HM Inspectorate of Probation

The quality of public protection work in probation – 2022 to 2023 inspections

HM Inspectorate of Probation

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Contents

HM Inspectorate of Probation is committed to reviewing, developing and promoting the evidence base for high-quality probation and youth justice services. Our *Research & Analysis Bulletins* are aimed at all those with an interest in the quality of these services, presenting key findings to assist with informed debate and help drive improvement where it is required. The findings are used within HM Inspectorate of Probation to develop our inspection programmes, guidance and position statements.

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We would like to thank all those who participated in any way in our inspections. Without their help and cooperation, the collation of inspection data would not have been possible.

Executive summary

Context

This bulletin provides an update on our 2018 research report on the quality of work by probation services to protect the public. Keeping people safe, in conjunction with other partners and agencies, is a key objective for probation. This duty to protect is complemented, not contradicted, by the rehabilitative imperative to promote personal change and growth with people being supervised; achieving change and growth for people on probation can reduce risk of harm beyond the period of supervision.

A broad focus on all the safety aspects of a case is required, as illustrated through the four pillars of risk management.

**Image used with the kind permission of Professor Hazel Kemshall, De Montford University*

Approach

The findings presented in this bulletin are based upon case assessment data from probation inspection reports published between February 2022 and August 2023 (n=1,748 cases). In each case, our inspectors considered key questions relating to public protection work, recording the rationales for their judgements alongside notable instances of good or poor practice.

The considerations which are presented for helping to improve the quality of public protection work build upon the findings from our case assessment data, as well as two discussion groups with our inspectors and a review of the wider literature and the evidence for good practice, encompassing inspection reports and effective practice guides.

Key findings and implications

- Probation services have been through a difficult and damaging journey over recent times, and our 2022/2023 probation inspections dataset reveals notable shortfalls in public protection work across the ASPIRE stages of assessment, planning, implementation and reviewing. The implementation and delivery of services was deemed to be effectively supporting the safety of other people in just over one in three (35 per cent) of the cases examined.

- In their case commentaries, inspectors identified a number of areas where individual practice could be improved including:
    - ensuring that essential enquiries with the police and other agencies about domestic abuse and child safeguarding are undertaken when necessary
    - using professional curiosity and critical evaluation when reviewing information
    - ensuring sufficient activity across the period of supervision
    - utilising the interventions framework, making relevant and timely referrals to programmes and services
    - bringing in multi-agency resources where relevant, including outside formal mechanisms
    - ensuring that contingency planning is undertaken, including preparing for the end of supervision
    - ensuring that cases benefit from management oversight and reflective practice supervision.
- Building upon these findings, as well as the points highlighted in the wider literature, the following considerations are set out to help improve the quality of public protection work:
    - increasing the analysis of critical information, with practitioners displaying professional curiosity and an analytical mindset
    - adopting a 'learning organisation' approach, with leaders paying attention to equitable treatment and psychological safety, and practitioners benefitting from reflective practice supervision, team exercises, peer consultation, and professional mentors/trainers
    - focusing on protective integration, balancing practice to manage risk with practice to enhance desistance, thus supporting longer-term change for people on probation
    - strengthening the interventions' evidence base, with a focus on continuous improvement and the embedding of best practice
    - focusing on effective cooperative and collaborative multi-agency and partnership working, maximising the sharing of information and access to services
    - supporting public health approaches to violence reduction, including the scaling-up of effective approaches and interventions
    - building a proficient, experienced and valued workforce, with a focus on induction and ongoing training and support, and in ensuring that policies and procedures are fully aligned (and streamlined where possible).
- While there is a need to be realistic about risk management, recognising that it is impossible to predict future human behaviour in every circumstance or to eliminate all risk, the public can reasonably expect probation professionals to be analytical and thorough, and to take all reasonable action to prevent offending and serious harm. The considerations set out above support such actions, and it vital that practitioners are fully supported and empowered to deliver their best practice to support people move away from offending behaviour while at the same time protecting the public. The future bedrock of an effective Probation Service will be a fully staffed, well-resourced and well-led cohort of practitioners, all of whom are given the time and space to build secure and trusting relationships with those they are supervising, with their colleagues, and with professionals across agencies and sectors within their local areas.

1. Introduction

This bulletin updates our 2018 Research and Analysis Bulletin on the quality of public protection work across probation services in England and Wales. We review the key points from recent inspection findings, before considering strategies and mechanisms to help improve the quality of the work. The focus is upon mainstream public protection work rather than specialist areas such as terrorism and violent ideologies.

What is public protection work in probation?

Public protection work in probation was historically concerned with identifying and containing the few people considered to be dangerous. Dangerousness as a legal concept was defined in 1976 by the Butler Report as, 'a propensity to cause serious physical or lasting psychological harm' (Butler Commission, 1976, p.8). Lord Butler, who was specifically tasked with reporting on mentally disordered people who present as dangerous, addressed the need to balance the best interests of those guilty of dangerous offences and the right of the public to be protected from harm. Butler recommended an expansion of secure hospitals to partially achieve this balance. This recommendation was implemented by the government of the time. However, it is still not fully resolved how best to assess, manage, and support those people in the criminal justice system presenting grave dangers to society, with or without mental health disorders. Nash (2017) reminds us that 'dangerousness' is itself an elusive concept, and subject to much distortion in the public mind, especially from social constructions of ideal victims, of innocence and guilt, and of who is deserving of othering, and who of empathy amongst perpetrators and victims.

Within probation, dangerousness is now encapsulated within the concept of risk of serious harm (RoSH). Nash (2017) also reminds us that danger is not the same as risk; danger is the potential source of harm, and is to be avoided; risk is the probability of an identified harm occurring. Public protection work is thus 'an attempt to see into the future in an attempt to avoid disastrous consequences' (Williams and Nash, 2008), and the task for probation practitioners is to predict the likelihood of future serious offending by the individuals they supervise, reduce any motivation to offend, and increase their capacity to live pro-socially (Nash, ibid).

All people under supervision are assessed and classified according to their RoSH level – that is, the probability that any reoffence would lead to death or serious personal injury, whether physical or psychological (s.224 *Criminal Justice Act 2003*). The Offender Assessment System (OASys), which is the primary assessment tool across probation and prisons in England and Wales, adds that serious harm is 'an event which is life threatening and/or traumatic and from which recovery, whether physical or psychological, can be expected to be difficult or impossible' (HMPPS, 2024b). RoSH assessment is largely based upon structured professional judgements – ideally using evidence from many sources including partner agencies – regarding the 'dynamic' factors of the individual, such as their employment status, their housing situation, personal relationships and peer groups, substance misuse, or mental health. Actuarial predictors have also been designed and introduced to aid practitioners – for example, the Risk of Serious Recidivism (RSR) predictor and the OASys Violence Predictor (OVP) – recognising that assessment reliability and validity can be supported through combining the best of actuarial methods of prediction with structured professional judgement (HMPPS, 2023).

The OASys RoSH levels are as follows:

- low: current evidence does not indicate a likelihood of causing serious harm
- medium: there are identifiable indicators of serious harm. The offender has the potential to cause such harm, but is unlikely to do so unless there is a change in circumstances – for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse
- high: there are identifiable indicators of serious harm. The potential event could happen at any time and the impact would be serious
- very high: there is an imminent risk of serious harm. The potential event is more likely than not to happen as soon as the opportunity arises, and the impact would be serious. 'Opportunity' can include the removal or overcoming of controls, and changes in circumstances.

Critically, there are two dimensions – the likelihood that a harmful offence will occur and the impact of that offence upon the victim(s). OASys further requires the probation professional to specify who is at risk: the public, known adults, children, other prisoners, staff, or if the individual is a risk to themselves. These assessments inform the risk management plan which aims to contain and reduce the factors related to RoSH, and the impact of any further offence. There is a need to be realistic about risk management, recognising that it is impossible to predict future human behaviour in every circumstance or to eliminate all risk. However, the public should expect probation professionals to be analytical and thorough, and to take all reasonable action to prevent offending and serious harm (Bridges and Torchia, 2014).

It is important that all practitioners understand how to recognise and minimise RoSH. For example, while the home is often taken to be a haven of safety, a third of homicides take place in domestic settings, and over half of homicide victims have had a prior ongoing relationship with their killer. Dobash and Dobash (2004) found that men who murder their partners are from more conventional backgrounds than those who murder other men who are not their partners, and they are more likely to be in employment and have lived a stable life. However, they are also more likely to have a history of intimate personal violence, which may not have led to convictions. This reinforces the imperative for probation professionals to undertake domestic abuse checks with police forces and seek intelligence from wider sources to ascertain all risks.[1]

Multi-agency working

Multi Agency Public Protection Arrangements (MAPPA) provide the legal and policy framework for the risk management of people convicted of serious violent and sexual offences. Police, probation and prison services form the MAPPA Responsible Authority for the MAPPA local areas in England and Wales. Other agencies, such as health and housing authorities, statutorily cooperate as required. The intensity of multi-agency collaboration varies across three levels of management:

- Level 1 – ordinary management by a single agency, usually probation. Level 1 represents 98 per cent of the MAPPA caseload of 91,040 people (as at 31 March 2023)
- Level 2 – collaboration of at least two agencies, most often police and probation
- Level 3 – full multi-agency collaboration involving senior leader oversight of the 'critical few'.

There are three categories of offenders under MAPPA:

- Category 1 – registered sexual offenders, who make up three quarters of MAPPA cases
- Category 2 – violent offenders, who make up the great bulk of the remainder

[1] Our Effective Practice guide on working with domestic abuse provides further practical advice on strategic and practitioner responses.

- Category 3 – other dangerous offenders; around 250 people.

The introduction of MAPPA in the early 2000s was associated with significant falls in serious reoffending. However, without a control group we cannot be entirely confident about causality, and further evaluation would be beneficial.[2]

Interventions

Over the years, and across jurisdictions, a range of interventions have been available for people who present risks of serious harm, and there is some evidence regarding positive impacts. For example, in their meta-analysis of 14 studies spanning three programme types, Henwood, Chou and Browne (2015) found a strong association between anger management training and subsequent reduced reoffending, estimating a reduction in general offending of 23 per cent and a reduction in violent offending of 28 per cent.

In relation to violence, a meta-analysis (Papalia et al., 2020) which combined 27 high-quality research studies found positive results for psychological treatments which targeted cognitions and personality traits associated with violence, with improvements in the psychological deficits associated with violent offending after interventions were delivered in a variety of hospital, prison and community settings. This study, however, did not measure recidivism; the focus was upon intermediate outcomes, including trait anger, impulsivity, social problem solving, and anti-social cognitions. Better outcomes were achieved where: (i) trained psychologists, or psychological assistants, facilitated the programme; (ii) there were more sessions available per week; (iii) group formats were used; and (iv) morals/values training was involved. More recently, a review of 19 studies (Giesbrecht, 2023) found that the odds of violent recidivism were 24 per cent lower for individuals who participated in interventions compared with the control groups.

