



HM Inspectorate of Probation

AN EFFECTIVE SUPERVISION  
INSPECTION PROGRAMME  
THEMATIC REPORT

Reducing Domestic Violence

An Inspection of  
National Probation Service  
Work with Domestic  
Violence Perpetrators

## Foreword

---

The headlines about the prevalence of domestic violence in society are alarming – every minute the police receive such a call; every day thousands of children witness domestic violence; every week two women are killed by a partner or ex-partner; and the Council of Europe has stated that it is the major cause of death and disability for women aged 16-44, and accounts for more death and ill-health than cancer or traffic accidents. The National Probation Service plays an important role in trying to make an impact on this offending. This inspection of domestic violence work was timely as the National Probation Service began to introduce a specific assessment tool and a nationally accredited programme for offenders.

The findings of this inspection show that there is much need for improvement. Although many of the current developments should make a difference, responding to the recommendations of this report will be a challenge against the backdrop of the introduction of National Offender Management Service and the implementation of the Criminal Justice Act 2003.

The benefits from reducing domestic violence reoffending could make a significant impact on reducing repeat victimisation, the levels of violent crime, demand on health and other public services and, importantly, the effects on the many children who witness domestic abuse daily.

**ANDREW BRIDGES**

HM Chief Inspector of Probation

## Acknowledgements

---

This was the second of our thematic inspections within the new Effective Supervision Inspection programme. Most of the evidence gathering was undertaken as an integral part of the fieldwork for the core Effective Supervision Inspection.

We would like to express our thanks to the Boards, managers and staff of the seven areas visited. All were very helpful in enabling the inspection to run smoothly. In each area local assessors also assisted with scrutinising files and interviewing case managers; their participation and commitment was greatly appreciated.

The Standards and Criteria were shared with a reference group and we were grateful for the feedback from RESPECT.

At every stage we consulted the National Probation Directorate and Sue Pearce, in particular, was very helpful.

**DI ASKWITH**

HM Inspector of Probation

**MARY BARNISH**

Inspection Officer

**ALAN MACDONALD**

HM Assistant Chief Inspector of Probation

July 2004

## Contents

---

	Page
Foreword and Acknowledgements	2
Glossary	4
1. KEY FINDINGS AND RECOMMENDATIONS	5
2. BACKGROUND TO THE INSPECTION	8
3. AIMS, OBJECTIVES AND METHODOLOGY OF THE INSPECTION	10
4. PUTTING VICTIMS FIRST	13
5. DIVERSITY	18
6. QUALITY OF DV MANAGEMENT	20
7. QUALITY OF DV ASSESSMENT	28
8. QUALITY OF DV INTERVENTIONS	35
9. QUALITY OF INITIAL DV OUTCOMES	42
10. CURRENT EMERGING ISSUES	45
11. FUTURE DEVELOPMENTS	52
12. PROFILE OF THE DV SAMPLE	56

## Glossary

---

ACO	Assistant chief officer
ACPC	Area Child Protection Committee
CDRP	Crime and Disorder Reduction Partnerships
CDVP	Community Domestic Violence Programme
CM	Case Manager
CPO	Community punishment order: a community sentence requiring the offender to complete unpaid work, measured in hours
CPRO	Community punishment and rehabilitation order
CPS	Crown Prosecution Service
CRAMS	Case Record Administration and Management System
CRO	Community rehabilitation order
DV	Domestic Violence
DVU	Domestic Violence Unit
ESI	Effective Supervision Inspection: HMI Probation's current programme of inspection of the 42 Probation areas over three years from June 2003
HMCPSP	HM Crown Prosecution Service Inspectorate
HMIC	HM Inspectorate of Constabulary
HR	Human resources
IDAP	Integrated Domestic Abuse Programme
ISP	Initial supervision plan: In a probation case record, the first formal assessment and plan for an individual offender's period of supervision
LCJB	Local Criminal Justice Board
LoR	Likelihood of reoffending
MAPP	Multi-Agency Public Protection
MAPPA	Multi-Agency Public Protection Arrangements
MAPPP	Multi-Agency Public Protection Panel
MAPPSMB	Multi-Agency Public Protection Strategic Management Board
NOMS	National Offender Management Service
NPD	National Probation Directorate: Although a part of the Home Office, the NPD is also the 'Head Office' of the NPS
NPS	National Probation Service: Consisting of 42 Probation Areas, each run by its own Board, plus the NPD
NSPCC	National Society for the Prevention of Cruelty to Children
OASys	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.
OGRS	Offender Group Reconviction Scale
PO	Probation officer
PSO	Probation service officer
PSR	Pre-sentence report: Reports that advise a court at point of sentence
RMP	Risk management plan
RoH	Risk of harm
SARA	Spousal Assault Risk Assessment
SMART	Smart – Measurable – Achievable – Realistic – Time-bounded
SPO	Senior probation officer
SSR	Specific sentence report
TPO	Trainee probation officer
VLO	Victim liaison officer

