JMc had been in the community for less than two weeks and had a history of committing serious offences within weeks of release from prison. The initial risk management plan detailed approved premises residence. His move to the family home was a cause for serious concern. The initial MAPPA meeting in January had also received reports of JMc's violence in prison prior to his release and that this behaviour was directly linked to family connections. In our view this information, combined with JMc's pattern of behaviour following previous releases, meant JMc should have remained the subject of multi-agency management.

The minutes of the initial MAPPA meeting in January 2019 document an action for SPO5 to contact PPCS to ask if recall could still be authorised at this late stage of JMc's determinate sentence. SPO5 has no memory of this action being set and, as we have noted above, it was not undertaken. There was no process in place for the MAPPA unit to ensure it was completed prior to JMc's release. By this stage the decision had been taken by ACO1 and SPO5 not to recall JMc. It is unlikely that the completion of this action would have resulted in them changing the decision. It is, however, of concern that a MAPPA action was set and no process was in place to ensure it was completed.

A condition of JMc's licence was that he had to disclose any developing relationships to his supervising OM. The concerns in relation to his ex-partner were documented on his records. He had breached this condition on his previous release by not informing either OM5 or OM7 of a relationship formed in the weeks before his arrest for burglary. Six weeks after his re-release on 03 April 2019, JMc informed OM10 he had been in a relationship for two weeks, and that he was engaged and living with his new partner at his family's address. This delay in disclosure was a breach of licence but, more importantly, it raised concerns in relation to the risk JMc presented to the new partner. On the same day as this disclosure OM10 was notified of JMc's aggressive and abusive behaviour in the company of a young woman at a housing office. It is difficult not to conclude that it was the knowledge that this altercation would be revealed that prompted JMc's disclosure of his relationship to OM10.

Enforcement of the licence breach was considered on 04 April by OM9 and SPO4, who was now based in Hertfordshire. In view of JMc's compliance with appointments since his

release, it was decided not to recall JMc. He had been seen weekly by OM9 and OM10 following his release from prison and in total had kept eight appointments up until this point. The police domestic violence unit had been contacted by OM9 due to JMc's disclosure of the new relationship but had reported no concerns. JMc had also been referred to a training agency, had attended an appointment, and had been accepted for a forklift training course. It was decided that he should receive a formal ACO warning and be placed in an approved premises as an alternative to custody. OM9 was again unable to secure an approved premises bed but the warning letter was sent to JMc on 05 April 2019.

The decision not to recall for this further breach of licence was in our view a mistake. It was again focussed on the immediate breach of licence and did not consider earlier patterns of behaviour. The failure to disclose a relationship repeated the pattern of his previous release and, given the involvement of family members in previous threats of violence, his new partner was at risk living at JMc's family home. This continued a pattern of non-compliance soon after release and was a clear demonstration that whatever his presentation, JMc's core behaviour and attitudes had not changed. A comprehensive assessment of risk, with previous behaviour as the key predictive factor, would have concluded that recall was necessary to manage the increased risk of serious harm and to prevent further offending.

Offender managers who managed JMc describe him as menacing and manipulative. At key points in his sentence he clearly put pressure on offender managers in relation to release, recall decisions, accommodation, and parole recommendations. It is evident that offender managers were threatened, blamed and lied to by JMc. There is no direct evidence that this affected decision-making, but as one offender manager stated to us:

> *"He was very intimidating and it is very difficult to have difficult conversations with someone you are scared of…"*

This controlling and intimidating behaviour is evidence of potential risk of harm and should be incorporated into supervision arrangements. In our view, the traditional model of one-to-one working is not always appropriate when offender managers are managing intimidating and violent individuals.

JMc was seen by OM10 on 10 April 2019 and OM9 on 18 April 2019. At both appointments he expressed unhappiness at receiving the ACO warning letter which he viewed as unfair. At the final meeting on 18 April 2019 he also stated that the new relationship was now over as the receipt of the warning letter had resulted in him being viewed as a sex offender by his new partner's family. Although angry, JMc's demeanour was not significantly different to his previous presentations. There was no indication that he would subsequently commit a series of violent and sexual offences.

On 23 April, the NPS was notified by the police that JMc was suspected of rape and an emergency recall was instigated. The NPS applies directly to the Ministry of Justice for emergency recalls via a phone call with PPCS. Once the recall is confirmed, a warrant for arrest for breach of licence conditions is issued within two hours of the application. This process was followed in JMc's case. Following the issuing of the warrant on the same day, OM9 and SPO5 worked closely with the police to help them in their investigation of serious crimes and the arrest of JMc. In particular, they identified close associates and family members; confirmed JMc's identity on CCTV footage; and ensured safeguarding actions had be taken for potentially vulnerable individuals including members of JMc's family. JMc was arrested on 05 May 2019 in the course of committing further offences.

Key findings

- The risk management plan in place at the time of JMc's release in February 2019 was insufficient to manage his risk of serious harm. He should have been placed in an approved premises and should not have been allowed to reside with his family. The risk management plan was further undermined by the premature move to manage JMc at the reduced intensity MAPPA Level 1.
- JMc should have been recalled when it was identified he was in another relationship at the beginning of April 2019. This was a repeat of the behaviour on his previous release. His new partner was at risk of harm residing with JMc at his family's address. The decision focussed on the immediate breach of licence. His previous patterns of behaviour and compliance on licence should have been fully assessed.
- The management of complex individuals like JMc requires skilled and experienced practitioners. HMPPS should enhance the status of this role and prioritise the development of high-skilled and experienced case management teams.

14. HMPPS Serious Further Offence action plan

Following JMc's arrest for the offences outlined in the foreword, the NPS undertook a review of the practice and management of the case. Disciplinary action was instigated against ACO1, SPO3, SPO4 and SPO5. SPO3 was subsequently demoted from a management position. OM5 and OM8 had already been dismissed from the service in relation to other matters. We did not identify any further concerns with the other individuals responsible for this case which require management action.

The NPS SFO review was undertaken by the NPS London SFO review team and completed in October 2019.[30] This was accompanied by an action plan focussed on ensuring that the NPS learns from failures in the management of JMc's case. Actions were identified for individuals and the organisation. There were four actions for individuals; our inspections confirmed these actions have either been completed or satisfactory actions are in place to monitor and improve practice.

The action plan identified one area of good practice. On his second release, direct contact was maintained with JMc when he resided out of area by the offender manager. Our findings and recommendations reflect our concern about the current inconsistency in the operation of case transfers between different NPS areas. We agree, however, that the two meetings OM9 held with JMc in Watford, when he was resident in Buckinghamshire, are an example of good practice in relation to managing offenders out of area.