Systematic reviews of sexual offender treatment programmes have reported mixed impacts on sexual reoffending, with community and hospital settings found to be more promising than programmes in prisons. Programmes based upon cognitive-behavioural therapy may be more effective in reducing sexual and violent reoffending. Schmucker and Losel's (2017) meta-analysis of 27 studies found an average 3.6 percentage point reduction in reoffending for such psychosocial sexual offender treatment programmes. However, there was such a wide range of interventions, and a broad range of positive and neutral results, that no firm conclusions could be reached on efficacy. Holper et al. (2024) updated this review, including eight new studies, and also reported a small statistically significant effect size, with greater treatment effectiveness suggested in high and medium compared to low-risk individuals.

In their review of the current evidence base in relation to domestic abuse perpetrator interventions, Renehan and Gadd (2024) argue that the following three elements should form the bedrock of – and be embedded throughout – any safe and effective intervention:

- establishing a sense of safety
- building working relationships
- stimulating curiosity in change.

Inspection standards

Our current inspections of probation services are underpinned by standards which are grounded in evidence, learning and experience. In developing the standards, we worked constructively with providers and others to build a common view of high-quality probation services and what should be expected.

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[2] Our Effective Practice guide on MAPPA provides real-life examples of leadership, strategy and policy, and different aspects of effective case supervision.

Within the standards framework, public protection work is inspected at a regional and probation delivery unit (PDU) level. We make judgements on the quality of this work against the following key questions and prompts.[3]

Does assessment focus sufficiently on keeping other people safe?

a) Does assessment identify and analyse clearly any risk of harm to others?
b) Does assessment draw sufficiently on available sources of information, including past behaviour and convictions, and involve other agencies where appropriate?
c) Does assessment analyse any specific concerns and risks related to actual and potential victims?

Does planning focus sufficiently on keeping other people safe?

a) Does planning address sufficiently risk of harm factors and prioritise those which are most critical?
b) Does planning set out the necessary constructive and/or restrictive interventions to manage the risk of harm?
c) Does planning make appropriate links to the work of other agencies involved with the person on probation and any multi-agency plans?
d) Does planning set out necessary and effective contingency arrangements to manage those risks that have been identified?

Does the implementation and delivery of services support the safety of other people effectively?

a) Are the level and nature of contact offered sufficient to manage and minimise the risk of harm?
b) Is sufficient attention given to protecting actual and potential victims?
c) Is the involvement of other agencies in managing and minimising the risk of harm sufficiently well-coordinated?
d) Are key individuals in the life of the person on probation engaged where appropriate to support the effective management of risk of harm?
e) Are home visits undertaken where necessary to support the effective management of risk of harm?

Does reviewing focus sufficiently on keeping other people safe?

a) Does reviewing identify and address changes in factors related to risk of harm, with the necessary adjustments being made to the ongoing plan of work?
b) Is reviewing informed by the necessary input from other agencies involved in managing the risk of harm?
c) Is the person on probation (and, where appropriate, are key individuals in their life) involved meaningfully in reviewing the risk of harm?
d) Are written reviews completed as appropriate as a formal record of the management of the risk of harm?

[3] The full standards framework can be found here

2. Findings

The findings presented in this bulletin are based upon case assessment data from our inspections of PDUs published between February 2022 and August 2023. Our inspectors examined 1,748 cases, broken down as follows:

- 67 per cent community sentence cases and 33 per cent post-custody cases
- 21 per cent low RoSH cases, 62 per cent medium RoSH cases, and 17 per cent high or very high RoSH cases.

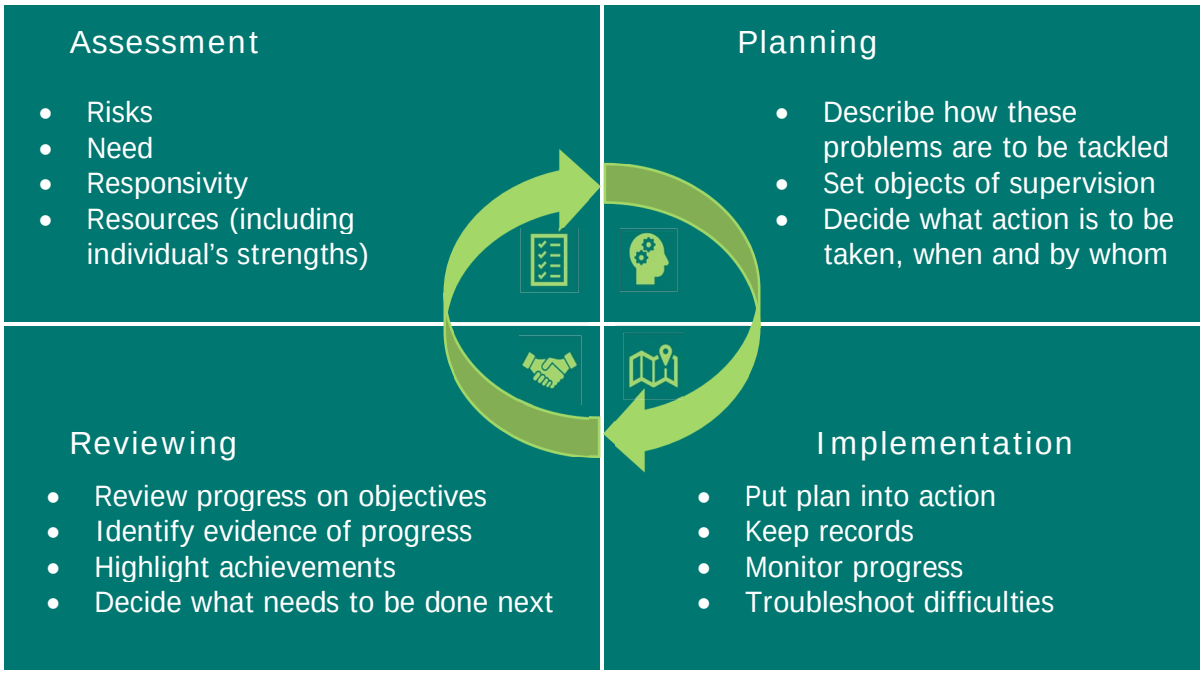
In each case, our inspectors considered key questions relating to public protection work, recording the rationales for their judgements alongside notable instances of good or poor practice. Key findings from these case assessments are set out in section 2.1. Logistic regression was used within the quantitative analysis to examine which differences were significant when accounting for the relationships between variables – it is these differences which are highlighted in the relevant sections. The accompanying inspectors' case commentaries were analysed thematically, with anonymised extracts presented in the report to help illustarte the themes. Further information on our inspection data and the analysis undertaken can be found in Annex A.

The considerations which are presented in section 2.2 for helping to improve the quality of public protection work build upon the findings from our case assessment data, as well as: (i) two discussion groups with our inspectors who shared their insights from professional practice, service management, and inspection fieldwork; and (ii) a review of the wider literature and the evidence for good practice in public protection in the probation context, encompassing inspection reports and effective practice guides.

2.1 The quality of recent public protection work

Contemporary probation practice is based upon the ASPIRE model of case supervision. In our probation inspections, we judge the quality of public protection work at each of the stages set out in Figure 1.

Figure 1: The ASPIRE model

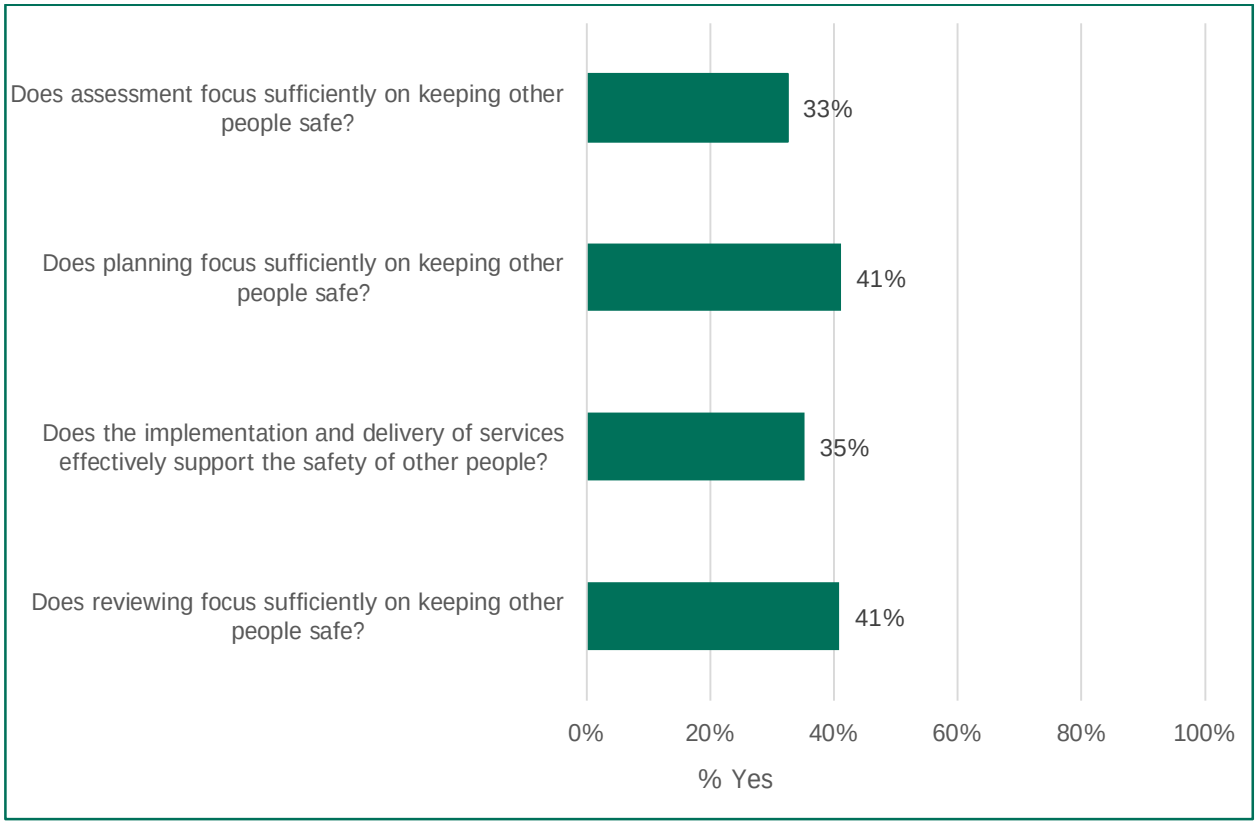


We always look at practice holistically and do not focus on the quality of specific documents, work products, or tools. As set out in our case supervision effective practice guide (HM Inspectorate of Probation, 2020), we expect to see the following in relation to keeping people safe:

- ✓ assessment practice that focuses sufficiently on the safety of others
- ✓ planning that is robust and prioritises the safety of both current victims and potential future victims
- ✓ implementation and delivery of interventions and services that are well coordinated and responsive to the risks posed by the individual
- ✓ reviewing practice that is meaningful and responds to the circumstances in the case, whether related to the person on probation or victims – reviewing should be dynamic and, where necessary, assessments, plans and the supervision process should be amended to ensure that individuals are kept safe.

We do not look for perfection, and always take a proportionate approach to assessing the quality of the work undertaken, considering whether the strengths outweigh any deficits. However, disappointingly, across our recent inspections, most cases were not judged as being sufficiently well managed at any of the four stages (see Figure 2). For context, in our regional and PDU inspections, a positive response rate below 50 per cent equates to a rating of inadequate, with a good rating requiring positive judgements in at least 65 per cent of cases and an outstanding rating requiring positive judgements in at least 80 per cent of cases.