# 1. KEY FINDINGS AND RECOMMENDATIONS

---

## OVERALL FINDINGS FOR QUALITY OF DV MANAGEMENT

### *Strengths*

- Areas had maintained a strategic focus on DV even though there had been little drive through national priorities, targets and performance measures.
- Internal management structures did facilitate a focus on DV issues and there was evidence that senior managers were working with colleagues on an integrated approach.
- The level of engagement of senior and middle managers and others in local DV forums was impressive.

### *Areas for improvement*

- Although the developments associated with accredited programmes were impressive, the NPD needed to ensure that these were comprehensive and covered all DV-related perpetrator, victim and staff issues.
- Few areas had a comprehensive up-to-date DV policy/plan.
- A lack of consistency of approach to DV work between and sometimes within areas was apparent.
- There were no outcome-focused targets for probation DV work.
- Little monitoring information was available about DV outcomes.
- There was inconsistency and lack of clarity in the allocation of cases to different grades of staff.
- Areas had not ensured that all relevant staff had appropriate knowledge, understanding and skills in DV work.
- Communication with sentencers did not include feedback on DV outcomes.

## OVERALL FINDINGS FOR QUALITY OF DV ASSESSMENT

### *Strengths*

- Most cases had been assigned the appropriate category of RoH.
- Orders and licences were fully explained to most offenders.
- Case recording was clear and sufficient in a majority of cases.

### ***Areas for improvement***

- The quality of assessment of RoH was insufficient and links with police DVUs needed strengthening.
- The LoR and DV-related criminogenic factors were not assessed well in many cases.
- ISPs did not contain SMART DV-related objectives.
- There was insufficient use of additional conditions in orders/licences.
- Risk management plans were not timely or sufficient.
- Confidential information was not being kept safely.

## **OVERALL FINDINGS FOR QUALITY OF DV INTERVENTIONS**

### ***Strength***

- Judgements about the acceptability of absences were mostly appropriate.

### ***Areas for improvement***

- There was a lack of appropriate interventions for DV offenders to address their specific criminogenic needs.
- Breach action was not always taken within national standards timescales.
- Information about breach of civil court or restraining orders was not passed promptly to the relevant authorities.
- There was a lack of specialist resources available to assist case managers.
- The quality of pre-release work was poor.
- Insufficient was done to respond to changes in the RoH status.
- The quality of risk management plans was poor.
- The RoH to children from DV was not addressed sufficiently.

## **OVERALL FINDINGS FOR QUALITY OF INITIAL DV OUTCOMES**

### ***Strengths***

- Over half of offenders had made progress on relevant criminogenic factors.
- Most offenders had attended all or nearly all of their DV-related appointments.

### ***Areas for improvement***

- Most evidence of progress relied upon offender self-report.
- Lack of clarity about what was to be achieved led to lack of clarity about what had been achieved.

