



**HM Inspectorate
of Probation**

**An Independent Review
of a Serious Further Offence case:**

Damien Hanson & Elliot White

February 2006

Foreword

In December 2005 Damien Hanson and Elliot White were convicted of the murder of John Monckton and the attempted murder of his wife Homeyra Monckton on 29 November 2004, at a time when both men were under the supervision of London Probation Area. The dreadful circumstances of these crimes were widely reported and very understandably caused much public concern. The Home Secretary Charles Clarke requested an urgent investigation into the decisions and management by the London Probation Area relating to the sentences being served by Hanson and White at the time when they committed the offences.

He also expressed his desire that our findings and recommendations should lead to lessons being learned by all responsible authorities. Accordingly we set out first:

- Our four *Principal Findings*, which identify the overall failures and specific deficiencies – some of them serious - in the way that the two cases were managed
- Our five *Key Recommendations*, three of which are supported in the main body of the report by lists of *Practice Recommendations*, designed to eradicate the failures we found, and to promote continuing long-term improvement in practice

The key theme that runs through this report is that people can perform poorly when they are unclear about their own responsibilities within a process, and this can put them and their employers in an indefensible position when a dreadful crime then takes place. Leaders of organisations must ensure that they assign to their people clear responsibilities, not simply tasks, and expect them to take the initiative to make decisions and act on them.

We put all these in the wider context of the continuing changes for, and rising expectations on, the National Probation Service and other responsible authorities. The Probation Service previously moved on from its original historic purpose “To advise, assist and befriend” offenders. It is now heading towards a new purpose to “Punish, Help, Change and Control” offenders within a new broader National Offender Management Service.

This consolidates the other changes in recent years such as the establishment of a clear role to work with others in helping to protect the public through the effective management of *Risk of Harm* – the “Control” purpose. Distressingly, although Probation Staff are generally well trained, dedicated and hard working, this Review has shown how the mismanagement of offenders in the community can fail to keep to a minimum the *Risk of Harm* to the very people that the Probation Service seeks to serve and protect.

Accordingly, all of us involved in any way in the supervision of offenders owe it to victims and the public generally to ensure that lessons are learned from the horrific death of John Monckton, the injuries suffered by his wife, and the loss to his family and friends.

Andrew Bridges
HM Chief Inspector of Probation

Contents

1.	Principal Findings and Key Recommendations	4
2.	Outline of events leading to this independent review	7
3.	Terms of Reference	7
4.	Sources of information	8
5.	The legal and professional context.....	8
5.1	<i>The release and supervision of prisoners on parole</i>	8
5.2	<i>Drug Treatment and Testing Orders</i>	9
5.3	<i>Likelihood of reoffending (LoR) and Risk of Harm (RoH)</i>	11
5.4	<i>London Probation Area</i>	14
6	A brief chronology of key dates leading to the offences	16
7	Findings relating to Elliot White's DTTO	18
7.1	<i>The assessments and decisions leading to White's DTTO</i>	18
7.2	<i>The management of Elliot White's DTTO</i>	19
8	Recommendations from review of Elliot White's DTTO	22
9	Findings relating to Damien Hanson's parole licence	24
9.1	<i>The assessments and decisions leading to Hanson's release on parole..</i>	24
9.2	<i>The management of Hanson's parole licence</i>	32
10	Recommendations from review of Damien Hanson's parole licence	37
11	Management and organisational issues	40
11.1	<i>Organisational Structure</i>	40
11.2	<i>Staff supervision and support</i>	40
11.3	<i>Geography</i>	41
11.4	<i>Resettlement policy</i>	42
11.5	<i>Assessment and management of Risk of Harm</i>	42
11.6	<i>Administrative arrangements</i>	43
11.7	<i>Liaison with the providers of services</i>	44
12	Recommendations from review of management and organisational issues	44
13	Future Independent Reviews by this Inspectorate	45
14	Conclusion: From offender mismanagement to Offender Management.....	46
	Appendix and Glossary	50

1. Principal Findings and Key Recommendations

Principal Finding 1: Doing the job properly

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. This did not happen in these cases:

- With Damien Hanson, a high *Risk of Harm* offender, there was an overall collective failure within London Probation Area, both to identify the nature of his risk to others and to act to keep that *Risk of Harm* to a minimum.
- With Elliot White, a medium *Risk of Harm* offender, London Probation Area failed to manage properly his compliance with the requirements of his Drug Treatment and Testing Order (DTTO).

Key Recommendation 1:

The National Offender Management Service should be able to demonstrate that:

- Throughout each offender's sentence all reasonable action has been taken to keep to a minimum that offender's *Risk of Harm* to others.
- All sentenced offenders, whatever their level of *Risk of Harm*, should be required to comply with all the conditions of their Order or Licence, and where there is a failure enforcement action should be taken in accordance with the relevant National Standard.

This involves assigning responsibilities clearly at every level, so that each person involved in the supervision of offenders has clarity about their own responsibilities for decision-making and taking action to achieve the purposes of the sentence.

Principal Finding 2: Lead responsibility in managing cases

The lack of clarity and continuity of *lead responsibility* for managing these cases is very apparent to us. This arose from poor organisational arrangements and the failure to deal effectively with both offenders' response to supervision and changes in their personal circumstances. This was a major cause of the deficiencies that we have identified.

Key Recommendation 2:

From start to end of an offender's sentence, managers should apply the principles of continuity and clarity of *lead responsibility* throughout, especially with those offenders assessed as *high Risk of Harm*

Principal Finding 3: Updating Parole Board release decisions

A further important issue arises from what happened between the Parole Board's decision to grant Hanson early release and the actual date of his release. Currently there is a lack of clarity about the responsibility for ensuring a review by the Parole Board of their decision to release following any substantial change in the offender's circumstances.

Key Recommendation 3:

The Parole Board should specify clearly how it wishes to deal with situations where the decision to grant early release is seen as particularly dependent on some specific requirement such as accommodation or location, and where the situation changes between the date of the decision and the prisoner's release date. Again this is about achieving clarity of responsibility for making decisions.

Principal Finding 4: Improving *Risk of Harm* work nationally

From this Review and from our recent inspections we identify a number of factors that in our opinion often hinder the drive by the National Probation Service to improve its *Risk of Harm* practice. These include:

- The setting of national targets that did not until this year specifically address *Risk of Harm work*.
- The organising of Probation staff into specialist teams, where some of the benefits this offers has to be set against some of the arising disadvantages: discontinuity of offender management, and an impaired understanding and awareness of *Risk of Harm work* by staff outside the specialist public protection teams.
- The challenging nature of performance managing *Risk of Harm work*.

Key Recommendation 4:

Chief Officers should ensure that the way that their Area is structured and managed supports their endeavours to increase the effectiveness of their *Risk of Harm work*. Once again this includes assigning responsibilities clearly at every level, so that officers in charge of cases (in particular) have clarity about their own responsibilities for taking the initiative in making decisions and taking action to achieve the purposes of the sentence.

Key Recommendation 5: Future Independent Reviews

In certain exceptional future Serious Further Offence cases HM Inspectorate of Probation should undertake a formal Independent Review of the way that the case has been managed. Any such reports should be directed to the Home Secretary and published, in accordance with our normal practice.

This Key Recommendation arises from a recognition that a review such as this one may be needed again in occasional exceptional circumstances, and may assist the continuing development of good practice. We reiterate that while it is inevitable that from time to time an offender under supervision in the community will commit a Serious Further Offence, the public will be entitled to know whether or not the responsible authorities did their job properly.

A note on the structure of this report:

In the first section we outline the purpose and context of this independent review, including the terms of reference.

The terms of reference for this review cover the assessments and decisions leading to Elliot White's Drug Treatment and Testing Order (DTTO) and Damien Hanson's release on parole. They also include the way that these two sentences were managed, the effectiveness of the offender management, and the management and oversight of the case managers and relevant organisational issues. Accordingly, in order to make this report as clear and accessible as possible, we then set out our findings on the assessments and management relating to the sentences on White and Hanson followed by our relevant specific practice recommendations.

After that we go on to consider the management and oversight of the people managing the cases, and the organisational issues, before proposing where an independent review by the Inspectorate would enhance the current Serious Further Offence review procedure.

Finally, our Conclusion explores the wider implications arising.

A note on language:

In the rapidly changing world of the Probation Service, many terms have been undergoing more than one change of name. One major example of this is the term for what was once the 'Probation Officer for x, a specific offender'. In this report we have used the terms 'supervising officer' or 'case manager' or 'offender manager' to denote the person who holds *lead responsibility* for managing a specific offender. The former two terms seem to us useful when describing the recent past, while the clear expectation at present is that *offender manager* is the best term to employ when referring to this role as it evolves in the future.

For transparency we have sometimes used 'plain English' instead of the official term e.g. 'hostel' in preference to 'Approved Premises'.

2. Outline of events leading to this independent review

- 2.1 In December 2005 Damien Hanson and Elliot White were convicted of the murder of John Monckton and the attempted murder of his wife Homeyra Monckton on 29 November 2004. The dreadful circumstances of these crimes were widely reported and very understandably caused much public concern. This concern was greatly exacerbated when it emerged that both Hanson and White had been under the supervision of the London Probation Area at the time of the offences.
- 2.2 Damien Hanson had been released from prison on parole on 27 August 2004, having been sentenced to 12 years imprisonment by the Central Criminal Court on 1 April 1998 for offences of attempted murder and conspiracy to rob. He was seventeen years of age at the time of that sentence and twenty-three years old at the date of his release.
- 2.3 Elliot White was subject to a Drug Treatment and Testing Order (DTTO) for six months made by West London Magistrates' Court on 26 August 2004. He was also twenty-three years old at that time. He had been sentenced to the DTTO for failing to comply with the conditions of a Community Rehabilitation Order for twelve months made by the same court on 15 July 2003. His original offence was unlawful possession of 2.8 grams of cocaine.

3. Terms of Reference

- 3.1 On 19th December 2005 the Home Secretary Charles Clarke wrote formally expressing his deep concern about the issues raised by the murder of John Monckton and the attempted murder of his wife. He requested an urgent investigation into the decisions and management by the London Probation Area relating to the sentences being served by Hanson and White at the time when they committed the offences. He also noted that the investigation might need to cover the work of other criminal justice agencies and concluded: *"It is vital to public confidence in community orders and licenses that your findings and recommendations lead to lessons being learned by the responsible authorities and that any necessary changes are implemented as the top priority across London and if necessary by other Areas and criminal justice agencies."*
- 3.2 The detailed terms of reference set by the Home Secretary are as follows:
- To make enquiries into the assessments and decisions leading to the making of a Drug Treatment and Testing Order in the case of White and to Hanson's release on parole
 - To investigate the management of the two sentences and the effectiveness of the offender management
 - To consider the management and oversight of the case managers and relevant organisational issues

- To advise on the criteria and circumstances where an independent review by the inspectorate would enhance the Serious Further Offence review procedure
- To report your findings and any recommendations direct to me.

4. Sources of information

- 4.1 In undertaking this independent review we have examined the case records kept on Hanson and White by the London Probation Area and in the case of Hanson the file kept by the Parole Board. We have also seen documents prepared by the National Probation Directorate as part of its normal procedure for reviewing cases where people under supervision have committed serious further offences.
- 4.2 In addition to the examination of the extensive written records kept on Hanson and White we have met with the relevant managers and case managers in the London Probation Area. These meetings provided them with an opportunity to supplement the written records and comment on the ways in which Hanson and White were supervised.
- 4.3 We have also had meetings with representatives of the Parole Board, the Metropolitan Police, the drug treatment centre that dealt with White and the hostel where Hanson was living at the time of the offences. A list of the people who contributed to the review is contained in Appendix 1.

5. The legal and professional context

To provide a context within which the supervision of Hanson and White occurred it may be helpful to outline the legal framework that applied to parole and Drug Treatment and Testing Orders at the time of the offences. As will become clear later, it is also important to understand the way in which probation staff are required to assess the likelihood of reoffending and *risk of harm* posed by offenders. Finally in this section there is a brief description of the London Probation Area (LPA) which was responsible for the management of Hanson's parole licence and White's DTTO. We also say more about LPA in Section 12.

5.1 The release and supervision of prisoners on parole

- 5.1.1 The legislative framework for the release of prisoners current at the time of the murder was contained in the 1991 Criminal Justice Act, as amended by the Crime (Sentences) Act 1997 and the Crime and Disorder Act 1998. The main procedural and legal guidance for prison and probation staff regarding the release of prisoners on licence and their subsequent supervision is contained in the Licence and Breach Guide issued to probation areas via Probation Circular 94/99. The National Standards for the supervision of offenders in the community published in 2000 set out in more detail the expectations for the supervision of offenders released on licence.
- 5.1.2 Following sentence there is an expectation of contact by the probation service with the prisoner and the prison staff in order to plan for

release. The National Standards for the Probation Service state that the level and nature of contact should be sufficient at the pre-release stage to enable the successful resettlement of the offender in the community and the preparation of a supervision plan.