Figure 2: Sufficiency of focus upon keeping other people safe



Our previous analysis of public protection work (HM Inspectorate of Probation, 2018) reported a deterioration in the quality of work by probation services from the Probation Trust era to the *Transforming Rehabilitation* era, based upon a comparison of case assessment data for the periods 2009-2012 and 2016-2017. While we have not matched our latest case assessment data to the earlier data, due to various changes in case inspection questions, routing, guidance and sampling, it seems clear that the quality of work has further deteriorated. For example, for the 2016-2017 data, we reported that there had been sufficient assessment of the risk of harm posed to the public in 78 per cent of cases, and that all reasonable action had been taken by the practitioner to keep to a minimum the risk of harm to others in 64 per cent of cases.

The following sub-sections examine the latest case assessment data in more detail, considering each of the stages of the ASPIRE model, with the full data outputs set out in Annex B.

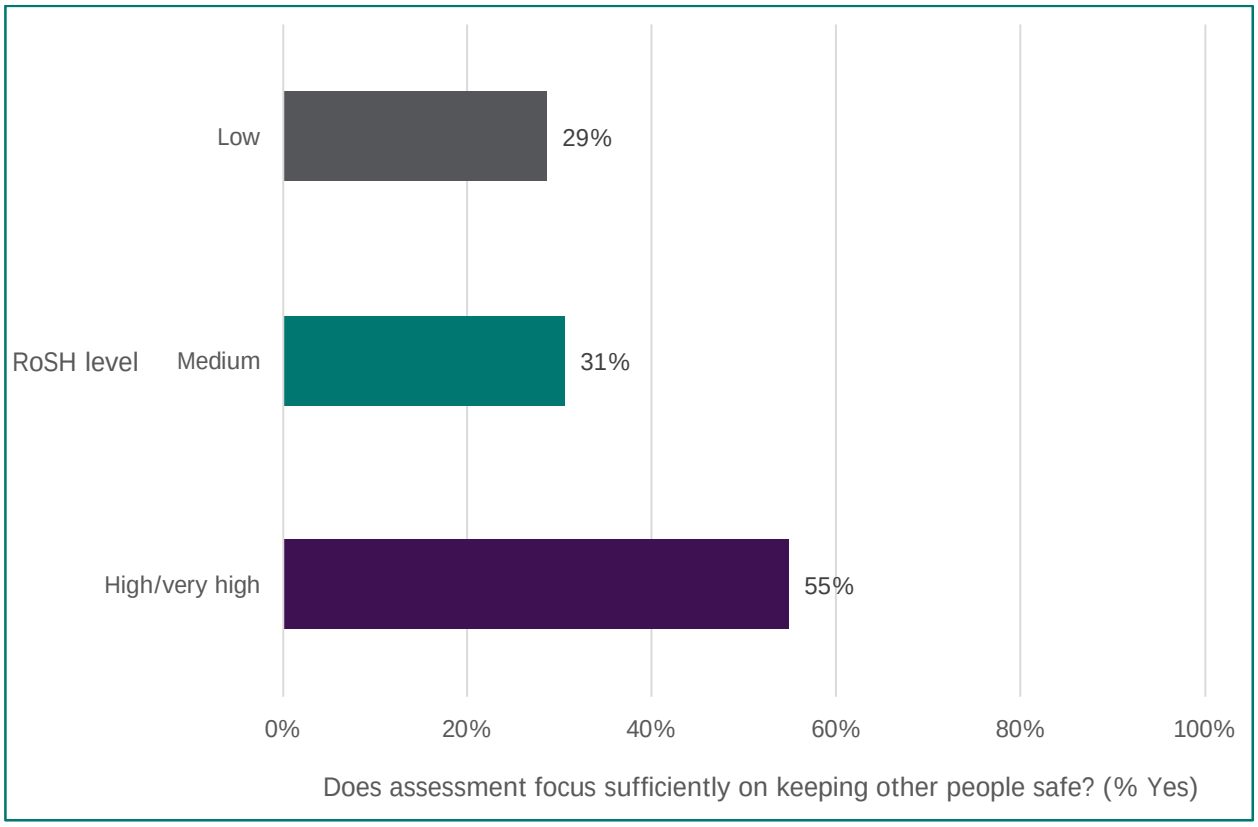
2.1.1 Focus within assessment upon keeping other people safe

Well-informed, analytical and personalised assessment is the starting point for effectively managing people on probation. At the assessment stage, practitioners should:

- clearly identify and analyse any risk of harm to others, including identifying who is at risk and the nature of that risk
- draw sufficiently on available sources of information, including past behaviour and convictions, and involve other agencies where appropriate
- analyse any specific concerns and risks related to actual and potential victims.

As set out in Figure 3, positive judgements regarding the sufficiency of the focus within assessment upon keeping other people safe ranged from 29 per cent of the low RoSH cases to 55 per cent of the high/very high RoSH cases. Importantly, inspectors consider the assessment of all risk of harm posed by the individual, not only risk of serious harm. Individuals assessed as low risk do not necessarily pose no risk, and the inspectorate's position is that work to manage and reduce risk of harm should take account of all potential risks, with the necessary attention given to people on probation for whom lower impact/severity harmful behaviour is probable. Any risk of harm is, by definition, something that should not be ignored, and we thus look to see that this has been recognised and responded to appropriately, also bearing in mind that many of the serious further offences which are committed are by people with an assessed RoSH level below high/very high.

Figure 3: Sufficiency of focus within assessment upon keeping other people safe, by RoSH level



The analysis of the inspector commentaries revealed the following public protection shortfalls at the assessment stage.

Assessments did not always identify all risks and concerns. Failure to identify and assess all risks, needs and strengths will likely lead to later failure in sentence planning and delivery. Our inspectors expect to see assessment drawing sufficiently on available sources of information, including past behaviour and convictions, and involving other agencies where appropriate.

The following inspector comments reflect the dangers of a limited assessment:

> *"The person on probation is homeless at the time of the assessment, and there is no information sought as to what can be put in place to support him and his*

partner as young adults (18-25) who are both of no fixed abode. There are no domestic abuse or safeguarding checks undertaken, and from the self-report of the person on probation there are concerns around potential domestic abuse within this relationship. The named person at risk in the index offence was his partner's father; there is a lack of analysis in the OASys risk summary with regards to this victim."

"The assessment does not sufficiently analyse (or identify) the most critical factors linked to offending or harm – accommodation (domestic abuse), employment (cocaine/alcohol use), lifestyle (further arrest incidents), finances (debts/supply of drugs) and emotional wellbeing and mental health."

Domestic abuse checks were not always undertaken. Inspectors noted that in about four out of ten cases (39 per cent), domestic abuse status checks with the police had not been undertaken when they should have been. The police, usually the domestic abuse or public protection unit, hold records of attendances for alleged domestic violence incidents, or concerns. This is vital intelligence for probation professionals for assessments and reviews of the case.

"Despite the individual reporting ongoing issues with her ex-partner and family members involving police callouts, no domestic abuse checks are undertaken."

"However, there was no domestic abuse check undertaken. There is subsequently a very hazy picture around childcare, living arrangements, and any concerns that may have been reported to police."

Child safeguarding checks and actions were not always undertaken. Of paramount concern to all state agencies is the protection of children. Probation services have a vital role in safeguarding children through their own assessments and reviews, and their multi-agency collaboration with police, social services, and youth justice services. However, inspectors found that in one third (33 per cent) of the inspected cases, child safeguarding enquiries had not been undertaken when they should have been.

"The main deficit in this case is the absence of police and children's services checks; in light of the nature of the offence being sexual offending against children, this is a critical omission."

A lack of professional curiosity and critical evaluation was sometimes evident. HM Prison & Probation Service (HMPPS) define professional curiosity as, 'a process of always questioning and seeking verification for the information you are given rather than making assumptions or accepting things at face value' (HMPPS, 2023, p.6). Unfortunately, a lack of such professional curiosity about the social and family life of the person on probation was a key deficit in many case assessments.

This comment from an inspector helps to illustrate the potential impact from a lack of critical evaluation:

"No attention was paid to risk issues. No safeguarding checks when contact with children is noted and no call out checks when the person on probation describes his relationship as volatile and when the relationship comes to an abrupt end. Would have expected at minimum some deeper exploration of the causal factors and an acknowledgement of the need to monitor relationships."

Inspectors found several cases where self-disclosure was taken as the sole source for making RoSH decisions, rather than pursuing more avenues for confirmation with other agencies.

"A lack of professional curiosity with review of risks predominantly relying on the person on probation's self-disclosure. A referral [to children's services] was made following an incident where the person on probation was very drunk around his child, however, review contingency arrangements not updated."

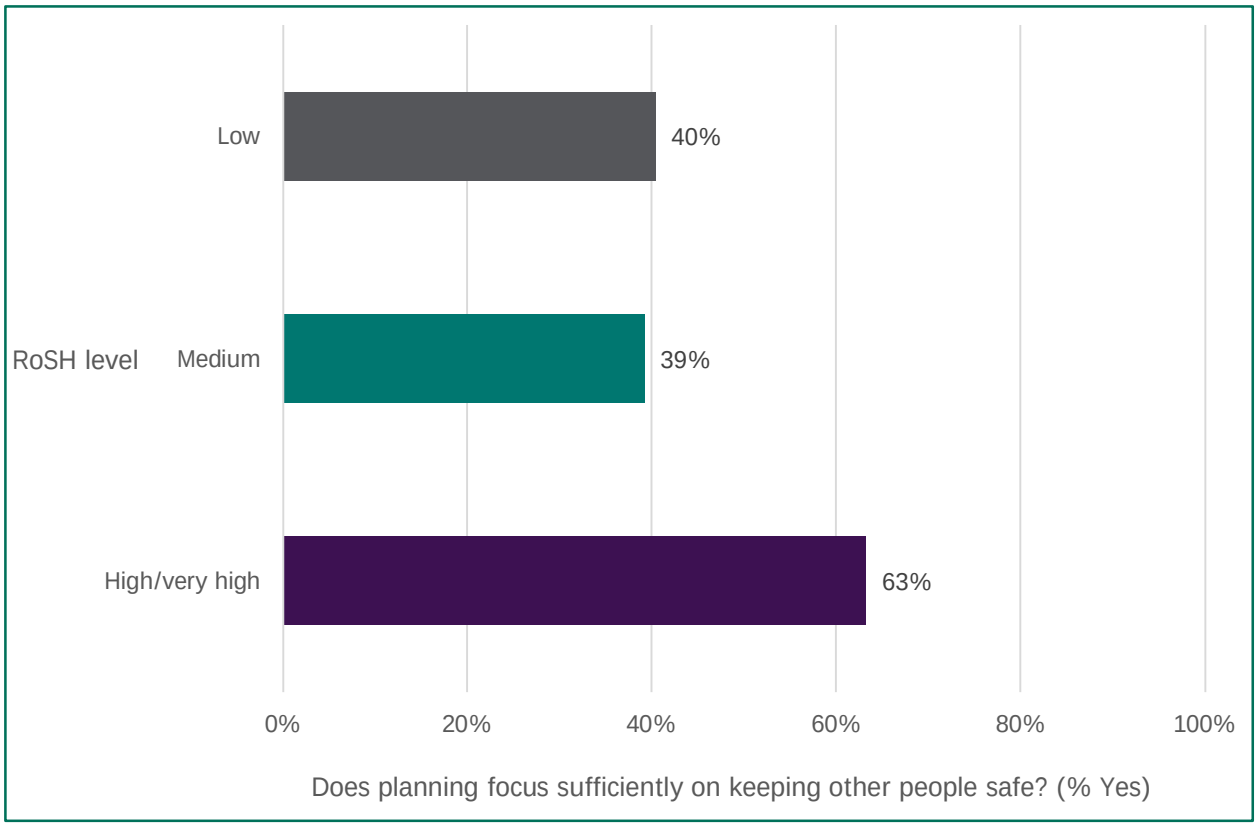
2.1.2 Focus within planning upon keeping other people safe

At the planning stage, practitioners should:

- address risk of harm factors and prioritise those which are most critical
- set out the necessary constructive and/or restrictive interventions to manage the risk of harm
- make appropriate links to the work of other agencies involved with the person on probation and any multi-agency plans
- set out necessary and effective contingency arrangements to manage those risks that have been identified.

