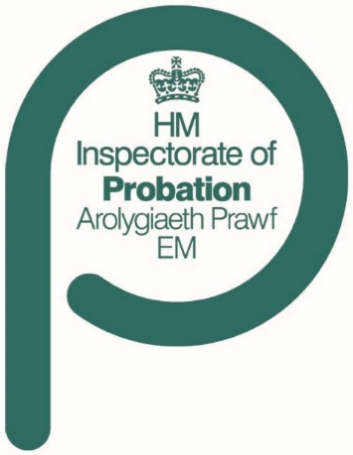
Independent review of the case of Leroy Campbell: final report

HMI Probation, September 2018



Contents

1. Overview

Leroy Campbell has a history of serious sexual offending, and a predilection for attacking lone women. Whilst under probation supervision in late 2016, he told his NPS probation officer that he felt vulnerable and isolated (feelings that he said were linked with his previous offending) and that he might reoffend, might rape again. A few weeks later he raped and killed Lisa Skidmore in her own home. He also attempted to murder her elderly mother in Lisa's home, and then set fire to the property, leaving her for dead. Mrs Skidmore survived.

These were dreadful crimes. They have been devastating for the family. We offer them our sincere and heartfelt condolences. We understand that they need to know in sufficient detail, how Leroy Campbell came to reoffend in this way, and whether there is anything in the way he was supervised that increased the risk of such a thing happening. If there were failings, then family members will wish to know what is being done about it, and whether any individuals are called to account.

When those under probation supervision commit serious further offences, the probation provider conducts a review of how well the individual was supervised by their staff while on probation. That happened in this case. The multi-agency supervision arrangements for Leroy Campbell meant that a second type of review could also be instigated, and that happened in this case as well.

We have evaluated both of those reviews, and found them honest and reliable overall. There are one or two areas where we might have formed a different judgement, but they are not material. We agree with the reviewers: the supervision of Leroy Campbell was inadequate in several crucial respects. As a result, Lisa Skidmore, other women and the wider public were put at risk unduly, with grave consequences.

We set out in this report the detail of what happened in the supervision of Leroy Campbell, starting in 2000 when he was sentenced to life imprisonment. Many good decisions were made about his supervision within prison and upon release, but a series of unrelated yet questionable decisions and one final, very poor decision meant that his risk was not adequately managed.

While in prison, Leroy Campbell was assessed as requiring management under what are known as Multi-Agency Public Protection arrangements (MAPPA), upon release. These are designed to ensure cooperation and integration of police, probation and other agencies' work to protect the public once the offender is back in the community. Many high-risk offenders are managed under one of three levels of MAPPA arrangements. Level 3 arrangements (the highest level) are reserved for the small proportion of individuals where the greatest agency cooperation and management is thought necessary, to protect the public. Level 1 is by far the most common level in use.

Leroy Campbell was expected to be managed under Level 2 or 3 upon release, but this was reduced to Level 1 during his time in prison. Although the MAPPA level was reconsidered pre-release the level was not revised and the supporting paperwork was not completed by the Probation Officer as it should have been. As a result he left prison assessed at the lowest level (Level 1) rather than the higher level expected and anticipated by senior probation staff: evaluation and record-keeping procedures were not followed properly. We find that unacceptable, and inexplicable.

While in prison, a series of 11 probation officers were responsible for his case. While changes over a long sentence are inevitable, this rate of change was exceptional. It does not support effective relationship-building or assessment.

Leroy Campbell had a persistent offending history, and was serving a life sentence for the latest in a series of violent and serious sexual offences when the Parole Board decided to recommend his release. At that stage he was 11 years over his five-year tariff. The Parole Board had a difficult decision to make in this case, and having looked at the evidence available to us, we do not criticise the decision.

Upon release, Leroy Campbell was managed in the community. In this case, police and probation responses at a critical time were not sufficiently co-ordinated, and a key piece of information was not recorded by Probation or shared with Police as it would have been, had Leroy Campbell been managed at a higher MAPPA level. Opportunities to review the MAPPA level during his release on temporary license were not taken. Curfew requirements imposed on Leroy Campbell by the Parole Board were relaxed, in a more casual manner than expected and sooner than expected as well.

There were some indications given to probation officers by Leroy Campbell to suggest he remained a risk to women. He said things that could have been taken either way, but when put together they should have given probation staff cause for concern. While under release on temporary licence, he breached licence conditions designed to keep the public safe.

However, most striking in this case is a decision by probation services when Leroy Campbell was no longer living in Approved Premises. Probation staff decided NOT to respond actively enough to a clear indication that risk may be increasing notably. This individual came into the probation office and stated to his probation officer that he was thinking of raping again, and that he has been looking at - or had noticed - open windows (he had previously entered a victim's house, to then rape her).

In our view that should have resulted in immediate, positive and firm action to protect the public – either an immediate move back to Approved Premises, or recall to prison. Instead, Leroy Campbell was left free to commit these terrible crimes. It was an aberrant decision, to leave Leroy Campbell at large.

In the circumstances, we have looked at how the NPS has acted since, and the steps it has taken to hold its own staff to account for their standard of work. We find it odd that managers did not consider conducting an investigation immediately, or suspending any of the staff involved pending an investigation. In our view there was sufficient evidence to indicate that immediate action could and should have been taken. It was not.

In the weeks following the offences, NPS managers scrutinised a broader sample of the work of the probation staff and managers involved in the case. The focus was to establish whether the poor judgement exercised was part of a pattern of poor practice. We have concluded that in the circumstances of this case, this approach was not sufficient.

In other areas of professional endeavour, professionals who fall far short of accepted professional standards on any occasion can be referred to their professional body for investigation and consideration of their fitness to practice. No such arrangements exist for probation professionals. While that remains the case, it is all the more important in our view that disciplinary procedures and their application pass muster, and provide the public and individuals with the assurance they need that appropriate actions are taken, and taken promptly when things go seriously wrong.

We question whether the organisation's disciplinary procedures and its underlying disciplinary culture are sufficiently robust. The guidance available to managers on handling conduct and disciplinary investigations focused on situations where there were clear breaches of professional conduct, with little about dealing with failures in professional judgement. Some disciplinary proceedings have now been instigated here, but exceptionally late in the day and only after our interim report. Disciplinary actions should be timely in our view, to be as fair as possible to all concerned, and to maintain public trust.

As well as dealing fairly and properly with significant professional failings, we and the wider public expect public services to learn from mistakes and put in place arrangements to reduce the risk of similar things happening again. Here the NPS has done that. It has put a lot of effort into developing a fulsome action plan and following it through. Regrettably however, the plan does not address two issues that are of national significance.

Firstly, what is expected of senior probation officers whenever they supervise and oversee the work of less experienced staff is not sufficiently clear in our view. Professional supervision failed in this case both when Leroy Campbell was in prison and after his release – most especially when the probation officer concerned consulted a senior probation officer when Leroy Campbell disclosed he was thinking of rape. The right actions were not decided, or taken, even though Campbell's history of offending suggested plainly the risk of a serious further offence.

The NPS has recently reminded staff of how to deal with such disclosures, and we welcome that, albeit it is late and it simply confirms what we already expect of professional probation staff. We think there is a broader problem, however. With senior probation officers now responsible for a range of management duties, it is not clear what is expected by way of their professional supervision of less senior professional staff and their cases, or the priority to be given to that important work. The NPS should be more specific about the requirements, in our view, but progress here is slow.

Secondly, the plan does not address in any way the shortcomings of the organisation's disciplinary procedure, or the disciplinary and accountability culture that prevails. In this case, managers responded to what we think are clear professional failings by looking at the quality of an individual's work overall. While that is valuable in checking that an individual generally works to standard in protecting the public, it does not go far enough.

Our view is that, whatever such an exercise shows, it is simply not acceptable that aberrant decision-making is left unaccounted for. It is unacceptable to the relatives and surviving victims of a further offence and to the wider public. In our view, the NPS should look afresh at its disciplinary policy and also consider how it deals with extremely poor decision-making, keeping public expectations about accountability in mind.

The Skidmore family feel they have been poorly treated by the NPS following these dreadful crimes, and we agree. The NPS's national procedures at the time for accounting to victims and their families were in our view difficult to defend: victims and families were presented with a review report to read on the spot, rather than take away. This does not build trust, and thankfully these procedures have now changed.

In this case, reports were prepared to a good standard but it was a lot for the family to take in. What is more, in the meeting that followed immediately after their reading of the material, and subsequently, the family have found the NPS defensive, and unwilling to admit management shortcomings or to hold any individuals to account.

Indeed, although the NPS developed and implemented its action plan, it is only after the family's determined pursuit of the facts and then the intervention of the minister, that certain actions have been taken by the NPS. That does not reflect well on the organisation, or restore the family's trust. Some individuals are now subject to disciplinary proceedings, but it is very late in the day.

Finally, this family's distress at the loss of Lisa and the ghastly circumstances of her death was exacerbated by an application by the defendant for a second post mortem. The NPS were unaware of this application. Leroy Campbell made that application just one day before the time limit for application expired. It had regrettable consequences for the family, and their grief. The family suspect the applicant had self-serving reasons for the request, rather than the pursuit of justice. We do think government should consider whether the process of application for second post mortems is sufficiently robust.

2. Introduction

On 12 May 2017, Leroy Campbell (LC) was sentenced to life imprisonment for the rape and murder of 37-year-old Lisa Skidmore in late 2016. He was also convicted of the attempted murder of Ms Skidmore's 80-year-old mother, Margaret Skidmore.

At the time of the offences he was being supervised by the Midlands Division of the National Probation Service (NPS). When individuals under probation supervision are convicted of such serious further offences, the probation service is required to formally review its supervision of the offender, and produce a report. That happened in this case. Under procedures at the time, victims and their families were not given a copy of the full report. Instead, a shorter Victim Summary Report (VSR) was produced for them. That happened here, and a copy of it was given to the Skidmore family.

LC was managed under what are known as Multi-Agency Public Protection Arrangements (MAPPA). These arrangements are commonly used to manage serious offenders when they are released. They provide for the police, probation services and others to work together, to keep the public safe. Again, a formal review may be undertaken when such serious offences occur, and that happened here. A panel was set up to undertake the review, as is usual, and the independent Chair produced a report. As with Serious Further Offence (SFO) reports, the victim or family are not given a copy of the full report. Instead an overview report is provided, and that happened in this case. Additionally, some of the Skidmore family accepted an invitation to visit an office to read the whole MAPPA Serious Case Review.

In April 2018, Rory Stewart, Minister of State for Justice commissioned Dame Glenys Stacey, Chief Inspector of Probation[1] to undertake a review of this case. In June we submitted an interim report in which we concluded that the two review reports had accurately and honestly reported on the failings identified in the management of LC. We noted that the organisation had put in place a fulsome action plan.