- 5.1.3 For prisoners sentenced to four years or more such as Damien Hanson, early release on parole can be applied for at the halfway point of sentence. The Parole Board considers each application carefully on its merits. If the Parole Board grants release the person is under supervision on licence by the probation service until the three-quarter point of the original prison sentence. This is called Discretionary Conditional Release (DCR). Although supervision expires at the three-quarter point of the original prison term the offender can be recalled to prison for any further offences until the sentence expiry date. If the Parole Board does not grant parole, Automatic Conditional Release (ACR) takes place at the two-thirds point of the sentence. Once again supervision expires at the three-quarter point with the offender at risk of recall until the sentence expiry date.
- 5.1.4 Central to the decision about release on parole are judgments about the *Risk of Harm* the offender presents and his or her resettlement needs. Parole supervision is intended to address these issues. In addition the Probation Service has a duty to contribute to the risk assessments undertaken by the Prison Service and the Parole Board as part of the parole decision-making process.
- 5.1.5 Probation National Standards set out the expectations regarding the supervision of those released on parole licence. These include a requirement for a written assessment to be made of the *Risk of Harm* and likelihood of reoffending for each parolee. The Standards also define the minimum acceptable level of contact to be maintained with the Probation Service.
- 5.1.6 Where a parolee does not keep appointments and maintain contact with the Probation Service as required, the National Standards include a clear procedure to be followed. After a second unacceptable failure by the parolee an Assistant Chief Officer of the relevant Probation Area must be involved in the process and must either issue a final warning or instigate recall of the parolee to prison. As will be seen later these assessments, standards, expectations and procedures are all of central relevance when assessing the quality of Hanson's supervision by the London Probation

5.2 Drug Treatment and Testing Orders

- 5.2.1 The purpose of a Drug Treatment and Testing Order (DTTO) such as that imposed on Elliot White is to break the link between drug use and crime. The order is designed to be an intensive experience and once again the requirements for the management of the order by the Probation Service are set out in National Standards. These include a treatment programme, drug testing, and attendance at regular court review hearings.

- 5.2.2 It should be noted that the funding for the treatment elements of a DTTO are provided from a 'Pooled Treatment Budget' administered by local health authorities. Under this arrangement Probation Areas draw up plans for the drug treatment needs of offenders to be managed alongside those of non-offenders. For the most part this funding arrangement has worked well across the country but at times it can lead to competing demands on a finite budget.
- 5.2.3 The most notable feature of a DTTO is the requirement on the offender to attend frequently and to submit to a regular testing regime, complemented by court reviews of each case. Originally all DTTO offenders were required to undergo 20 hours of contact each week for the first 13 weeks of the order, spread over a five day period each week. In February 2004, however, Probation Circular 68/04 reduced this requirement to 12 hours per week for those offenders deemed by the treatment providers to require a lower intensity programme. This lower intensity programme was used typically for those offenders with less ingrained patterns of drug use and offending. Whilst there is some flexibility as to the content of contact under these orders, for example it may involve some structured leisure activity, it is clearly intended that a DTTO should make real demands on the offender. This is achieved in part by imposing a challenging regime on people whose lives may previously have been disorganised and otherwise marred through their involvement with illegal drugs.
- 5.2.4 As with parole, the National Standards for the Probation Service are also very explicit in setting out the procedure to be followed where an offender fails to comply with the conditions of a DTTO. Given the demanding nature of the order it is particularly important that the terms and conditions are clearly explained to the offender at the outset and that prompt action is taken to deal with any breach. National Standards make it clear that the success and credibility of the DTTO is dependent upon such appropriate and rigorous enforcement. The supervising officer is required at the outset of supervision to provide the offender with a clear statement explaining in what circumstances breach action will be taken. Breach action may be taken after one unacceptable failure where appropriate and this may amount to a single failure on a particular day. Refusal to provide a sample for analysis is always interpreted as a failure to comply with the requirements of the order.
- 5.2.5 The drug-testing requirement that forms part of a DTTO is more flexible in terms of enforcement, in that a positive test is a type of 'failure' that does not always mean breach. National Standards state that "Positive tests need to be seen in the context of the offender's overall response to the order. Persistent test failures when indicative of a failure to engage with the order or of unsatisfactory progress shall lead to the initiation of breach proceedings". In other words the purpose of the tests is to provide an objective measure of progress but the results need to be seen in the context of the offender's overall performance on the order. Once again the clear and detailed expectations and procedures for the management of DTTOs provide an objective yardstick in assessing how White's supervision was conducted, just as

the parole procedures do for Hanson. In practice we shall see that both cases revealed significant deficiencies in a variety of ways.

5.3 Likelihood of reoffending (LoR) and Risk of Harm (RoH)

- 5.3.1 The distinction between *Likelihood of Reoffending* and *Risk of Harm* is an important one. Whilst the two factors are often linked, it should be borne in mind that an offender can have a high likelihood of reoffending whilst not necessarily presenting a high *Risk of Harm* to the public. Other offenders, in contrast, such as some sex offenders, might have a relatively low likelihood of reoffending but the nature of their crimes when they do offend can cause their victim major distress or serious harm.
- 5.3.2 At first sight this distinction might seem obscure, but it is relevant to the Hanson and White cases because of what the Probation Service (and other relevant authorities) have to do with each case in relation to these two factors. We use the new language of Offender Management to make the next points: With an offender's likelihood of reoffending an officer works to "Help" and "Change" the offender in numerous ways, using *constructive interventions*, so that the offender can learn to change his or her own behaviour. With an offender's *Risk of Harm*, the officer works to "Control" the offender, using *restrictive interventions* that keep to a minimum the offender's opportunity to behave in a way that is of *Risk of Harm* to others.
- 5.3.3 The challenging task for the *offender manager* (supervising officer, with *lead responsibility* for managing the case) is to assess each individual offender's own Likelihood of Reoffending and *Risk of Harm*, plan the right quantity and quality of constructive and restrictive interventions as appropriate to that individual case, and then ensure that the plan is carried out. Additionally the officer must of course ensure that the offender complies with the requirements of the sentence of the court, and enforce the Order or Licence if there is a failure to comply.
- 5.3.4 One key difficulty, currently being addressed by the National Probation Service, is to help all staff understand what they are being required to achieve with their *Risk of Harm work*. We have identified three factors that hinder the NPS's drive to improve this area of its practice.
- i) National target setting: Although it has been stated since 2001 that Public Protection is the top priority for the National Probation Service, performance targets have been set in other areas of work but until the current year not in *Risk of Harm work*. It is almost certain that this has had the effect of distracting staff from focusing effective attention on *Risk of Harm work*. Although an important start has been made this year, we believe from our inspection reports that there is still a long way to go to put *Risk of Harm work* more clearly into the centre of Probation practice.
 - ii) Specialist teams: There are many benefits to the work of the service to be gained from having teams of staff specialising in aspects of practice, such as assessments or public protection, but there also significant disadvantages. Having assessments undertaken by

separate specialists builds in a *discontinuity of lead responsibility* for the case in the offender management process. Having a specialist team deal with all the high *Risk of Harm* cases also has obvious benefits, but one problem arising from this is that staff outside those specialist teams often have much less understanding and awareness of *Risk of Harm work*. Yet they need this to know how to work effectively with medium *RoH* offenders, and to know how to identify when an offender's *RoH* is increasing or when it has been assessed wrongly. It will be seen that these matters were a factor in this case.

- iii) Performance-managing *RoH work*: The nature of this work makes it very difficult to set targets. With each individual case it is a matter of skilled judgement to determine whether or not the supervising officer has taken all reasonable action to keep to a minimum that particular offender's *Risk of Harm* to others. This makes it extremely difficult to performance manage *RoH work*. It is logistically challenging for a Probation Area or a Youth Offending Team to arrange regular internal audits of cases to measure performance against a target that, say, 90% of the cases audited will have had their *Risk of Harm* managed sufficiently well. However, despite that challenge, it is clear that either a target such as this must be introduced, or a better alternative must be found that will drive up the quality and effectiveness of *RoH* practice.

We consider these background issues about managing *Risk of Harm* nationally to be so important as to make them our **Principal Finding 4**

- 5.3.5 In order to assess cases, Probation staff historically used professional judgement and experience. With the growth of research and more sophisticated interventions, however, *actuarial* approaches to assessment have been developed. One *actuarial* assessment tool now used by probation staff is the Offender Group Reconviction Score (OGRS2). This is in effect a statistical formula derived from large sample groups that enables a predicted likelihood of reconviction (expressed as a percentage) to be produced. The score is based on a number of factors, such as type and frequency of previous offences, age at first conviction etc. These are all *static factors*, i.e. factors in someone's history that by definition can subsequently never change.
- 5.3.6 OGRS scores provide a useful reference point for probation staff as part of the assessment process, but it is easy to over-emphasise their significance. The main limitation of OGRS is that the percentage score is representative of a sample group of similar offenders as a whole. In effect the score indicates the proportion of that particular group of offenders who are likely to be reconvicted. However, there remains a crucial judgment as to whether a specific individual will be part of the proportion that reoffends or part of the proportion that does not. Furthermore the OGRS score in an individual case does not include the *dynamic factors*, i.e. the factors in the individual's circumstances

and behaviour that can change subsequent to the calculation. Despite these caveats the appropriate use of the OGRS score is important, as we shall see once again in the cases under review.

- 5.3.7 In order to ensure that the assessments of likelihood of reoffending and *Risk of Harm* gave proper weight to both *actuarial* and professional approaches an ambitious programme started in 2001. This was a national initiative to implement a consistent and structured assessment framework in all probation areas, and was known as OASys (Offender Assessment System). The system combined the unchanging *static factors* such as previous offences with the changeable *dynamic factors* such as the employment status of an offender. OASys was originally paper-based but by April 2004 all probation areas were required to use the electronic version, known at first as 'e-OASys'. In addition the new system also contained a structure for the creation of supervision plans and was introduced in prisons at the same time to assist in the joint assessment of prisoners.
- 5.3.8 OASys includes a framework to assess *Risk of Harm* and ascribes four categories of level of *RoH*: Low, Medium, High and Very high. The national standard is that Probation staff should undertake a *Risk of Harm* 'screening' on every offender at or soon after first contact. If this initial screening results in a 'concern', for example the nature of the offence or pattern of behaviour, a full *Risk of Harm* assessment is required. For all cases other than those assessed as low *Risk of Harm* a risk management plan should also be completed. This plan would normally include a specific additional level of management oversight and monitoring of the case.
- 5.3.9 For those offenders assessed as presenting a high or very high *Risk of Harm*, consideration should be given as to whether they should be referred to the local Multi-Agency Public Protection Arrangements (MAPPA), and the decision should be recorded. The purpose of MAPPA is to ensure that all relevant agencies work together to assess and manage offenders' *Risk of Harm* to others.
- 5.3.10 Most but by no means all MAPPA cases are Probation Service referrals. Thus overall there are three categories of MAPPA offenders: all registered sex offenders; all violent and non-registered sex offenders sentenced to 12 months or more imprisonment, and finally any other offender posing a serious *Risk of Harm*. And there are three levels of MAPPA oversight. Level 1 involves single agency management with information exchange, Level 2 requires local multi-agency risk management meetings, and for Level 3 the Multi-Agency Public Protection Panel provides more intensive oversight for the 'critical few cases'.
- 5.3.11 The issues of risk assessment and reduction have wider management implications for Probation Areas, which have tended to allocate resources according to the assessed level of *Risk of Harm*. It is becoming clear from the OASys statistics that about 7% of offenders under supervision come into the High or Very high *RoH* category, and it is wise to devote more staff time and other resources to these

offenders. This approach is given evidenced support by an analysis of Serious Further Offences (SFOs) that shows that these 7% of high *RoH* cases are responsible for 20% of these SFOs committed by offenders under current supervision. Hence it is right to give priority attention and resource to high *RoH* cases.

- 5.3.12 However, it logically follows that this analysis is also telling us that 80% of SFOs are committed by low or medium *Risk of Harm* offenders. Although they are indeed, as one would expect, proportionately 'under-represented' in this category, their sheer size of absolute numbers means that they still account for the great majority of Serious Further Offences. This means that all Probation (and YOT and other) staff who find themselves with *lead responsibility* for supervising a number of offenders need to have sufficient awareness and understanding of *Risk of Harm* to ensure that each offender is regularly assessed, and restrictive interventions planned and acted upon as appropriate to the case. As we said earlier, we have some concerns as to whether this is sufficiently understood outside the specialist public protection teams. By rightly giving priority attention and resource to high *RoH* cases the service is risking making the mistake of not giving enough attention and resource to *RoH work* with the other cases.
- 5.3.13 For, as we reiterate here, Probation staff must assess and review regularly the level and nature of the offender's *Risk of Harm* to others in all cases, not just the high *RoH* cases, and then take all reasonable action as appropriate to the case to keep that offender's *RoH* to a minimum.
- 5.3.14 National Standards rightly require Probation staff to complete an OASys assessment at the start of each offender's supervision. There should also be a clear assessment of the likelihood of reoffending and *Risk of Harm*, and where appropriate a risk management plan should be developed. This process should in turn lead to the creation of a sentence plan that should be reviewed and updated. In order to assess progress and properly manage the *Risk of Harm* and likelihood of reoffending this Inspectorate advocates that the OASys assessment should be formally reviewed regularly during the period of supervision.
- 5.3.15 These expectations on offender managers are vital to effective practice. Although some might consider them bureaucratic at first sight they go to the core of a Probation Area's responsibility for effective practice and public protection. They also place expectations on each and every offender manager in the form of specific requirements for good practice. In the cases of both Hanson and White it is very apparent that these expectations were not met.

5.4 London Probation Area

- 5.4.1 London Probation Area (LPA) came into existence in 2001 following the creation of the National Probation Service and the consequent amalgamation of five smaller Probation Services in the Greater London area. LPA is the largest probation area in England and Wales, and has already undergone a number of reorganisations in an attempt to

improve management arrangements and performance. In parallel to the division of the Area into four operational units, London North, South, East and West, each comprising a number of boroughs, LPA faced severe financial difficulties during 2003/2004.