As set out in Figure 4, positive judgements regarding the sufficiency of the focus within planning upon keeping other people safe ranged from about four in ten of the low and medium RoSH cases to over six in ten (63 per cent) of the high/very high RoSH cases.

Figure 4: Sufficiency of focus within planning upon keeping other people safe, by RoSH level



Our case assessment guidance highlights the need for contingency planning where an increase in risk of harm can be anticipated, but our inspectors judged that necessary and effective contingency arrangements to manage identified risks had not taken place in over half (56 per cent) of the inspected cases.

> *"The contingency plans do not mention the action that would be taken if the person on probation began a new relationship, or if there were safeguarding concerns. This lets this section down, which is unfortunate because otherwise it would have been sufficient."*

> *"Despite the previous domestic violence in the case, no contingency plan focusing on new relationships, or rekindling of an old relationship. Very basic contingency around child safeguarding, but no clear enforcement actions."*

> *"No contingency arrangements for negative peers or involvement in a gang/anti-social culture and therefore no planning to protect the person on probation from being groomed as was evidenced from previous concerning behaviour."*

In contrast, the following case example provides an illustration of strong risk management and contingency planning.

Positive practice example – risk management and contingency planning

The Risk Management Plan is robust and comprehensive. The person's current situation is clearly documented, and he will be supervised closely by probation and the police. In terms of monitoring and control, his licence conditions are provided, including not to have any device with an internet connection, and any devices will be subject to inspection. The risk management plan also states he is a MAPPA case, subject to a Sexual Harm Prevention Order and Sexual Offender Registration for 10 years. The contingency measures are particularly strong in this case and outline when communication should take place with the police and children's services. The possible resulting actions are also documented, for example recall to prison.

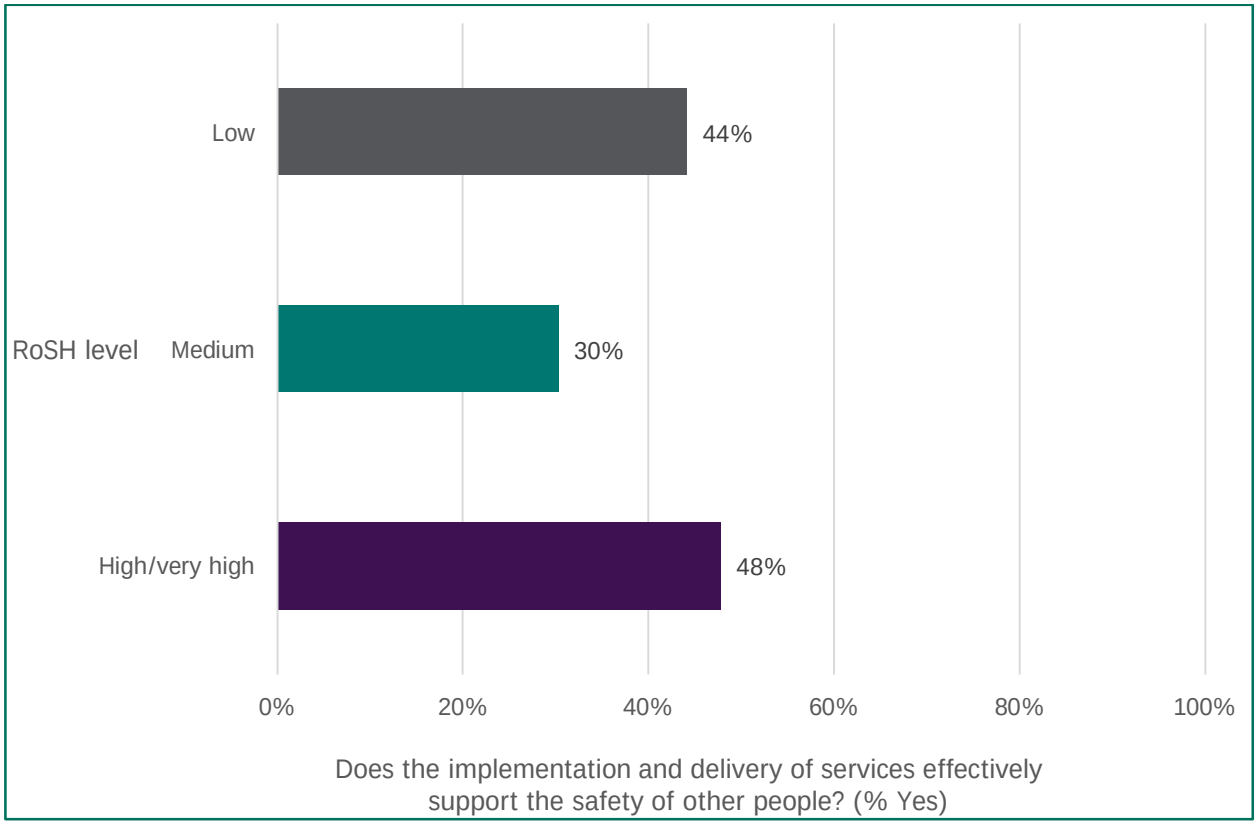
2.1.3 Effectiveness of implementation and delivery upon supporting the safety of other people

At the implementation and delivery stage, practitioners should:

- provide a level and nature of contact that are sufficient to manage and minimise the risk of harm
- give sufficient attention to protecting actual and potential victims
- involve other agencies in managing and minimising the risk of harm and coordinate the work of these other agencies appropriately
- engage key individuals in the person on probation's life, where appropriate, to support the effective management of risk of harm
- include home visiting, where necessary, to support the effective management of risk of harm.

Our research examining the links between probation supervision and early outcomes (HM Inspectorate of Probation, 2023b) found that in those cases where inspectors made a positive judgement regarding the quality of the delivery in terms of the safety of others, they were far more likely to judge that reasonable progress was being made and that the early outcomes were positive. Unfortunately, in the 2022/2023 cases examined in this report, too often the implementation and delivery of services was not judged to be effectively supporting the safety of other people safe; inspectors' positive judgements ranged from three in ten (30 per cent) of the medium RoSH cases to just under half (48 per cent) of the high/very high RoSH cases (see Figure 5).

Figure 5: Effectiveness of implementation and delivery upon supporting the safety of other people, by RoSH level



The analysis of the accompanying inspector commentaries revealed the following shortfalls in public protection work at the implementation and delivery stage.

A general lack of activity was too often evident. In about four out of ten (41 per cent) of the inspected cases, our inspectors judged that the level and nature of contact offered was not sufficient to manage and minimise the risk of harm. We have previously highlighted how the quality and quantity of supervision has been undermined by excessive caseloads and workloads for frontline staff (HM Inspectorate of Probation, 2021).

> *"This case is characterised by an indefensible gap in reporting of four months… He was inducted, attending two appointments but there was no further contact until four months later in December when he was reallocated."*

> *"Two doorstep visits were planned, but these did not take place and were not rearranged. He was not seen for a period of three months and there was no liaison*

with the police, children's services or his ex-partner to see when he was to be released from custody."

"In that five-month period there is no multi-agency working or ensuring he had access to right support services through probation to reduce risks. The probation professional did not take reasonable steps to ensure child was safe, nor did she refer to CRS [commissioned rehabilitative service] agencies to implement interventions to support risk reduction."

There was often a lack of management oversight and support. We have recently examined the excessive demands placed upon senior probation officers (SPOs) – the middle managers who lead frontline probation teams – and how they are beset with a wide range of time-consuming demands which prevent them from leading and coaching those they manage (HM Inspectorate of Probation, 2024a). We also highlighted that when enough management oversight is provided, the results are impressive; public protection work was more than three times as likely to be judged as effective when inspectors assessed manager input to be sufficient.

Unfortunately, in this report's examination of 2022/2023 cases, management oversight was often found to be lacking.

"No management oversight was present. Practitioner stated that they do not receive management oversight and when they ask questions, they are directed to EQUIP [the Probation Service intranet for policy and procedures]. Disclosed that they often go to [another] manager as they felt that he was much more helpful."

"There was no evidence that this case was discussed in supervision, or any oversight/advice was provided."

Some cases would have benefitted from intervention referrals, but appropriate interventions were not always available. Our research on probation interventions (HM Inspectorate of Probation, 2024b) revealed that too few people on probation were benefitting from structured rehabilitative programmes and activities. Underlying this were system failings, including poor ICT, excessive bureaucracy, and workload and staffing pressures. One adverse outcome of this situation was a retreat into basic public protection work by probation professionals, at the expense of desistance-focused activity which would enhance risk management.

Thee following inspector commentaries exemplify how the deficits in interventions work undermined public protection.

"Alcohol is linked to risk of harm and there is no evidence of any structured intervention being delivered in this area or appropriate monitoring of his alcohol use."

"Level of contact was insufficient due to the level of needs, chaotic lifestyle and risk issues. As such, there has been a lack of intervention work completed around motivation, engagement, offending behaviour, victim awareness and strengths building."

"Delivery of interventions to keep other people safe are limited in relation to domestic abuse."

More multi-agency working was required in some cases. People presenting public protection concerns often have co-occurring issues, such as substance misuse or poor mental health, that are the purview of partner agencies. Building strong partnerships with a variety of

agencies and service providers is thus a key task for probation leaders. Probation professionals need to be able to receive and share relevant intelligence about people being supervised; and to deliver services in conjunction with their partners in the police, health services, local authorities, the third sector, and other agencies, acknowledging that no single agency can provide all the necessary support.

However, our inspectors found that too often multi-agency working did not happen in cases which would have benefitted from effective collaboration. In about half (49 per cent) of the inspected cases, the involvement of other agencies in managing and minimising the risk of harm was judged to be insufficiently well-coordinated.