What was less clear, at that stage, was whether the actions taken by managers in the immediate aftermath of the offence and subsequently were sufficient, in relation to the staff

[1] This review was led by HMI Probation, with input from HMI Constabulary and Fire & Rescue Services (HMICFRS) in relation to the MAPPA SCR.

whose practice was under scrutiny, and whether the organisation's action plan was sufficiently robust. In this final, full report we have additionally considered these matters.

3. Terms of reference

The detailed scope of this review is as follows:

- To examine the SFO and MAPPA reviews and consider whether they are robust and honest
- To examine the action plans arising from the reviews and consider whether they adequately addressed the issues identified
- To consider the extent to which the identified actions were implemented
- To consider whether additional issues should have been identified and addressed.

LC committed these offences just four months after he was released from prison, on life licence. Inevitably this raises questions about the release decision, the information on which this was based and - potentially - the work done with LC during his prison sentence. Examining these issues in depth would require a more detailed and lengthy review beyond our terms of reference. Nevertheless, we summarise what we think are the key points, in this report.

This report covers the period 2000 to 2016. LC was in custody in 2000. In 2014 he was moved to an open prison and in 2016 he was released. Our report is in four sections, covering:

- The period in closed prison
- Open prison and release
- Supervision in the community
- The quality of the SFO and MSCR reviews.

4. Methodology

During the first stage of our review we read the following case records relating to LC:

- Probation case records,
- ViSOR records[2]
- Parole Board decision letter
- Parole dossier (a file of information about the prisoner)
- Probation SFO review report, chronology, victim summary report and action plan
- MSCR, action plan and summary report
- Police Internal Management Report (IMR)

[2] ViSOR is the secure database used by police, probation and prison staff to communicate information about MAPPA managed offenders.

We also interviewed the:

- MAPPA co-ordinator for the West Midlands
- Probation Head of Public Protection/Stakeholder Engagement and Chair of MAPPA Strategic Management Board
- Parole Board director, and Parole Board quality assurance lead
- Head of Public Protection for the NPS, Midlands (responsible for conducting the SFO review)[3]
- Head and Deputy Head of the Local Delivery Unit (LDU)
- Chief Executive Officer of the Fry Accord Housing Association4
- Head of Integrated Offender Management (IOM) with MAPPA responsibilities, West Midlands police
- Head of Professional Standards, West Midlands police

In the second stage of our review, we have interviewed Michael Spurr (Chief Executive Officer of HMPPS); Sonia Crozier (Executive Director of NPS and women); Gordon Davison (Deputy Director HMPPS and Head of Public Protection Group) and Sarah Chand (Divisional Director, Midlands division of NPS).

5. Previous offending

LC has a history of similar offences.

He has six previous convictions for 11 offences including rape, burglary, attempting to strangle, acquisitive offences and drug-related offences. In 1983 he entered a nurses' home and attempted to choke or strangle a nurse with intent to rape or otherwise sexually assault her. He received a seven-year prison sentence for that. Then in January 1992 he was sentenced to 10 years imprisonment for an offence of rape, which he committed after breaking into the flat of a woman and her five-year old child, and threatening her with a knife. He was made subject to the requirements of the sex offenders' register, for life.

In May 2000 LC was sentenced to life imprisonment with a tariff of five years for offences of false imprisonment. He also received concurrent determinate sentences of eight years and three years respectively for linked offences of burglary (x2) with intent to rape and indecent assault. The tariff on this sentence expired in 2005, but as we detail below, the Parole Board did not direct his release on life licence until 2016.

[3] In addition, the independent author of the MSCR provided a statement in response to questions we sent him by email.

[4] Fry Accord Housing is a registered charity providing a range of services to vulnerable adults with an offending history. It provided housing to LC after he left the hostel he was placed in immediately after his release from prison.

6. The period in closed prison

6.1. The period 2000 – 2011

Following sentence in 2000, the probation officer who prepared the post sentence report assessed LC as posing a high risk of serious harm to others, in particular adult females.

In 2003 LC was detained at HMP Manchester, and it was there he had his first parole review[5]. He had completed the Enhanced Thinking Skills course, a course designed to help individuals think more clearly and take responsibility for their actions. The Parole Board determined that he was not suitable for release or transfer to an open prison.

The following year a senior probation office (SPO) reviewed LC's progress in custody and concluded that if released he should be managed at Multi-Agency Public Protection Arrangement (MAPPA) **Level 3,** the highest level of multi-agency supervision.[6]

In 2005, while at HMP Wakefield, he had a second parole review. By then he had completed the Sex Offender Treatment Programme (SOTP)[7] as well as alcohol and drugs awareness courses and drugs therapy. He had attended a workshop on alternatives to anger. He had also participated in one to one counselling in relation to the sexual abuse he had experienced as a child. The Parole Board again determined that he was not suitable for release or transfer to an open prison. The panel thought he needed to complete further offending behaviour work.

He commenced the Extended SOTP[8] in 2007. A third parole review happened that year. The Parole Board panel dealing with the case considered that despite having served seven years in prison and having completed two sex offender programmes (the first being on a previous sentence), the fact remained that LC was still obsessed with sex. He continued to be assessed as posing a high risk of harm to others.

The Parole Board decided once again that he was not suitable for release or transfer to open conditions.

---

[5] Life sentenced prisoners are contacted three years before their earliest release date ('tariff'). They complete and application and the prison puts together various reports – the parole dossier. The Parole Board decides whether the case needs a hearing if there is a prospect of release or a move to open conditions. If the prisoner does not get parole, a date is set for the case to be reviewed again after two years.

[6] Three different MAPPA levels enable resources to be deployed to manage identified risk in the most efficient and effective manner. Although there is a correlation between the level of risk and the level of MAPPA management, the levels of risk do not equate directly to the levels of MAPPA management. This means that not all high-risk cases will need to be managed at Level 2 or 3. Although MAPPA management does not equate directly to the risk of serious harm the offender has been assessed at, this will always be central to the reasons for increased oversight and management. *MAPPA guidance (2012). Version 4.2. Updated November 2017.* MoJ

[7] The results of a recent evaluation report of this programme were disappointing, and indicated that treatment had little to no impact on recidivism. In fact, more treated sex offenders went on to commit at least one sexual reoffence during the follow up period when compared with offenders who did not received this intervention. Mews, A., Di Bella, L. and Purver, M. (2017*) "Impact evaluation of the prison-based Core Sex Offender Treatment Programme"* Ministry of Justice: London.

[8] A programme for high risk offenders who have completed the core SOTP.

In January 2008 a senior probation officer responsible for MAPPA reviewed the file, and noted that LC was considered as a MAPPA **Level 1** whilst in custody but likely to rise to **Level 2** on release, due to the concerning pattern of offending and the need for active multi-agency management when he was in the community. The SPO noted that six months before release. LC should be reassessed and the required MAPPA screening[9] completed so that he could be referred into Level 2 or 3 management.

A fourth parole review took place in 2009. By then, LC had completed SOTP, Extended SOTP, Enhanced Thinking Skills, art and design courses and a tailoring course. This time, the panel did not recommend release, but that he should be moved to a prison that provided a therapeutic community (such as HMP Dovegate). This prison has a separate 200-bed therapeutic community for repeat serious offenders. The unit offers residents daily group therapy. The move did not happen straightaway.

Subsequently, the Sentence Planning Board[10] noted that LC was in a low and uncooperative mood during its discussion about the prospect of a move to HMP Dovegate. The Board agreed nevertheless that the transfer should take place. LC subsequently re-engaged with the HMP Wakefield's psychology team, in preparation for the transfer, and he was moved to HMP Dovegate in 2011.

6.2. HMP Dovegate Therapeutic Community 2011 – 2014

After LC was transferred to HMP Dovegate, his next parole review was deferred until he completed specific offending behaviour work. When the review took place in 2011, the panel was still concerned about the risk of harm this individual posed to others, specifically women. The Parole Board decided against release: it was not thought to be a viable option.

By May 2012, LC was six years over his tariff. At his therapy review that month, those working with him stated that he was not addressing the underlying issues of anger relating to the sexual abuse he himself had experienced. He had previously said that one reason he committed the offences and humiliated and degraded his victims was to make them feel the same way he had felt when abused. The assessor concluded that he was still posed a high risk of harm to others, and proposed that he should remain at HMP Dovegate in order to reduce future risk.

The assessor recommended that LC's past abuse and emotions could be explored by LC participating in the SOTP 'Better Lives Booster' programme. However, LC was later informed that he would not be able to complete the programme whilst in custody, as the programme was only available in a limited number of closed prisons. In June 2013, LC's probation officer contacted the Probation Divisional Sex Offender Unit (DSOU) and was advised to refer LC to the unit three months before release. In

[9] MAPPA screening determines whether an individual is eligible for management under MAPPA and if so, the level of management required. It therefore provides the gateway into management at Level 2 or 3.
[10] Sentence planning meetings are held in the prison at least once a year to plan and review the prisoner's activities and progression through custody. The meetings are attended by the prisoner, the community based probation officer, prison offender supervisor and others involved with the prisoner.

that way, he could be allocated to the 'Better Lives Booster' in reasonable time and complete the programme whilst on licence in the community.

An addendum to the parole report was prepared by the PO in June 2014, in readiness for the parole review anticipated for a few months hence. The probation officer noted that he had made some progress, and presented as having overcome the difficulties regarding emotional management which had previously led to isolation and negative thoughts. He still needed to demonstrate that he could maintain this over a period of time, however. At times he remained over-confident in his ability to remain offence free.

The report summary stated that although LC had been in HMP Dovegate since 2011, at times he seemed more interested in moving to a lower category of prison than in the content of the programmes. The report concluded, however, that he could be moved to open conditions with a view to focussing on emotional management, substance misuse and education, training and employment.

In June 2014, following the implementation of the government's Transforming Rehabilitation programme, all cases held by the former probation trusts were transferred to either the National Probation Service (NPS) or to a Community Rehabilitation Company. LC was transferred to the Midlands division of the NPS. For LC this meant a change of PO and SPO. The new PO attended the parole oral hearing in August 2014. On this occasion, the Parole Board decided that LC could move to North Sea Camp, an open prison, and he transferred there the following month.

6.3. HMI Probation key findings from this period

We have not examined in detail all the records of the period in prison. From what we have read, however, it appears that probation staff retained contact with LC and the prison, attending lifer reviews, therapeutic reviews and sentence planning board meetings.