## **Recommendations**

### ***The NPD should ensure that:***

1. *Policy and practice development covers all aspects of DV work undertaken by the NPS.*
2. *Areas develop local policy based on a new national DV policy supported by consistent targets and monitoring.*
3. *The quality of assessment and risk management planning improves.*
4. *As part of the roll-out of accredited programmes guidance is issued about appropriate SMART objectives for those on programmes but also for those DV offenders considered unsuitable.*
5. *Urgent action is taken to improve the quality of risk management plans.*
6. *Guidance is issued for practitioners on DV-related civil and criminal court orders.*
7. *The policy on the suitability of different types of court report for DV cases is clarified.*
8. *Guidance is developed for practitioners on RoH thresholds for DV cases and the links between alcohol misuse and DV.*
9. *Work is undertaken with other departments and agencies to develop a more consistent and coherent approach to the management of DV cases.*

### ***Boards should ensure that:***

10. *All relevant staff have appropriate levels of DV-related knowledge, understanding and skills.*
11. *Allocation of cases is based on a clear and consistent policy and procedure.*
12. *Communication with sentencers on DV-related issues includes feedback on the outcome of interventions.*
13. *Protocols are established with the police to ensure the routine exchange of information about DV perpetrators.*
14. *Confidential information is kept safely.*
15. *DV cases that require breach action are dealt with promptly.*
16. *There are local specialist resources available to advise case managers on DV cases.*
17. *Case managers take appropriate action in relation to civil court and restraining orders.*
18. *Pre-release work with DV offenders is improved.*
19. *Action is taken in every case to address the risks to children from DV.*
20. *Steps are taken to gather independent evidence of progress.*
21. *Action is taken so that CPS documentation is available for initial assessments.*

## 2. BACKGROUND TO THE INSPECTION

---

- 2.1 As part of the duty to protect the public and reduce reoffending the National Probation Service for England and Wales assesses and manages the risks presented by DV offenders sentenced to community sentences and released from prison on licences.
- 2.2 The NPS aims “to increase public protection and reduce recidivism through effective management of adult offenders in the community” (*Bold Steps: Objectives and Targets 2004/2005 NPS*). The main mechanisms for achieving this are the assessment of offenders both pre- and post-sentence, by delivering interventions designed to reduce the LoR and RoH and by managing cases often in collaboration with others in order to minimise RoH to others. The NPS also works with some victims of DV by providing information to them about prisoners’ progress through their sentence and enables the victim to have a voice in planning a safe release.
- 2.3 In the last five years there have been significant developments in all these aspects of the probation task:
- the introduction of OASys, a joint prison/probation assessment tool
  - the development of two accredited programmes which were being rolled out as this inspection took place
  - the creation of MAPPA as a framework within which high RoH cases are managed.
- 2.4 Work done by the NPS takes place within an overarching Government strategy to address DV. The Government White paper – *Safety and Justice* – described a three pronged approach aimed at effective prevention, swift justice including the protection of victims during this process, and support. Many statutory and voluntary organisations are part of the delivery framework. The White Paper also sets out the range of initiatives that have already been put in place. Amongst these was *Multi-Agency Guidance for Addressing Domestic Violence* (London: Home Office 2000), published under the Government's 'Living Without Fear' campaign to tackle violence against women. It remains the framework for joint working to address DV. New legislation was about to be introduced as the inspection drew to a close.
- 2.5 The NPS response has included the introduction of a specific assessment tool (SARA) and the development of accredited DV programmes for offenders. The recognition of the importance of an integrated response to DV has meant that the programme delivery framework included a local inter-agency approach to dealing with DV from the reporting of an incident through to an offender’s release on licence and sometimes beyond. It also included the development of a supportive community infrastructure for victims.

2.6 This inspection took place at a time when probation practice was improving. The introduction of OASys, SARA and accredited programmes meant that positive steps were being taken to improve somewhat patchy provision. The aim of this inspection was to take stock of the quality of management, assessment, interventions and initial outcomes, measuring current against best practice and to identify key areas for improvement. The serious consequences of DV led us to develop a set of Standards and Criteria that aimed to represent best practice. This meant that areas were some way from meeting them in 100% of cases. The impact of this on the findings should be taken into account when considering this inspection report.