> *"Lack of inter-agency liaison impacting upon both the provision of other services, which may have impacted positively upon risk, but also with regard to risk management."*
>
> *"Social care have not been informed of the arrangements in place for his children and information with family members has not been verified (professionals meetings are planned). Mental health is not fully understood, and inadequate efforts are made to explore diagnosis, previous interventions, and compliance with medication."*
>
> *"Previous offending history wasn't discussed with YJS [youth justice service], and was dismissed as no longer relevant by the practitioner."*

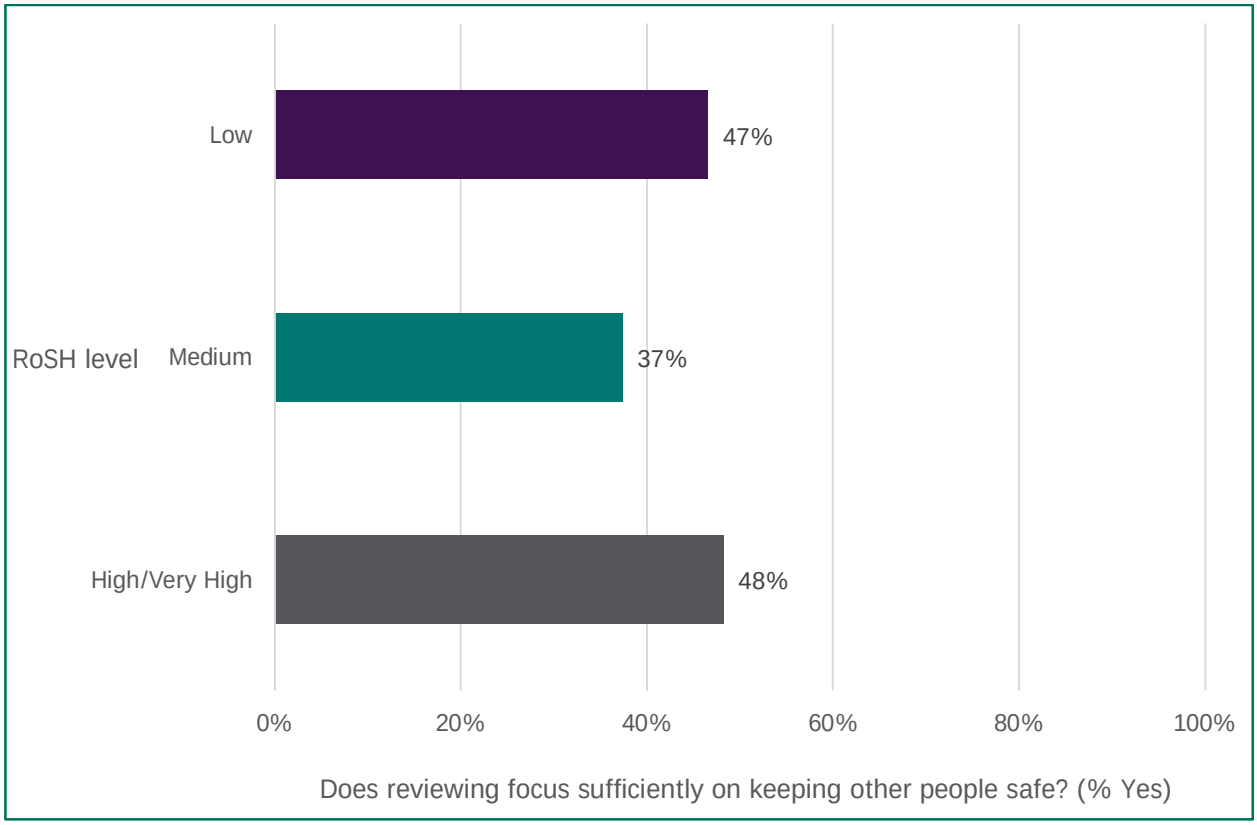
2.1.4 Focus within reviewing upon keeping other people safe

At the reviewing stage, practitioners should:

- identify and address changes in factors related to risk of harm, and make the necessary adjustments to the ongoing plan of work
- be informed by information from other agencies involved in managing the risk of harm
- involve the person on probation (and, where appropriate, key individuals in their life) meaningfully in the review of their risk of harm
- be supported by a formal written record that evidences the changes made to the management of the person on probation's risk of harm.

As set out in Figure 6, positive judgements regarding the sufficiency of the focus within reviewing upon keeping other people safe ranged from 37 per cent of the medium RoSH cases to 48 per cent of the high/very high RoSH cases.

Figure 6: Sufficiency of focus within reviewing upon keeping other people safe, by RoSH level



It is important to recognise that risk and risk behaviours are dynamic and fluid, and can change rapidly and unexpectedly. Ongoing assessment is required to respond to changing circumstances and emerging information, often information from other agencies – there should be established channels of communication to readily share intelligence and risk assessments. For example, in domestic abuse cases, we expect to see regular information-sharing with police domestic abuse staff about any new reported behaviour. In cases where children's services are working with a child in contact with the person on probation, we expect to see regular communication with social workers. Reviewing activities should be recorded on the relevant case management systems, and may involve a formal review following significant incidents or information, or as required by policy.

Regrettably, inspectors were often concerned that timely and comprehensive reviewing had not taken place.

> *"Although the probation officer discussed some of these [issues] with the person on probation, she did not consider completing a formal review or increasing the RoSH and reporting frequency until an SPO very recently reviewed the case and provided actions for her to do so."*

> *"The case would benefit from a further formal review as an opportunity to take stock and re-evaluate what needs to be done in addressing both desistance and risk."*

> *"The review did not happen and despite initial efforts to obtain missing information, not enough information was obtained, and this was not pursued."*

Inspectors are also mindful that risks and threats may well continue beyond the period of supervision; case reviewing should thus consider how potential victims could continue to be protected through broader safety nets of support.

> *"No termination review was completed, and this decision was endorsed by a senior probation officer. It would have been an opportunity to complete and review domestic abuse checks or to look at progress with child contact."*

In contrast, the following case example provides an illustration of well-informed and regular reviewing which involved the person on probation.

Positive practice example – regular reviewing

Changes in relationship status were taken into account and the potential risks associated with a relationship breakdown were explored with the person on probation. The probation officer investigated the nature of the relationship breakdown, and checks were carried out with the police. This was also discussed in MAPPA 1 review meetings. There was evidence that the person on probation was involved in the reviewing of risk of harm and shared his intention to re-enter into the relationship. There was regular reviewing of progress evidence on nDelius and timely OASys reviews were completed. There was evidence the probation officer was regularly reviewing their understanding of interventions and checking coping strategies etc. with the person on probation.

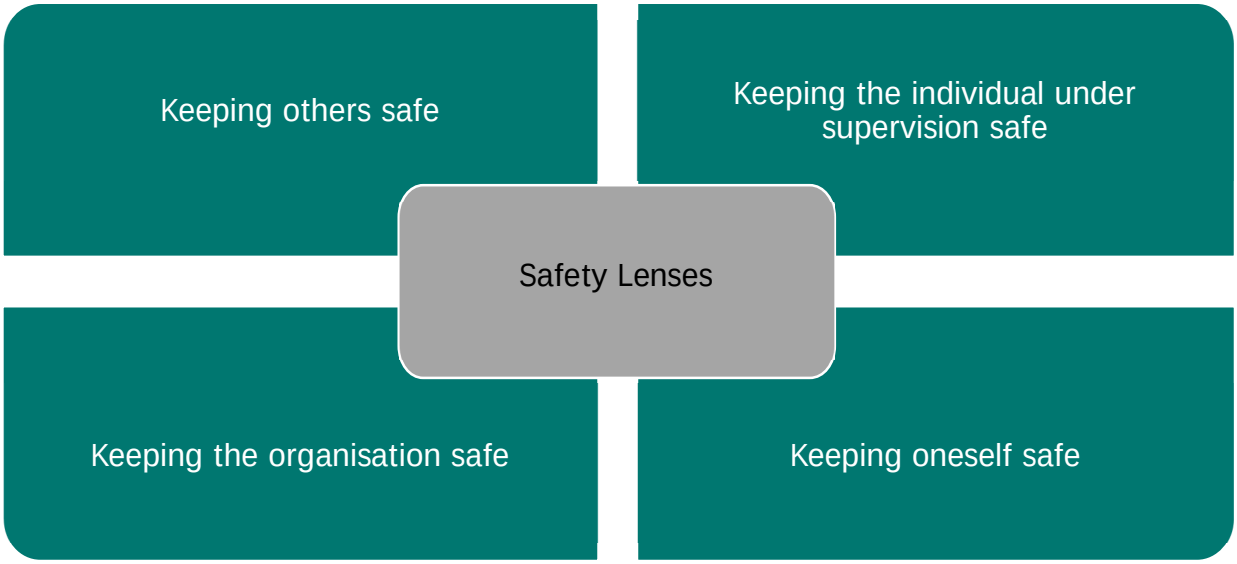
2.2 Improving the quality of public protection work

The preceding section of this bulletin clearly highlights an urgent need to improve the quality of work undertaken by probation services to keep other people safe. There is some long-standing literature which can be used to guide developments; for example, Nash (2005) summarises his research into public protection (and his experience as a senior probation officer) as follows:

- For sound judgements, the practitioner must gather all possible information about the circumstances, intentions and motivations of the individual. Establishing intentions is the surest way to predict rare events. Opinions should also be obtained from colleagues, with the case record continually updated with new insights and intelligence.
- Seriousness and imminence should be paramount considerations in risk management plans. These issues need to be assessed holistically; a legalistic focus upon the index offence risks missing vital information and insight about motivation and future intentions. For example, indecent exposure, although at the lower level of sexual offending may be a sign of more entrenched compulsion and obsession, which may lead to escalation to contact offences.
- Multi-agency working will enhance knowledge of the case, and assist with external controls (curfews, exclusions, surveillance). However, sustainable results beyond the term of supervision will come from improving the individual's internal controls, such as, resistance to peer pressure, personal agency, or resilience to setbacks. Strengthening the internal locus of control is largely the purview of the probation service.
- Partnership working will also enable more needs to be addressed, and more strengths and protective factors to be bolstered.

More recently, McKenna (2024) has highlighted the value from thinking about the dynamic interplay of four safety lenses which can be incorporated together to support safe practice.

Figure 7: Four safety lenses (McKenna, 2024)



In terms of keeping oneself safe, the following activities are outlined:

- seek managerial oversight when unsure or facing challenging situations
- utilise team knowledge by drawing on the experience and support of colleagues
- maintain a growth mindset and pursue continuous professional development
- be mindful of the need to protect professional credibility
- avoid taking unsanctioned risks that could jeopardise your reputation
- explore all possibilities for ensuring the safety of others and the individual under supervision
- collaborate with services involved with the individual
- record interactions to promote accountability for both the practitioner and the individual under supervision.

Building upon the findings presented in this bulletin, as well as the points highlighted in the wider literature, Figure 8 sets out eight considerations for helping to improve the quality of public protection work.