During this time, 11 different POs were responsible for the case. Whilst it is inevitable that supervisory changes take place, this level of change was unusual at that time, and it is both undesirable and unsatisfactory. It cannot have assisted effective relationship-building or assessment, or the continuity of work.

Continuity of management oversight can facilitate effective transfer of responsibility between probation officers, helping new staff to become familiar with the case. This is particularly important in a case like that of LC, whose files dated back many years and contained extensive information. However, over the period, five different SPOs held oversight responsibilities in this case.

In these circumstances, good case records are critical. Key information needs to be communicated from one member of staff to another, but we found little evidence of formal handovers. The recording of decisions about MAPPA management was not always clear, and with hindsight that is especially regrettable. For example, there was no record of what had contributed to the proposal that MAPPA management should be Level 2 on release, when it had previously been suggested as Level 3.

Although there is some evidence of active management oversight, with SPOs checking and chasing outstanding actions, this was not always effective. In May 2010, a PO was required to complete a MAPPA screening to provide a structured, considered way of determining the appropriate level of MAPPA management. Although recorded as completed, there was no evidence of the required discussion between probation and police, to determine the level of management.

The SPO sent a reminder to the PO four months later, and repeated the request again after another four months. In December 2010 the screening was still incomplete, with the required discussion outstanding. There was still no evidence that the MAPPA screening had been competed in February 2012 when the PO went off sick.

In our view this constitutes exceptionally poor management supervision. To provide effective oversight, managers should take an investigative approach. They should be familiar enough with the case whilst providing objectivity, asking the challenging questions and interrogating actions and decisions.

The parole hearing in August 2014 took place shortly after the restructuring of probation services heralded by the government's Transforming Rehabilitation programme. While this is no excuse, it is a relevant consideration. We understand that the PO to whom LC had been transferred had just been given a full caseload of offenders who presented a high risk of harm to others; this amounted to 36 cases, of which 35 had committed MAPPA eligible offences. The SPO at this point was also new to the transferred cases.

The changes brought in by the restructuring of probation services meant that the NPS became entirely focused on MAPPA cases and those presenting a high risk of harm to others. This is a significant change for those staff and managers who had previously held a more varied caseload. Prioritisation now meant identifying the highest risk cases within a caseload where few present a low risk. One could speculate that the benchmark for cases that receive the most attention moved upwards.

7. Open prison and release

7.1. Open prison 2014 - 2016

In August 2014 LC was transferred to North Sea Camp open prison in accordance with the recommendation of the Parole Board. The purpose of an open prison is to test prisoners in conditions similar to those they will face in the community. In that sense this period should be a stepping stone towards release, with a subsequent spell in a probation hostel (Approved Premises) designed to provide the next stage – support and close monitoring following release.

Whilst at the open prison LC moved, with four other prisoners, to an independent house located within the prison grounds. He complied with the requirements of living there.

Release on temporary licence (ROTL)[11] is used as part of this testing period, and provides the prisoner with the opportunity to organise work, housing and to re-establish relationships with their family. In February 2015, the PO liaised with the prison in relation to ROTL and with the hostel to which he would be released.

Following three successful accompanied town visits, the prison considered unescorted visits and requested confirmation of LC's MAPPA level and additional licence conditions from the PO.

The PO supported unescorted visits, but there was still no evidence of a MAPPA screening. LC progressed from escorted to unescorted town visits to periods of ROTL in a hostel. Between October 2015 and May 2016 LC completed five ROTLs. Whilst on ROTL he visited his adult son and daughter who had been in contact with him throughout his sentence, and his 11-year-old grandson.

After the fourth ROTL in March 2016, the prison informed the PO that LC would be placed on report as he disclosed that he visited a wine bar, in breach of his ROTL Licence. The prison enquired how LC was spending his time whilst out on ROTL and was notified that he spent little time at the hostel outside curfew hours. The PO confirmed they knew LC visited his family and supplied the names and addresses, but there was no record that the PO spoke to LC about his attendance at the wine bar.

7.2. The parole hearing

A parole hearing arranged for June 2016 coincided with a period of planned absence for the PO who, by this point, had been LC's PO for two years. To avoid delay, the PO completed the necessary report and briefed another member of staff who had provided previous temporary cover, to participate in the hearing by teleconference. The hostel confirmed they would accept LC for 12 weeks if the Parole Board directed release. The Parole Board reviewed a dossier containing the suite of reports from prison and probation staff that we would expect to see in this case12.

The PO recommended release based on the following: LC had made excellent progress in open prison, including completing successful ROTLs and periods in the hostel; he had managed to rebuild ties with his family, which was seen as a protective factor; he had completed all the offence focused work he had been required to complete and he seemed motivated to lead a law-abiding life. The PO commented that little further would be achieved by him remaining in prison.

All the reports submitted recommended LC's release on parole licence. A note of caution, however, was sounded by the custody probation officer (known as the offender supervisor), who expressed concerns around his 'compliance and complacency' – factors which may be associated with risk. An individual's compliance

[11] Decisions on whether to grant ROTL are taken by the prison governor or a delegate (acting on behalf of the Secretary of State) following a risk assessment process, although some prisoners are expressly prohibited from getting ROTL. In practice, many prisons operate ROTL boards to which prisoners apply for ROTL. MoJ (2018) *"The reoffending impact of increased release of prisoners on Temporary Licence"*.

[12] A Structured Assessment of Risk and Need; psychologist report; prison offender supervisor report; Parole Assessment Report of the Offender Manager from the PO in the community; medical officer report; and security report.

with requirements may, for example, be false or manipulative. Or they may, as was the case with LC, express too much confidence in their ability to remain offence free. This may indicate avoidance of the topic, or a lack of recognition of their risk.

In this case the offender supervisor was concerned that LC had, without permission, visited his family at their home addresses and on a subsequent occasion had met with them in a public house. Both incidents were a breach of a condition of the ROTL and were dealt with by the prison governor. While not necessarily an indication of increased risk of harm, these breaches did suggest a willingness to disregard the constraints. This was discussed with LC by the offender supervisor, who decided on balance that LC could be managed in the community provided that a robust risk management plan was in place.

LC had previously reported that he suffered from anxiety and depression. At the time of the parole review he was not assessed or treated for any mental health problems nor was he on any medication. The Parole Board considered that together with appropriate licence conditions, appropriate offending behaviour work, and a robust risk management plan, he was safe to be released.

In June 2016 the Parole Board directed release. On 25th July 2016 LC was released from prison on life licence. The conditions of his licence are included at Annex A. These include standard licence conditions, a condition to reside at an Approved Premises and conditions designed to address aspects of his behaviour and to protect victims.

7.3. HMI Probation key findings about the period 2014 – 2016

There were shortfalls in practice relating to the ROTL period. The PO did not complete a MAPPA screening when LC was assessed for unescorted visits and ROTL. The PO and the police sex offender manager decided together based on the evidence, intelligence and information available to each organisation - without the required screening - that there would be no added value in LC being managed at MAPPA Level 2 and kept him as Level 1. They either disregarded or did not (in our view) give due weight to previous reports and assessments by colleagues relating to further offending behaviour work required, the ongoing risk he posed to others, and the proposed management level on release.

Level 1 management is appropriate where the risks posed by the offender can be managed by the agency responsible for the supervision. Other agencies may be involved, but regular multi-agency meetings are not generally held. Had LC been managed at Level 2 or 3, the agencies involved would have been more familiar with the case. When concerns arose, the agencies involved may have been better placed to discuss intelligence and make prompt, informed decisions about the appropriate action. This is the great benefit of MAPPA, and it was lost in this case.

We believe that the process of deciding to keep the management at Level 1 was not sufficiently rigorous. We would have expected a more formal – and hence more defensible - process for making this decision, particularly given the previous assessments of the appropriate level of MAPPA management on release, and given this individual's history of offending.

Separately, the PO should have considered the location of the hostel, as the victim of the previous serious sexual offences appeared to live within a few miles of it. Although this was not a material issue in this case – that victim had, it emerged, moved abroad - it was a failure to consider fully the possible implications of the placement. Similarly, the PO failed to complete a safeguarding referral in relation to LC's contact with his grandson.

On the second ROTL, the PO extended the curfew from 7pm to 9pm, and on the third ROTL which was over Christmas, extended it to 11pm. This was done without consulting the police. In addition, the PO did not inform the police or prison the names and addresses of family members LC would be visiting. The PO should have liaised with the police before changing the curfew and prior to giving approval for the domestic visits.

The lack of vigilance in relation to the ROTL period, and the assumption that there was little further to be achieved by keeping him in prison, raise the question about whether release was being seen as inevitable.

It was unfortunate that the probation officer was away at the time of the parole hearing, but it is clear that a substitute had been well-briefed and was familiar with LC. Given the concerns expressed by the prison offender supervisor, we queried whether the Parole Board had considered deferring their decision until the responsible probation officer was available. We are aware that the Parole Board has been working to reduce delays, and, given the evidence available to the panel, we consider its decision to go ahead with the meeting was, on balance, reasonable.

The offender supervisor had suggested including a licence condition that LC be required to participate in polygraph sessions and examinations. It is not clear from the documents we have seen, whether this option was explored by the panel. The polygraph[13] became available as a licence condition in 2014. On the face of it this was a sensible suggestion. To be eligible, however, LC would have had to have been currently on licence for a specified sexual offence. Although he was on life licence for other offences, the licence period which would have related to his sexual offences had expired before his release, so in any event LC was not eligible for testing.

The decision letter by the Parole Board shows that the panel had considered LC's previous offending history, risk factors and evidence of progress during the custodial sentence. No mention was made of the breaches of ROTL, but we have seen that the panel knew of these.

No mention was made in the decision letter of management by the MAPPA. We are not clear whether the panel interrogated the witnesses about the plans for multi-agency management of LC, but had this issue been pursued, the possibility of management at Level 2 or 3 could have been further considered.

[13] "The polygraph is a device that measures certain physiological responses such as heart rate, breathing rate, blood pressure and skin resistance, changes in which are thought to indicate whether the subject is lying… The imposition of the condition allows compliance with other licence conditions to be monitored and gives information about an offender's behaviour that will improve the effectiveness of how an offender is managed during the licence period". PSI 36/2014 *"Polygraph Examinations: Instructions for Imposing Licence Conditions for the Polygraph on Sexual Offender"*.

Curfews are commonly used as part of residence at a hostel. An overnight curfew ensures that the residence requirement is enforceable. LC's curfew of 20:00 to 07:00 was longer than the standard 23:00 – 06:00 or 07:00. A daytime curfew can, and should, be used for specific offender management reasons[14] – for example to protect the public at particular times of the day, to restrict travel, or to help with resettlement.[15] The intention of the parole panel in determining the curfew times was not clear, and we speculate this perhaps contributed to the probation officer's subsequent rationale for allowing the times to be relaxed – an issue we comment on in the next section.