### 3. AIMS, OBJECTIVES AND METHODOLOGY OF THE INSPECTION

---

3.1 In this section we set out the nature and purpose of the inspection, as well as explain how it was conducted.

#### **Purpose and scope of the inspection**

3.2 The overall aim of the inspection was to:

- determine the extent to which the NPS contributes to the reduction of harm to primary and secondary victims of domestic violence.

3.3 The specific objectives were to:

- determine the extent to which, in relation to DV, the NPS:
  - identifies all relevant cases consistently
  - assesses accurately the risks/criminogenic needs of offenders
  - delivers effectively evidence-based interventions to address risk and criminogenic need
  - collaborates with other agencies sufficiently and effectively
  - reduces offending behaviour
  - reduces the risk of harm to victims and others
  - gives priority to victims' concerns
  - addresses race, gender and other aspects of diversity for both victims and perpetrators.

3.4 There has been considerable national debate about what should be included in a definition of DV and when the inspection took place there was no agreed form of words. The definition of DV then defined by the Home Office that we used for the inspection was:

- "Any violence between current or former partners in an intimate relationship, wherever and whenever the violence occurs. The violence may include physical, sexual, emotional or financial abuse".

3.5 Following an inter-departmental review, the definition has recently been widened to incorporate violence by family members as well as between adults who are, or were intimate partners. This was done to ensure that those issues of chief concern to black and minority ethnic communities, such as so-called 'honour crimes', are properly reflected. It follows the definition used by the Association of Chief Police Officers, and is:

- "Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality".

This now forms a common Government definition of DV.

- 3.6 The scope of the inspection meant that the focus was narrower than we would have wished. The fieldwork interviews focused solely on those offenders on licences, CROs and CPROs where DV had been, or should have been a main feature of supervision. We included men and women who had abused their partners or ex-partners whether same sex or opposite sex. We excluded men and women who had abused their parents, children or other relatives. We did not look at offenders as victims of DV, although inevitably there was some crossover.
- 3.7 We had a very limited focus on the work done with the victims of DV, identifying a very small number of cases in our sample where there had been matched victim contact work done. As a result of the small number we decided not to follow these cases up with the victims themselves. We asked specific questions about how areas dealt with staff who were perpetrators or victims of DV.
- 3.8 The criteria for both the ESI and the DV thematic element used the same structure and both evaluated:
- Quality of Management
  - Quality of Assessment
  - Quality of Interventions
  - Quality of Initial Outcomes.
- 3.9 This approach was based on our belief that offenders are effectively supervised if they are assessed well, receive good quality interventions and achieve some identifiable initial outcomes. Furthermore, certain management criteria needed to be met to support this front line process. It will be seen that this report applies the same structure and principles as ESI, but applies them specifically to DV.
- 3.10 We visited seven probation areas:
- Hertfordshire
  - Essex
  - Teesside
  - County Durham
  - Gwent
  - South Wales
  - Staffordshire.
- 3.11 The nature of the areas in the sample meant that we did not look at some of the initiatives around the country that were addressing DV offending.
- 3.12 We asked for a range of evidence in advance from areas which provided much of the evidence for the quality of management section of the inspection. In each area we asked to see at least 20 DV cases taken from the main ESI sample or chosen randomly to make up the numbers. We interviewed the case managers and, where possible, the offenders and any significant others involved in delivering interventions. In addition, we asked to see the victim contact case managers for any offenders in the sample where there was work being done with the victim.

- 3.13 We undertook a range of interviews with senior and middle managers, practitioners, specialists and partners and service providers. We also interviewed members of the NPD with specific responsibility for DV work.
- 3.14 In addition, information has been drawn from a review of incidents of serious further offending which looked at all those notified during 2002/2003.
- 3.15 The focus of this inspection was on the work of the NPS. The nature of DV provision made it inevitable that we would also look at the quality of inter-agency working. However in order for there to be a comprehensive report into the effectiveness of DV work, there would need to be a joint inspection involving many Inspectorates.