Figure 8: Considerations for improving public protection work

2.2.1 Ensuring analysis of critical information

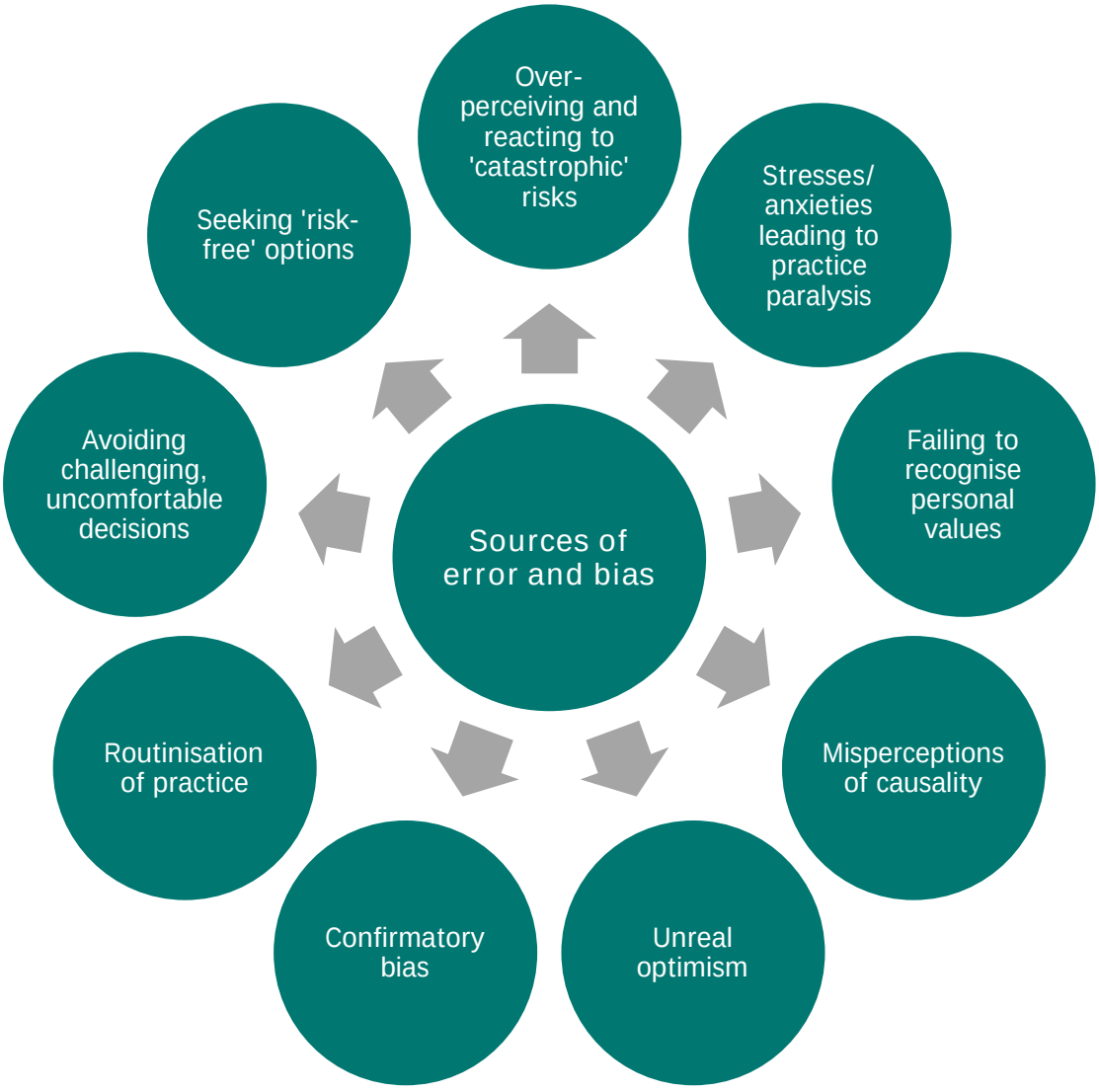
To ensure that decisions are balanced, reasoned and well-evidenced, and to minimise error, there is a need for practitioners to seek and critically appraise information, and adopt an open, honest and reflective approach. Practitioners need to have the time to reflect and review their practice with managers and colleagues, and display professional curiosity and an analytical mindset in understanding the life of the person on probation.

Judgement under uncertainty (Tversky and Kahneman, 1974) can be seen as the chief challenge for public protection work, as risk management is concerned with what *may* happen in the unknowable future. The key task for practitioners is to act in transparent, defensible and evidential ways (as in the following practice example); a defensible decision being one that will withstand 'hindsight scrutiny' should negative outcomes occur.

Positive practice example – deploying professional curiosity and challenge
Based on what is known about the person on probation, there was sufficient assessment of offending behaviour, of the risk factors linked to harm towards others, and the triggers and motivations for offending, despite denial and excusing the behaviour at the initial assessment. There was evidence through recording and case interview of ongoing assessment providing a greater understanding of the person on probation by way of professional curiosity being exercised.

It is vital that practitioners and line managers are self-aware in their practice and scrutinise their own assessments and analysis. This means looking for opportunities to triangulate or verify information and inform the weighting or importance placed upon it. Seeking out all potential sources of information and assessing any discrepancies creates a robust assessment process – this includes any differences between the practitioner's structured professional judgement and the scores/ratings from actuarial prediction, with a focus on understanding the reasons for the misalignment, e.g. taking into account additional risk or protective factors. Throughout, it is vital that practitioners and managers are aware of their own values and the effect these may have on their analysis, assessments, and decision-making. Kemshall (2021a) provides advice on how to improve decision making in probation by being aware of and minimising common sources of cognitive bias and error, summarised in Figure 9, recognising that subjective biased are more common in situations of limited time and resource.

Figure 9: Common sources of bias and error in probation work (Kemshall, 2021a)



2.2.2 Building a learning culture

Giving and seeking timely feedback, engaging in performance discussions, and coaching should be a core part of probation work. Managers should be approachable and available when needed (as in the positive practice example below) and meet regularly with their staff, particularly those who are new in post and less experienced. They should provide sound professional guidance, challenge, encouragement and motivation, with thoughtful, honest and constructive feedback on performance.

Positive practice example – management oversight and support

There has been a supportive and guiding approach employed by the senior probation officer [SPO]… This case has been well managed by the SPO from the time of the pandemic when staff were working remotely through to the person's recent release. The management discussions involved a summary of the case, and actions were set for the Probation Service Officer [PSO] to complete. When the risk was increased to high (post-unification), it is positive to see the PSO supported by a Probation Officer with case responsibilities being shared.

Supervision meetings between practitioners and their managers can have many purposes and can be conducted in a range of ways. More specifically, they can provide individual practitioners with a safe space to reflect on their practice, while affording them an opportunity to develop their skills and knowledge in delivering difficult and challenging work. Staff have positively described supervision sessions which blend opportunities for reflection, skills development, support and action-setting. There is specific evidence to support the use of reflective supervision, delivering the following benefits:

- higher standards of practice
- higher levels of morale, engagement and productivity
- higher levels of confidence
- continuous learning, creating greater opportunities for ongoing improvement
- reduced anxiety and fewer mistakes
- a better working environment to retain existing staff and attract new ones
- a stronger sense of professionalism.

Practitioners have also highlighted the benefits of the positive support they can receive through mentors, regular team meetings, and informative briefings about recent practice developments or changes. Reflective practice supervision can involve other senior practitioners, professional trainers or mentors, and there can also be considerable benefits from peer consultation (Canton and Dominey, 2018), including the wider sharing of knowledge through team/group discussions and exercises, recognising the role of teams as fundamental learning units in modern organisations (Senge, 2006).

Importantly, a healthy learning culture needs to be driven and modelled by leaders across the organisation, with compassionate and inclusive leaders paying attention to equitable treatment and psychological safety (which includes a safe environment for learning from mistakes), helping everyone to achieve their full potential.

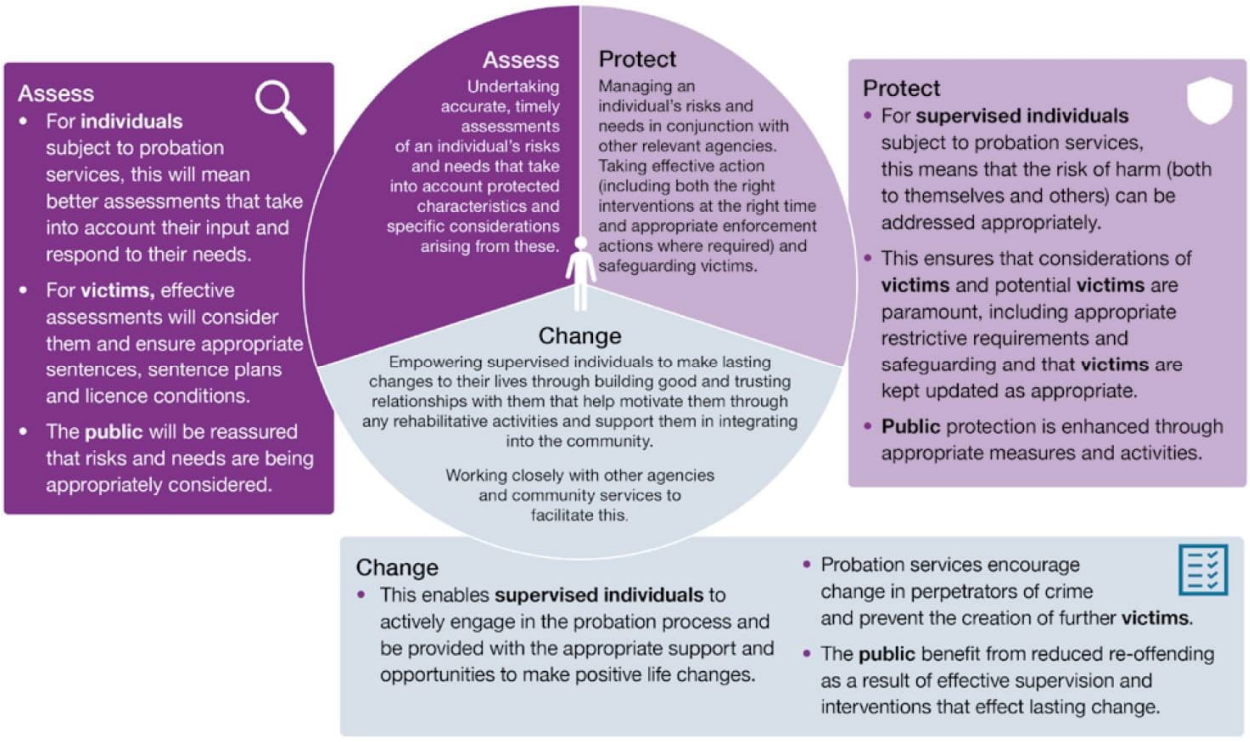
> *"Your most important job as a leader is to drive the culture and not just any culture. You must create a positive culture that energizes and encourages people, fosters connected relationships and great teamwork, empowers and enables people to learn and grow, and provides an opportunity for people to do their best work."*
>
> Jon Gordon (Leadership author)

It is notable that in Wales, probation senior leaders have implemented a 'learning organisation' model in a bid to transform the operational culture and to improve service delivery. The design of the model involved extensive engagement with staff, and led to a number of key strands, one of them being leadership and team development. Practitioners are now supported through: (i) early morning check-in meetings for all team members, which allow potential concerns to be raised and for them to be resolved at an early stage; and (ii) daily protected time when senior probation officers are available for consultation.