- 5.4.2 As a result of these financial difficulties budget cuts were made, including freezing staff recruitment and curtailing staff training. Aside from those staff delivering specific interventions such as unpaid work by offenders, staff in the Area were assigned to three broad types of work. The Community Assessment Teams (CATs) concentrated on the assessment of offenders and focused on pre-sentence reports and parole assessment reports. After assessment most offenders were supervised by Community Intervention Teams (CITs). For those cases deemed to represent a high *Risk of Harm*, the Public Protection Teams (PPTs) took responsibility for the supervision of the designated offenders. As indicated earlier, this arrangement meant that staff in a Community Assessment Team would complete most parole assessment reports. Where parole was granted the offender would then be allocated to a Probation Officer in the appropriate supervision team just before release. As we have stated earlier, while there are some operational advantages to this approach, this constitutes an example of a built-in discontinuity in offender management arrangements.
- 5.4.3 Performance overall within London Probation Area has been a matter of concern since it was created following the merger in 2001 of the five former Probation Services covering the area. At the end of 2003/2004, LPA had been placed bottom out of 42 probation areas on the weighted score card of the National Probation Directorate (NPD). This is a basket of key performance indicators collected by the NPD to enable comparisons of performance across time and between areas. While the results for 2004/2005 indicated some encouraging upward movement this also showed that much work on performance continued to be needed. There was however good evidence that the Board and senior managers were focusing on national targets and starting to achieve some success.
- 5.4.4 Performance in relation to *Risk of Harm work* in LPA has also been weak in its early years, as shown in our inspection reports. But equally in this specific area too LPA has shown a drive to improve in recent months, and we expect to measure the progress they have achieved when we undertake our scheduled Follow-up inspection of *Risk of Harm work* in London in July 2006.

6 A brief chronology of key dates leading to the offences

Damien Hanson		Elliot White	
17 Dec 1980	Damien Hanson born	15 Mar 1981	Elliot White born
3 Feb 1993	First conviction, for indecent assault on a female. Supervision Order for 6 mos.		
6 Sep 1993	Theft from shops. Fined		
3 May 1995	Assault ABH and theft. Attendance Centre		
19 Aug 1996	Wounding and contempt. Young Offenders Institution (YOI) 18 mos.		
4 Sep 1996	Burglary and theft. Conditional Discharge 12 mos.		
17 Feb 1997	Attempt burglary. YOI 4 mos.		
1 Apr 1998	Attempted Murder YOI 12 years, Conspiracy to rob YOI 8 yrs concurrent.		
1998-2003	Served sentence in at least eight institutions.	17 Oct 2001	First conviction for possessing heroin and cocaine with intent to supply. 18 mos Prison. Possession (x2) 12 mos concurrent
		10 Apr 2002	Released from HMP Dover on home detention curfew
23 Jul 2003	First application to Parole Board. Parole refused.	15 Jul 2003	Possessing cocaine and heroin (x2). Community Rehabilitation Order (CRO) 12 mos.
27 Aug 2003	Earliest date eligible for parole		
		11 Sep 2003	Case file indicates that proceedings for breach of CRO were initiated
		5 Jan 2004	Breach proceedings not properly processed so letter sent to White re-establishing contact
		30 Mar 2004	Summons for breach of CRO applied for. Court date set for 15 July 2004
19 Jul 2004	Second application for parole. Parole Board grants release on licence conditional on Essex hostel. When turned down, officer finds Hestia hostel placement in Battersea		

**HM Inspectorate of Probation
Serious Further Offence review:
Damien Hanson & Elliot White**

27 Aug 2004	Released on parole from HMP Highpoint. Accommodation re-arranged at Hestia hostel Streatham	26 Aug 2004	Appeared at West London Magistrates Court. Sentenced to 6 mos DTTO for breach of CRO
21 Sep 2004	New supervising probation officer notes OGRS score & various concerns in case record	Sep 2004	Failed to attend various appointments with DTTO team for drug tests
5 Oct 2004	Supervision transferred to another new supervising officer in public protection team	29 Sep 2004	Failed to attend for initial assessment at Munster Road Substance Misuse Service
7 Oct 2004	Concerns noted about attitude at Hestia hostel	21 Oct 2004	Review report for West London Magistrates' Court notes minimal compliance with Order
8 Nov 2004	Supervisor makes abortive visit to new address suggested by Hanson	1 Nov 2004	Started at Munster Road programme
11 Nov 2004	Hanson arrives at hostel 15 minutes late for 11pm curfew	5 Nov 2004	Appeared at Kingston Crown Court for drugs offences committed on 4 Feb 2004. Sentence deferred until 18 Mar 2005.
29 Nov 2004	Mr and Mrs Monckton attacked at their home. John Monckton murdered, Homeyra Monckton seriously wounded		
		29 and 30 Nov 2004	White telephones Munster Road Service to say that he is sick.
2 Dec 2004	Hanson telephones case manager to say that he has slipped disc and is attending hospital		
3 Dec 2004	Hanson leaves message that attending GP today	7 Dec 2004	Munster Road discharges White from programme for failure to attend
14 Dec 2004	Police meet with Probation staff at Probation Office	13 Dec 2004	Case record states that letter sent to White for breach of order
15 Dec 2004	Hanson arrested	14 Dec 2004	White's home searched by police
23 Dec 2004	Recalled to prison for breach of parole licence	17 Dec 2004	Elliot White charged with murder and attempted murder
8 June 2005	Damien Hanson charged with murder and attempted murder		

7 Findings relating to Elliot White's DTTO

7.1 The assessments and decisions leading to White's DTTO

- 7.1.1 Elliot White's first period of supervision by London Probation Area started on 15 July 2003. What happened during that 12 month Community Rehabilitation Order (CRO) provides an important backdrop to the Drug Treatment and Testing Order (DTTO) for 6 months made a year later on 26 August 2004. The Probation case file for the earlier CRO is poorly organised and difficult to understand at times but the contact sheet starts with an entry dated 7 August 2003 that states: "This file/order is a late allocation. It is not his fault that he has not been contacted until this date." Elliot White then failed to attend his first appointment on 11 August 2003, and this poor response continued subsequently despite warning letters. On 11 September 2003 the contact log records simply: "File passed to Admin to instigate breach proceedings".
- 7.1.2 The next entry on the contact sheet is not until 16 December 2003 and states that "Breach has not been properly processed at Marsham St." and notes that there is to be further discussion. A letter that refers to "an administrative error" in processing the earlier breach is then sent to Elliot White on 5 January 2004, who is urged to attend two appointments later that month. He kept the first of these but then the pattern of poor response was resumed and the case records again appear incomplete.
- 7.1.3 By the end of March 2004 a summons for breach of the CRO was applied for and White had indicated that he was likely to be charged with a further offence of possessing heroin with intent to supply. On 26 August 2004 West London Magistrates' Court imposed the DTTO for six months for breach of the CRO and the original offence. The Court did not have the advantage of a full Pre-sentence Report but did receive an expedited report. This noted that there was no history of violent behaviour and proposed a DTTO with the first appointment being made for the following day.
- 7.1.4 Before moving on to the way in which the DTTO was managed in the following months it is worth reflecting on the events in the year leading up to the making of that court order. The experience of an offender when he or she is first dealt with by the Probation Service is crucial. If the relevant Probation staff make the terms and conditions of the order crystal clear and go on to motivate the offender by outlining how compliance will benefit them, a good foundation has been laid on which to manage the Order subsequently. This is one of the reasons why National Standards are so insistent on prompt first contact and regular continuing contact especially in the early stages of an Order.
- 7.1.5 In this case a rather disorganised start to the supervision of his CRO was compounded with the administrative errors that led to a failure to take breach action appropriately. Nearly four months went by without contact between Elliot White and London Probation Area, and yet when contact was resumed there was no special meeting to explain what had

happened and to set the scene clearly for the second chance that he was in effect being given. It seems entirely reasonable to suppose therefore that Elliot White would have had a very weak understanding of the seriousness of community supervision and a low regard for the importance of complying with the Order at the time when the DTTO was made. The absence of a full Pre-sentence Report might well have exacerbated the situation, especially in the light of the lengthy periods with limited contact since the original court order had been passed.

- 7.1.6 The expedited report presented to the court on 26 August 2004 lacks any significant information about Elliot White's previous supervision, drug history and motivation. In addition no OASys or OGRS2 assessment was undertaken to inform the advice to the court. In short, the making of this DTTO was based on very inadequate information, bearing in mind the experience of LPA in working with him over the previous year. To add to this sorry state of affairs there is even some subsequent confusion between LPA staff about the nature of the order made by the court.

7.2 The management of Elliot White's DTTO

- 7.2.1 From the outset of the DTTO no proper supervision plan was drawn up and subsequently it is hard to see from the case records that the National Standards minimum requirements for contact have been either expected by staff or met by White. The contact log is certainly incomplete and it is unclear exactly what level of compliance is being achieved or even when the next appointment is due in several instances.
- 7.2.2 The administration of the drug testing requirement in White's DTTO is a further cause for concern. Although he attended for swab tests on several occasions the level of appointments demanded did not meet National Standards. Furthermore he failed to attend on at least six occasions, including his first assessment for the Munster Road Substance Misuse Service on 29 September 2004. Throughout this period it is there is little evidence that White was being actively managed by LPA. The first review report to West London Magistrates' Court was not available as it was apparently overwritten in error by the second report to that court on 21 October 2004. This report noted that: "Mr White has minimal compliance with his Order, he needs to start to regularly attend testing and attend Munster Road drug project or enforcement action will be taken." The next review was scheduled for 18 November but it was noted that White was expecting to be sentenced in the meantime for earlier drug offences.
- 7.2.3 On 5 November 2004 White appeared at Kingston Crown Court for offences of possessing heroin and crack cocaine with intent to supply on 4 February 2004. He pleaded guilty and on this occasion a Pre-sentence report was prepared. The Probation Officer report writer completed a fairly full OASys assessment in advance of the hearing. Elliot White was assessed as representing a medium *Risk of Harm* to the public in view of his drug dealing, but it was noted that he had no

record of violence. His OASys risk of reconviction score was 67 out of a maximum possible of 168.

- 7.2.4 This November 2004 Pre-sentence Report provides a clear account of the offences and of White's explanation for almost £3000 cash found in the glove compartment of his car. It states that his compliance with the DTTO had been minimal but notes that he had tested negative for heroin and crack since 9 September and was due to start at the Munster Road day programme. The report also notes Elliot White's lack of remorse and tendency to minimise the element of intent to supply in the offences. It goes on to acknowledge that "a custodial sentence is likely today" but argues that a concurrent DTTO would be most likely to address his drug related offending.
- 7.2.5 In the event on 5 November the Judge decided to defer the case for sentence until 18 March 2005. A note on the DTTO case file from the Probation court duty officer records the Judge's comments as follows: "People may think that I am doing the wrong thing, the facts of the matter were not wholly sorted out on the last occasion – I am going to defer sentence to the 18/03/2005. You have started making progress on the DTTO; any backsliding as far as the DTTO and you will not have cause for optimism. As I say already this does warrant a prison sentence – if you mess it up it will be a substantial prison sentence."
- 7.2.6 The Munster Road Substance Misuse Service is an independent centre that runs a daily programme for users. Many attend voluntarily but the centre also takes people who are subject to court orders. Elliot White started attending the programme on 1 November 2004. Representatives from the project explained that their programme covers various aspects of substance misuse such as the health dimension, relapse prevention, anger management, relaxation and sharing experience between those attending. They stressed that it is an abstinence-based programme, which means that people are expected to be clear of drugs before they start.
- 7.2.7 At the time White attended there were relatively few people on the programme, and by White's second week the staff had formed a clear view that he was not dependent on drugs. They described him as insecure and very committed to presenting himself as both smart and relatively successful. Unlike other people on the Munster Road programme White dressed in designer clothes and drove himself to the centre daily. Although there was no firm evidence available, the representatives of the project considered that White's presentation and lifestyle might well have led someone to see him more as a drug dealer than a user. They stated that they were in weekly contact with the Probation Service by telephone but there was no formal contract or agreement relating to White's attendance and progress. Furthermore they said that the written record of his attendance was not contemporaneous but produced later. A copy of the attendance report on the Probation case record was faxed on 15 December 2004.
- 7.2.8 The lack of adequate communication between the Probation case manager and Munster Road is very evident, and may well have

hampered the effectiveness of the day programme. For example, Elliot White's drug tests under the DTTO were carried out at a different location, and probation records appear to show that he tested positive for cannabis on 4, 8, 15 and 16 of November.

- 7.2.9 The Munster Road record sheet for Elliot White actually shows a reasonable level of attendance by him from the start of November until 29 November, although he missed three and a half out of twenty days. On that date, which was of course the day of the murder, he did not attend the programme but telephoned to say that he was sick. On 1 December the Probation contact log records that White had been to hospital for stitches to his arm and a letter dated that day was received from a GP. This stated simply: "This is to confirm that the above man was stabbed in his left hand and arm on Monday 29th November 2004 at 6pm. Unfortunately due to this he has been unable to attend the substance misuse programme this week". With hindsight the significance of that brief note is very disturbing, but even at the time it should have sounded loud alarm bells about White, his lifestyle and potential Risk of Harm.
- 7.2.10 White did not attend Munster Road again, nor did he respond to instructions to report to the Probation case manager. The Munster Road attendance sheet records that he was discharged from the programme on 7 December and the Probation record states that action to take him back to court for breach of the DTTO started on 13 December.
- 7.2.11 As indicated earlier, the written records in relation to White's supervision leave much to be desired. What they do show is a very poor level of case management, and inadequate liaison between the case manager, day programme provider and drug testing arrangement. This view is confirmed by the Senior Probation Officer who described the relatively chaotic administrative arrangements existing at that time. And it is also evident from the Serious Further Offence report prepared subsequently by an Assistant Chief Officer at LPA.
- 7.2.12 The Serious Further Offence (SFO) Review procedure is led by the National Probation Directorate and seeks to understand and learn lessons from cases where people under the supervision of the National Probation Service have committed serious further offences. In the case of Elliot White, the SFO report notes the inadequate record keeping and the failure to achieve the level of contact required under probation National Standards. It points out that there is only evidence of 11 drug tests taking place where there should have been at least 32, and this record coupled with White's failure to attend appointments with his case manager meant that "He should have been warned and breached early on in his order."