## 4. PUTTING VICTIMS FIRST

---

4.1 Much of the work done by the NPS does not involve a clearly identifiable victim. In DV cases however there is always at least one individual whose safety and welfare should be at the top of the list of priorities. In recent years there has been a stronger focus on victims with the introduction of a national strategic focus on improving work on victim issues, victim contact work as a statutory duty and victim awareness modules in accredited programmes. We were looking for 'victim first thinking' in work with offenders.

4.2 The table below provides an analysis of some of the relevant criteria we looked at during the inspection.

Table 1: The focus on victims in offender assessments, interventions and outcomes

Criteria	All areas
When planning DV interventions sufficient consideration of victim safety issues	34%
Information from victim contact staff sought and used in the assessment	43%
For high/very high-risk cases RMP included a victim safety plan	19%
Victim protection taken into account when ensuring compliance	69%
Victim issues properly addressed by interventions	54%
Work undertaken to make offender aware of victim impact issues	58%
Case manager actively liaises with others providing interventions to victims	54%
Victim protection paramount throughout management of the case	39%
Confirmation of no further DV-related behaviour by the victim	16%

4.3 When planning interventions only just over a third of cases included sufficient consideration of victim safety, e.g. research has shown that RoH may increase when an intervention begins, this should be taken into account by case managers. Too many supervision plans focused exclusively on the offender.

4.4 There were a small number of cases involving victim contact staff and we looked for evidence that information from their work with victims had been sought and used in assessments. Generally information was sent by victim contact staff. Case managers and report writers less often took the initiative to contact VLOs for information.

4.5 In cases assessed as high and very high RoH, where a RMP was mandatory, we hoped to find action plans relating to the safety of the victim, probably developed in consultation with the victim and in a multi-agency risk management forum. We asked whether a victim would feel safer having read a plan. It was of great concern that victim safety plans were included in less than a fifth of cases.

### ***What might be included in a victim safety plan***

*Victim safety plans should be developed in consultation with the victim and can include:*

- *assistance with rehousing*
- *alarm installation, security improvements and other target hardening action*
- *appropriate and monitored order/licence conditions*
- *legal assistance*
- *incident reporting arrangements*
- *community safety unit contact, etc.*
- *implementation that is likely to be carried out by other voluntary or statutory agencies and may involve the local probation victim contact unit.*

- 4.6 When DV offenders fail to comply with their order/licence certain steps should be taken in line with national standards. In DV cases these steps may result in raised RoH, e.g. an offender may blame the victim and increase their violence by way of punishment, and so it is important that the impact of enforcement action is taken into account. Although areas performed better against this criterion, there were still nearly a third of cases where this was not so.
- 4.7 In a significant proportion of cases interventions did not address victim issues sufficiently, sometimes not at all, nor was specific work done to raise offenders' awareness of the impact of their offending on victims. This was best achieved where a DV-related programme was used, but was rarely sufficient where it was integrated into general one-to-one work by the case manager.
- 4.8 We asked whether victim protection had been paramount during the management of the order and this was only evident in just over a third of cases. Too often the case was only considered from the offender's perspective and, whilst this could bring benefits for the victim, it often left out some critical factors.
- 4.9 In looking at outcomes we were interested to see what percentage of case managers were able to verify progress by having direct or indirect confirmation by the victim that there had been no further DV-related behaviour by the offender. Whilst this information may not always be accurate, it is perhaps the best means of determining how effective interventions have been. It should also be acknowledged that not every victim would want to have any further involvement and that this should be respected. In less than a fifth of cases was this information available.

### **Victim contact work**

- 4.10 This section deals with the work done by the NPS as part of its statutory duty to contact and provide information to victims of serious violent or sexual offences. We asked areas to identify any cases in the DV sample where contact had been made and sustained with the victim of the offence. This yielded only four cases and so caution should be exercised about the findings in this section. Table 2 below shows the findings from the inspection that focused on victims issues.