2.2.3 Focusing on protective integration, balancing practice to manage risk with practice to enhance desistance

HMPPS have summarised the work of probation in the slogan 'Assess, Protect, Change' (HMPPS, 2021), as exemplified in Figure 10. Each of these three elements involves complex work with people who have often had exceptionally difficult lives, and can be resistant to authority. Critically, all three elements should be complementary, and we highlighted in our research into the probation interventions system that a retreat into a rigid public protection focus at the expense of work to promote rehabilitation and longer term desistance is 'self-defeating as the best way to reduce risk of harm is to tackle offending-related needs and build upon strengths through evidence-informed and evidence-based interventions' (HM Inspectorate of Probation, 2024b, p.38). This is also recognised within the Probation Professional Registration Standards which state that registered probation officers will 'influence decision making around public protection with a focus on rehabilitation and community integration'.

Figure 10: The 'Assess, Protect, Change' approach (HM Prison & Probation Service, 2021)



Weaver (2013), on the basis of her in-depth qualitative research with people leaving a criminal lifestyle, argues that a focus by practitioners on the merely punitive or restrictive is not

sustainable. Such narrowness will not build the social capital amongst those being supervised, which is necessary to facilitate their long-term reintegration and acceptance of the reciprocal social duties of all citizens. Practitioners need to focus their work with those they supervise on (re)building the positive social networks, especially family networks, if possible. Such positive practice will develop their understanding and appreciation of connection to the community they live in – what Weaver (ibid) calls "we-ness". Research evidence also highlights strong associations between good mental health and prosocial lifestyles, including community involvement (Hood, 2024).

Kemshall (2021b) proposes that 'protective integration' should guide probation practice. In real-world practice, there should be no tension between risk management and rehabilitation. All probation work should blend promoting public safety and positive personal change, while also seeking to reduce the stigmatisation of those in conflict with the law. Practitioners will always need to balance protection and integration, asking first, "can this be done safely?". However, being overcautious and neglecting rehabilitative work will in the end defeat the probation mission. Supervision will end one day, and if the person is unchanged, the risk of harm remains unchanged as well. Kemshall thus highlights various approaches for supporting desistance, set out in Figure 11, and how they can all be linked to risk management. More generally, the desistance research highlights the importance of building positive relationships, with people most influenced to change by those whose advice they respect and whose support they value. Individuals have reported how feelings of personal loyalty towards their supervising officer can make them more accountable for their actions, and more willing to share their views and experiences, communicate their needs, and utilise available forms of help.

Figure 11: Desistance approaches for supporting protective integration (Kemshall, 2021b)

2.2.4 Building the interventions' evidence-base

While there is some evidence regarding positive outcomes from the use of interventions with those who present risks of violent and sexual reoffending, there is clearly much scope for strengthening the evidence base. Policymakers need to be fully appraised of the risks of assuming that the accreditation of any new programme is an instant panacea, and they should be encouraged to support robust ongoing evaluations, allowing for continuous improvement and the embedding of best practices.

Just because something makes intuitive sense does not mean it will work and there can be unintended consequences. Attention should always be given to whether interventions are delivered with fidelity to the programme design, and to whether facilitators receive the necessary training and support. Consideration should also be given to whether specific services and interventions work better with some individuals than others. While there is good evidence supporting the use of some types of intervention, detail is often lacking, particularly when considering differing sub-groups. Robust evidence on both the costs and benefits of differing approaches and interventions is also generally lacking.

The research questions across the interventions landscape will vary markedly in nature, and there is room for action-based research, in-depth case study work and longer-term experimental designs, while always being aware and fully transparent about the differing strengths and limitations of all approaches. It needs to be recognised that assessing the effectiveness of interventions for sexual offenders is a methodologically challenging area. There are relatively small numbers of sexual offenders, many diverse sub-types of contact and non-contact offending, with differing degrees of deviance, obsession and opportunism; in addition, reoffending is often many years apart from the original offence. These complexities can be overcome, but can make evaluations expensive and difficult.

Evaluations of interventions for domestic abuse also face challenges. Relatively long follow-up periods are again required, allowing time for new relationships to be formed and developed beyond the 'honeymoon period'. In addition, there are a wide range of motivations and orientations to abuse in relationships, and a wide range of unacceptable behaviours to consider and capture.

2.2.5 Increased multi-agency and partnership working

An evaluation of Level 2 and 3 multi-agency MAPPA management (Bryant, Peck and Lovbakke, 2015) identified the following critical success factors:

- effective communication among police, probation and prisons is important post-release for high-profile cases and those presenting a high risk of serious harm
- systematic exchange of information enables the lead agency to manage the individual with the best possible intelligence
- enhanced access to services is required, especially for the highest risk cases. Access to housing is particularly important in challenging cases
- good links with social services are vital for child protection, especially identifying 'at risk' children and potential victims.

More generally, cooperation, collaboration and co-production is vital for all multi-agency working, with all providers working together in partnership through a whole-system approach, supported by strong leadership with a shared and well-communicated vision and values. Collaborative partnerships between key agencies can increase effectiveness and efficiency through sharing information and ideas, improving the engagement and participation

of stakeholders, avoiding duplication, and enhancing access to services (as in the positive practice example below) and sources of funding. Practitioners can also benefit from regular multi-agency training, helping to ensure a common understanding, facilitating discussions of different agency perspectives, and strengthening roles and expectations.

Positive practice example – multi-agency working with complex cases

Multi-agency forums have been used to coordinate the delivery of services to effectively support the safety of other people. MAPPA, WISDOM, and PREVENT have facilitated information sharing and safeguarding measures. The probation officer presented with a good understanding of the extent of conflicting information disclosed by the person on probation. The management of the risk of serious harm was proactive and the appropriate trigger plans were followed as a guideline to respond to predicted behaviours.

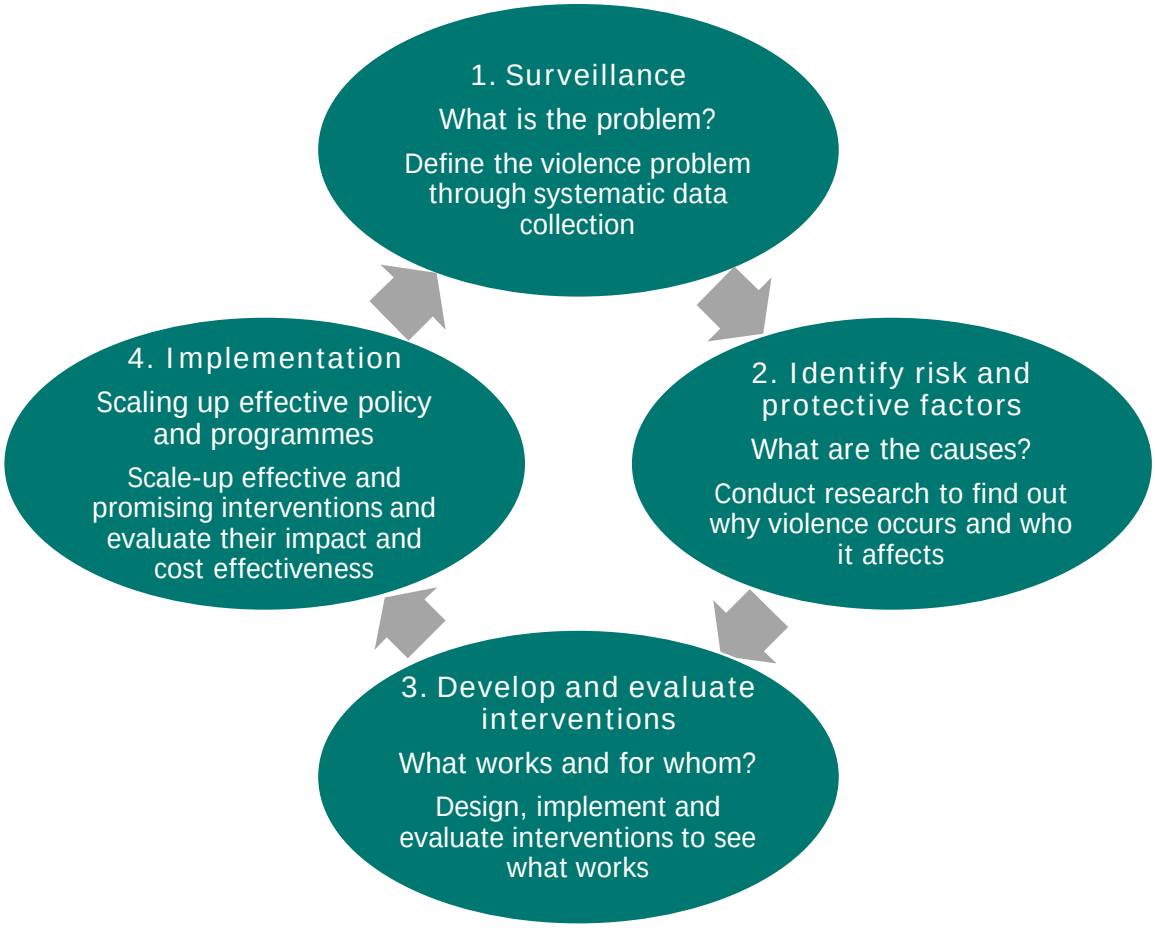
2.2.6 Engaging with public health initiatives

The public health approach aims to take the partnership approach to a more strategic level and to facilitate agencies in being more proactive and preventative in tackling violence in the community, treating violence as a transmissible infection (Local Government Association, 2018). The aim is to disrupt the virus-like transmission of violence, such as, revenge attacks or intergenerational transmission of antisocial values, through multi-agency community mobilisation rather than simply police 'crackdowns' following public and political disquiet. The most promising example of the public health model is the Ceasefire project. Ceasefire was aimed at reducing gun violence and was pioneered in Boston, USA. The approach was adapted for the British context by the Glasgow Violence Reduction Unit, led by the police.

Tackling violence against women and girls (VAWG) through public health approaches has also proved to be effective at all levels of intervention – individual, relationship, community and societal. In their systematic review, Addis and Snowdon (2023) note that more evidence is needed in relation to domestic abuse interventions, but conclude that an 'eco-system' of interventions at all levels is effective in reducing VAWG, with successful programmes characterised by 'multi-agency and multi-dose approaches, well-trained staff, and long program length'.

In Figure 12, the World Health Organisation (2017) helpfully outlines how a public health approach to tackling violence is initiated, highlighting the need for evaluation prior to any scaling up.

Figure 12: The public health approach to violence reduction (WHO, 2017)



2.2.7 Building a proficient, experienced and valued workforce

The Chief Inspector of Probation, Martin Jones, has emphasised that individual practitioners should not be blamed for the current performance issues in probation, most clearly exemplified through the quality of public protection work. Rather, organisational deficits underlie the problems; "our probation service has too few staff, with too little experience, managing too many cases" (Jones, 2024). It is thus vital that there is sufficient recruitment and that staff then benefit from ongoing investment, developing their professional knowledge, expertise and autonomy (HM Inspectorate of Probation, 2025). Tidmarsh (2022) argues that a focus on enhancing the tenets of professionalism is required, with an investment in staff at the core – practitioners need to be provided with the right guidance, development, support and oversight to ably manage cases and keep other people safe, and to enable them to reflect critically on practice and continually develop and improve. Senior leaders need to ensure that policies and procedures are fully aligned (and streamlined where possible), and that they then have sufficient oversight of the whole system to ensure that good practice can be maintained (Kemshall, 2021a).