Accordingly we have made it part of our **Principal Finding 1** that London Probation Area failed to manage properly his compliance with the requirements of the Drug Treatment and Testing Order (DTTO).

8 Recommendations from review of Elliot White's DTTO

Our **Key Recommendation** here is:

The National Offender Management Service should be able to demonstrate that:

- Throughout each offender's sentence all reasonable action has been taken to keep to a minimum that offender's *Risk of Harm* to others.
- All sentenced offenders, whatever their level of *Risk of Harm*, should be required to comply with all the conditions of their Order or Licence, and where there is a failure enforcement action should be taken in accordance with the relevant National Standard.

This involves assigning responsibilities clearly at every level, so that each person involved in the supervision of offenders has clarity about their own responsibilities for decision-making and taking action to achieve the purposes of the sentence.

We provide a number of **Practice Recommendations** to support this. We present them for consideration in order to illustrate through specific aspects of practice the principle of staff being assigned clear responsibilities for decision-making and taking action to achieve the purposes of the sentence.

- 8.1 *An offender who is in breach of the requirements of a court order should be brought back to court promptly as required by the National Standards for the Probation Service. This not only makes for good quality offender management but also is vital for public confidence in the supervision of offenders in the community.*
- 8.2 *The importance of clear contemporaneous record keeping by all Probation staff should be emphasised as the bedrock for the responsible and accountable management of offenders.*
- 8.3 *Achieving early first contact with people under supervision is not only a requirement of National Standards but also it conveys the seriousness of supervision to the offender and sets the pattern for future contact and compliance.*
- 8.4 *Where an offender manager takes action for breach of an order by an offender, that officer should exercise clear lead responsibility for ensuring that the breach action is properly and promptly progressed until the matter comes to court.*
- 8.5 *Where contact is resumed with an offender who has been out of touch with the offender manager for more than a month for whatever reason there should be a special face-to-face interview to confirm the requirements of the order or licence.*

- 8.6 *Where an offender under the supervision of the Probation Service appears in court for breach of a previous order a full Pre-sentence Report based on a full current OASys assessment should be prepared by the offender manager wherever possible.*
- 8.7 *In all DTTO cases the offender manager should be responsible for maintaining an up-to-date record that collates all contact with the offender, including attendance on programmes and drug testing appointments and results.*
- 8.8 *Where an offender has demonstrated a poor level of compliance with a previous court order or licence a Pre-sentence Report should not propose a similar sentence unless there are special reasons stated in the report.*
- 8.9 *The offender manager should ensure that proper written information about the offender is made available to appropriately registered programme providers, and this should include copies of the Pre-sentence Report, OASys assessment and a copy of the court order or licence.*
- 8.10 *There should be clear protocols in place requiring effective two-way communication between offender managers and programme providers, including a minimum standard for joint case reviews.*
- 8.11 *Wherever possible the drug-testing element of a DTTO should be held where the programme is provided. Where this is not possible the results of drug tests should always be copied immediately to the programme provider whilst an offender is on the programme.*
- 8.12 *Unless there are exceptional and urgent reasons, a person under statutory supervision should never be discharged from a programme without a prior discussion between the programme provider and the offender manager.*

9 Findings relating to Damien Hanson's parole licence

9.1 *The assessments and decisions leading to Hanson's release on parole*

- 9.1.1 On 1 April 1998 Damien Hanson was sentenced at the Central Criminal Court to 12 years imprisonment for attempted murder. He was also convicted of conspiracy to rob for which he received 8 years concurrent. In view of his age at the time both these determinate sentences were passed under the Children and Young Person's Act. He had pleaded not guilty to both charges.
- 9.1.2 The offence in August 1997 was a premeditated and planned attack on someone who had stolen an expensive watch in a street robbery prior to the incident. Damien Hanson and his co-defendant Aston Tew confronted the man and Tew shot him three times. Hanson had a machete in his possession but claimed at the time that he did not know about the gun. The victim was seriously wounded and was left lying in the street. When passing sentence the Judge commented that the offenders had intended to kill and left their victim "near to death having found the watch and you did not give any thought to his survival".
- 9.1.3 The Judge went on to state that Damien Hanson's criminal record was not as serious as Tew's and he was satisfied that it was Tew who had pulled the trigger. He sentenced Tew to 15 years imprisonment and pointed out: "they will not be released until they have served at least two thirds of their sentence, so the Parole Board cannot recommend their release until they have served at least half of their sentence. Upon their release, that will not be the end of the matter, they will be supervised thereafter and if they commit any offence they will come back and have to complete the sentence that has already been passed."
- 9.1.4 Damien Hanson's criminal record may have been less extensive than his co-defendant's but it included theft, burglary, assault occasioning actual bodily harm, wounding and even an indecent assault on a woman when he was just twelve years of age. Now at seventeen he was facing a substantial prison sentence that would cover the important period when most young people mature into adulthood.
- 9.1.5 The Pre-sentence Report prepared for the court when Damien Hanson was sentenced suggested that he was starting from a relatively immature point. He had a poor school attendance record and had left school unable to read or write, although he had made progress with literacy during an earlier custodial sentence. The report mentioned that previously Hanson had seemed to have "a powerful aversion to any contact or close physical proximity with other people" and that although his mother had described him as respectful at home, the approval of his peers was of utmost importance to him. It was interesting to note that the offences occurred when his mother and sister were abroad, and the Probation Officer went on to say "My impression is of someone with fairly low self esteem and self confidence who is anxious to

conform in whatever setting he finds himself.” When commenting on Hanson’s likelihood of reoffending the report concluded: “As he is likely to meet more negative rather than positive influences during the course of his forthcoming sentence, it is difficult not to be pessimistic about his prospects of avoiding further offending”.

- 9.1.6 In the event the prison records on the early part of Damien Hanson’s sentence suggest that he found it difficult to conform to life inside. Between August 1998 and April 1999 he faced disciplinary proceedings on eight occasions, several of these hearings involving assaults on other prisoners and staff. He was moved between institutions a number of times, and his behaviour gradually settled down until he became a relatively compliant and respectful prisoner. By March 2003 a prison review report describes him as “a quiet individual who is polite to staff and causes no problems on the wing. Would benefit from getting some kind of employment”.
- 9.1.7 Damien Hanson’s parole eligibility date was 27 August 2003. This was the very earliest date that he could possibly have been released on licence. A panel of the Parole Board met on 23 July 2003 to consider his application. As is normal the panel had reports from HMP/YOI Highpoint and from a Probation Officer in the prisoner’s home area. At that time it was also regular practice for a member of the panel to interview the prisoner and report in writing, and there is little doubt that the independent member’s report was very significant on this occasion.
- 9.1.8 The prison assessment for the parole board dated 14 April 2003 noted that Hanson had been transferred to the category C prison at Highpoint in November of the previous year, having been moved six times previously between institutions. The report was generally positive, saying that Hanson regretted the offence and felt sorry for the victim. He had made use of the library and had gained NVQs and GCSEs in Maths, English and Business Studies. He had participated successfully in several prison courses, including victim awareness and drug awareness and “would try to find a hostel away from the area of the offence”.
- 9.1.9 The parole panel also had an assessment from the Probation Officer seconded to the prison. This echoed many of the positive comments in the prison assessment and noted that as far back as 2001, when he completed an Enhanced Thinking Skills Course, the course tutors had noted that Hanson had apparently gained from the experience. The seconded Probation Officer noted a considerable change in attitude from that displayed at the time of the court case and stated that Damien Hanson seemed to have developed some insight and a willingness to accept responsibility for his role in the offence. Although no formal risk assessment appears to have been undertaken, the report comments: “The acquisition of new skills and knowledge combined with attitudinal and behavioural change will I believe have contributed to an overall reduction of risk.”
- 9.1.10 Interestingly in the light of subsequent experience the same report goes on to state: “Mr Hanson does not wish to return to his home area

although it is likely that he will visit his family there”. It suggests that if a plan involving hostel accommodation can be put in place then early release might be appropriate but is very clear that “it is essential that he receives maximum close supervision on his release to help prevent a return to his old ways.”

- 9.1.11 The Parole Assessment Report (PAR) from the home Probation Officer dated 8 April 2003 reported that Damien Hanson had a different outlook on life and that “he feels he now has the ability to avoid peer group pressure”. He maintained that he did not know that Tew had a gun when they approached the victim, but said that he regretted the offence and had allowed himself to be led into it. So far as a release plan was concerned, Hanson had suggested that he might live with his grandmother in London W12, but in the light of the Probation Officer’s concerns Hanson had since written to a hostel “outside of the area”. Once more there was no formal risk assessment but the Probation Officer concluded that Damien Hanson’s maturation, experience in prison and “high levels of motivation” combined to suggest that the level of risk had reduced over the duration of the sentence.
- 9.1.12 The PAR states that Hanson’s offending was predominantly linked to peer group pressure, immaturity and an inability to look at the long-term consequences of his actions. It continues: “He is keen now to break from the influence of those he used to mix with.” The report supports release on parole, subject to Hanson securing appropriate hostel accommodation. It recommends additional conditions that he should not approach or communicate with his victim or the victim’s family and that he should not enter the London Borough of Hammersmith and Fulham without the prior permission of the supervising probation officer. An addendum to the report dated 16 May 2003 informs the panel that Damien Hanson has made an application to a Probation hostel in Basildon, Essex, which if available would be “the first option. If a placement is not available at Basildon on the date of his release, further Probation and Bail Hostel accommodation will be sought”.
- 9.1.13 Returning for a moment to the issue of formal risk assessment, there is in the London Probation Area case file a full assessment of *Risk of Harm* dated 25 April 2003, two weeks after the PAR was prepared. This rather surprisingly assesses him as being of intermediate risk of serious harm, despite the nature of his previous offending and an Offender Group Reconviction Scale score of 91%. There is no evidence that this information was made available to the parole panel, nor is there a copy of the assessment in the Parole Board’s dossier.
- 9.1.14 As indicated earlier, the report from the parole panel’s independent member appears to raise important questions about the optimistic assessments from the various professionals involved with Damien Hanson. This report is dated 8 May 2003 and includes a detailed review of the attempted murder and his previous convictions. In relation to Damien Hanson’s attitude the report states: “He does not accept that his offending was getting more serious, he said, “You can’t say ‘my

offending'. It's not me that has actually done anything on any of my offences.'" Although the report continues with a number of positive statements from Hanson it also raises questions about the extent of his victim awareness and points out that, despite reports to the contrary, Hanson had not undertaken an anger management course. He currently denied having an anger problem. It went on to point out the discrepancy between his expressed desire to "do architecture" and his intention to study economics, and generally questioned the reality of his plans.

- 9.1.15 On the day the panel met in July 2003 a written parole notification was produced informing Hanson that his application for early release had been rejected. The reasons given included Hanson's minimisation of his offences, lack of insight into the serious nature of his crimes and the consequences to victims, and the absence of an anger management course although that had been recommended previously. Whilst accepting that he had made some progress and that his behaviour was generally better it was considered that "his moral reasoning was lacking and further work is clearly necessary". Noting that the release plans had not been confirmed, the panel concludes: "Mr Hanson has optimistic plans for his future but in the past they have failed. The supervision plan offers little which could help secure Mr Hanson's rehabilitation or reduce his risk, particularly given the longer period in which he will be under supervision. Parole is therefore refused."
- 9.1.16 The rejection of Hanson's parole application in the summer of 2003 seems to have led directly to his attendance on a specific anger management programme at Highpoint in the following months. He attended all 24 sessions of the CALM programme, completing the course on 10 December of that year. A detailed report on Hanson's response to the programme noted his growing confidence as the course progressed and his development of relevant anger management skills and a personal relapse prevention plan. Of particular note was his level of motivation to practice social skills and "his ability to dispute his irrational thinking". He was seen as a respected member of the group and the tutors wished him every success in the future.
- 9.1.17 Hanson was next considered for early release by the Parole Board panel on 19 July 2004. On that occasion there were once again positive reports from the Prison and Probation staff at Highpoint. The prison assessment dated 23 March 2004 states: "Hanson appears to have no problem with authority now and conforms well to wing routines. He is polite, approachable and never afraid to approach staff with a problem." The report from the seconded Probation Officer in the same month noted that from the start of his sentence Hanson had worked hard to improve his basic literacy, numeracy and other life skills. The CALM programme was seen to have had a particularly beneficial effect and Hanson had reported that "it helped him to understand why he reacts to certain situations and how to control the feelings that led to him becoming angry and in some cases violent". It

should be noted however that whilst such anger management approaches may well have had some beneficial effects, for the most part Damien Hanson's past offending does not seem to have been about loss of control; rather it was characterised by the use of *instrumental violence* i.e. using violence in a calculated way to get something he wanted. This aspect of his behaviour and personality does not appear to have been given sufficient attention. The seconded Probation Officer again indicated that Hanson had shown "a marked change in attitude towards the offence and particularly in relation to his own part in it". Parole was recommended, subject to a suitable hostel placement being found.