We recognise that those with the responsibility to advise on the release of LC, and those who had to make the decision, had a difficult task. The evidence available about LC's behaviour, thinking and attitudes was largely positive. He had done what was asked of him in closed conditions, and had been tested in open conditions. The panel was therefore faced with the difficulty of weighing the previous history of offending (including offending soon after release from prison) with the apparent evidence of change.

8. Management of LC on life licence

8.1. 25th July 2016 – 28th November 2016

LC was released on 25th July 2016. The following day, the PO visited him at the hostel and discussed his curfew, licence, registration as a sex offender, and the offending behaviour work to be completed, as well as move-on plans once he left the hostel.

On the 04 August 2016 the PO discussed with LC the possibility of extending the overnight curfew to 9pm. On 24 August 2016 the PO extended the overnight curfew to 9pm and removed the lunchtime curfew.

In September 2016 LC started a 'restorative thinking' course in the hostel. The sessions included developing conflict resolution and life management skills, strategies for dealing with negative thoughts, and considering how behaviour impacts on others. He was involved in other activities at the hostel, such as art and design and a breakfast club. He informed hostel staff that he wanted to go into business selling T-shirts, arts and crafts, and to design and sell women's stiletto shoes. He also asked for advice about whether visiting prostitutes would be a breach of his licence conditions. His drug tests were negative; he saw his PO and hostel key worker weekly.

There are very detailed records of some aspects of LC's stay in the hostel, for example in relation to his experience of preparing breakfast. Records are not clear,

[14] PI 32/2014 *"Approved Premises"*
[15] HMI Probation (July 2017) *"Probation Hostels' (Approved Premises) Contribution to Public Protection, Rehabilitation and Resettlement"*.

however, about some important matters such as how he spent his time whilst out of the hostel.

In October 2016 LC moved out of the hostel into Fry Housing accommodation - housing with additional support provided by the organisation. Individuals generally move out of Approved Premises after several months, in this way, and there is nothing unusual in the move.

That same month, LC's PO went on leave and another PO who knew the case provided temporary cover. On 17th October, one week after moving into the supported accommodation, LC attended the office for a scheduled interview with the cover PO. he was extremely tearful, and said he felt anxious, vulnerable and isolated. He stated that these feelings were triggered by the absence of his children who were away on holiday. LC reported that similar feelings had been triggers to previous offending, and that he had taken to looking at open windows when he was walking around.

When asked by the cover PO whether he was having thoughts of burglary, Leroy Campbell confirmed that he was thinking of the same offences as before. When it was put to him that surely he was not thinking of rape, he confirmed that he was.

The cover PO consulted with their own SPO (who was not familiar with the case) whilst LC remained in the office. This was the only SPO in the office at the time. The cover PO then talked with LC about making use of the techniques he had learned and used on therapeutic programmes. He was also given telephone numbers for the Samaritans and the police sex offender manager, and told to attend the probation office whenever he wished, in addition to his specified appointments.

The cover PO also contacted the police, requesting that the police sex offender manager increased their contact with him to provide both support and enhanced monitoring.

There was not a clear and explicit Probation record made of this important exchange at the time by Probation, although the Police have since confirmed they recorded this information exchange on ViSOR. We noted that during the internal SFO review the cover PO reported that at this meeting LC spoke of feeling that he may return to his 'previous offending'. On further exploration by the reviewing manager it emerged that LC had said he had thoughts of rape. This seems to have been the first time that this significant detail came to be recorded in any NPS record, the absence of this detail being shared with the Police at the time, prevented escalation to senior police management for a decision regarding higher MAPPA level management.

LC returned to the office two days later, without an appointment, stating that he still felt isolated. He thought he might want to return to prison, as he found things were harder in the community. The police had not contacted him.

The cover PO contacted the sergeant in the area that LC had moved from, and discussed the concerns. We cannot tell from the case record whether this discussion was specific about the nature of these concerns, however the police have since confirmed that all conversations were recorded verbatim on ViSOR. The cover PO was told during the call that there was no police sex offender manager assigned to LC as they had not been notified that he had moved into the area, but they would assign someone to visit later that day.

The police visited LC later that day and also liaised with the hostel manager via email, highlighting the concerns and discussing the option of LC returning to the hostel. The manager was willing to accept LC back into the hostel but there is no evidence that this option was discussed between the hostel manager and the cover PO or the relevant SPO. The SPO emailed the police and the hostel manager to explain the decision.

On 24th October, LC returned to the office for a planned appointment. He seemed in a better mood and presented as more settled. He stated that he had spoken with two police officers and had had a further visit from the police sex offender manager. LC stated that he did not feel it was necessary to return to the hostel, he was feeling better and his family were due to return home soon. The cover PO was convinced that all was now well. The SPO supervising LC's PO was available, and spoke to LC herself. The SPO was satisfied that his mood had improved considerably and decided not to return him to the hostel.

The PO returned from annual leave on 7th November, and the following day LC reported to the office and discussed events of the past few weeks. LC left the office in a positive mood. The PO visited LC at home with a support worker on 18 November 2016. LC presented as settled. The PO planned to return to visit LC at home the following week, on 25 November, but was delayed at court. The PO contacted the accommodation to speak to LC but was informed that he had gone out. Staff reported that LC seemed well and that there were no issues. The PO arranged to visit in three days' time.

On the 28 November 2016, the day the PO was due to visit, he was informed by the police that LC had been arrested for murder.

8.2. HMI Probation key findings about the period on life licence

There was insufficient focus on public protection and managing the risk that LC posed to others. The right work was not done to reduce his likelihood of reoffending or to protect the public.

The PO did not make a referral to the DSOU for the SOTP Better Lives Booster Programme. This should have been done prior to release as intended, so that a place could have been allocated and LC could have started the programme promptly. This had been identified as necessary by the Structured Assessment of Risk and Need which followed the prison SOTP, and was stipulated by the Parole Board as a licence condition. Not only would this have continued to address LC's thinking and behaviour, but it may also have provided evidence about any change in the risk that he presented.

Victim work did not commence. This was also a condition of the parole licence. Nor was the Active Risk Management System (ARMs) assessment completed. This should have been completed within six weeks of release and used to identify future work. This meant that opportunities to tackle problems associated with offending were missed.

There had been little progress on the problem areas identified in the assessment, as insufficient offending behaviour work had been completed. The planned work was not delivered despite there being strong partnership arrangements with providers of relevant services. The plan to manage LC's risk to others contained appropriate links to the police and MAPPA to work collaboratively to manage his risk of harm to others, albeit the process for determining the appropriate level was not adequate.

Probation hostels play an important role in both rehabilitation and public protection. Good communication between hostel staff and the probation officer is critical. Hostel diary sheets should give a clear account of how a resident uses his day. The PO should have had clarity about how LC used his time and his engagement with purposeful activity. The contact log stated that he engaged in the regime, and indeed in some respects the hostel records are very detailed, but they do not make clear how he spent his time when he left the hostel for many hours.

Probation staff did not work well with other agencies. The amendment to the curfew was not made in conjunction with the police and in our view the decision to remove the lunchtime curfew and extend the evening curfew to 11pm less than one month after release was premature. The licence condition stated that the curfews should be reviewed on a monthly basis, but in effect these were gradually removed during the first month. LC's good compliance provided the rationale for the relaxation, without a full risk assessment.

The hostel provided LC with a routine, and curfew controls. His transfer from the hostel into supported accommodation, at a time when his children were away and he felt isolated, was a significant event. The risk assessment should have been reviewed at this stage but this was not done. Nor were the police contacted to check LC's new address for suitability, in advance of his move, and they were not notified when LC moved in. Regardless of the MAPPA level, information should have been exchanged with the relevant agencies, specifically the police, to discuss this transfer to a different area. Had he been managed at MAPPA level 2 or 3, there would have been routine MAPPA meetings for such issues to be raised and discussed.

The failure to notify the police of the change of address is a significant omission, ameliorated only because LC notified the police of the change himself, within three days of moving and in accordance with his sex offender registration requirements.

Active risk management should also have been supported by better use of ViSOR. LC's risk management plan identifies contingency arrangements to be triggered if there were signs of risk escalation. These arrangements included a return to the hostel, referral to MAPPA and ultimately a recall to prison. Signs that may have been indicators of risk were not recognised as such – for example, his expressed interest in designing women's shoes and his question about the use of prostitutes.

When LC visited the office in a stressful state, we would have expected a thorough discussion with LC about his disclosure, in order to assess the likelihood of him acting on his thoughts. This is core probation practice, but we cannot be clear from the case records about the extent to which this took place. We recognise that disclosure may be an indication that an individual is seeking help to manage their risk – and in this respect, it can be a positive sign - but the imminence and seriousness of the risk must be properly assessed and appropriate actions taken to protect the public.

In some situations, reminding an individual of the techniques they have learnt to manage risk may be an appropriate response. However, without a properly conducted assessment of the imminence and seriousness of the risk, the decision to adopt this approach was not adequately informed and was not, in itself, sufficient.

A full risk assessment at this stage may have determined that LC's own management of his risk was not enough to protect the public. The options available to probation – namely, recall to prison or a return to the probation hostel for further close monitoring – would have been an appropriate response.

We would have expected the cover SPO to play a key role in ensuring that the PO – particularly as they were covering for a colleague – was sufficiently well-informed and equipped to go back into the interview with LC ready to explore his disclosures in more depth.

There are different accounts about the extent to which LC's disclosure was explicitly discussed with the cover SPO. Whatever the truth of this discussion, the case records do not adequately record the cover PO's interview with LC or the management oversight. We conclude, therefore, that there were significant failures in practice, recording and management oversight.

Following LC's disclosure of his thoughts, we would have expected to see an emergency MAPPA meeting called to discuss concerns with other professionals. Such a meeting would have drawn in information from the housing provider and have allowed all the available intelligence to be considered together and may have triggered an increase to multi-agency management at level 2. No such meeting was called.

LC's evaluated mood some days later was not sufficient evidence that he was no longer at high risk of reoffending. The SPO decided that there was no longer a need to return LC to the hostel, without calling a MAPPA meeting or consulting with other professionals or a senior manager. Important conversations between LC and the cover PO, the cover PO and cover SPO, and subsequently the SPO and police were not recorded on Probation systems.

The oversight by managers was not effective. Insufficient attention was paid to identifying and addressing the performance of staff who did not adhere to protocol and procedures.