Fourteen more general actions were identified for either NPS teams or the South East and Eastern division to undertake with immediate effect:

- to refer all relevant cases into MAPPA six months prior to parole review and/or potential release to ensure timely release planning
- managers to ensure that comprehensive handovers take place between offender managers in Watford and during out of area transfer process
- to ensure the effective management of IPP prisoners including enforcement action
- all offender managers in Hertfordshire should refer all relevant cases to the Offender Personality Disorder Pathway
- managers to ensure timely and effective enforcement decisions in line with the recall policy framework are made and are documented clearly in the record
- all staff in the South East and Eastern division should ensure they adhere to the recall policy framework in making decisions about enforcement for offenders on licence
- offender managers in Watford to make the relevant safeguarding checks in all cases
- managers in Hertfordshire and Suffolk should ensure that the workloads of staff are reviewed regularly. Cases should be reviewed in supervision and through regular monitoring of the workload management tool
- ensure that OASys reviews are completed when required including following case transfer. Investigative approach and thorough examination of case records, current circumstances and all intelligence to be undertaken when reviewing OASys. All risk

[30] Ministry of Justice. (2020). *Serious further offence review in the case of Joseph McCann.*

indicators and evidence of concerning behaviour to be incorporated into OASys reviews in order to meaningfully assess risk

- reviews should accurately reflect a robust risk management plan including licence conditions to protect those at risk
- managers in Hertfordshire will escalate the requirement of an approved premises bed space to senior management in all relevant cases
- MAPPA meetings in Hertfordshire should incorporate the use of relevant ViSOR intelligence
- offender managers in Watford will utilise ViSOR in the completion of assessments
- offender managers in Hertfordshire should explore all indicators of risk in every case including sexual harm.

The progress of actions is reported in a detailed tracker and this is overseen by the Divisional Director who reports to the Chief Probation Officer. We found evidence of the action plan being implemented, although sufficient progress has not been made on all actions. This can partly be attributed to the deferral of some benchmarking and dip-sampling events since March 2020 as a result of the Covid-19 outbreak. The progress of the plan is, however, tracked on a monthly basis and we are satisfied that there is the necessary level of scrutiny to ensure actions are implemented and their outcomes monitored.

Since JMc committed the serious further offences, panels to review MAPPA Level 1 cases have been implemented across NPS South East and Eastern Division. Quality development officers have audited all 156 of the MAPPA Level 1 cases in the Watford office. Eighty of these cases were subsequently subjected to an "early look" process with actions identified for managers to improve the immediate management of these cases. These actions have been progressed and the routine quality assurance of cases has continued. Direct feedback has been given to offender managers with the emphasis on ensuring professional curiosity is demonstrated in all cases.

The revised HMPPS recall, review and re-release of recalled prisoners policy framework issued in April 2019 and re-issued in January 2020 has been implemented across NPS South East and Eastern division. In December 2019, it was the subject of continuing professional development briefings across the division. The recording of management recall discussions and decisions on nDelius is being monitored. Divisional benchmarking exercises focussed on enforcement decisions have had to be postponed but recall data is discussed at the senior leaders' weekly meeting to ensure there is consistency in the recall threshold across the division. In Hertfordshire, the number of recalls has significantly increased during 2019-2020. In the preceding year the number of recalls stood at 67 cases, but this has increased to 126. This is three per cent of the Hertfordshire community licence caseload and is in line with the other LDUs in the division. In NPS South East and Eastern as a whole, recall numbers dropped by 10 per cent between 2015-2016 and 2017-2018 (1,326 cases down to 1,198). In 2019-2020, this figure has risen to 1,631 – an increase of 36 per cent on 2017-2018 figures. This is a significant increase in the number of recalls across the division and demonstrates the impact of the revised recall framework.

The workloads of staff in the South and West Hertfordshire team in Watford remain high and all offender managers are recorded at over 100 per cent on the Workload Management Tool. As part of the action plan, two offender managers have been transferred from the court team and two additional trainee offender managers have been deployed to work in the Hertfordshire office. Additional SPO support has also been put in place to help manage the team. However, across the Hertfordshire LDU, vacancies for qualified offender managers

remain at 20 per cent (6.3 posts) despite the employment of five agency offender managers. There are still two full-time offender manager posts unfilled at the Watford office although there are plans to re-deploy staff when the Covid-19 crisis is over. This continuing staff shortage has been raised by the Divisional Director at the national workforce planning board.

NPS South East and Eastern division issued revised guidance in January 2020 in relation to the transfer of cases. This has been implemented within the Hertfordshire LDU and includes clear instructions on information-sharing, recording and timeliness of transfer. Transfer cases have been audited to monitor compliance with the new instructions. Ten cases in the Hertfordshire office were reviewed in February 2020; this identified that only three of the cases complied with the new guidance. This finding has been addressed directly with team members and further audits will take place to ensure compliance.

The action plan tracking document shows evidence of other actions being actively monitored. All cases in the Watford office are now screened for the Offender Personality Disorder Pathway, OASys quality assurance is routinely undertaken, and cases are being reviewed in relation to sexual harm in one-to-one supervision. When the division is re-inspected as part of our core inspection programme, its effectiveness in learning systematically from SFOs will be inspected as part of our domain one standards.[31] Evidence will be sought that the division has fully implemented SFO action plans and the learning from such incidents has been embedded in process and practice changes.

The SFO action plan focusses primarily on individual and local practice issues. These are appropriate but in our view the case also has significant practice and policy implications that require action at a national level. These are discussed in the next section.

[31] HM Inspectorate of Probation. (2018). *Standards for inspecting probation services*.

15. National issues

Assessment

The over-reliance on OASys as the key source of information undermined the assessment practice in JMc's case. OASys is primarily a structured assessment tool designed to guide risk assessment and sentence planning. Information from a range of sources should be analysed and summarised, using professional skills, judgement and curiosity. Done well, OASys can be a valuable resource to manage a case and prioritise the key risk factors.

Too often, however, completing OASys has become a process-driven task. Offender managers refer to "doing an OASys" as though this is an end in itself, instead of a document that supports and records professional judgement, the outcome of skilled, investigative interviewing, professional curiosity and analysis.