Table 2: Work with victims

Criteria	All areas
Information from victim contact staff sought and used in the assessment (these data taken from the main ESI sample)	43%
Case manager liaises with those providing interventions to victims (these data taken from the main ESI sample)	54%
VLO contributed information to RoH assessment	2 out of 4 cases
VLO contributed to RMP	3 out of 3 cases
VLO contributed to victim safety plan	2 out of 3 cases
Liaison and information sharing arrangements clearly specified	3 out of 4 cases
Timely information provided to victims on RMP and victim safety plan	2 out of 3 cases
Appropriate action taken by VLO in response to any incidents of concern	1 out of 1 cases
Appropriate use made of specialist resources made to meet victims needs	3 out of 4 cases
Active liaison by VLO with case manager	3 out of 3 cases
Active liaison by case manager with VLO	1 out of 3 cases
RoH managed well by the VLO	4 out of 4 cases
Victim safety paramount throughout VLO management of the case	3 out of 4 cases

- 4.11 We looked at victim contact work from two perspectives – first, the VLO's work with the victim and communication to the case manager and, secondly, the extent to which the case manager liaised with the VLO about what was happening with the offender. In general we found that the work being done by VLOs was of good quality, albeit limited by their specified role. Where cases fell down was the extent to which the VLO was kept informed by the case manager, e.g. in one case the case manager had failed to notify the VLO promptly that an offender had been recalled. If passed on to the victim this information might have reduced any anxiety about repeat victimisation.
- 4.12 VLOs generally attended MAPPA meetings and so their contribution to RMPs was good. Most of the examples of insufficient practice related to one case where the VLO had not discussed the DV-related offending with the victim in any depth and so could not have made a realistic assessment of the level or RoH from the victim's perspective. In one case, where a voluntary organisation was actively involved, this had the effect of sidelining the VLO. Whilst it was sensible to keep to a minimum the number of points of contact with the victim, there also needed to be clarity about information sharing, communication and roles and responsibilities.

### Learning lessons from experience

- 4.13 When an offender under the supervision of the probation service commits a serious further offence this triggers a review aimed at determining whether the case had been managed appropriately. HMI Probation, in collaboration with the NPD, periodically carries out a scrutiny of these cases. For 2002/2003 all the management reviews were

scrutinised and for this inspection an analysis done of all those cases which were DV related. There were some important lessons to be learnt.

4.14 The profile of the DV sample had some significant differences to the whole sample.

*The DV sample was:*

- *less heavily convicted*
- *more likely to have the case withdrawn*
- *more likely to be serving a community penalty*
- *likely to have had a lower RoH*
- *more likely to have previous sexual or violent offences*
- *more likely to be a MAPPa case and level 3*
- *more likely to be a rape offence*
- *more likely to act alone*
- *less likely to have been transferred*
- *likely to have had a lower LoR*
- *more likely to have alcohol/drugs as a risk factor.*

4.15 The sample also showed that in 58% of cases the victim had been previously subject to DV. 84% of incidents took place within the first nine months of the order/licence, indicating the importance of a rigorous approach in that first period of supervision. The assessed level of RoH at commencement was lower for DV cases but the same just before the incident. This is a significant finding which indicates that there is a need to improve assessment accuracy at initial contact.

4.16 The management reviews commented on the quality of RoH assessment and management. We compared the results for DV cases to the whole sample. The findings hold lessons for the future development of practice. The following positive findings were drawn:

- contact and supervision plans were more likely to be in line with national standards
- it was more likely that policy and procedures would have been followed and failures to attend followed up
- cases were more likely to be properly recorded.

4.17 On the other hand the following were less likely to be the case than for the whole sample:

- changes to RoH to have been managed sufficiently
- to have RoH accurately assessed
- line managers to have been consulted by the case manager
- middle managers to provide adequate support
- senior and middle managers to be involved in these cases
- to have appropriate liaison with other agencies
- successful MAPPa
- appropriate training

- the serious incident to have been considered unpredictable
- the high RoH had been recognised.