8.3. Summary

There is no evidence to enable us to identify the point at which LC decided for certain to reoffend, but the circumstances of the offence and the evidence available do show that the offence was pre-meditated. There were some key failings in the way he was supervised. LC was not managed properly:

- the failure to undertake a MAPPA screening meant that the decision to manage LC at Level 1 was made without access to information that may have been sought from a range of sources, to ensure that this decision was robust and defensible.

- the police were actively involved with LC, as he is a registered sex offender. There should have been better liaison between probation and police during his licence.
- When LC reported that he felt vulnerable and isolated – and even pointed out that these had been triggers to his previous offending – this should have led to a full assessment.
- Once he confirmed that he had thoughts of rape, then it is beyond our comprehension that he was left to remain at full liberty. At that stage he could have been recalled to prison or else returned to the hostel to allow for close monitoring of his mood and behaviour. These options should have been pursued, but they were not and we find that a very significant failing.

These are not the only failings in the supervision and management of LC, but in our view, they are the key issues in relation to public protection. Effective line management oversight of the probation staff involved could, and should, have identified these issues.

9. The quality of the probation SFO review

Here we consider whether the SFO review was sufficiently honest and reliable.

9.1. The period 2000 - 2014

The SFO reviewing manager prepared a detailed chronology of events dating back to 2000, commenting on key aspects of practice and management oversight. This is a balanced record of the case, which notes the lateness of the post sentence assessment and some poor record keeping – a point that we observed in relation to the transfer of responsibility.

Positive aspects of the case management were noted in the SFO review, including the probation officers' constructive prison visits, challenging of LC's behaviour and attitudes, liaison with the prison and contribution to sentence planning and reviews.

However, we note that management oversight of PO work in the early stages was generally seen as good by the reviewing manager. In our opinion, the failure of LC's probation officer to complete certain actions could and should have been picked up more quickly by their manager.

When LC was registered as a MAPPA Level 1, the reviewing manager states that this was the appropriate process at that time, with the level to be reassessed six months prior to release. We agree that Level 1 was appropriate during the custodial period of his sentence. The reviewing manager comments that the case notes should have led future probation officers to consider that the level was likely to rise to Level 2 on release.

In 2010 when the MAPPA screening remained outstanding, the reviewing manager notes that a deadline should have been set for this task.

9.2. The period 2014 - 2016

The chronology produced by the reviewing manager highlights good liaison between prison and PO during 2014 but also identifies the problems that occurred following the Transforming Rehabilitation restructuring. In particular, the new PO, an experienced officer, had been given a full caseload of high risk cases. It is reported that prior to LC's oral hearing, the new PO had limited time to read through all the historic files. The SPO was also new to all cases and was relying on file records rather than personal knowledge of the case.

Following the Parole Board's decision in June 2016 to release LC the reviewing manager notes that liaison with prison and hostel continued. The SFO review concludes that the process for determining the MAPPA level at this stage was not adequate, and did not take account of the previous records and as a result *"it is not possible to defend the final decision to manage this case at Level 1, taking it out of the formal MAPPA 2 multi agency panel process"*. We agree.

The reviewing manager also notes that there should have been more checks relating to temporary releases, in particular to consider how best to safeguard the previous victim. Again, we agree.

9.3. Supervision on life licence

The review notes that there was positive evidence of joint working between the probation officer and the hostel staff, with an appropriate focus on rehabilitative and purposeful activities. On the face of it, good work was taking place: LC was complying with the hostel regime, attending programme sessions as required and providing negative drug test results.

However, the reviewing manager also notes the PO's failure to refer LC to the Better Lives programme and missed opportunities to focus on offending, for example by looking in detail at the reports from the SOTP and the Therapeutic Community which gave details of work that needed to be completed or maintained. LC's interest in designing women's shoes should have prompted concern – something that is recognised by the reviewing manager, who sought specialist advice on this matter. We agree with the reviewing manager that insufficient attention was paid to previous assessments that LC's over-confidence in his ability to resettle and not offend should have been seen as a risk factor.

The review is uncompromising in the criticism of probation liaison with the police, noting that there should have been proper communication before the curfew was amended and prior to LC's move out of the hostel.

The period following LC's move out of the hostel was significant in many respects and the review provides a detailed analysis of the failure of parties involved to make a joint decision about the best course of action. The reviewing manager concludes that, on the available evidence, LC should have been required to return to the hostel where his mood and behaviour could have been observed, to reach a balanced review of his future risk.

In our analysis we have noted that LC's improved mood was not sufficient evidence of a reduction in his risk. The reviewing manager also states clearly that this should have been seen in the context of previous behaviour, a long custodial sentence, and recent disclosures. Risk management should, at this stage, have been informed by post programme reports which would have reminded staff that LC's over confidence in his ability to lead an offence free life could be a risk factor. Management at MAPPA Level 2 should also have been considered at this stage.

9.4. Quality assurance of the review

The SFO review was countersigned by the senior manager responsible for reviews prior to submission to the SFO team in HMPPS Safer Custody and Public Protection Group. This team provides scrutiny of the objectivity and thoroughness of the review and an appraisal of the appropriateness of the actions identified. The review was deemed to be a of a 'satisfactory' standard in that process.

9.5. HMI Probation view of SFO review

Overall, we conclude that the SFO review was comprehensive, accurate and robust. The review was completed by a senior manager who had worked in a wide range of probation service grades up to her current substantive post as head of the local delivery unit. It is clear from assessment of the contact log, that the content of the review was based upon a thorough enquiry, using all available sources of information perusing documents that spanned 17 years, and scrutinising practice of the relevant staff members.

Elements of good practice were identified at various stages in this case. For example, the cover PO arrangements in late 2016 were set up well, as the individual PO had been appraised beforehand of the risk issues, when this is not the norm – but of course, there were subsequent failings, in practice. Looking further back, the liaison between the PO and Approved Premises' staff while LC was resident there was of good quality, and the pre-2014 engagement with LC and with the prison was constructive and regular as well.

Overall, however, the reviewing manager concluded that the case was managed to an insufficient standard in relation to risk assessment, risk management and offender management. It is our view that almost all the shortfalls were accurately identified.

The review highlighted the lack of adherence to effective risk management procedures, the absence of MAPPA assessment, failure to refer to the DSOU, extension of curfew without liaison with police, lack of attention to victim contact, no safeguarding referral, insufficient response to escalating risk, and the lack of effective management oversight particularly after June 2014.

We have also considered whether the summary reports provided to the victim's family are a fair and accurate reflection of the full detailed report. We thought that the Victim Summary Report prepared by the National Probation Service was a clear, honest summary of the case and the failings identified.

10. Probation management actions

10.1. Probation management actions concerning individual members of staff

The SFO review appropriately identified individual failures in offender management and management oversight. This raises the question of whether the organisation took appropriate management action in response.

The offence triggered an expedited review which was allocated to an experienced senior manager. At the time of this offence, in common with most probation divisions, the Midlands did not have a specialist case reviewing team. Such teams are now in place throughout the NPS.

The review was completed within six weeks and submitted to HMPPS. The case was discussed on 10th January by the Probation Divisional Director (PDD) and the NPS Executive Director. By this point the PDD had formed the view that there was no pattern of poor practice by those involved in this case. Although there were learning points for all involved, there was said to be no cause to take disciplinary action in relation to any individual.

Some key failings had, however, emerged. Firstly, the decision to manage the case at MAPPA Level 1, as a result of a lack of information being shared across agencies; secondly the failure properly to interrogate and record LC's comment about 'thoughts of rape'; and thirdly the failure to act on this clear indication of escalating risk by either recalling him to prison or sending him back to the approved premises. In our view, the latter would have been a defensible decision. Doing neither was not. All three issues identified show poor professional practice.

The work of four key individuals has been scrutinised by the NPS. For the purposes of this report, we will refer to them as A, B, C and D.

A) The probation officer who had held the case for two years and was the responsible officer at the time of the parole hearing
B) The probation officer who was covering for A at the time when LC discussed reoffending
C) B's line manager – a Senior Probation Officer who was consulted by B when LC discussed reoffending
D) A's line manager – a Senior Probation Officer who was unavailable at the time when LC discussed reoffending.

Probation Officer A was responsible for preparing for LC's release from prison. Some aspects of A's practice with LC show a lack of diligence. A MAPPA screening should have been undertaken prior to release; the ROTL should have been more closely monitored; and LC should have been referred to the DSOU. Following the SFO, in February/ March the NPS undertook an audit of A's work. This exposed some concerns, in particular, whether this probation officer was achieving the appropriate balance between resettlement and public protection.

The cases of B - the cover probation officer to whom LC disclosed he was thinking of rape - have also been examined in detail. No general concerns have emerged. This does not, of course, exonerate the clear failures in practice on this occasion.

Probation officer B's SPO (known here as C) failed to record adequately the discussion with B when LC discussed reoffending. As it happens, C had recently become B's line manager, and this was their first substantial discussion. No specific action was taken in relation to this SPO, although the need for clear recording of management oversight has been emphasised.

D is the SPO who made the decision, without appropriate consultation, not to require LC to return to the hostel and not to recall him to prison. The NPS instigated weekly supervision by D's line manager and scrutinised D's work. SPOs are required to countersign assessments completed by the probation officers in their teams. The countersigning work of the SPO in question was therefore examined as part of the NPS action plan.

All the countersigned work was of a satisfactory standard, and it was noted that D sometimes rejected documents, requiring amendments to be made before they were signed off. D's line manager reported that on appropriate occasions D escalated matters for discussion or decision, and that on one occasion, D had used HR processes appropriately in relation to staff issues. In summary, it was concluded that although there were areas for improvement there was no pattern of poor judgement. Again, this does not exonerate the failure on this occasion.

Both A and D have been suspended very recently, following a recently instigated investigation in relation to this case. Disciplinary proceedings are underway. Officers B and C have not been suspended following the investigation, and do not face disciplinary proceedings.

10.2. Managing poor performance in the NPS

Probation staff must abide by the Civil Service Code[16] and the MoJ Conduct Policy (2012)[17]. Additionally, NPS managers must follow probation instructions on managing poor performance'[18] and on conduct and discipline[19]. The latter was reissued in September 2017, when a statement about professional standards was included.