1.(a) Difficulties in accessing multiple systems and historic case information

Analysis of an individual's risk of serious harm should be supported by information from a range of sources. Where historical information has been lost or not communicated adequately between departments, the accuracy of an assessment will be jeopardised. Where the focus of the assessment is on the satisfactory completion of programmes and the sources of information are limited, the value of the assessment will be further undermined.

The basic requirement that risk assessment should balance historical information about an offender such as previous convictions (static factors) with their presentation, attitudes and behaviour that can be changed (dynamic factors) has been highlighted in previous independent reviews (Hanson and White[32] and Rice[33]). This is a highly skilled task. This case highlights the necessity for offender managers to maintain a long view of historical behaviour and to always balance this with progress on dynamic factors. Too much focus was on his immediate presentation and too much credit given for the completion of sentence plan objectives. His previous behaviour was either not known or not analysed sufficiently. As a result, patterns of behaviour and the implications for his risk of harm were not identified. For instance, when JMc was arrested on 05 May 2019, this was the third occasion that he had committed serious offences within three months of release from prison. The importance of this core professional task is, however, undermined by a number of difficulties. In a case like JMc, the case files are likely to be extensive and dispersed between different systems, spanning a lengthy period of time. While not condoning poor practice, we do have some sympathy for over-stretched probation staff faced with the task of trawling through computerised records, without ever knowing if they have found all the relevant information.

A prime example of this was the failure to record in recent OASys documents JMc's breach of licence in 2007. Inspectors only located this information by reading the original CPS information and then cross referencing with historical nDelius records, which themselves had been copied from a different case management system.

The operational staff interviewed confirmed their reliance on OASys for information and their difficulty in locating information from other sources. The storage of information on nDelius in particular was highlighted as inconsistent and staff are not confident they always have access to all the key information on a case.

---

[32] HM Inspectorate of Probation. (2006). *An independent review of a serious further offence case: Damien Hanson and Elliot White.*

[33] HM Inspectorate of Probation. (2006). *An independent review of a serious further offence case: Anthony Rice.*

One SPO stated:

> *"Reading the file can take over five hours. Staff simply do not have the time to read all the information… it is very difficult with complex cases. Information is in different parts of the system: OASys, paper files, nDelius, and ViSOR. It is difficult to be certain you have read all the relevant information as information can be saved in different places on the system. We are very dependent on OASys analysis – information flow is reliant on the quality of analysis."*

These difficulties, and the operational reliance on OASys as a source of information is a cause of serious concern. The management of complex individuals necessitates that practitioners have access to all the relevant risk information. In JMc's case that did not happen. Key information that had a direct impact on JMc's risk assessment was either lost or not identified. For example, the fact that he committed a serious further offence while on licence in 2008, was effectively lost.

1.(b) Poor information-sharing

Information-sharing arrangements between the prisons and supervising offender managers have also been highlighted by the review as causes for serious concern. Comprehensive assessment and analysis rely on probation staff having access to the key information about individuals. Significant intelligence was not shared by prison security with the probation service or with the Parole Board, allowing JMc to present a false picture of his behaviour. This was compounded by the over-reliance on programme completion as evidence of JMc's progress.

During this period, the LASPO test for release applied by the Parole Board and focussed on public protection, did not change. There was however, a policy drive to progress IPP prisoners through their sentence. It is our view that the failure to fully assess and question JMc's presentation and behaviour can, in part, be attributed to the pressure prison and probation authorities were under to progress IPP prisoners to release.

Separately, it is also important that the police share all relevant intelligence with the probation service after someone has been released on licence. Although not directly applicable to this case, our focus groups with offender managers and SPOs revealed examples of delays in the police notifying the probation service that an offender had been arrested – or this information only came to light when the offender self-disclosed it during a routine appointment. Given the importance of this real-time information to recall decisions or other enforcement action, this was concerning and will be explored further in the second part of this review.

Recommendations:

HMPPS should:

- ensure that probation staff are able to access all relevant information about an individual, including from historical case records
- ensure prisons comply with the requirement to share all relevant information, including from prison security departments and records of prison behaviour with the Parole Board
- require prisons to share all relevant information, including from prison security departments and records of prison behaviour with probation offender managers in prison and in the community to assist with parole reports and recommendations and with planning for release.

Measuring progress

As an IPP prisoner, JMc was prioritised for access to offending behaviour programmes. His progress on these, however, was not assessed against the background of his overall prison behaviour. Programme reports and offender manager assessments were over-reliant on his self-disclosure as evidence of progress.

HMPPS' implementation of Offender Management in Custody (OMiC) should improve this information exchange but this will rely on prison security departments pro-actively sharing information with prison offender management units. OMiC was implemented in October 2019. As a result, prisoners with more than ten months left to serve became the responsibility of offender managers based in prisons rather than in the community. This model has the potential to ensure that prison information is included in assessing the risk of serious harm of prisoners.

The risk management plan agreed for JMc by the Parole Board in January 2017 was not implemented. Key elements such as MAPPA Level 2 management and assessment by the Offender Personality Disorder Pathway were not enacted. We have highlighted the poor quality of the parole reports completed in 2017 by the NPS. Since 2017, the NPS has implemented a performance improvement tool focussed on improving the quality of parole reports. During the period 2016-2017, JMc's case was managed poorly and this was the primary reason for the risk management plan not being implemented fully. The Parole Board, however, should have confidence that when it makes decisions to release high risk of harm prisoners, the arrangements agreed are implemented.

Recommendation:

NPS should:

- monitor the implementation of post release risk management plans presented to the Parole Board, including referral to MAPPA, access to relevant interventions, residence in approved premises, and move on plans.

Recall

Recalled prisoners were a growing part of the prison population when the Ministry of Justice launched its recall action plan in 2016. The NPS alternatives to recall strategy was a key part of this plan. The clear message of the strategy was that, with the appropriate support, recalls could be reduced. The test of recall decision-making became one of whether an individual could be managed safely in the community and this was accompanied by a series of measures that probation officers had to consider before recall was actioned. The implementation of the strategy prompted probation officers and managers to consider community alternatives in every case.

The influence of this strategy was evident in the recall decisions taken in relation to JMc. For example, following his arrest for burglary in 2017, the immediate response of probation managers was to look for reasons not to recall rather than to consider whether he needed to be recalled on the grounds of increased risk.