- 9.1.18 The Parole Assessment Report from the home Probation Officer dated 7 May 2004 reiterates the positive comments about Damien Hanson's progress, motivation, victim awareness and eagerness to break from the influence of those he used to mix with. Yet remarkably the report was based largely on various reports from other people, while the reporting Probation Officer had not seen Hanson in person since April 2003. Again there was no formal risk assessment, nor did the report refer to the assessment dated 25 April 2003 or the OGRS score on that date. Parole was supported, subject to the same conditions recommended the previous year and the securing of appropriate hostel accommodation. It was noted that an application had been made to the hostel in Basildon.
- 9.1.19 A handwritten OASys assessment was completed by the home Probation Officer dated 14 May 2004 subsequent to the completion of the PAR. This included an OGRS score of 91% with a high probability of sexual or violent offending. Significantly on this occasion the OASys *Risk of Harm* analysis had been completed. This assessed Damien Hanson as presenting a high *Risk of Harm* to a known individual (we take this to mean the victim of his original offence) and indicated that as part of a risk management plan he should be referred to MAPPA.
- 9.1.20 The quality of the *Risk of Harm* assessment is questionable. There was little evidence to support the contention that Hanson presented a risk to a known individual. He had not at any time indicated that he still bore a grudge against his victim, although information from the Victims Unit of LPA showed that the victim was fearful of meeting Hanson on release. It was thought that a special condition in any parole licence excluding Damien Hanson from Hammersmith and Fulham would help reduce the victim's anxiety. Yet it seems clear that, far from representing a risk to a known individual, Hanson's previous offences suggested that he was capable of acting in a reckless or dangerous way to a range of people. In view of his record a more accurate assessment might have been to categorise him as presenting a high *Risk of Harm* to the public in general. In addition, the fact that he had been convicted of a sexual offence when he was a juvenile in 1993 does not seem to have been taken into account and was dismissed as a 'one-off.' However, in the light of the way events unfolded after this, this analysis of the OASys assessment in May 2004 may seem almost irrelevant. The assessment was not made available to the parole panel and certainly does not

appear to have been acted on subsequently by LPA. This latter failure included the important point that Hanson was not referred to MAPPA, as he quite clearly should have been.

- 9.1.21 When considering Damien Hanson's application on this second occasion the parole panel did not have the benefit of a report from an independent member. There was however a lengthy written personal statement from Hanson himself and representations from his solicitors. Both make note of his growth in maturity since he was sentenced and his positive response to his sentence, concern for the victim, and future plans. In his personal statement Hanson admits for the first time that he knew about the gun and expresses his determination to associate with "law abiding citizens". His statement and solicitor's representations generally make impressive reading but it has to be said that the section in which Hanson goes on to outline his plans for further education and employment suggest a high level of confusion and unreality.
- 9.1.22 In the event the Parole Board decided to grant early release on this occasion, and confirmed that the licence period would be from 27 August 2004 until 27 August 2006. When notifying its decision the panel outlined the detailed conditions of the licence, which included a requirement to reside as directed by the supervising officer, not to approach or communicate with the victim or his family, to comply with any requirements reasonably imposed by his supervisor and not to enter the London Borough of Hammersmith and Fulham.
- 9.1.23 The reasons given in support of the positive parole decision were based on Hanson's good behaviour in custody, the successful completion of the various courses, his acceptance of responsibility for the offence, his genuine victim empathy, the absence of substance misuse and his mature response to the previous refusal. The formal parole notification also highlighted the issue of accommodation and what now emerges as the geographical dimension in Hanson's release. It stated firmly: "All report writers identify that, having been in prison from the age of sixteen to twenty four, Mr Hanson will require strong support on release and a hostel placement is essential to achieve this. The panel agreed and noted that his release plan is based upon hostel accommodation in Essex (away from his home area) but that this is still to be confirmed. Release will be strictly conditional upon such a place being available."
- 9.1.24 It should be noted that Hanson was released from a closed category C prison where he had been held owing to his security classification. This meant he was never tested in the open conditions of a category D prison prior to release, which is the experience of many long-term prisoners and which is generally regarded as good practice.
- 9.1.25 The exclusion zone in Hanson's parole licence and the issues of where he would live and where he would report to the Probation service, together make up the geographical dimension in his supervision. As we shall see there are many aspects relating to this geographical dimension that give rise to substantial concern. The first indicator of future problems occurred when on 22 July 2004 a representative of the

Basildon Probation and Bail Hostel telephoned the LPA to say that Hanson's application for accommodation with them had been refused.

- 9.1.26 As a result of the change of release plan the home Probation Officer referred the case to the central allocations unit of LPA. This unit dealt with hostel placements within London. A placement was found in a voluntary Approved Premise – a hostel run by the Hestia organisation in Battersea. This was despite the original release plan being contingent on a hostel placement away from Hanson's home area and the expressed emphasis on this issue from the Parole Board. We return to this point further below.
- 9.1.27 It may be useful to pause here to review first the decision to release 'in principle'. We note that the national Parole Board has a special arrangement for reviewing cases where prisoners are recalled due to an allegation that they have committed a specified sexual or violent offence. This Review Committee was established in January 2004 and seeks to "maintain and quality assure the general high standard of the Board's decision making processes". The committee issues newsletters that highlight lessons learnt and suggest good practice in parole decision-making. Amongst the guidance provided by the parole review committee in the last two years are several points that are very relevant to a case such as that of Damien Hanson.
- 9.1.28 These points include the note that "*static* factors are not always given sufficient due weight in relation to *dynamic* risk factors". In a newsletter last year the committee explains in clear terms exactly what it means by this comment: "The majority of a dossier is concerned with *dynamic* risk factors e.g. change of a prisoner's attitude to their offending behaviour as evidenced by completion of a relevant course. However, at all times, panels should weigh this against the *static* risk factors evident in an offender's previous convictions and details of the index offence. The Committee have tentatively come to the view that upon reviewing the recall cases before it, Members are not giving sufficient weight to the *static* risk factors before balancing them with the *dynamic* risk factors."
- 9.1.29 Another important and highly relevant area covered by the parole review committee is the distinction between instrumental and expressive violence. *Instrumental violence* is where violence is used as a means of achieving an objective, such as a robbery. Expressive violence involves the use of violence towards another person in order to reduce the offender's negative emotional state, such as a spontaneous pub brawl. The review committee points out that criminal culture and peer group influences can result in instrumental violence continuing to be rewarded despite apparent attitude changes on the part of the offender. Once again its conclusion is neatly summarised: "Prisoners who use *instrumental violence* are more difficult to assess regarding reduction of risk, even with successful interventions such as offending behaviour programmes."
- 9.1.30 When the review committee examined the decision process relating to Damien Hanson it concluded that in general terms the decision to

release Hanson was defensible given the information available to the panel in 2004. It did however point to several issues that might have been considered more fully, and in a meeting with representatives of the Parole Board in connection with this independent review these issues were discussed and added to.

- 9.1.31 The key points to emerge in relation to the decision to release Hanson on parole relate to the balance between dynamic and static risk factors already mentioned and the absence of a full assessment of *Risk of Harm*. Also of concern was the fact that geography and peer group pressure were identified as important yet his early release went ahead despite the late move to a hostel in London. So far as the information actually available to the panel was concerned, it was noted that the practice of a prisoner interview with a panel member has now ceased, despite its obvious value in Hanson's case in 2003.
- 9.1.32 In addition, and despite an understandable and appropriate caution on the part of parole panels in the weight given to prisoners' personal statements, this case highlighted their potential value. It was noted that Hanson's long personal statement, if scrutinised closely, might have raised more concern about his state of mind and the reality of his plans for the future. These are all matters to which we allude in our recommendations.
- 9.1.33 Overall, we concur with the view that on balance the Parole Board's decision to release at this stage was in principle a defensible one, despite some significant contra-indications. But this required an excellent release plan to be devised and implemented in practice, and it is very evident from events subsequent to the parole decision that this most certainly did not happen.
- 9.1.34 When the application to the hostel in Essex fell through we agree that it was reasonable to seek a suitable alternative release plan. But we have no clear evidence as to why this did not lead to a properly assessed alternative release plan that was fit for purpose. Instead there was in effect an assumption by those involved that release was to go ahead provided an address was found. The licence was issued direct from HMP Highpoint, with the hostel address in Battersea and the exclusion zone requirement included.

Accordingly, our **Principal Finding 3** concerns the lack of clarity about the responsibility for reviewing parole release decisions when there has been a major change in circumstances. The Parole Board will need to clarify how it wishes to deal with these situations, as we advocate in our **Key Recommendation 3**

9.2 *The management of Hanson's parole licence*

- 9.2.1 We begin our review of this period by reflecting for a moment on the arrangements for managing Damien Hanson, and other cases like him, through his sentence. He had a home Probation Officer who was a member of a Community Assessment Team and who was responsible for producing parole assessment reports as and when they were needed. But this was not the same as being given clear *lead responsibility* for managing the case during this period – indeed the officer would know that on release the case would be transferred to one of the two community supervision teams. We note that this is a markedly different arrangement from the planned future world of Offender Management, and indeed is different from the arrangements in various parts of the country for what was in the past called 'throughcare'. We find it very significant that there was a *discontinuity* actually built-in to the arrangements for managing Damien Hanson, making it very difficult to achieve proper management of the case just at a particularly critical point in his 12-year sentence. We are also very critical of the fact that the individuals who found themselves having to deal with this case under these unsatisfactory organisational arrangements did not show greater initiative in making decisions and taking action to ensure that the case was better managed despite these difficulties.
- 9.2.2 We have already reviewed the pre-release developments from when the original hostel placement fell through. The home Probation Officer referred the case for a hostel placement to be found in London, and we have had no satisfactory explanation as to why a place was not sought in another part of the country. However, there was a good liaison with LPA's victims' unit, and although we have our doubts about the wisdom of the precise nature of the exclusion zone this was a good demonstration of taking into account the victim perspective – that is, the perspective of the victim of Damien Hanson's original offence. However, having made that provision, it was utterly extraordinary to require Hanson to report to a Probation Office that was inside that exclusion zone. We have no evidence that the Probation Officer who arranged this release plan thought through what message this was giving to this 23-year-old man who was emerging from over six years in prison, and what the officer's own responsibility might be in terms of either improving the release plan or checking that the Parole Board were content with the new arrangements. That Probation Officer's assigned role in this case was indeed limited and unclear, but we think that the officer could and should have shown much more initiative.
- 9.2.3 As that officer had arranged, on 27 August 2004 Hanson was released from prison under the terms of his parole licence and reported to the Probation Office as directed. In a most unfortunate new development the Battersea hostel could not accommodate him on the day of his release so he was placed in an alternative Hestia hostel, in Streatham. This hostel was approved by LPA but run by an independent management committee. No explanation for this late change was

recorded, although as the Streatham hostel was closely linked to the Battersea hostel it does not appear to have been especially significant. The licence conditions were explained to Hanson, including the exclusion zone requirement that stated: "Do not enter London Borough of Hammersmith & Fulham as delineated on the map supplied by your supervising officer without the prior approval of supervising officer". As we have already indicated, the fact that the office to which Hanson was required to report was actually located within the exclusion zone area remains a most glaring deficiency in the management of his parole.

- 9.2.4 The victim unit of LPA had proposed the exclusion zone condition. A member of staff had interviewed the victim's family and had decided in the light of this that the family was anxious not to come into contact with Hanson when he was released. The parole assessment report took this recommendation seriously. This was right in principle, but in terms of its specific details in practice the feasibility and appropriateness of the exclusion may be open to question. The breadth of the exclusion area was considerable and therefore difficult to enforce, Hanson was required to report to the Probation Office within the borough from which he was excluded, and he still had family and friends in the area. A more limited exclusion area keeping Hanson away from the immediate area where the victim and his family lived might have been more effective, although we recognise that there would be other potential issues with that option. Following the murder of John Monckton and attempted murder of his wife, police investigations indicated that Hanson regularly visited the borough from which he was excluded by virtue of his parole licence.
- 9.2.5 It has to be the opposite of good Offender Management – hence we call it offender mismanagement – to convey, in effect, the following messages to this man of 23, returning from closed conditions to the community for the first time in over six years:
- *Your release on parole was conditional on you going to a hostel in Essex, and failing that anywhere away from London, but we have arranged for you to go to London on release after all*
 - *We had arranged that your new home on release was going to be in a hostel in Battersea, but today – your day of release – we are sending you to a hostel in Streatham instead*
 - *You will live in London, but are excluded from entering the entire London Borough of Hammersmith & Fulham, where many of your friends and family live, but you must nevertheless enter that borough in order to keep your statutory appointments with your Probation Officer*
 - *We can't tell you who your new Probation Officer will be yet, but we'll tell you as soon as we can*
 - *But you must follow our instructions to adhere strictly to the conditions of this licence, and it is a serious matter if you do not do as we require of you*
- 9.2.6 We cannot see that this would have inspired the respect, credibility and confidence that one would be seeking from this difficult offender.