Where a conduct or discipline issue is identified, the line manager must decide whether to:

- *"deal with the matter informally (e.g. the line manager may consider mediation (see policy Guidance on* My Services*), training, coaching, etc.);*
- *deal with it as a performance or capability issue (action must be taken in accordance with the HMPPS/NPS Performance Management policy and / or the Management of Attendance policy;*
- *arrange for it to be investigated formally under the procedure set out in this Instruction; or*

[16] https://www.gov.uk/government/publications/civil-service-code/the-civil-service-code
[17] *Conduct Policy*. Ministry of Justice. (2012)
[18] *NPS Policy on Managing Poor Performance*. Probation Instruction 13/ 2017
[19] *Conduct and Discipline. Probation Instruction* 34/2014 (reissued 1st September 2017)

- *if fraud is suspected, the line manager should refer it to the HMPPS Head of Audit and Corporate Assurance Unit and follow the other mandatory actions in the Anti-Fraud Strategy (to be published shortly)".*

A formal investigation may lead to disciplinary action for either misconduct or gross misconduct. The latter is defined as "misconduct that is so serious as may make any further relationship and trust between HMPPS and the member of staff concerned impossible".

The policy also notes that "*In determining what level of misconduct the alleged misconduct constitutes, the Commissioning Manager must take into account the member of staff's current disciplinary record."*

The professional standards statement which was added to the policy deals with matters such as discrimination and harassment, relationships with offenders, corruption, conflicts of interest and general matters of propriety. It makes no reference to dealing with failures of professional judgement, and offers no guidance on the type of professional failings that may be regarded as misconduct or gross misconduct.

There has been a recent change to the procedures. In June 2018 and following ministerial intervention, the NPS developed and implemented a new procedure known as 'Early Look'. Where an offender under probation supervision is charged with a serious further offence, the NPS will consider immediately whether there is evidence of failings in the way the offender was managed. Under this new procedure, managers consider whether to invoke disciplinary or poor performance procedures.

Most recently, the Director of the NPS has instigated a review the Conduct and Disciplinary policy and guidance, to address the issues signalled in our interim report and fleshed out here.

10.3. HMI Probation view of the management actions taken

Tragically some offenders do commit serious offences whilst under the supervision of probation. In some cases, these offences could not have been foreseen and it can be concluded that probation staff were doing all they could realistically be expected to do to manage identified risks. In other cases, the SFO review may identify gaps in practice, but it can reasonably be concluded that minor oversights in practice did not contribute to a failure to prevent the offence.

In the case of LC, the failures were sufficiently serious for the NPS to undertake an audit of the practice of the individuals concerned. The underlying approach was to regard the incident as a performance or capability issue that could be examined in the context of the general practice of the individuals concerned.

In our view, this was an inadequate response. LC was a man who had demonstrated that he was capable of serious offending and by any standards should have been managed robustly. Failing to put in place arrangements for police, probation and other agencies actively to manage him jointly through MAPPA was a significant gap in the preparation for his release. Not responding promptly and appropriately to

signs of escalating risk was a major failure. These matters emerged during the course of the SFO review and could at that stage have triggered a formal investigation under disciplinary procedures.

The NPS instigated an investigation relating to the four individuals late in the day, and after the commencement of this independent review. It has now concluded, and two of the four individuals have very recently been made subject to disciplinary proceedings as a result. We cannot comment fairly on the detail of decisions to discipline, or not, as there will no doubt be evidence and other legal considerations. What we can say is that these decisions have come about only after the family have persisted in their efforts to seek an explanation and as they would put it, 'to see justice done'.

We welcome the recent introduction of Early Look procedures and the very recent decision to review the Conduct and Disciplinary procedure.

11. Probation management actions – learning for the organisation

11.1. SFO review action plan

Here we consider whether, in addition to examining the work of individuals, the organisation examined whether the case exposed failings in systems, procedures or training. All SFO reviews must include an action plan designed to ensure that the organisation learns from the failures identified and that the necessary improvement is made.

The draft action plan in this case consisted of 14 actions to be completed by end of April 2017.

1. All MAPPA cases in custody to be MAPPA screened at least six months pre-release to ensure management at the correct level.
2. Level of management oversight to be recorded in all NPS cases. Managers to be fully appraised of requirements.
3. Referrals to Divisional Sexual Offender Unit for delivery of interventions to be timely, and two months pre-release
4. ARMs assessment to be completed within six weeks of first contact, as per guidance April 2017
5. SPO countersigning of OASys risk assessment and management- Line manager to ensure competence of RO in terms of risk assessment risk, management and the ability to make accurate judgements. Five risk assessments were to be reviewed.
6. Where there are differing opinions, in particular between mangers concerning risk management matters must be escalated to a senior manager
7. OASys initial and review documents to accurately reflect updated issues and risk information including any referrals made to other agencies and outcomes

8. Lack of awareness and attention to policy and guidance requirements relating to the risk management of sexual offenders on licence. PO must be familiar and comply with the checklist
9. VISOR should be used by staff to ensure exchange of information in relevant cases.
10. Sequencing of sentence plan objectives to ensure ROH is prioritised and completed
11. SPO decision making process in relation to risk assessment and risk management
12. Police liaison and address checks – ensure improved liaison with Police offender manager
13. Ensure review of MAPPA status screening where there is considered escalation of risk
14. New information regarding risk should be accurately recorded.

Some amendments to the draft action plan were made following the HMPPS quality assurance process.

In November 2017, an audit tool was deployed to assess application of learning to all staff in the LDU. Managers audited specific types of cases for each member of staff, provided feedback and took the necessary remedial action if required. The key issue was to provide assurance that other staff in the LDU were completing work to the required standard.

This audit was completed in February 2018, findings were analysed and highlighted where further improvements needed to be made. A similar audit is due in October 2018. To ensure continuous management oversight, managers are now expected to discuss each case with their staff six times per year.

The Head of Public Protection had planned and arranged for workshops to be delivered across the division starting in February/March 2018 based on issues arising from this case.

The NPS have developed and delivered several training events and produced eight learning bulletins, the eighth one being as a direct result of the deficiencies highlighted in this case. This has been disseminated to staff across the Midlands division. Again, these actions have taken a long time, with the latest guidance (reminding staff what to do when an individual discloses thoughts of reoffending) issued in late July 2018.

11.2. HMI Probation view of the action plan

The action plan was fulsome and has been followed through comprehensively. It covered some matters of national import – for example, amendments to MAPPA guidance.

It did not identify, however, any fundamental changes to the systems already in place to manage those who are potentially a high-risk of harm to others. Instead it

reinforced the need for all staff who were responsible for the supervision of LC to adhere to processes and procedures that were already in place.

While reminding staff of clear requirements is welcome, the SFO action plan would have been strengthened if it had dealt comprehensively and quickly with two issues of national relevance. The Divisional action plan is understandably focused mainly on issues for the Division, but it could have been accompanied by a national review and plan dealing firmly and promptly with the two issues outlined below.

Firstly, there is in our view a need to review and make plain the minimum requirements for the management oversight of professional staff, and quality assurance. This comes down to what we should expect of senior probation officers, the priorities in the role, and what good, professional staff supervision entails.

For example, although there was an action in the plan for managers to record accurately the discussions held with staff, it made no mention of the frequency, content and quality of those important discussions. In our view, more attention was required nationally to how to ensure that oversight is sufficiently investigative and suitably focussed on public protection, so as to be effective.

NPS is now testing a Supervision and Line Management Meeting Framework, with an expectation of national implementation from March 2019. It includes reflective supervision and in-depth case discussion, developments we welcome given the clear shortcomings exposed in this case. NPS is also partway through a specification, benchmarking and costing exercise on SPO tasks as part of NPS 2020, part of which is to ensure that SPOs have the capacity to focus on case discussion with their staff. We look forward to seeing the outcomes of these developments, in our regular inspections of NPS divisions.

Secondly, we think there is strong case to review the organisation's disciplinary procedure and to reflect on the organisation's disciplinary culture. We have not been given management information on how frequently disciplinary investigations take place in cases where seemingly aberrant professional judgements are made, but we suspect this happens very rarely at the moment.

Of course, there should always be room for professional judgement, and indeed it is key to the role of probation professionals. And yes, two professionals can reach different judgements on the same facts quite legitimately. But here we are talking of exceptional cases where on the face of it, the judgment reached was exceptionally poor.

There are one or two other ways in which we think the action could be better. It missed the opportunity to promote the need to make good use of available guidance and training materials, in order to improve practice across the division, and finally, the plan set out an expectation that managers discuss all cases with their teams. We see this was well-intentioned, but we wondered how sustainable it was. A high proportion of NPS cases are assessed as medium or high risk of harm to others. If 40 cases were discussed for just three minutes each, it would take over 2 hours.

In the longer term, there needs in our view to be a better way of identifying and prioritising cases that need attention. Senior probation officers must be discerning, using their experience to target their staff supervision effectively.

12. The MAPPA Serious Case Review

So far in this report, we have focused on the National Probation Service's review of the case and the actions taken by the probation division. LC fell under the remit of MAPPA, and as such responsibility for his management was shared between agencies. In this section we consider the Serious Case Review commissioned under MAPPA.

12.1. The MAPPA Serious Case Review

Mandatory serious case reviews (MSCR) are required on all those offenders, managed at Level 2 or Level 3 under multi-agency public protection arrangements (MAPPA), who commit, or attempt to commit, offences of murder, manslaughter or rape.

The MSCR confirms that LC was not managed at Level 2 or 3 at any point but was managed as a Level 1 offender by Probation and Police, the former under the terms of his life licence and the latter as a registered sex offender. The West Midlands MAPPA Strategic Management Board (SMB) commissioned this review because of the nature and seriousness of the offences LC committed and because it was seen to be in the public interest to do so.

The task of a serious case review is to examine whether multi-agency public protection arrangements have been effectively applied and whether the agencies worked together to do all they reasonably could to manage effectively the risk of further offending.

The review should establish whether there are lessons to be learnt, to identify these clearly, to decide how they will be acted upon, and, as a result, to inform the future development of MAPPA policies and procedures in order to protect the public better.

The Terms of Reference for the MSCR were:

- The period 2007 to 2016, that is, from the point at which he was first reviewed as a MAPPA offender to the point of arrest
- The preparation for his release undertaken in prison
- The recommendation to the Parole Board for his release
- The content and adequacy of the risk management plan and subsequent implementation of that risk management plan
- Consideration as to whether the offender was identified as a MAPPA offender at the correct time, referred for Level 2 or 3 management at a point at which it was appropriate to do so, and managed effectively via multi - agency public protection meetings thereafter
- The contacts made and information exchange between key agencies
- The assessments made following release and, specifically, agencies' responses to significant events during the period of supervision

Additionally, the MSCR Panel took account of concerns raised later by the victim's family regarding:

- The decision to release LC[20]
- The decision to place LC in Approved Premises in Wolverhampton
- The reasons why LC was not recalled after the disclosures he made
- The level of monitoring, supervision and contact with agencies after his release

It was positive that the SMB commissioned a MSCR on a discretionary Level 1 case and that the terms of reference for the MSCR were extended to take into account the concerns of the victim's family.