The influence of the strategy on recall decisions during this period was confirmed to us by both SPO4 and ACO1. Indeed, operational staff and managers at all levels emphasised to us that the clear message was to reduce the number of recalls. Statements included:

> *"We were being encouraged to manage people outside of prison. This permeated our operational culture for a number of years. It's enshrined in the paperwork around recall, explicit that the OM and SPO needs to examine every opportunity to avoid recall."*

"We were being told in 2017 that prisons are full, we need to progress IPPs through the sentence, getting them out of prison. So with the IPP agenda and alternatives to recall there was a really big pressure from the top."

"A different culture was introduced – (the message was) don't come and talk to me about recall, tell me what you have done not to recall."

Senior managers in the NPS and HMPPS confirmed the perception of operational staff and stated there was a policy to reduce the demands on the prison system from unnecessary recalls. The Ministry of Justice recall action plan 2016-2017 was intended to ensure that the probation service was exploring alternatives to recall where appropriate.

The implementation of the strategy was followed by a reduction in the number of recalls. In the NPS South East and Eastern division, recalls fell by 10 per cent between 2015-2016 and 2017-2018. The pattern, however, was not consistent across all the division's local delivery units. In Hertfordshire, the LDU where JMc was managed, recalls fell by a greater proportion – 49 per cent (from 118 to 60 cases) in the same period. Performance was monitored at senior management meetings where reductions in recalls were viewed positively. This may have led to a perception that the number of recalls was subject to performance monitoring by the NPS. This was not the case, although the timeliness of recall and the quality of supporting documentation were service level measures.

The perception of recall performance management was potentially reinforced for senior managers by a previous target that 65 per cent of licences should be successfully completed. Clearly, a high number of recalls would undermine delivery of this target, potentially creating a perverse incentive not to recall. The target has since been withdrawn for NPS divisions and CRCs, although the data is still collected for management information.

A revised HMPPS recall, review and re-release of recalled prisoners policy framework[34] has now been disseminated throughout the South East and Eastern division. This policy framework was issued nationally in April 2019 and re-issued in January 2020. There is a recognition by senior HMPPS leaders that the terminology of 'alternatives to recall' was open to misinterpretation. The new guidance sets recall decisions firmly within the parameters of public protection. For example, in contrast to PI 27/2014, the new guidance states that individuals subject to IPP licences should be considered for recall where they exhibit behaviour similar to the index offence without the requirement to demonstrate evidence that there is an increased risk of violent or sexual offending.

Actions to communicate and embed this new framework in the NPS South East and Eastern division have included: continuing professional development events; video guidance; divisional and local briefings reinforcing messages from the Probation Director-General; and the monitoring of improved recording on nDelius. Our review confirmed that operational staff have renewed confidence in the threshold for recall and managers are clear that public protection considerations should always be the focus of recall decisions. The proportion of the prison population that has been recalled to prison increased by 24 per cent (8,933 prisoners) in the year ending on 31 March 2020.[35]

However, other than the requirement for counter-signing of individual recalls by an ACO, recall decisions across England and Wales are still not quality assured routinely. This is also the case for decisions not to recall, which are as important, if not more so, to quality assure.

[34] HMPPS. (2019). *Recall, review and re-release of recalled prisoners policy framework.*

[35] Ministry of Justice. (2020). *Offender management statistics quarterly*: October to December 2019.

As a result, there is no assurance that a key element of probation public protection practice is undertaken consistently and effectively.

Recommendations:

NPS should:

- ensure that the new recall framework is fully embedded in practice
- introduce quality assurance processes to review the consistency and outcomes of recall decisions. This should include cases where recall was considered but not instigated as well as cases where it was approved
- ensure that recall decisions are recorded and implemented regardless of staff absence. A digital prompt should be built into the nDelius system to keep automatically reminding offender managers and their line managers of the need to execute a recall until this action is marked as completed or cancelled by the relevant ACO.

Case transfer arrangements

The arrangements for transfers of cases between probation areas are contained in Probation Instruction 07/2014 which outlines the relevant responsibilities of each area.[36] This instruction was intended to ensure that common procedures, underpinned by clear principles regarding the responsibility for cases, were applied.

Offender managers and managers at all levels across the two NPS divisions we visited reported that these arrangements are applied inconsistently. Senior Probation Officers and offender managers stated that the "caretaking" of cases by offender managers away from the original responsible area can continue for several months before a proper transfer of responsibility is agreed. The reason for the inconsistency, in part, stems from the profile of individuals subject to probation supervision. Their lives are often challenging, and their accommodation status and location changes frequently. Formal transfers of case responsibility are, therefore, only agreed once it is established the individual is stable and can be managed safely in the receiving area. Given the need to consider risk of harm concerns, accommodation availability and the permanence or otherwise of the proposed arrangements, it is perhaps inevitable that any process will need to incorporate some flexibility. However, the current transfer policy is not being applied consistently and the different interpretations of the procedures results in some transfer cases not being prioritised appropriately and delays in transfer of responsibility. This is a matter of concern. An internal review in the NPS South West South Central division demonstrated that during 2018-2019, a case transfer had occurred during the supervision period in 35 per cent of cases where an offender had committed a SFO. This does not mean there is a causal link, but it does indicate the need to prioritise the careful management of case transfers.

In the case of complex individuals like JMc, public protection and safeguarding must be paramount. The decision about transfer needs to be supported by information which may not be immediately available. There is a tension, therefore, between a prompt transfer and a transfer that is well grounded in assessment of the appropriateness and likely stability of the arrangements.

[36] HMPPS. (2014). P1 07/2014 – *Case Transfers: for offenders subject to statutory supervision either pre-release from custody or whilst completing an order or licence.*

Comments made by offender managers and SPOs about the effectiveness of the current arrangements included:

> *"Transfer policy does not reflect the reality of an unstable and complex caseload. Policies assume planning and cooperation."*

> *"The policy does not specify a caretaking policy or process… that is why everyone has a different interpretation of the policies. Caretaking can be seen as a bolt-on – the other area has the responsibility. Probation officers covering cases are expected to have knowledge of the case but they will not have the same level of knowledge and insight as the probation officer holding the case."*

It is perhaps understandable that staff working under excessive pressure would pay less attention to these 'caretaking' cases for which they did not hold formal responsibility. Similarly, it is equally understandable that the offender manager would rely on their caretaking colleague to pick up the reins. Neither position is professionally defensible. They arise, however, from a combination of workload pressures and the inconsistent application of roles and responsibilities.

The NPS Workload Management Tool has been adjusted to allow caretaking offender managers to enter contacts manually on the case management system so that their management of transferring offenders is added to the measurement of their workload. We view this as unsatisfactory. The transfer of cases can result in an increased risk of serious harm; therefore, these cases should be prioritised by the offender managers having contact with the offender. For cases to be prioritised, offender managers should have a clear sense that their work is recognised, and this should be automatically reflected in the Workload Management Tool when the caretaking role is allocated.