- 9.2.7 On Damien Hanson's release from prison there were delays in transferring the case from the former home Probation Officer (the officer in the Community Assessment Team) to one of the two community supervision teams - either the Community Intervention Team or the Public Protection Team. As author of the parole assessment report, that officer was required to complete an initial supervision plan prior to the formal transfer of the case. This plan should have linked right back to the OASys assessment that had been completed in May 2004, whilst Hanson was still in custody, and which had placed him in the high *Risk of Harm* category and therefore subject to MAPPA. In reality the initial supervision plan was very rudimentary. It lacked detail and was not based on an updated OASys assessment, as it should have been. Consequently the case was allocated to the wrong team, the Community Intervention Team.
- 9.2.8 Damien Hanson's case record contains both a handwritten supervision plan and the following entry both dated 7 September 2004: 'File placed in [SPO's] pigeon hole.' This was eleven calendar days after release. It appears that it was accepted practice to wait until the licensee was newly released, then do the supervision plan, and then arrange for transfer of the case. We have already criticised the built-in *discontinuity* in the management of licence cases between pre-release and post-release – and we are especially critical of a practice that means that such a change of *lead responsibility* for a case is designed to take place during the first month of the licence.
- 9.2.9 In addition there was no referral to MAPPA as there should have been, and no risk management plan. A duty Probation Officer saw Damien Hanson on 16 September 2004 but this officer had no access to the case file. Eventually Hanson was directed to report to his newly allocated supervising officer in the Community Intervention Team on 22 September 2004. On reviewing the case this officer considered quite correctly that based on the available information, primarily the index offence, the case should be dealt with by the Public Protection Team. Significantly the officer noted and recorded that there was neither a detailed OASys on the file nor a *Risk of Harm* assessment. Why this was the case is unclear. Our investigation suggests that the most plausible explanation was that the handwritten OASys document became detached from the file when information was sent to the central hostels allocation unit.
- 9.2.10 The file on Damien Hanson was passed on to the Senior Probation Officer responsible for the Public Protection Team on 23 September for allocation to a new supervising officer. (In fact at this time the same SPO was managing both the community supervision teams.) There was a further delay in this allocation. The new supervising officer picked up the case on 5 October 2004 according to the contact log. In the meantime we note that Damien Hanson, rather to his credit, had telephoned the office to express his concern and to enquire about the progress of allocation. There is no explanation in the case record for the delay in allocation. When interviewed for this review the Senior Probation Officer described the difficulties in covering both the two

teams at that time. Furthermore staff shortages had led to a large number of cases needing to be allocated. By the SPO's account, Hanson's case was allocated on 30 September 2004.

- 9.2.11 In our view the supervision plan was of poor quality, as is the ensuing contact log. The evidence from the case records leaves it very unclear whether the National Standards minimum requirements for contact have been either expected by staff or met by Hanson. Although we found evidence of a total of nine appointments kept in the three-month period, the contact log is incomplete and it is unclear exactly what level of compliance was being achieved and sometimes when the next appointment was due.
- 9.2.12 There was telephone contact with Hanson and some liaison with the hostel but we note that the appointment made for 18 October 2004 was 18 working days after his previous appointment and certainly did not accord with the minimum requirements of National Standards.
- 9.2.13 Hostel staff subsequently expressed their concerns by telephone about Hanson's rent arrears but for the most part they saw him as someone who kept a low profile. A three-way meeting was planned between Hanson, the supervising officer and hostel staff to agree a way forward over the rent arrears. But when arrangements were made for payment of his rent the planned meeting was cancelled without further ado. This was clearly a missed opportunity to have established clear roles, responsibilities and expectations between all concerned, and a meeting might have gone some way to overcome the dreadfully confused and faltering start to Hanson's parole supervision. Instead there remained a lack of clear planning about the purpose and boundaries of Hanson's stay in the hostel as a direct result of this lack of formal liaison. This situation is all the more remarkable in the face of an initial supervision plan that lacked detail and was not fit for purpose, and the 'normal expectation' by the hostel that a three-way meeting should be held in order to set out the ground rules clearly to all concerned.
- 9.2.14 Within a week of release from prison Hanson made it clear that he wished to move out of the hostel. On occasions he was allowed leave of absence to stay at other addresses by the supervising officer. How these decisions were made by the supervising officer and the hostel was inadequately recorded. The fact that the hostel and Probation recording systems were not linked and therefore not accessible by the relevant groups of staff exacerbated this situation. Whilst it is not unreasonable for a released prisoner to consider a move from hostel accommodation at some stage, in this situation the supervising officer was unsuccessful in impressing upon Damien Hanson the need to manage the process properly. It was clearly important that any move was carefully planned and should not lead to an increase in the *Risk of Harm* he presented. In the event Hanson set the agenda by supplying a number of addresses of friends or relatives. On one occasion the supervising officer visited a proposed address given by Hanson but failed to gain access.

- 9.2.15 The supervising officer was also rightly concerned about the fact that Damien Hanson was reporting to an office within his licence exclusion zone and was travelling across the borough from the hostel to reach the Probation Office. Consideration was apparently given to transferring the case to another office but because of the constant flow of possible new addresses from Hanson this was not followed through. The option of seeing him at the hostel each time does not appear to have been considered. Overall, it was a further disappointment for us to find that even the allocation of a supervising officer from the Public Protection Team had not led to this case being effectively managed.
- 9.2.16 The level of compliance by Damien Hanson with the hostel rules began to deteriorate and he broke the conditions of curfew on more than one occasion. There is no evidence on the record that the supervising officer took up these infringements with Hanson. Enquiries made with the Metropolitan Police in Hammersmith and Fulham revealed that in October 2004 the Probation supervising officer informed them that Hanson was not paying his rent and that this might lead to recall. Police records state that the following information was given: "Damien Hanson was at the time of his release considered a category 2 MAPPAs subject being managed at level 1 by the Probation Service." However, this exchange of information was not recorded in the Probation case file. It also indicates a level of confusion, as there is no evidence from the probation records that any decisions at all about MAPPAs had been taken earlier. The supervising officer took the view that this was normal practice in the borough; in other words that it was usual to have an informal exchange of information focusing primarily on offenders who posed an imminent *Risk of Harm*. The Senior Probation Officer on the other hand described the failure to refer formally to MAPPAs as an "oversight". The police also pointed out that even if Hanson had been referred to MAPPAs it would have been in the Lambeth area where he lived, not in Hammersmith and Fulham where the Probation Office was located.
- 9.2.17 On 2 December 2004, shortly after Elliot White had reported his absence due to injury, Damien Hanson telephoned his supervising officer to say that he could not report as requested as he had to attend hospital for treatment to a slipped disc. Hanson later brought in evidence of this from his GP. Significantly Hanson also asked for permission to be absent from the hostel on Sunday 5 December. This request was granted without reference to the hostel staff or any indication as to where he would be going. On 9 December 2004 hostel staff informed the supervising officer that Hanson had been absent for two nights instead of the one agreed and that his attitude and behaviour were poor. For this he received a final warning from the hostel. It is worth noting here that while he was a resident at this hostel he was subject to a regime whereby his room was regularly checked by staff for drugs, weapons and pornography. Contrary to some Press reports, there are no grounds for believing that any untoward material was in evidence in his room during this period, and even the papers found by the Police after his arrest were of a very marginal nature.

Hence we are critical of the way the supervising officer liaised with the hostel while managing this case, but we have no evidence of any significant deficiencies in the work done by the staff of the Hestia-run Approved Premises.

- 9.2.18 On 15 December 2004 Hanson was arrested and subsequently recalled to prison for breach of his licence. The Serious Further Offence review completed by LPA concluded that Hanson's *Risk of Harm* status had been incorrectly assessed at the time of his release, leading him to be placed inappropriately with the Community Intervention Team. The review also pointed out that while he was living at the Hestia hostel in Streatham the case was not transferred to Lambeth borough because of the uncertainty of when he would be allowed to move out of the hostel into an alternative address. Damien Hanson produced a number of alternative addresses, but it was only on one occasion that he was confronted with the fact that he would not be allowed to leave the hostel in the immediate future.
- 9.2.19 Finally in this section we seek to review the assessment and management of Damien Hanson's *Risk of Harm* to others, and whether all reasonable action was taken to keep his *RoH* to a minimum. The evidence is very weak. We have criticised the OASys assessment of *RoH* where one had been made, as it did not reflect an offender who had demonstrated serious offending behaviour as a teenager and who employed *instrumental violence* to get what he wanted. Nevertheless this assessment should still have led to a referral to MAPPA – but this did not happen. (We cannot criticise MAPPA, as they received no referral.)
- 9.2.20 There were self-contradictory licence conditions, and periods early after release when no one was exercising *lead responsibility* for managing the case. When an allocated supervising officer took charge of the case there is still little evidence of seeking to identify the nature of Damien Hanson's risks to others – the officer actually cancelled an appointment to visit the hostel which if kept would have provided an opportunity to review these matters with hostel staff.
- 9.2.21 We keenly appreciate the very challenging demands made on staff trying to manage some very difficult cases in an inner-city setting, in addition to the difficulties of working within some rather unsatisfactory organisational arrangements as we have already reviewed. But what we have found here are some qualified officers showing an apparent poor awareness of the *Risk of Harm* dimension of this case, together with an evident lack of initiative and determination to ensure that this aspect (and all the other aspects) of Damien Hanson's supervision were managed properly. Hence our use of the term 'collective failure'.

Accordingly we have made it part of our **Principal Finding 1** that there was an overall collective failure within London Probation Area, both to identify the nature of his risk to others and to act to keep his *Risk of Harm* to a minimum.

10 Recommendations from review of Damien Hanson's parole licence

Our **Key Recommendation** here is:

The National Offender Management Service should be able to demonstrate that:

- Throughout each offender's sentence all reasonable action has been taken to keep to a minimum that offender's *Risk of Harm* to others.
- All sentenced offenders, whatever their level of *Risk of Harm*, should be required to comply with all the conditions of their Order or Licence, and where there is a failure enforcement action should be taken in accordance with the relevant National Standard.

This involves assigning responsibilities clearly at every level, so that each person involved in the supervision of offenders has clarity about their own responsibilities for decision-making and taking action to achieve the purposes of the sentence.

We provide a number of **Practice Recommendations** to support this. We present them for consideration in order to illustrate through specific aspects of practice the principle of staff being assigned clear responsibilities for decision-making and taking action to achieve the purposes of the sentence.

- 10.1 *Contact with a prisoner before release should focus on issues of Risk of Harm as well as resettlement. Wherever possible there should be continuity of contact with one offender manager (i.e. it is not helpful to design in discontinuities).*
- 10.2 *The Probation Service should ensure that a full OASys assessment is completed and that the findings are always made available to the parole panel considering an application for early release on licence.*
- 10.3 *The Parole Board should review its current policy on the question of a member interviewing the offender and reporting independently to parole panels when considering high-risk cases.*
- 10.4 *Parole panels and probation staff should be reminded of the importance of static factors in the assessment of risk, and the particular difficulty of assessing offenders where their previous offences involve instrumental violence.*
- 10.5 *Whenever possible prisoners serving sentences for instrumental violence should be tested in open prison conditions prior to release on parole.*
- 10.6 *If scrutinised carefully a prisoner's personal statement to a parole panel may on occasions provide a unique source of important evidence about the prisoner's state of mind and the reality of any future plans.*

- 10.7 *Where an exclusion zone is included as a condition of a parole licence it should be framed as narrowly and specifically as possible both to achieve its specific purpose and to enable feasible enforcement.*
- 10.8 *The Probation Service should ensure that an offender is not required to report to a Probation Office or other facility within an exclusion zone unless there are quite exceptional circumstances that are agreed and recorded in advance by a senior manager.*
- 10.9 *The Parole Board should specify clearly how it wishes to deal with situations where the decision to grant early release is seen as particularly dependent on some specific requirement such as accommodation or location, and where the situation changes between the date of the decision and the prisoner's release date.
[Also listed as **Key Recommendation 3**]*
- 10.10 *When imposing a geographical exclusion as a licence condition proper attention should be paid to its feasibility, purpose and the impact on victim(s).*
- 10.11 *The Probation Service should ensure that the relevant prison is informed immediately if it appears that a specific requirement of a parole licence is not likely to be met.*
- 10.12 *Where release under licence from prison is contingent on an offender going to a particular address or area and this subsequently changes a further assessment of Risk of Harm should be undertaken before release is confirmed.*
- 10.13 *In the case of parolees there should be a clear expectation about the purpose and length of residence in an approved premise.*
- 10.14 *Consideration should be given by the Parole Board and the National Offender Management Service to a multi-disciplinary review procedure for high profile cases involving serious further offences by parolees.*
- 10.15 *The importance of clear contemporaneous record keeping by all Probation staff should be emphasised as the bedrock for the responsible and accountable management of offenders.*
- 10.16 *There should be clear protocols in place requiring effective two-way communication between Probation offender managers and accommodation providers, including a minimum standard for joint case reviews.*
- 10.17 *There should be clear and unambiguous guidance in every Probation Area for the referral of cases to MAPPA.*
- 10.18 *The quality of OASys assessments of likelihood of reoffending and Risk of Harm should be an offender management priority.*
- 10.19 *There should be minimum standards for internal transfers of cases within offices, including standards relating to timeliness, to ensure continuity of lead responsibility for managing the case..*

11 Management and organisational issues

There are a number of management and organisational issues that have emerged from this independent review. The following section of the report explores these issues. As part of our review we had a number of meetings with the staff and senior managers of the London Probation Area. We were shown a considerable amount of impressive evidence that indicated that a great deal of work has been undertaken within LPA during the last year to learn the lessons from these cases and improve current and future performance. While we are grateful for the openness we experienced and the co-operation we received, it is outside the scope of this review to assess at this stage what these developments have achieved, or the quality of the work being undertaken by LPA today. However we are next undertaking an inspection in London in July 2006.

11.1 Organisational Structure

11.1.1 When examining the case of Damien Hanson it appears that the structuring of staff into Assessment, Interventions and Public Protection teams meant that there were significant *discontinuities* in the supervision of the case. At a crucial point in the parole process, the time of release, the case was transferred from the assessment team to the interventions team. The fact that Hanson was wrongly assigned to this team only served to compound the problem. The system had been introduced in 2003 in an effort to ensure that cases assessed as presenting a high *Risk of Harm* in particular were allocated extra resources through the public protection teams. In the case of Damien Hanson this structure contributed to a situation where no one felt especially responsible for him or had detailed knowledge of his antecedents, behaviour and attitude.

11.1.2 With the advent of the National Offender Management Service (NOMS), Probation Areas including London have been required to rethink organisational structure in order to distinguish more clearly between offender management (i.e. the assessment, planning, sequencing of interventions and the enforcement of supervision), and the delivery of interventions. LPA was required to draw up plans and implement these new arrangements. The intention of NOMS is to reduce the discontinuities in supervision that characterised the management of Hanson and to lessen the demarcation between the custodial and community elements of a prison sentence.