As set out in our research report on frontline leadership (HM Inspectorate of Probation, 2024a), attention should also be given to improving the induction and ongoing training for senior probation officers, including how best to implement reflective practice sessions. The need for more specialist training for staff with managerial and leadership responsibilities is similarly recognised within the Council of Europe guidelines covering the recruitment, training and professional development of probation staff (Council of Europe, 2019; Carr, 2020).

3. Conclusion

Keeping people safe, in conjunction with other partners and agencies, is a key objective for probation, and it is thus an area of focus for our probation inspections, alongside the complementary work undertaken to engage people on probation and support their desistance. We always take a proportionate approach to assessing the quality of work undertaken, considering whether the strengths outweigh any deficits, and also recognise that it is impossible to eliminate all risks in all situations.

However, despite these considerations, our analysis of 2022/2023 inspection data reveals notable shortfalls in public protection work across the ASPIRE stages of assessment, planning, implementation and reviewing. The accompanying inspector commentaries highlight how many of the fundamental requirements for public protection – such as domestic abuse and child safeguarding checks, referrals to interventions, multi-agency working, and ongoing assessment – have not been happening. As we have highlighted previously (e.g. HM Inspectorate of Probation, 2023a; 2025), the recent organisational context for probation – with high levels of staff vacancies and turnover, and excessive workloads and caseloads – has not created an environment conducive for high-quality work. Relying upon the 'heroic efforts' (Stacey, 2019) of individual practitioners to support people to move away from offending behaviour while at the same time protecting the public can be no substitute for properly resourced and staffed probation services.

All of this is recognised within the following considerations which are set out to help improve the quality of public protection work (and the complementary work supporting desistance and integration):

- increasing the analysis of critical information, with practitioners displaying professional curiosity and an analytical mindset
- adopting a 'learning organisation' approach, with leaders paying attention to equitable treatment and psychological safety, and practitioners benefitting from reflective practice supervision, team exercises, peer consultation, and professional mentors/trainers
- focusing on protective integration, balancing practice to manage risk with practice to enhance desistance, thus supporting longer-term change for people on probation
- strengthening the interventions' evidence base, with a focus on continuous improvement and the embedding of best practice
- focusing on effective cooperative and collaborative multi-agency and partnership working, maximising the sharing of information and access to services
- supporting public health approaches to violence reduction, including the scaling-up of effective approaches and interventions
- building a proficient, experienced and valued workforce, with a focus on induction and ongoing training and support, and in ensuring that policies and procedures are fully aligned (and streamlined where possible).

There are clear links here to the PRESENCE components (see Figure 13) for the delivery of high-quality probation services which capture the importance of building a personalised understanding of each individual, cooperative and collaborative partnership working (with attention being given to the continuity of support at the end of the period of supervision), and a commitment to evidence and evaluation, enabling services and delivery to be improved over time. Crucially, practitioners need to be supported and empowered to deliver their best practice and given the time and space to build secure and trusting relationships with those they are supervising, with their colleagues, and with professionals across agencies and sectors within

their local areas. Adopting a relationship-centred approach can help to shine a light on the building of all of these relationships, reducing 'relational distancing' to the benefit of both individuals and local communities.

Figure 13: The PRESENCE components for high-quality services and delivery

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Annex A: Methodology

Probation inspections published during 2022 to 2023

The findings presented in this bulletin from our recent inspections are based upon data from 26 inspections of probation services completed between October 2021 and May 2023 (fieldwork weeks). The 26 PDUs were spread across 11 of the 12 probation regions (England and Wales).

Table A1: Inspections of probation services

Probation Delivery Unit	Month of report publication
Gwent	February 2022
Swansea and Neath Port Talbot	January 2022
West Kent	May 2022
West Sussex	May 2022
Essex North	May 2022
Northamptonshire	May 2022
Birmingham North, East and Solihull	August 2022
Staffordshire and Stoke	August 2022
Warwickshire	August 2022
Hammersmith, Fulham, Kensington, Chelsea and Westminster	October 2022
Ealing and Hillingdon	October 2022
South Tyneside and Gateshead	December 2022
Derby City	February 2023
Leicester, Leicestershire and Rutland	February 2023
Kirklees	March 2023
Sheffield	March 2023
Hull and East Riding of Yorkshire	March 2023
North and North-East Lancashire	March 2023
Tameside	May 2023
Wigan	May 2023
Blackburn and Darwen	June 2023
Cumbria	July 2023
Portsmouth and the Isle of Wight	July 2023
Somerset	August 2023
Dorset (includes Bournemouth, Christchurch and Poole)	August 2023
Bristol and South Gloucestershire	August 2023

A total of 1,748 cases were inspected – which included community-based sentences (community orders and suspended sentence orders) that had a rehabilitation activity or accredited programme requirement, and cases starting post-release supervision. A cohort approach was used across the inspections, examining cases drawn from two separate weeks in the period between 27 and 32 weeks before the fieldwork, including all cases commenced (or released from custody) in each of those weeks. However, potential exclusions were as follows:

- cases where the same person had more than one sentence in the eligible period
- cases where the order or licence had terminated within seven days of commencement
- cases where there was a current serious further offence (SFO) investigation, serious case review, child practice review, or other similar investigation.

All cases in the cohort were allocated to individual inspectors, who examined the relevant records and interviewed the probation practitioner for the respective case. To support the reliability and validity of their judgements against our standards framework, all cases were examined using standard case assessment forms, underpinned by rules and guidance, and further reinforced through training and quality assurance activities.

Analysis

In this bulletin, the percentages presented in the tables and charts relate to the inspectors' judgements within their case assessments. Binary logistic regression was used to analyse which variables predicted inspectors' judgements on the quality of public protection work – see the tables in Annex B.[4] Within all the regression models, a forced entry method was used, entering all relevant independent variables in the same step. This method identifies the unique effect of each independent variable on the prediction of the dependent variable after taking into consideration the effect of all other variables in the model. The associations highlighted in the bulletin are those which were found to be statistically significant within the regression models; the significance level used was five per cent ($p < 0.05$), meaning that there is a 95 per cent certainty that the difference did not occur randomly or by chance.

Inspectors' case commentaries were analysed thematically using nVivo. A 25 per cent random sample of the cases were selected for reading and coding. This sample achieved 'exhaustion'; no new codes were emerging after reviewing all the commentary within the sample. Key themes were identified and developed from the codes, and are illustrated in this bulletin through the use of anonymised extracts.

[4] The number of cases contributing to each model will differ according to any missing data across any of the variables included.

Annex B: Analysis outputs

Table B1: Does assessment focus sufficiently on keeping other people safe?

		N	Positive judgements	
			n	%
All Cases		1,748	568	32.5%
Age group	18-24	265	178	32.8%
	25-29	286	198	30.8%
	30-39	617	423	31.4%
	40-59	520	347	33.3%
	60+	50	28	44.0%
Sex	Male	1,474	471	32.0%
	Female	224	75	33.5%
Ethnicity	White	1,317	436	33.1%
	Ethnic minority	313	97	31.0%
Likelihood of reoffending	Low	987	340	34.4%
	Medium	405	125	30.9%
	High/very high	280	95	33.9%
Risk of serious harm	Low	346	99	28.6%
	Medium	1,013	310	30.6%
	High/very high	275	151	54.9%
Case type	Community	970	302	31.1%
	Post-custody	577	201	34.8%
Previous sanctions	None	283	104	36.7%
	1	176	64	36.4%
	2 – 5	382	113	29.6%
	6 – 10	268	87	32.5%
	11 – 20	294	91	31.0%
	21+	326	103	31.6%

N.B. Shaded cells indicate statistically significant relationships between the independent variables/values (i.e. personal /case characteristics) and the key question ($p<0.05$; based upon logistic regression analysis).

Table B2: Does planning focus sufficiently on keeping other people safe?

		N	Positive judgements	
			n	%
All Cases		1,744	717	41.1%
Age group	18-24	265	111	41.9%
	25-29	286	112	39.2%
	30-39	616	240	39.0%
	40-59	519	220	42.4%
	60+	50	31	62.0%
Sex	Male	1,472	599	40.7%
	Female	224	92	41.1%
Ethnicity	White	1,315	557	42.4%
	Ethnic minority	313	115	36.7%
Likelihood of reoffending	Low	986	432	43.8%
	Medium	404	162	40.1%
	High/very high	280	113	40.4%
Risk of serious harm	Low	346	140	40.5%
	Medium	1,011	397	39.3%
	High/very high	275	174	63.3%
Case type	Community	969	379	39.1%
	Post-custody	577	247	42.8%
Previous sanctions	None	282	140	49.6%
	1	176	83	47.2%
	2 – 5	382	135	35.3%
	6 – 10	268	117	43.7%
	11 – 20	293	119	40.6%
	21+	326	117	35.9%

N.B. Shaded cells indicate statistically significant relationships between the independent variables/values (i.e. personal/case characteristics) and the key question ($p<0.05$; based upon logistic regression analysis).

Table B3: Does the implementation and delivery of services effectively support the safety of other people?

		N	Positive judgements	
			n	%
All Cases		1,742	613	35.2%
Age group	18-24	263	98	37.3%
	25-29	285	107	37.5%
	30-39	617	197	31.9%
	40-59	519	172	33.1%
	60+	50	35	70.0%
Sex	Male	1,470	512	34.8%
	Female	224	85	37.9%
Ethnicity	White	1,314	481	36.6%
	Ethnic minority	312	101	32.4%
Likelihood of reoffending	Low	983	378	38.5%
	Medium	405	128	31.6%
	High/very high	279	93	33.3%
Risk of serious harm	Low	344	152	44.2%
	Medium	1,011	306	30.3%
	High/very high	274	131	47.8%
Case type	Community	966	300	31.1%
	Post-custody	578	211	36.5%
Previous sanctions	None	282	134	47.5%
	1	176	79	44.9%
	2 – 5	382	115	30.1%
	6 – 10	266	90	33.8%
	11 – 20	293	98	33.4%
	21+	326	89	27.3%

N.B. Shaded cells indicate statistically significant relationships between the independent variables/values (i.e. personal/case characteristics) and the key question ($p<0.05$; based upon logistic regression analysis).

Table B4: Does reviewing focus sufficiently on keeping other people safe?

		N	Positive judgements	
			n	%
All Cases		1,740	711	40.9%
Age group	18-24	264	121	45.8%
	25-29	285	109	38.2%
	30-39	616	231	37.5%
	40-59	517	213	41.2%
	60+	50	33	66.0%
Sex	Male	1,470	599	40.7%
	Female	222	92	41.4%
Ethnicity	White	1,311	546	41.6%
	Ethnic minority	313	124	39.6%
Likelihood of reoffending	Low	980	420	42.9%
	Medium	405	162	40.0%
	High/very high	279	108	38.7%
Risk of serious harm	Low	344	160	46.5%
	Medium	1,008	376	37.3%
	High/very high	274	132	48.2%
Case type	Community	964	365	37.9%
	Post-custody	578	238	41.2%
Previous sanctions	None	283	144	50.9%
	1	174	82	47.1%
	2 – 5	381	138	36.2%
	6 – 10	266	105	39.5%
	11 – 20	293	114	38.9%
	21+	326	118	36.2%

N.B. Shaded cells indicate statistically significant relationships between the independent variables/values (i.e. personal/case characteristics) and the key question ($p<0.05$; based upon logistic regression analysis).

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