The Hertfordshire LDU and NPS South East and Eastern division have made progress in improving timescales and handover arrangements for transfers. A transfer framework has been introduced within the division to achieve timely and effective transfers between the LDUs. This includes directions in relation to information-sharing, address checks and timescales.

Recommendations:

The NPS should:

- review the Probation Instruction for case transfers (PI 07/2014) to ensure the exchange of all risk information; establish an effective communication framework between transferring areas, including clarity about roles and responsibilities; and to ensure cases are prioritised and transfer is expedited.

Approved premises

Approved premises are central to the NPS's management of high risk of serious harm offenders in the community. The demand for beds far exceeds their availability and this was evident in the unavailability of a placement for JMc following his release in February 2019. The need to increase the approved premises estate is recognised by the NPS and we acknowledge that the opening of such facilities is often a complex process. The problem of accessibility to approved premises placements was recognised in the SFO action plan. NPS South East and Eastern division have subsequently introduced an escalation process that involves local senior managers directly in accessing beds where necessary. We welcome this response to JMc's case but believe this is a national policy issue. Access to approved premises beds was a key part of the alternatives to recall strategy but, as we have found in

JMc's case and our meetings with operational staff, emergency access is not consistently available. Despite the introduction of the central referral units, it is still often reliant on offender managers making several direct calls to approved premises requesting a bed. In our view, emergency admissions should be managed by means of a responsive emergency referral process.

Recommendations:

HMPPS should:

- ensure there are clear and responsive arrangements for emergency referral to approved premises where required to manage offenders who present a high risk of serious harm
- ensure there is sufficient capacity in the approved premises estate to accommodate all high risk of harm offenders who require a placement.

Workload management

The management of complex individuals requires appropriate training, a manageable workload and skilled management oversight. Individuals managed by the probation service are frequently chaotic and demanding, and probation staff often have to respond quickly to difficult behaviour and unplanned events. This can only be done effectively in a stable work environment. This was not present in the South and West Hertfordshire team based in Watford during 2018 and 2019.

This does not excuse poor practice in this case but does provide context to the management and decision-making in relation to JMc. In total the South and West Hertfordshire team should have seven offender managers to manage the high risk of serious harm cases. During 2017 there were ongoing staff shortages and the team carried three vacancies. Of the four offender managers in post, two were agency staff. The agencies who supply staff to the NPS are approved at national level by the NPS Business Strategy and Change division. This inspection identified that performance concerns from previous employment were not always identified when agency staff are deployed in the NPS. This is a matter of concern and may have led to the re-employment of staff who had been managed out of the service previously, on the grounds of poor performance. In February 2020 there were still 55 agency probation officers employed in NPS South East and Eastern division. Our inspection of the division in 2019 highlighted the fact that across the division there was a 16 per cent (102 posts) vacancy rate for probation officers.[37]

The NPS's Workload Measurement Tool is not a definitive guide to the measurement of workload. It is, however, an important management information tool providing detailed information on offender managers' caseloads. From March 2017 to September 2017 all offender managers in the Watford team had a measured workload of over 120 per cent in terms of capacity. For much of this period the measured workload of probation officers was over 140 per cent. OM7's workload in the NPS South West South Central division was also high during this period. OM7 had recently joined the Buckinghamshire team and had a new caseload. In line with PI 07/2014, which does not recognise the "caretaking" of cases, OM7's engagement with JMc was not specifically measured on the Workload Management Tool during this period.

Previous HM Inspectorate of Probation reports have expressed concern about areas where staff turnover is high and where experienced staff are short on the ground. We identified

[37] HM Inspectorate of Probation. (2019). *Inspection of NPS South East and Eastern division.*

this issue in our report on the South East and Eastern division in September 2019; we highlighted it as a national issue in February 2020.[38]

The recruitment of additional probation officers that is being undertaken nationally will help to address this issue.

Skills of offender managers

JMc was a very challenging individual. His intimidation and manipulation of staff is well documented. On the other hand, he was seen as someone who had engaged positively with the programmes that he needed to complete in prison in order to be considered for release.

The assessment and management of individuals of this profile requires resilient staff who are trained and able to analyse, interpret and challenge difficult behaviour. They need the ability to seek out and synthesise information from different sources and use professional curiosity to question superficial compliance. Assessment should be based on a full analysis and understanding of the individual's previous behaviour.

JMc's management in the community was characterised by poor assessment, poor planning and poor decision-making. When he was in custody, his case was not prioritised consistently by his offender managers and there was insufficient analysis of his progress and behaviour.

It takes experience, time and support to develop the skills of reflective practice. It also requires a stable organisational structure and a high level of professional support. The Watford office during the time JMc was being supervised had none of these key features, although we note that managers were already addressing performance issues within the team.

In our report in February 2020 we highlighted inadequate post-qualification training for offender managers.[39] Probation officers supervise complex, dangerous and frequently unpredictable offenders. Continuing professional development for them is essential if this is to be done effectively. The current training framework for qualified offender managers does not meet this requirement. The quality of training is inconsistent and does not support the development of the necessary confidence and skills to manage high risk of serious harm offenders.

Recommendations:

The NPS should:

- ensure that probation staff have adequate time to become familiar with complex cases for which they assume responsibility
- improve the professional training of qualified and experienced probation staff to enhance skills in interviewing; interpretation and analysis of information from different sources; and risk assessment.

[38] HM Inspectorate of Probation. (2018). *Standards for inspecting probation services*.

[39] HM Inspectorate of Probation. (2020). *An inspection of the central functions supporting the National Probation service.*

16. Conclusion

As we have noted before,[40] when an offender is being supervised in the community it is simply not possible to eliminate risk altogether, but the public is entitled to expect that the authorities will do their job properly, that is to take all reasonable action to keep risk to a minimum in order to protect actual and potential victims. That did not happen in this case.

Mistakes and poor judgement by several individuals meant that JMc remained in the community when he could, and should, have been recalled to prison. These issues of individual professional negligence have been examined in the internal SFO review, and appropriate action has been taken.

In our review, we have examined these individual failures within the wider context of probation policy, procedures and operational reality. Inadequately trained and overworked staff and managers, as identified in this case are not new findings; we have highlighted these issues in several of our core local inspections and in our report on the central functions supporting the NPS.[41]

In this report we have also highlighted areas where HMPPS must take action to improve the role the NPS plays in protecting the public from dangerous offenders.