12.2. Methodology and governance of the MSCR

An independent chair was recruited by the SMB chair to chair the panel, produce the MSCR and action plan. The SMB chair pointed out that there is no established procedure for identifying independent people to write MSCRs. We have confirmed (by examining his CV) that the chair was sufficiently independent, experienced and qualified to undertake the task

Following an initial commissioning meeting in December 2016 a MSCR panel met on five occasions between February and July 2017. The members comprised:

- Independent Chair
- Chief Executive, Fry/Accord Housing
- West Midlands Police Deputy Head of Integrated Offender Management with MAPPA responsibilities
- Head of Probation, Birmingham, Her Majesty's Prison & Probation Service
- Head of Public Protection, Her Majesty's Prison & Probation Service
- Consultant Forensic Psychiatrist, Birmingham and Solihull NHS Mental Health Trust
- ex officio member of the panel, MAPPA Coordinator and adviser to the independent chair

The MSCR stated that:

"The process for the review involved the MSCR Panel calling for findings and a chronology of events, by way of internal management reports, from the three main agencies involved, that is, West Midlands Police, Her Majesty's Prison and Probation Service and Fry Accord Housing. Each of these reports was examined by the MSCR panel and the Independent Chair. There was also a review of any psychological and psychiatric assessments and interventions, conducted by a Consultant Forensic Psychiatrist."

We concluded that the SMB exercised due diligence in selecting an independent chair for the MSCR panel. An independent Consultant Psychiatrist (who had not been

[20] We note that the Parole Board was not contacted as part of this review.

involved in the case) provided an additional layer of expertise and insight to inform the MSCR panel. There was no Lay Adviser appointed to the panel as there was no Lay Adviser member of the MAPPA Strategic Management Board at the time.

We noted that the MSCR were not permitted by the National MAPPA team to see the SFO Review prepared by a member of staff from the West Midlands NPS. This meant that a new report (containing similar information to the SFO review document had to be written). Both the independent chair and ourselves could not see the logic of this decision.

The chair did not interview staff involved directly, but relied on full access to relevant records and the panel review of evidence contained in the internal management report to complete the MSCR; we conclude that this was an effective approach to the task. He confirmed that he given unfettered access to records and documents and confirmed that there was no undue editorial influence in the process of producing the MSCR and action plan.

We found the structure of the MSCR is confusing. It sets out in different parts of the document, key findings, conclusions and learning points. This problem was mitigated later by the Probation-led group tasked with overseeing the plan; the group restructuring the action plan into a summary document (see below).

The chair thought (and we agree) that the absence of a representative from the Prison Service meant that the panel did not have as much information about LC's time in custody and release arrangements as it might have had because it had to rely on the parole dossier and there were limitations as to what could be quoted directly from the dossier.

12.3. Findings of the MSCR

There are 22 key findings in the MSCR, a number of which relate to LC's time in custody and some which focus on the actions of single agencies. These findings are consistent with our view of the case (which includes sight of Probation and ViSOR records) and accurately reflect the failings.

In relation to the findings relevant to MAPPA and multi-agency management of LC we take the view that the critical areas of practice were identified. We have set these out below.

- There is no evidence that the decision on MAPPA level was taken after full consideration of previous offending behaviour and behaviour in prison nor was there any mention of the Senior Probation Officer in 2010 recommending he be considered for MAPPA Level 2 prior to release.
- There was no evidence of a discussion having taken place with the police to assess this request. The PO later explained that such changes to curfew times (including those made following release) were usually to accommodate family events.
- The plan was not informed by an accurate MAPPA screening to determine the level of MAPPA risk management, (this screening should have been completed six months prior to his first parole hearing and reviewed 6 months prior to release).

There should also have been an ARMS (Active Risk Management System) assessment within the first six weeks following release in order to prioritise areas of work within the plan. A MAPPA screening was not undertaken prior to release nor was an ARMS assessment post release. The former could have opened up the opportunity for a broader multi-agency approach to assessment and risk management while the latter could have helped to identify whether LC would be suitable for future work using the Maps for Change toolkit.

- From the outset of community supervision there was a reliance on self-report that did not seem to take account of his tendency to be over confident about his ability to manage his own risks.
- Rewarding his compliance in this way might be deemed reasonable if that decision was taken as part of a joint risk assessment with police and if relaxation was reasonable and proportionate and consistent with the level of risk. The purpose of that review is to consider whether they remain reasonable and proportionate consistent with the level of risk posed. In addition, licence conditions were explicit, they should only be reviewed on a monthly basis. None of these curfew decisions were discussed beforehand with the police offender manager who conceivably might have had intelligence about his behaviour outside the AP regime. The decisions were taken by probation without police intelligence and without consultation.
- The joint information system used by police and probation, ViSOR, was not used routinely by probation to communicate important information and decisions to police, including recording the decision to move LC out of the hostel and into a new area. While the police were unlikely to have objected to such a move, no attempt was made to establish whether the police thought this was a suitable address or to notify them that the move had actually taken place.
- Probation should have notified Wolverhampton police sex offender managers of LC's prospective move to Birmingham and because they did not do so this meant there was no planned handover to an allocated sex offender manager from Birmingham. This had consequences for the timeliness of the transfer of police sex offender management following LC's move from Wolverhampton to Birmingham on 10.10.16. The Detective Sergeant for Wolverhampton sex offender management stepped in to provide continuity pending a completed transfer.
- Neither the probation officer nor the police sex offender manager decided to escalate the case to MAPPA Level 2 or call an emergency MAPPA Level 2 meeting as specified in the risk management plan. The cover probation officer offered LC increased probation contact ahead of his next scheduled appointment and he was given contact details for Samaritans. The PO and SPO did not have a discussion about returning LC to Approved Premises or any other control measures. They concluded that the measures in place and the action taken were sufficient.
- A wider view of the situation, including hypotheses, would have been provided if any one of the PO, police sex offender manager, or their line managers had decided to call an emergency MAPPA Level 2 - meeting on the basis of an escalating risk.
- This was an opportunity for the PO to look at the situation afresh and to use the OASys review (dated 14.11.16) to step back and assess all the circumstances, to consider what had occurred in the context of triggers to previous offending and

the risk management plan. At the very least it was an opportunity to refer to MAPPA Level 2.

12.4. The MSCR Action Plan

The MSCR Action Plan comprised 17 points; three are addressed to the SMB, one to the Fry/Accord Housing Association and the remainder divided between the Police and Probation.

In response a time limited task group was set up, led by the Midlands Divisional Director of the National Probation Service. One of the first tasks of this group was to reformat the confusing structure of the original document by designing a grid setting out the key findings and then highlighting the conclusions and learning points. A 'Gold Group' was also established by senior managers in the police in an effort to address the Action Plan. Members of the SMB had regularly discussed the MSCR and follow-up activity and this is documented in SMB minutes.

12.5. HMI Probation and HMICFRS view of the MSCR and action plan

The MSCR identified the key MAPPA issues in the case. Whilst the offences may still have been committed, the failure to manage this case at Level 2 meant that opportunities were lost to escalate the concerns about LC to a broader group to improve the effectiveness of risk assessment and planning.

There was a lack of professional curiosity, and too much attention on resettlement at the expense of public protection.

LC was managed as a Level 1 case. As part of our investigation we sought the views of the staff we interviewed as to whether they thought this this was the right classification. There was a view amongst them that LC did meet the criteria for Level 1 management and that many other similar cases being managed at that level. We were surprised that an offender with such a serious offending history and notoriety would not have been considered as a Level 2 case. There were also comments that limited resources may have led to threshold for referrals to MAPPA panels rising. Across England and Wales, the small proportion of MAPPA cases managed at Levels 2 and 3 is an area of concern identified in previous Joint Inspection reports on MAPPA practice.

The Strategic Management Board was well sighted on the MSCR and the Action Plan as evidenced by the minutes of Board meetings. The Action Plan flows logically from the MSCR and is comprehensive, but parts of it lack an outcome focus, which may lead to difficulties in measuring progress.

The commissioning process for the MSCR was robust and the methodology sound. The correct issues were identified and the Action Plan flowed logically from the main body of the report (although the structure of the report was a little confusing). The Action Plan was not sufficiently outcome focused, but despite this there was a commendable effort to learn and improve practice through training, briefing and the issuing of instructions. There has been good oversight by the SMB and the task

group. There is evidence of improvement in practice but it remains important to monitor properly and consistently this critical aspect of practice.

The MSCR summary provided to the victim's family was almost as detailed as the full report. We did notice, however, that it omitted to mention LC's question about using prostitutes and his interest in women's shoes. There was no obvious reason why these would have been omitted in what was otherwise a detailed and lengthy summary.

12.6. Progress on implementing the MSCR Action Plan

In order to reduce the likelihood of such tragic and catastrophic offending taking place in the future it is clearly important that the relevant organisations learn lessons from the MSCR and implement the Action Plan recommendations. Without carrying out a full inspection we cannot be totally certain at the extent of progress and some of our findings are based on 'self-reporting'; wherever possible however we have attempted to triangulate our evidence.

Action 1 Police: Timely ARMS assessments and when to do them.

Comment: There is still a backlog of old cases, but the Police are now achieving 100% compliance in completing assessments on newly Registered Sex Offenders.

Action 2 Police: Re-evaluation of risk and management oversight in response to new concerns or significant events.

Comment: Staff have been told that conversations with offenders need to be recorded on ViSOR. An audit is to take place in summer 2018 to assess progress.

Action 3 Police: Acknowledgement of new entries on ViSOR so that it is transparent that new information has been received, particularly in relation to case transfer and new ownership of the case.

Comment: There is a new process whereby every new entry is acknowledged and initialised.

Action 4 Police: For sex offender managers to increase their knowledge and understanding of the behaviour of predatory sex offenders.

Comment: The pre-existing MOSOVO course covers predatory sex offenders and there are refresher inputs. Zoe Loderick, a renowned expert in this field has also been commissioned to provide training.

Action 5 Police: Improve management oversight and recognition as to when MAPPA Level 2 management is required.

Comment: Instructions issued to staff, including the necessity of recording the reasons for decisions on ViSOR.

Action 6 Probation: Improve inter-agency communication and liaison

Comment: Instructions have been issued to staff in accordance with the action plan. This is being treated as a continual theme to drip-feed to staff through various mediums, such as workshops and bulletins.

Action 7 Probation: Improve management oversight and recognition as to when MAPPA level 2 management is required.

Comment: Local staff had received further training on this.

Action 8 Probation: Complete ARMS assessments.

Comment: An audit conducted in February 2018 had revealed that Birmingham LDU now improved their performance considerably but still produced only about half of the ARMS assessments that they should be doing. There is another audit planned in October.