11.2 Staff supervision and support

11.2.1 In the case of Elliot White it is clear that the Probation Service Officer managing the case was inexperienced and required support. An internal inquiry by LPA into the circumstances of the case concluded that the level of staff supervision provided by the Senior Probation Officer was inadequate. That Senior Probation Officer was interviewed for this review. Whilst he agreed that not all his planned staff supervision sessions had taken place owing to pressure of work, he

considered that the level of oversight was reasonable. What is clear was that the DTTO team was working without the benefit of effective administrative and information systems. In view of this it is difficult to see how the Senior Probation Officer could have discharged the supervisory responsibilities properly, regardless of how many supervision sessions had taken place. Access to information about key areas of practice such as contact levels with the offender and the enforcement of the court order would have been central to effective staff supervision and this information was simply not available.

- 11.2.2 Turning to the case of Damien Hanson the level of oversight provided by the Senior Probation Officer should have been better in view of the clearly recorded *Risk of Harm* posed by the offender. It should be borne in mind however that the manager was relatively inexperienced and was covering two posts at the time. In addition there were reports of a generally dysfunctional management group in the borough, together with high sickness rates. The LPA Interim Risk of Harm Strategy January 2004 – January 2005 replaced previous policies and procedures and made it clear that public protection was a priority for all staff. This strategy stated that particular attention should be paid to the management of high *Risk of Harm* cases, and required the Senior Probation Officer to actively monitor the frequency of contact in such cases. The Senior Probation Officer should also have been more proactive in directing the case manager and endorsing the case record to demonstrate accountability for the decisions made.

11.3 Geography

- 11.3.1 The impact of geography on these cases is significant on a number of levels. In the case of Elliot White the complicated arrangements for the provision of treatment services across three different London boroughs covered by the drug treatment and testing team meant that the provision of treatment was dependent on the varied priorities of different health authorities. This led to difficulties in referring offenders to the providers of treatment in the community (in this case Munster Road) as access had to be negotiated via the health authority.
- 11.3.2 In the case of Damien Hanson the question of geography is more complex. The first issue that arose was the parole decision to grant release on licence subject to a place being available at a hostel in Essex. The refusal of the hostel to take Hanson led to his being accommodated in London. Whilst there are questions about the legality of failing to release a prisoner on a date named by a parole panel, the demands of effective public protection suggest that in such circumstances release into the community should be held up until a satisfactory release plan is firmly established, bearing in mind that release was stated to be conditional on a specific release plan.
- 11.3.3 The second key issue was the exclusion condition in Hanson's parole licence. With the benefit of hindsight it is possible to view this condition as unrealistic and unworkable. It also led to the entirely unacceptable situation of Hanson reporting to the Probation Office in an area from

which he was excluded. In addition, the fact that the hostel was not in the same borough as the Probation Office hindered effective liaison. It also meant that even if the required referral to MAPPA had been made, the impact of any joint agency work would have been compromised because of the cross borough issue. We understand that LPA has subsequently issued an instruction that in future all such cases should be supervised by a member of staff in the borough where the offender lives. This should significantly improve hostel liaison and make referrals to MAPPA and the multi agency oversight of high *Risk of Harm* cases more effective.

11.4 Resettlement policy

- 11.4.1 For some time in LPA (as in many other Probation Areas) the priority given to contact with prisoners had gradually decreased when compared with contact with offenders in the community. This was generally a result of resource allocation, and additionally in London the difficulties in recruiting and retaining sufficient numbers of qualified staff needed to carry out the full range of statutory responsibilities. At the start of 2004 budget problems in LPA had led to firm restrictions on visiting prisoners outside of the London area, although by August 2004 these restrictions had been relaxed to a limited degree for prisoners assessed as presenting a high or very high *Risk of Harm*.
- 11.4.2 The result of this LPA policy at the time when Hanson was being considered for parole was that for most prisoners contact with the Probation Area was minimal whilst they were in prison. In most cases the only time that prisoners came to the attention of Probation Officers was when specific reports on them were required or immediately prior to their release. Administrative staff managed systems that kept a track of these prisoners and the progress of reports with little input from qualified Probation Officers.
- 11.4.3 Damien Hanson was managed in such a manner. For much of his time in prison contact with LPA was sporadic. The only engagement with Probation Officers occurred at the points where a report was required to inform release decisions. This approach did little to establish a sense of ownership of the case within LPA. Even more importantly, it led to the situation where there was no regular assessment and review of *Risk of Harm* and likelihood of reoffending. Had this happened the parole decision would have been better informed, Hanson would have been allocated to the public protection team, and the required referral to MAPPA would almost certainly have been made.

11.5 Assessment and management of Risk of Harm

- 11.5.1 At the heart of this independent review into the management of Hanson and White lies the issue of effective *Risk of Harm* assessment and management. It is clear in both cases that LPA policy was not followed properly.
- 11.5.2 In contrast to a number of other Probation Areas LPA experienced considerable difficulties in implementing OASys, in part due to the

problem of inheriting several outdated electronic case management systems from its predecessor Probation Services. It had secured an agreement from the NPD to postpone full implementation until April 2005, from which date it was able to operate one system across the whole of the Area. In the meantime LPA operated OASys on the basis of an interim implementation that did cover both these cases. This was important, because if operated effectively OASys provides a clear framework not only for the regular assessment of likelihood of reoffending but also crucially for the assessment of *Risk of Harm*. It also identifies the specific issues and actions that flow from these assessments in each case.

- 11.5.3 Hence OASys was re-launched in LPA from 26 July 2004 and required an OASys to be completed on supervision cases made via an expedited court report. Elliot White was such a case but despite this requirement no OASys assessment was made on him. For resettlement cases (in other words those released from prison) an OASys was to be completed at the point of release if it had not already been done. In the case of Hanson an OASys assessment was completed in May 2004 but it was not updated on his release. In any case the actual document was not available to the parole panel and was apparently not in the case file at the crucial point of release and allocation.
- 11.5.4 The absence of good quality OASys assessment and supervision plans was a result of LPA's inability to implement the OASys arrangements consistently in all locations. Any future assessment of LPA's ability to deliver effective *Risk of Harm* assessment and management will depend on its ability to demonstrate that the arrangements for delivering OASys are robust.
- 11.5.5 There was also a lack of clarity within LPA as to whether Hanson should have been referred to MAPPA. As far as this review is concerned we consider that the national guidelines are clear and that such an offender should always be referred. However this clarity was lacking amongst LPA staff at the time of Hanson's release. We have been informed that the matter has since been taken up with the London MAPPA Strategic Management Board in order to confirm the policy and avoid any future misunderstandings.

11.6 Administrative arrangements

- 11.6.1 The arrangements for the administration of the cases of both Hanson and White left much to be desired. This was particularly relevant in the case of Elliot White's DTTO. The lack of systems to record contacts, drugs tests and treatment severely impaired their capacity to manage the case properly. We were informed that on some days 70 offenders could report to the office but without a receptionist much information simply never got through to the case manager. Some attempts had apparently been made to secure funding from health service resources for additional clerical and administrative support but this was not forthcoming.

- 11.6.2 The Ministerial priority that had been set for 2004 was to increase the number of offenders starting DTTOs, and the Senior Probation Officer spent much time and energy seeking referrals from courts. Whilst this was laudable the strategy was not balanced by the need to develop an infrastructure that could cope with the rise in the volume of referrals.
- 11.6.3 Against this background it is clear that the DTTO on Elliot White was not enforced as it should have been. Whilst there is evidence to suggest that the case manager did not keep records up to date, the major deficiency lay in the chaotic administrative arrangements that surrounded the DTTO team at the time in question.

11.7 Liaison with the providers of services

- 11.7.1 In both the cases under review the case manager was required to manage and liaise with the providers of services. These were the Hestia hostel in the case of Damien Hanson and the Munster Road substance misuse service in the case of Elliot White. In both cases the liaison was inadequate and the quality of supervision was adversely affected.
- 11.7.2 It is very apparent that in 2004 there were inadequate procedures in place detailing the expectations of LPA and the providers of services in these cases. This led to significant deficiencies in the management of both men, a situation that was compounded by the lack of common information systems that both LPA and the service providers could access.

We found the lack of clarity and continuity of *lead responsibility* for managing these cases to be of such significance that we made it the subject of our **Principal Finding 2**.

12 Recommendations from review of management and organisational issues

Our **Key Recommendation** here is that from start to end of an offender's sentence, managers should apply the principles of continuity and clarity of *lead responsibility* throughout, especially with those offenders assessed as *high Risk of Harm*

We provide a number of **Practice Recommendations** to support this. We put them forward in order to illustrate in specific aspects of practice the principle of staff being assigned clear responsibilities for decision-making and taking action to achieve the purposes of the sentence.

- 12.1 *The organisational structure within LPA should promote clear lines of responsibility and accountability for the management of Risk of Harm.*
- 12.2 *OASys should be fully implemented within LPA and used consistently.*

- 12.3 *There should be planned continuity of contact and engagement between the offender manager and the offender.*
- 12.4 *Clear contemporaneous record keeping and the need to take prompt action are both vital to enforce the conditions of the order or licence.*
- 12.5 *Managers should plan to have regular supervision sessions with each of their staff.*
- 12.6 *Plans should be made to increase the level of purposeful contact with prisoners during sentence and immediately prior to release.*
- 12.7 *Administrative arrangements should be improved in order to ensure the effective and efficient implementation of court orders and licences.*
- 12.8 *Clear agreements should be drawn up to between LPA and the providers of interventions and services detailing the level and content of information exchange.*

13 Future Independent Reviews by this Inspectorate

- 13.1 A dialogue has been taking place between this Inspectorate and the National Probation Directorate to consider how to strengthen the procedure for reviewing what has happened and what lessons are to be learned each time there is a Serious Further Offence. It is inevitable that from time to time offenders under current supervision will commit an SFO, but the public need to be assured that the responsible authorities have done their job properly. With this in mind, it seems clear that in the very exceptional cases which raise major concerns there needs to be an option of arranging for a Review that is conducted independently. Accordingly, it is with my full support that a revision to the existing procedure is being developed along the following lines:
- 13.2 *In exceptional cases, [the manager of the SFO review process] will inform the Chief Officer of an Area that a case requires an Independent Review, either because of immediate and urgent concerns; or following the quarterly review of Full Reviews where reports have demonstrated that it is necessary. Examples of such reports may be*
 - *The management of the case was so exceptionally poor that an SFO Full Review is clearly insufficient to demonstrate clear public accountability*
 - *The Full Review fails to sufficiently address the necessary issues; for example evidence that the Probation Area has not responded appropriately or adequately addressed significant areas for improvement, evidence that the Probation Area has failed to address staff performance.*
- 13.3 *HMI Probation will formally submit the review to Ministers and communicate the outcome to the National Probation Directorate, and to the Chief Officer of the Area involved. The report will be published.*
- 13.4 The wording of this revision is still to be finalised, but I recommend a revision to the current procedure along these lines in order to offer to the public a measure of transparent assurance about this very challenging area of work.

14 Conclusion: From offender mismanagement to Offender Management

- 14.1 This independent review has identified many deficiencies in the way in which London Probation Area managed the cases of Elliot White and Damien Hanson. Overall we have described this as an illustration of 'offender mismanagement'. Our aim has been to be fair in assessing the behaviour of individuals working within, we agree, a very difficult organisational context, but we have criticised the individuals who are experienced qualified practitioners and managers for not exercising more initiative in making decisions and taking action.
- 14.2 In this Conclusion we will summarise these points and then aim to move beyond the immediate Findings and Recommendations to set the 'Lessons Learned' aspect of this review into a more long-term strategic context.
- 14.3 Looking first at the parole release decision for Damien Hanson, we are aware of all the information available at the time, and we have concluded that on balance the Parole Board's decision to release at this stage was in principle a defensible one, despite some significant contra-indications. But this required an excellent release plan to be devised and implemented in practice, and it is very evident from events subsequent to the parole decision that this most certainly did not happen.
- 14.4 Damien Hanson should have had a full assessment of *Risk of Harm*, and much greater attention should have been paid to the geographical factors that had been identified as an important ingredient in his case. In particular the late change in his release plan should have led to a re-assessment of the parole panel's decision and he should have been referred to MAPPA. Nevertheless at the time when parole was granted in 2004 Damien Hanson appeared to have matured substantially during his years in prison and the professional advice from several sources supported the decision to grant early release on licence. But the fact that his original offence involved *instrumental violence* at a very serious level indicates that it might have been better to test him in open prison conditions before release on parole.
- 14.5 After his release from prison there were significant deficiencies in the way in which Damien Hanson was supervised. At the core of these deficiencies was the fact that he had previously been assessed as an offender who posed a high *Risk of Harm* but he was not dealt with as such. In addition our review has identified numerous shortcomings relating to the enforcement of his licence conditions, poor liaison with the hostel where he was staying and the general poor management of the case.
- 14.6 In the case of Elliot White our review has also highlighted many reasons for concern. The assessment and decision relating to White's Drug Treatment and Testing Order were based on insufficient information, having regard in particular to his previous poor response to a Community Rehabilitation Order. There was also a failure to enforce

the order properly, poor record-keeping and poor liaison between the case manager and those providing the drug testing and treatment components of the court order.