[40] HM Inspectorate of Probation. (2006). *An independent review of a Serious Further Offence case: Damien Hanson and Elliot White* and HM Inspectorate of Probation (2006). *An independent review of a Serious Further Offence case: Anthony Rice*.

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

References

Crime (Sentences) Act 1997, section 28 (6)(b).

Hare, RD. and Herve, H. (1998). *Hare P-Scan*. Multi-Health Systems.

Hare, RD. (1998). *The Hare PCL-R.* Multi-Health Systems.

HM Inspectorate of Probation. (2018). *Independent review of the case of Leroy Campbell: final report.*

HM Inspectorate of Probation. (2018). *Enforcement and recall.*

HM Inspectorate of Probation. (2018). *Standards for inspecting probation services*.

HM Inspectorate of Probation. (2006). *An independent review of a serious further offence case: Damien Hanson and Elliot White.*

HM Inspectorate of Probation. (2006). *An independent review of a serious further offence case: Anthony Rice.*

HM Inspectorate of Probation. (2019). *An Inspection of the South East and Eastern Division of the National Probation Service.*

HMI Probation. (2020). *An Inspection of central functions supporting the National Probation Service.*

HM Prison Service. (2014). *PSI 37/2014.*

HMPPS. (2017). *Alternatives to Recall team briefing pack.*

HMPPS. (2017). *IPP action plan.*

HMPPS. (April 2019, re-issued February 2020). *Recall, review and re-release of recalled prisoners policy framework.*

HMPPS. (2014). P1 07/2014 – *Case Transfers: for offenders subject to statutory supervision either pre-release from custody or whilst completing an order or licence.*

HMPPS. (2016-2017). *Recall action plan*.

HMPPS. (2017). *Effective licence management plan.*

James, Wells and Lee v the United Kingdom. (2013). European Court of Human Rights.

Jones, M. (2017). *IPPs, recalls, and the future of parole.*

Justice Committee, House of Commons. (2019). *Oral evidence: Legal Aid, Sentencing and Punishment of Offenders Act 2012.*

Justice Committee, House of Commons. (2017). *Oral evidence: work of the Parole Board.*

Ministry of Justice. (2020). *Serious Further offence review in the case of Joseph McCann.*

Ministry of Justice. (2015*). Practice Framework: National standards for the management of offenders for England and Wales.*

Nicholas Wells v The Parole Board and The Secretary of State for Justice. (2007). EWHC 1835 (QB).

NPS. (2017). *Alternatives to Recall guidance.*

Osborn, Booth & Reilly v The Parole Board and The Secretary of State for Justice. (2013). The Supreme Court.

Annexe 1: Methodology

For the purpose of the review we read the following documents:

Case file

- Probation case records including nDelius case management records and ViSOR records
- Parole dossier
- Parole Board decision letter (January 2017)
- Prison security information reports
- MAPPA minutes
- NPS SFO review, chronology and action plan.

Policy and guidance

- NPS policy documents in relation to indeterminate sentenced prisoners
- NPS policy documents in relation to recall procedure, performance and practice
- NPS performance information in relation to indeterminate sentenced prisoners and recalls
- Relevant NPS policies and procedures including those relating to the transfer of cases, Approved premises and personality disorder.
- HMPPS operational guidance on the completion of SFO reviews
- MAPPA guidance.

We also interviewed staff with direct knowledge of the case from NPS South East and Eastern division and NPS South West South Central division. In addition, we had meetings with:

- Sonia Flynn, Chief Probation Officer and Executive Director Women
- Steve Johnson-Proctor, NPS Divisional Director South East and Eastern
- Angela Cossins, NPS Divisional Director South West South Central
- Gordon Davison, NPS Deputy Director, Head of the Public Protection group
- Ruth Johnson, Head of Strategy, NPS Business Strategy and Change Division
- Angela Colyer, Head of Policy, and Michael Atkins, Head of Legal at the Parole Board for England and Wales
- Hazel Mehta, Head of Intelligence operations, National Intelligence Unit, HMPPS.

We also held focus groups with the following groups of staff and managers:

- Heads of Local Delivery Units, NPS South East and Eastern division
- Head of Oxfordshire and Buckinghamshire and Senior Operational Support Manager, NPS South West South Central division
- Senior Probation Officers, NPS South East and Eastern division

- Offender managers, NPS South East and Eastern division
- Senior Probation Officers, NPS South West South Central division
- Offender managers, NPS South West South Central division.

These meetings enabled us to explore issues of policy, practice and organisational culture that helped us to understand the context within which decisions about the management of JMc were made.

Annexe 2: The key recall decisions

Date	Circumstances of the decision
August 2017	SPO4 is informed that JMc has been arrested for domestic burglary. SPO4 is also informed he will be remanded into custody. On the basis that more information is required, the decision is taken not to recall JMc immediately but to await the outcome of his court appearance. JMc is remanded into custody and SPO4 discusses the case with ACO1. It is decided not to recall and to await the outcome of the court case. SPO4 and ACO1 are not certain the circumstances of the new offence demonstrate an increase in the risk of violent or sexual offending in line with P1 14/2014. They also take into consideration the fact that if JMc was recalled on the IPP sentence, he would remain in custody if he was acquitted of the new offence of domestic burglary. The decision is focussed on the recent offence of burglary and not patterns of behaviour. Reference to alternatives to custody in the event of the court releasing JMc on bail, are made in the case recording. The decision to instigate recall in the event of conviction is not recorded.
January 2018	JMc is convicted of domestic burglary and SPO3 decided that because the new offence of burglary was not aggravated, there was no evidence of an increased risk of sexual or violent behaviour to warrant recall. This decision was not discussed with the line manager ACO1. The decision is focussed on the offence of domestic burglary and not patterns of behaviour.
February 2018	OM5 is contacted by the prison service and asked to recall JMc on his IPP licence. OM5 informs the prison that the decision has been taken not to recall JMc. This decision is not discussed with ACO1.
August 2018	The prison service contact SPO3 and request that the recall of JMc is considered. SPO3 discusses recall with ACO1 who advises that the case is discussed with the PPCS to obtain their view as to whether the recall threshold has been met. Following discussion with PPCS, SPO3 decides to instigate recall. This decision is not recorded or immediately implemented. In October 2018, SPO3 informs the prison service that JMc will be recalled. SPO 3 is subsequently absent from work. As the decision had not been communicated to colleagues or discussed with the line manager ACO1, the recall is not instigated.
November /December 2018	SPO5 undertakes an audit of cases in the Watford office and directs OM5 to recall JMc on his IPP licence. OM5 is subsequently absent from work and in December, SPO5 learns that the recall has not