Action 9 Police and Probation: Complete MAPPA screening to ensure cases are managed at the appropriate level.

Comment: Members of the Police custody team now do screenings on all cases six months before release. There has been an increase in the numbers of Probation cases screened – from 700 in March 2017 to 2700 a year later - and there is still a backlog of cases which lack a screening.

Action 10 Probation: Increase use of VISOR as a risk tool.

Comment: This has not been progressed adequately due to continuing access problems brought about by the IT infrastructure. We understand that from December 2018, NPS access to ViSOR should significantly improve, as NPS replaces IT infrastructure.

Action 11 Probation: Implement risk management plans in a timely way.

Comment: Instructions have been issued but the limited capacity to audit practice means that it is difficult to know whether learning from training and guidance has impacted on practice.

Action 12 Probation: Notify safeguarding concerns.

Comment: Instructions have been issued to staff reminding them of Safeguarding procedures.

Action 13 Fry/Accord: Improve internal recording.

Comment: Training has been delivered to all staff, guidance had been changed and the contents of the staff briefing pack had been updated. Fry/Accord had satisfied itself that these principles were embedded in practice we were told that there had been an internal audit of cases, which was broadly positive.

Action 14 Fry/Accord: Reciprocal information exchange.

Comment: As above.

Action 15 SMB: Feedback from official visits

Comments: We were told that the need to ensure that information is exchanged when staff from other agencies visit accommodation providers has been covered in the training and briefing, but there has been no formal audit to assess the impact of this. SMB has established a time-limited group with the Community Rehabilitation Company and all supported housing providers, to provide consistent practice.

Action 16 SMB: A timely multi agency approach is deployed to screening of all MAPPA referrals.

Comment: The number of screenings has improved, as has management oversight.

Action 17 SMB: Increase contributing agencies' knowledge & understanding of behaviour of predatory sex offenders, such as how compliance may be a means to divert attention and potentially mask a decision to offend, trigger factors that indicate risk escalation and contingency plans when no longer safe to manage in the community.

Comment: Although there have been some individual agency training initiatives, for example in the Police, little measurable progress was reported on this.

12.7. HMI Probation general comment on MSCR action plan

Progress against much of the Action Plan has proved difficult to measure because of the imprecise wording of many of points. This meant that evidence of the impact of the action plan was not always available.

A number of the actions taken would have occurred as part of the normal management practice of officers and were not directly mandated by the SMB, for example some of the training for police. Many of the actions taken simply consisted of issuing instructions or restating existing guidance.

The lack of auditing and/or peer review means many of the qualitative aspects of good MAPPA practice remained unexamined.

13. Some general reflections

All NPS staff should focus as a priority on the public protection requirements of each individual case. They should use the process and protocols in place to manage those that are potentially high risk of harm to others and should pursue an investigative approach at all times. It would appear that this was not always the case with LC.

The literature on bias and error in risk assessment in all fields of endeavour is well established and has been applied to decisions within criminal justice. Hazel Kemshall and others[21] have noted, for example, 'confirmation bias' where "practitioners select and use the information which confirms and reinforces the decision and course of action that they have already chosen" and 'unreal optimism' where "practitioners see case improvement, change and progress, although the weight of evidence for this may actually be small. Practitioners work hard to achieve change and consequently invest small changes with a greater significance than they actually deserve. This can result in risk minimisation."

Evidence of day to day behaviour in prison – not just formal programme reports – can make a significant contribution to risk assessment, particularly in identifying offence paralleling behaviour.[22] Guidance issued to prison and probation staff[23] in 2016 identifies the important

[21] Kemshall, H., Wilkinson, B. and Baker, K (2013) *"Working with Risk: Skills for Contemporary Social Work"*. Polity Press, Cambridge
[22] Edited by Daffern, M., Jones, L., Shine, J. (eds) (2010) *"Offence Paralleling Behaviour"*. Wiley-Blackwell. 2010
[23] National Offender Management Service (2016) *"Public Protection Manual".*

role prison staff can play in daily interaction with the offender, and in careful observation and recording.

The guidance also notes the importance of avoiding assumptions. The points made may be relevant to the case of LC.

"It is crucial that staff regard public protection as paramount and do not make assumptions about the risk posed by an offender. Offenders must be given a chance to show motivation to change, but decisions about risk levels should be made only after a careful assessment. Although positive improvements and motivation to change can indicate a reduction in risk of re-offending and serious harm, that is not always the case. The following are common beguiling assumptions:

- the passage of time since an offence was committed automatically decreases risk;
- if an offender is pleasant, courteous and punctual, their risk of re-offending or causing serious harm has changed;
- progress made by an offender automatically means a lower risk of re-offending;
- compliance with the requirements of their sentence means they will not offend (false compliance may conceal significantly elevated risk)
- good progress in custody is always an indicator expected progression in the community on eventual release (especially during the early days of release when different environments and pressures can be a factor)"

The National Probation Service is responsible for high risk offenders and for those who fall under MAPPA – that is the vast majority of those convicted of sexual offences. Working effectively with these individuals requires skills, knowledge and confidence. Many probation staff have the necessary expertise and do excellent work with some demanding and serious cases.

The nature of the challenge facing the NPS has, however, changed since Transforming Rehabilitation. There are fewer opportunities for new staff to develop their skills by working with lower risk offenders. The span of control of front line managers has not reduced, but they must now be skilled in identifying and prioritising risky situations and cases from within a caseload where few present no risk.

Until 2017, some probation staff worked as tutors on the community based SOTP. Following an evaluation[24] of the prison based programme this was discontinued, and in the community it has been replaced by a new treatment programmes, Horizon (for medium risk offenders). A second treatment programme, Kaizen (for high risk, high need, high priority offenders) is being piloted in one division. To date these have catered for a relatively small proportion of the NPS caseload, and fewer staff are gaining specialist skills by working as programme tutors.

We are currently undertaking a thematic inspection of the work of the National Probation Service with men who have committed sexual offences. As part of this we will be examining the training, skills and confidence levels of probation staff.[25]

---

[24] Mews, A., Di Bella, L. and Purver, M. (2017) *"Impact evaluation of the prison-based Core Sex Offender Treatment Programme"* Ministry of Justice: London.

[25] We have previously reported that probation staff lacked confidence in working individually with sex offenders who were not attending a group programme. HMI Probation (2010) *"Restriction and Rehabilitation: Getting the Right Mix".*

The majority of sexual offenders fall under MAPPA, with most being managed at Level 1[26]. We have raised concerns about the decision to manage LC at Level 1, and about the process whereby this decision was made. As part of our thematic inspection we are considering whether the process for determining and reviewing MAPPA levels is applied consistently and robustly across the country.

As we have highlighted, the role of probation staff and their manager is demanding, and requires a high level of professional skills and expertise. Unlike other professions, probation is not regulated. There are no professional arrangements for the review of professional conduct in individual cases. In our view, this puts the onus on probation providers to develop and apply disciplinary procedures that cater effectively for significant professional shortcomings in individual cases.

14. Summary and conclusion

Any serious sexual assault, murder or attempted murder is devastating for the victim's family and loved ones. The offences committed by LC were horrific. When such offences occur, those affected rightly ask how it could have been allowed to happen. In this case, how could someone commit such an offence only four months after release from prison, when he was under the supervision of the authorities?

As we have noted before[27], 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, i.e. to take all reasonable action to keep risk to a minimum. That did not happen in this case.

In our report we have identified some significant shortcomings in the practice and management oversight in this case – issues that were highlighted in both the SFO review and the MSCR. We have concluded that these reviews were sufficiently comprehensive, accurate and robust.

In many SFO reviews the issues identified are systemic failures, whereas in this case we have identified points when practitioners and managers simply did not do what they should have done. The failure properly to determine the MAPPA level meant that staff could not draw on the benefits of active multi-agency management at the critical times. Most significantly, clear indicators of significantly increased risk were not acted upon anywhere near well enough. At several points, a more investigative approach by practitioners and managers could have exposed issues that may have changed the risk assessment and management of Leroy Campbell.

The NPS, alongside MAPPA partners, focused on the organisational issues raised by the case. Action plans are in place and are being monitored on a regular basis, but in our view the circumstances of this case revealed pressing national issues for the NPS and other probation providers to consider.

Having suffered such a tragic loss, the Skidmore family have found it difficult to find out in simple terms what happened in the lead up to the crimes. They were given a truncated but

[26] *Multi-Agency Public Protection Arrangements, Annual Report 2016/2017* (2017) Ministry of Justice: London
[27] HMI Probation (2006) *"An independent review of a Serious Further Offence case: Damien Hanson and Elliot White"* and HMI Probation (2006) *"An independent review of a Serious Further Offence case: Anthony Rice".*

nevertheless complex report to read rather than take away, and were moved immediately into a meeting designed to allow them to ask questions. They found it stressful, and it did nothing to build trust.

In the family's view, they have been treated badly by the NPS. From their perspective, it is only after their meetings with ministers that they have the prospect of a trustworthy assessment of the quality of work here, and some prospect that individuals may be held to account in some way.

We have just begun a full inspection of the Midlands division of the NPS. In that inspection we will report on the performance of the division against our inspection standards[28], which include standards relating to the quality of public protection work.

Annex A

Licence conditions

- He shall be of good behaviour and not behave in any way which undermines the purpose of the licence period
- He shall not commit any offence
- He shall keep in touch with the supervising officer in accordance with instructions given by the supervising officer
- He shall receive visits from supervising officer in accordance with instructions given by the supervising officer
- He shall reside permanently at an address approved by the supervising officer and obtain the prior permission of the supervising officer for any stay of one or more nights at a different address
- He shall not undertake work, or a particular type of work unless it is approved by the supervising officer and notify the supervising officer in advance of any proposal to undertake work or a particular type of work
- He shall not travel outside the UK, Channel Isles, Isle of Man except with the prior permission of the supervising officer except for the purposes of immigration deportation or removal
- He shall confine himself to Bilston Approved Premises, Bilston, Wolverhampton between the hours of 20:00 and 07:00 and 12:00 and 13:00 daily, unless otherwise authorised by the supervising officer. This condition will be reviewed by the supervising officer on a monthly basis and may be amended or removed if it is felt that the level of risk he presents has reduced appropriately;
- He shall comply with any requirements specified by the supervising officer for the purpose of ensuring that he addresses his alcohol/drug/sexual/violent/anger offending behaviour problems including, but not limited to completing the Better Lives Booster programme and engaging with any alcohol or drug treatment provider
- He shall notify supervising officer of any developing intimate relationships with women
- He shall continue to address his victim awareness by completion of the victim awareness workbook.

[28] HMI Probation (2018) *"Standards for inspection probation services"*