4.18 These findings provide us with some important pointers for the future and will be picked up later in this report.

4.19 One initiative aimed at identifying lessons and disseminating them was the South Wales pilot of DV Homicide Reviews. Based on an established multi-agency process for reviewing child deaths, the review process had been in operation since 2002. All homicide case reviews were undertaken by the South Wales DV Forum and aimed to establish whether there were lessons to be learnt from the case, disseminate the lessons and ensure they were acted upon. In addition, there was an aim to improve inter-agency working and response and to more effectively safeguard DV victims.

4.20 Another initiative was under way in Gwent. The Gwent Criminal Justice Board had developed a one year project aimed at improving the way agencies worked together. The project was set up to gather information on the efficacy of measures that contribute to:

- bringing more DV offences to justice
- improving victim and witness satisfaction and safety
- addressing the equality, diversity and discrimination issues in relation to both victims and perpetrators
- integrating the needs of children as victims and witnesses.

## 5. DIVERSITY

---

5.1 Throughout all HMI Probation inspections diversity is integrated into the methodology. However, in order to give a focus to what the inspection told us about diversity and DV, we have extracted all the findings and present them in a specific section.

5.2 The table below shows the findings for all the individual questions used during the inspection.

Table 3: Diversity in assessment and interventions

Criteria	All areas
Supervision plan sensitive to diversity issues	67%
Plans for DV interventions take account of diversity issues	56%
Issues of literacy and dyslexia addressed	68%
Arrangements for interventions takes into account race and other diversity issues	82%
Delivery of interventions sensitive to diversity issues	80%
Victim diversity taken into account by VLO	3 out of 4 cases

5.3 We looked for consideration of diversity issues to be built into every aspect of work with DV offenders and their victims. Of the 152 offenders only five were women, nine were from a minority ethnic background and 25 had a disability. Of the offenders with a disability, about half had a physical disability and about half had a mental health issue.

5.4 Two-thirds of plans were sensitive to diversity issues. We looked for plans that took into account diversity in relation to relevance (e.g. if it was a woman offender did the plan take into account her different needs given that most DV work is geared towards male offenders), responsiveness (e.g. did plans take into account the different cultural backgrounds of offenders), and fairness (e.g. did plans take into account the problems for offenders living in rural settings).

5.5 There were a small number of offenders for whom literacy and/or dyslexia was a problem. We found that assessments had taken place in the majority of cases, although in some cases steps had not been taken to put in place plans to address the issues. In effect, this sometimes hampered offenders' ability to make the most of other interventions.

5.6 Although small in number there was evidence from the inspection that DV in same sex relationships was not dealt with appropriately, e.g. one case where issues of sexuality were ignored.

- 5.7 In many cases where the perpetrator was a woman she had also been a victim of DV. This was not always taken into account when planning interventions, e.g. one female perpetrator, who was also a victim of DV, was placed in a mixed hostel where other male DV perpetrators were residents.
- 5.8 Arrangements for interventions and their actual delivery did take into account diversity issues in most cases. This will become even more important with the delivery of accredited programmes where programme tutors and case managers will need to ensure that programme arrangements and delivery take account of the diverse needs and circumstances of offenders and victims.

## 6. QUALITY OF DV MANAGEMENT

- 6.1 This chapter considers five aspects of the quality of management. We sought evidence that areas had in place a strategic framework dealing with work with DV perpetrators and victims, that they were clear about what was to be achieved, demonstrated their commitment to this and could show what had been achieved. Evidence came from the interviews conducted with managers, practitioners, service providers and partners. Some evidence was included in documentation provided in advance of the inspection.
- 6.2 We were aware that there had not been a national focus on developing DV work for a significant period of time and that it was likely that areas had focused their efforts on other developments. This proved to be the case.