	been initiated. The case is discussed with ACO1 and the decision is taken not to recall JMc. Instead they decide that on his release from prison in February 2019, his risk in the community is manageable, if he is managed at MAPPA Level 2 and referred to an approved premises. This decision takes into consideration their view that it was very late in his determinate sentence to recall him on his IPP licence. They were concerned that such a decision would run contrary to notions of procedural justice. In addition, SPO5 and ACO1 believed a recall decision at this late stage may be subject to a legal challenge. This decision was taken without an analysis of JMc's previous behaviour on licence being considered.
January 2019	The Watford office is contacted by the prison service and SPO5 is asked to review the recall decision. SPO5 is also asked to review the recall decision by an SPO colleague. On the basis that the decision to manage JMc in the community has been agreed with ACO1, the recall is not further re-considered.
January/February 2019	At a MAPPA Level 2 meeting, SPO5 is given an action to contact PPCS to ascertain their view on whether JMc can be recalled on his IPP licence prior to his release from prison in February 2019. This action is not undertaken by SPO5 who has no recollection of it being set at the meeting. At the next MAPPA Level 2 meeting, JMc's case is moved to MAPPA Level 1 management without the action being completed.
April 2019	Following his release from prison in February 2019, JMc informs OM9 in early April 2019 that he is in a relationship with a young woman who is residing with him in the family home. It transpires that JMc has been in this relationship for a sustained period but has previously failed to disclose it. A condition of his licence is that JMc must disclose developing relationships to his offender manager. A housing officer informs the offender manager that JMc, in the company of a young woman, has been aggressive and abusive in the office. OM9 discusses the case with SPO4 and they decide to issue a final ACO warning to JMc for this breach of licence and not to recall him. This decision was based on the immediate circumstances of the breach of licence conditions and did not consider previous patterns of behaviour.

Annexe 3: 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 as 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.
Approved premises	Premises approved under Section 13 of the Offender Management Act 2007, and managed either by the NPS or by independent organisations. They are used as a short-term residence for offenders considered a high risk of serious harm, who require close monitoring and supervision, to begin to integrate them back into the community.
CRC	Community Rehabilitation Company: 21 CRCs were set up in June 2014 to manage most offenders who present low or medium risk of serious harm.
CNomis	CNomis is the case recording system used by HMPPS inside prison. Since 2019, it has been linked with NDelius so that probation staff have access to prison officer entries on prisoners.
Criminal justice system	Involves any or all of the agencies involved in upholding and implementing the law – police, courts, youth offending teams, probation and prisons
CSCP	Cognitive Self Change Programme: a high intensity cognitive behavioural programme for high risk, repetitively violent, adult male offenders. During 2011, CSCP was been replaced by the Self Change Programme (SCP).
Determinate sentence	A determinate prison sentence is where the court sets a fixed length for the prison sentence and is the most common type of prison sentence. For example, an offender may be sentenced to four years in prison. This is the maximum period of time the offender could spend in prison. However, the offender will not necessarily spend the whole of this time in prison. The rules governing when a prisoner is released vary depending on the length of the sentence and when the offence was committed.
EQuiP	Excellence and Quality in Process: an NPS web-based national resource providing consistent information about the processes to be followed in all aspects of NPS work. The process mapping is underpinned by quality assurance measures.
ETS	Enhanced Thinking Skills: Addresses thinking and behaviour associated with offending through a sequenced series of structured exercises designed to teach inter-personal problem-solving skills.

HMPPS	Her Majesty's Prison and Probation Service: from 01 April 2017, HMPPS became the single agency responsible for delivering prison and probation services across England and Wales. At the same time, the Ministry of Justice took on responsibility for overall policy direction, setting standards, scrutinising prison performance and commissioning services. These used to fall under the remit of the National Offender Management Service (NOMS).
HMPPS SFO review team	This team is located in the Public Protection group of the NPS. It is responsible for administering the SFO review process and for quality assuring all reviews and action plans. It provides guidance to probation providers and is responsible for developing national policy and guidance relating to SFOs.
HRP	Healthy Relationship Programme: A prison based programme for men who have committed violent behaviour in an intimate relationship. There are two versions of HRP – the moderate intensity programme for men assessed as having a moderate risk/moderate need profile and the high intensity programme designed for high risk/high need offenders.
Indeterminate sentence	An indeterminate sentence has no fixed length. The person will have to spend a minimum amount of time in prison (the 'tariff') before they are considered for release. Indeterminate sentences (e.g. IPPs and Life Sentences) are given if the court thinks an offender is a danger to the public. The Parole Board is responsible for deciding if they can be released from prison.
Intervention	Work with an individual that is designed to change their offending behaviour and/or to support public protection. A constructive intervention is where the primary purpose is to reduce likelihood of reoffending. A restrictive intervention is where the primary purpose is to keep to a minimum the individual's risk of harm to others. With a sexual offender, for example, a constructive intervention might be to put them through an accredited sex offender programme; a restrictive intervention (to minimise their risk of harm) might be to monitor regularly and meticulously their accommodation, their employment and the places they frequent, imposing and enforcing clear restrictions as appropriate to each case. Both types of intervention are important.
IPDE	International Personality Disorder Examination: a semi-structured clinical interview used to assess personality disorders.
IPP	Sentences of Imprisonment for Public Protection (IPPs) were created by the Criminal Justice Act 2003 and started to be used in April 2005. They were abolished in 2012. They were designed to protect the public from serious offenders whose crimes did not merit a life sentence. Offenders sentenced to an IPP serve a minimum term (the 'tariff') in prison after which they can apply to the Parole Board for release. The Parole Board will release an offender only if it is satisfied that it is no longer necessary for the protection of the public for the offender to be confined. On release on licence they are supervised by the National Probation Service.