- 14.7 In both cases the major deficiencies identified by the review relate in the main to the failure to supervise both Damien Hanson and Elliot White in accordance with the expectations of Probation National Standards and the standards of effective management of offenders normally established during the qualifying training for Probation Officers. There were some considerable organisational constraints faced by the staff and managers dealing with these cases, but even after taking account of these we have been strongly critical in this report of their collective failure as responsible supervisors of offenders to take the initiative to make decisions and act on them to ensure that these cases were properly managed.
- 14.8 As far as their employers are concerned there is evidence that during the last year London Probation Area has been actively addressing a number of the shortcomings documented in this report. However, it is beyond the scope of this review to assess what these changes have achieved so far, in the year after the period we are reviewing here, although we are scheduled to undertake a Follow-up inspection of *Risk of Harm work* in London in July 2006.
- 14.9 But we do not wish to make wide-ranging recommendations about future offender management practice based simply on two very extreme cases, even though everyone involved in these cases is clearly properly very distressed at the crimes that these two men went on to commit. Yet there is so much in the stories of these two cases that genuinely illustrates some deep rooted themes of what makes for effective practice in managing offenders through their sentences.
- 14.10 But we have two cautionary notes before we develop this theme. On the one hand we must point out that it would be wrong to suggest that because these two cases were managed badly this reflects a poor standard that is currently widespread – it does not. As I write we have nearly completed an inspection programme of all 42 Probation Areas in England & Wales since June 2003, assessing *Risk of Harm work* along with all the other key elements of Effective Supervision. We can put these two cases in a wider perspective in which we confirm that in every Probation Area we visit we see some examples of very good or excellent work with some very difficult High or Very High *Risk of Harm* offenders. We have attended MAPPA meetings in which it is most encouraging to see the various agencies around the table work diligently and skilfully to find the best actions to take to keep to a minimum a particular offender's *Risk of Harm* to others. And of course, the public will not hear of the work where this is done most effectively, because by definition there is no news to report when an offender doesn't reoffend.
- 14.11 On the other hand it is most certainly not a sufficient response to say that these cases are exceptional and that there are no wider lessons to learn. Having acknowledged the examples of excellent work that we

regularly find when we inspect Probation Areas we also have to confirm what we have said before that *Risk of Harm* has been a recurring area where we have found a need for improvement. We work by examining representative samples of individual cases, and we don't find the practice we see to be of a sufficiently high standard often enough. We therefore welcome the fact that in recent months the National Probation Directorate, the Youth Justice Board and NOMS itself are paying increasing attention to this vital area of practice. And we have said previously that we recognise that by the very nature of this work it is a 'long haul' job, not achieved overnight.

- 14.12 Our purpose in promoting the development of *Risk of Harm* work as a priority is not to create a disproportionate emphasis to it, but to redress a balance. In the new language there is a need for NOMS to ensure that all four purposes of each sentence are achieved with each offender as appropriate to that case, to "Punish, Help, Change and Control". But there is a clear need to focus on the "Control" purpose, because currently it needs a lot of attention to redress the proper emphasis within the context of developing good offender management practice overall.
- 14.13 Returning now to the two cases reviewed here, we find that these two cases powerfully illustrate what needs to be put in place in order to develop good quality offender management practice. This is because in many respects these cases illustrate the exact opposite of effective offender management – hence we have called it offender mismanagement. As we have already said, some of this is about the organisational arrangements and some of it is about the lack of initiative and judgement demonstrated by the staff involved.
- 14.14 We therefore now suggest by contrast what needs to be designed into future arrangements in order to build good quality offender management. We have on previous occasions said that although we are positive about the NOMS vision the current planning process has shown the wrong emphasis. Much attention has been given too early to the structural issues of 'NOMS-as-an-organisational-innovation' before completing thinking through the strategic issue of what precisely we want Offender Management to achieve with offenders. And while much of the thinking about the future of Offender Management has been quite reasonably about how to divide the work up (e.g. commissioning and providing) not enough has been about how to join the work back up again with each offender. And it is clear to us that there are real lessons to be learned from these two cases in planning for the future, not only as two individually mismanaged cases but more as illustrations of the opposite of what we want to happen with sentenced offenders generally. And you start this by planning *what it is that you want the offender to experience*.
- 14.15 Absolutely central to this is the idea that an offender should have a single integrated ('joined-up') experience of undergoing a properly managed sentence. Unlike our assessment of the effect of the messages implicitly given to Damien Hanson at the point of his release,

what is needed is for each offender manager to have done their best to inspire the respect, credibility and confidence of the offender so that the offender can feel that he or she is being competently managed by this representative of the Criminal Justice System.

- 14.16 To this end, when designing Offender Management, the strategic planners will need to ensure that they delegate the role of offender manager as a responsibility (not simply as a task), and then manage them accordingly, which will include expecting those offender managers to take the initiative in making decisions and taking action with the cases for which they are responsible. It will of course not always be possible for an offender to have the same offender manager from start to end of their sentence – e.g. due to staff turnover or offender relocation – but because each point of handover is potentially problematic it would seem wise at the design stage to build in as few *discontinuities* in the offender management arrangements as possible. And of course when a handover of *lead responsibility* does have to take place both parties have to take an enhanced level of initiative to manage the transition successfully.
- 14.17 There are lessons here too for other aspects of future Offender Management. For *Risk of Harm* to be managed successfully each commissioned ‘provider’ will have to take some responsibility for contributing to the effective management of the case. The provider has to know enough about the offender, and have enough basic awareness of RoH issues, to be able both to carry out their commissioned service effectively (e.g. accommodation, unpaid work, education, drug treatment) and be alert enough to identify problematic developments and inform the offender manager accordingly. Providers will have to be able to demonstrate a sufficient understanding of *Risk of Harm* work and their role within it in order to fulfil their role properly. Furthermore, it seems clear to us that the role of some ‘commissioned providers’ will have to include a responsibility for an enhanced clearly designated ‘contribution to effective offender management’ – e.g. managers of Approved Premises (hostels) and Prison Governors. Already, the role of the Police with some of the high *Risk of Harm* and other priority offenders under NOMS supervision almost entirely takes the form of ‘contribution to effective offender management’ (not that of a ‘commissioned provider’).
- 14.18 All of these points illustrate our general theme that when managing any organisation or designing a new service it is necessary to delegate responsibilities not tasks. These responsibilities need to be assigned at each level in the organisation and they need to be clear. In the case of Offender Management designing in as much continuity as possible is also important. If managed properly, the people who have been assigned *lead responsibility* to ensure that the purposes of the sentence are achieved can be expected to take the initiative in making the necessary decisions and acting on them.
- 14.19 Inevitably the question will be asked: “In this case, if the officers concerned had behaved in the way you advocate, managing these two

offenders properly, would Mr Monckton still be alive today?" Equally inevitably, the answer has to be that no one can know, because when an offender is being managed in the community it is simply not possible to eliminate risk altogether and this was a particularly calculated crime for which the offenders themselves should bear their full responsibility. But we stress that the public is entitled to expect the authorities to do their job properly, and to be duly informed if they fail. We find that the poor management of these cases did fail to reduce the *Risk of Harm* to the public posed by these two supervised offenders.

- 14.20 As for the lessons learned, we have argued that the cases have clear implications for changes in policy and practice that could significantly improve public safety and confidence. It is vital that everyone connected with the early release of prisoners and the supervision of offenders in the community commits themselves to improving practice to ensure that the mistakes made in these cases are not repeated.
- 14.21 Accordingly, we reiterate that all of us involved in any way in the supervision of offenders owe it to victims and the public generally to ensure that lessons are learned from the horrific death of John Monckton, the injuries suffered by his wife, and the loss to his family and friends

Andrew Bridges
HM Chief Inspector of Probation
February 2006

Appendix and Glossary

Appendix: People who contributed to this Review

The HMI Probation team:

Andrew Bridges, HM Chief Inspector of Probation
Andy Smith, HM Inspector of Probation
Malcolm Bryant, HM Inspector of Probation
HMI Probation Support Service

The people we interviewed:

Chief Officer and Chief Operations Officer, and eighteen other managers and staff of London Probation Area
Chairman and Chief Executive of Parole Board for England & Wales
Detective Chief Inspector, Metropolitan Police

Glossary:

<i>Actuarial</i>	A system for measuring probabilities in a way that can be calculated, made possible by attributing numerical values to the relevant factors in someone's circumstances and behaviour.
<i>CALM</i>	A programme aimed at reducing the aggression of appropriately referred offenders
<i>CO</i>	Chief Officer of a Probation Area
<i>Constructive intervention</i>	As distinct from a <i>restrictive intervention</i> . A <i>constructive intervention</i> is where the <u>primary purpose</u> is to reduce Likelihood of Reoffending. In the new language of Offender Management this is work to achieve the "Help" and "Change" purposes, as distinct from the "Control" purpose.
<i>Discontinuity</i>	A break in a work process – in this report most frequently referring to the point where the management of a specific offender is transferred from one offender manager to another
<i>DTTO</i>	Drug Treatment and Testing Order: a community sentence requiring the offender to undergo treatment, and be tested regularly
<i>Dynamic factors</i>	As distinct from <i>static</i> factors. Dynamic factors are the factors in someone's circumstances and behaviour that can change subsequent to the calculation.
<i>ESI</i>	Effective Supervision Inspection: HMI Probation's current programme of inspection of the 42 Probation areas over 3 years from June 2003.
<i>ICT / IT</i>	Information (and Communications) Technology
<i>Instrumental violence</i>	Where violence is used as a means of achieving an objective, such as a robbery. (In contrast to <i>expressive violence</i> , where the use of violence towards another person is in order to reduce the offender's negative emotional state, such as in a spontaneous pub brawl.)
<i>ISP</i>	Initial Supervision Plan: In a Probation case record, the first formal assessment and plan for an individual offender's period of supervision
<i>LPA</i>	London Probation Area, by far the largest of the 42 Probation Areas of the National Probation Service for England & Wales. Each Probation Area is a corporate body
<i>Lead responsibility</i>	In this report our point here is that many people have to carry out their assigned responsibilities in helping to ensure the effective management of a specific offender – but someone has to take <i>lead responsibility</i> for ensuring that the purposes of the sentence are achieved overall. This is in the old language either the supervising officer or the case manager, and in the new language the offender manager. We emphasise that the person undertaking this role should be expected to take the initiative in making the necessary decisions and acting on them in order to achieve this purpose.
<i>MAPPA</i>	Multi-Agency Public Protection Arrangements. Where Probation, Police and other agencies work together in a given area, e.g. a London Borough, to manage some of the particularly high RoH offenders
<i>NOMS</i>	National Offender Management Service: The evolving single Service designed to include responsibility for both the HM Prison Service and the National Probation Service.
<i>NPD</i>	National Probation Directorate: Although a part of the Home Office, the NPD is also the 'Head Office' of the NPS
<i>NPS</i>	National Probation Service: Consisting of 42 Probation Areas, each run by its own Board, plus the NPD
<i>OASys</i>	Offender Assessment System: The nationally designed and prescribed framework for both the NPS and the Prison Service to assess offenders, implemented in stages from April 2003. It makes use of both <i>static</i> and <i>dynamic</i> factors.
<i>Offender Manager</i>	In the new language of Offender Management, this is the term for the officer in charge of managing the case "from end to end" See also case manager, supervising officer

OGRS	Offender Group Reconviction Scale, an actuarial scale employing only <i>static</i> factors. It is derived from large sample groups and enables a predicted likelihood of reconviction (expressed as a percentage) to be produced. The score is based on a number of factors, such as type and frequency of previous offences, age at first conviction etc. The main limitation of OGRS is that the percentage score is representative of a sample group of similar offenders as a whole. In effect the score indicates the proportion of that particular group of offenders who are likely to be reconvicted. However, there remains a crucial judgment as to whether a specific individual will be part of the proportion that reoffends or part of the proportion that does not.
PC	Probation Circular: Statutory instruction or briefing by the NPD to areas.
PAR	Parole assessment report, in the context of this review a report prepared by the home Probation Officer for a prisoner being assessed for release on parole.
PSR	Pre-sentence report: Probation Service reports that advise a court at point of sentence.
<i>Restrictive intervention</i>	As distinct from a <i>constructive intervention</i> . A <i>restrictive intervention</i> is where the <u>primary purpose</u> is to keep to a minimum the offender's <i>Risk of Harm</i> to others. In the new language of Offender Management this is work to achieve the "Control" purpose, as distinct from the "Help" and "Change" purposes. Example: With a sex offender, a <i>constructive intervention</i> (to reduce his LoR) might be to put him through an accredited sex offender programme; a <i>restrictive intervention</i> (to minimise his RoH) might be regular meticulous monitoring of his accommodation, and/or his employment and the places he frequents, imposing and enforcing clear restrictions as appropriate to the case. The sex offender programme will hopefully have some impact on RoH in the long term, but its primary purpose is to reduce LoR. In the short term; hence cases such as this require <i>restrictive interventions</i> as well.
<i>Risk of Harm (RoH)</i>	As distinct from <i>Likelihood of Reoffending</i> . If an offender has a medium or higher RoH it means that there is some probability that he or she may behave in a manner that causes physical or psychological harm (or real fear of it) to others. The offender's RoH can be kept to a minimum by means of <i>restrictive interventions</i> .
<i>Risk of Harm work</i>	a) In the Inspectorate's existing language: planning and implementing <i>restrictive interventions</i> b) In the new language of Offender Management: work to achieve the "Control" purpose (as distinct from the "Help" and "Change" purposes). Hence with <i>Risk of Harm</i> , the officer works to "Control" the offender, using <i>restrictive interventions</i> that keep to a minimum the offender's opportunity to behave in a way that is of <i>Risk of Harm</i> to others.
SDA	Service Delivery Agreement: Performance targets set at national level
SFO	Serious Further Offence, committed by an offender under current supervision
SLA	Service level agreement
<i>Static factors</i>	As distinct from <i>dynamic</i> factors. Static factors are factors in someone's history that by definition can subsequently never change
YOI	Young Offender Institution: a prison establishment for those aged under 21