Licence	Almost all individuals sentenced to imprisonment are, at some point, released on licence under probation supervision. This part of the sentence is served in the community. The licence includes a number of requirements and/or restrictions. Where the individual does not comply with these requirements, the probation offender manager may initiate their recall to prison.
LDU	Local Delivery Unit: an operational unit comprising an office or offices. They are generally coterminous with police basic command units and local authority structures.
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.
NOMS	National Offender Management Service: until April 2017, the single agency responsible for both prisons and probation services, now known as Her Majesty's Prison and Probation Service (HMPPS).
NDelius	National Delius: the approved probation case management system used in England and Wales.
NPS	National Probation Service: a single national service which came into being in June 2014. Its role is 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 to assess the risks and needs of offenders under supervision.
Offender Rehabilitation Act 2014 (ORA)	Implemented in February 2015, applying to offences committed on or after that date. This legislation extended supervision in the community to all adults sentenced to more than one day in prison. Formerly, only those sentenced to more than 12 months were supervised in this way.
OM	Offender manager: This is the officer who is responsible for supervising the case. It could be a probation officer or probation services officer. In focus groups, both grades of staff were present so we have used the generic term when referring to evidence.
Offender management	A core principle of offender management is that a single practitioner takes responsibility for managing an offender through the period they are serving their sentence, whether in custody or the community
OMiC	Offender Management in Custody: the way prisoners are case managed through the custodial sentence has been revised within the OMiC model. The model provides the framework to co-ordinate and sequence an individual's journey through custody and post release. Under the

	model, prison staff and probation offender managers work closely together and with the offender.
Offender Personality Disorder pathway	An initiative jointly commissioned by NHS and HMPPS that aims to provide a pathway of psychologically informed services for a highly complex and challenging offender group who are likely to have a severe personality disorder, and who pose a high risk of harm to others or a high risk of reoffending in a harmful way.
Parole Board	The Parole Board is an independent body possessing quasi-judicial function. It determines whether prisoners can be safely released into the community. Parole Board is an executive non-departmental public body, sponsored by the Ministry of Justice.
PCL-R	A psychological assessment tool used to assess psychopathy in an individual. Originally developed by Dr Robert Hare in the 1970s it is conducted by qualified psychologists.
PI	Probation Instruction. These are mandatory instructions issued by the HMPPS, detailing policies and guidance.
PIPE	Psychologically informed planned environment: PIPEs form a key part of the offender Personality Disorder strategy. They operate in selected prisons and approved premises. They are specifically designed environments where staff members have additional training to develop an increased psychological understanding of their work. PIPE services are supported by additional prison/probation staff and a qualified psychological therapist. PIPEs focus on providing prosocial relationships and interactions and form part of a treatment pathway of services. PIPEs are not a treatment programme in the traditional sense, instead they support progression and transition through a pathway operating in Prison and Probation settings.
PO	Probation officer: this is the term for a responsible officer who has completed a higher-education-based professional qualification. The name of the qualification and content of the training varies depending on when it was undertaken. They manage more complex cases
PPG	Public Protection Group: the group within HMPPS in which the national Serious Further Offence team sits.
PPCS	Public Protection Casework Section: the section in HMPPS that deals with pre and post-release casework in respect of the release and recall of prisoners.
Progression regime	Progression Regimes have been developed for male Indeterminate Sentences Prisoners who are: excluded from open conditions, serving the recall period of their licence in custody, or having difficulty progressing through their sentence via the usual routes. The purpose of a progression regime is to re-introduce the responsibilities, tasks and routines associated with daily life in the community, to test prisoners'

	readiness to respond appropriately to the trust placed in them, and to actively pursue activities and relations which support rehabilitation.
Providers	Providers deliver a service or input commissioned by and provided under contract to the NPS or CRC. This includes the staff and services provided under the contract, even when they are integrated or located within the NPS or CRC.
P-Scan	A screening tool devised by Dr Robert Hare for situations when it is not possible to conduct a full PCL-R. It provides indications of psychopathy rather than a full clinical diagnosis.
Recall	An offender subject to licence can be recalled to prison if they fail to comply with the conditions of their licence. They can be released again after 28 days if they meet certain criteria, if not, the parole board will decide if they can be re-released at any point prior to the end of their sentence. In some instances, the responsible officer can support executive release which allows the public protection casework section to decide whether an offender is suitable for re-release without a full parole board review. An offender subject to an IPP licence can be recalled to prison if they fail to comply with the conditions of their licence. Their case must be referred to the independent Parole Board within 28 days of their return to custody. They may only be released again at the direction of the Parole Board.
Risk assessment	The process of collecting, verifying and evaluating information to establish the nature and extent of risk, either of likelihood of re-offending or of the occurrence of serious harm. Risk assessment is often aided by the use of formal risk assessment tools. Good quality risk assessment builds on strengths as well as identifying difficulties; is grounded in evidence; is offender-centred; is a continuing process, not a single event.
Risk of serious harm	The assessed level of risk of harm that the service user is identified as presenting. Serious harm is defined below. This assessment is part of the OASys assessment tool. There are four levels of ROSH: *Low* risk of serious harm: Current evidence does not indicate likelihood of causing serious harm. *Medium* risk of serious harm: There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, and drug or alcohol misuse. *High* risk of serious harm: There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. *Very high* risk of serious harm: There is an imminent risk of serious harm. The potential event is more likely than not to happen imminently

	and the impact would be serious. This assessment is likely to relate to a 'critical few'.
Risk management	Refers to those strategies used to manage risk, either by reducing the likelihood that a harmful offence will occur, or in reducing the impact of the offence should it take place (e.g. victim protection). Strategies most usually restrict opportunities to offend, restrict access to or impact on potential victims, and target risky behaviours for change. The term tends to be used with reference to risk of harm rather than risk of re-offending. Risk management is more effective when the offender is committed to and supports the activities, which is made more likely by a clear focus on desistance principles and opportunities to change.
Risk management plan	A shared, actively monitored plan, for managing the identified risk of serious harm. Such a plan is required to be in place and documented for all offenders assessed as Medium, High or Very High RoSH.
SFO	Serious further offence: where a service user subject to (or recently subject to) probation commits one of a number of serious offences (such as murder, manslaughter, rape etc.) These are offences committed by service users that fall within the remit of PI 06/2018 Annex A.The CRCs and/or NPS must notify HMPPS of any individual charged with one of these offences. A review is then conducted with a view to identifying lessons learned.
SFO review	This the review undertaken when a service user commits a SFO eligible offences.
ViSOR	ViSOR is a national confidential database that supports MAPPA. It facilitates the effective sharing of information and intelligence on violent and sexual offenders between the three MAPPA Responsible Authority agencies (police, probation and prisons), as well as the recording of joint risk assessments and risk management plans.
Workload Management Tool	A tool to calculate the overall workload of an individual responsible officer. It takes into account numbers and types of cases.