### **Leadership and planning:**

- In conjunction with partner agencies, the area operates a comprehensive DV harm reduction policy consistent with national guidance and supported by a strategic implementation plan. Effective management structures and processes exist for delivering DV policy, and managers are held accountable for its effective operation.*

- 6.3 Most areas did not have an up-to-date and comprehensive DV policy; see the box below for the elements inspectors were looking for. A draft national policy had been circulated in May 2003 and some areas had decided to await the publication of the policy before developing their own. This was a reasonable position to take, although delays in the publication of the policy had meant that some areas had been without a strategic framework in the interim. The development and implementation of IDAP had meant a recent renewed focus on DV as areas appraised their readiness to deliver a programme requiring a complex multi-agency infrastructure. Most areas were in a good position to speed up their developments.

CRITERIA	Herts	Essex	Teesside	County Durham	Gwent	South Wales	Staffs
... the area operates a comprehensive DV harm reduction policy ...	NOT MET	PARTLY MET	PARTLY MET	PARTLY MET	PARTLY MET	PARTLY MET	NOT MET

***In order to meet the criteria, a good example of a policy/plan should:***

- *cover services for perpetrators, victims and issues for employees*
- *include local DV-related targets and priorities stating how they will be met*
- *have race equality and diversity measures (including monitoring by race/gender)*
- *be integrated with other relevant NPS national and area policies/plans (e.g. child protection, risk management, accredited programmes) and with other criminal justice agency DV plans*
- *have been developed in consultation with other criminal justice agencies and with victim/survivor groups*
- *have been communicated to relevant staff, courts, partner and other criminal justice agencies*
- *be implemented consistently across the area*
- *include regular arrangements for monitoring, review and effectiveness evaluation, and progress reported to the Board and other partners.*

- 6.4 The delivery arrangements for DV work are complex and would normally touch on the responsibilities of most senior managers in an area, e.g. ACOs with responsibility for community sentences, resettlement, risk and public protection, HR, programme delivery and partnerships would probably have some role to play in the delivery of DV work. In all areas one ACO had been given responsibility for DV policy in general, often combined with the public protection brief. Sometimes a different ACO dealt with programme delivery. There was a commitment to collaboration in all areas inspected and joint work had already been undertaken in many areas to develop an implementation plan for IDAP.
- 6.5 DV featured in area business plans focusing on the implementation of IDAP. More thought could have been given to integrating the plans and associated targets developed by multi-agency DV forums.
- 6.6 All the areas inspected, except one, had engaged with partners in DV forums in building a multi-agency approach. Generally they were members of an overarching area DV forum which coordinated the strategies of smaller forums based on local authority areas. The senior managers who sat on these forums were making a significant contribution to the development of DV work. In Wales, senior managers were also contributing to the development of an All-Wales strategic framework. Middle managers and in one area probation community safety officers sat on the local forums and in many cases took a leading role. Members of partner agencies interviewed as part of the inspection were in the main very positive about the probation service's contribution.
- 6.7 Areas trod a difficult path between trying to be responsive to local needs and building consistency. This was hampered by the lack of a clear national strategic approach, e.g. many different definitions of what constituted DV were in operation.
- 6.8 None of the areas visited was able to provide detailed data on DV. Although some DV forums had basic information provided by the police about the volume of DV incidents, there was little other detailed information about the nature and extent of DV in an area. As part of the inspection, in order to find out if DV cases were being correctly identified, we asked areas to liaise with their local police DVUs to find out if any of the sample of cases looked at had been subject to a police callout. No area was able to provide us

with a full list. In one area, where we were provided with a relatively complete list, it showed nearly half of cases had been subject to police attention because of a DV incident, either as a victim or as a perpetrator. This represented a much higher number than had been anticipated. OASys pilots seemed to indicate that 20% of cases were DV perpetrators. It seems likely that this is an underestimate. There is an urgent need for better information collection.

- 6.9 We found no probation outcome focused targets either nationally or in areas. Some areas had development targets in relation to policy and programme implementation, but none had considered, for example, a reduction in police callouts for DV offenders as a target. The Women's Safety Unit in Cardiff was an impressive example of how a multi-agency initiative could clearly set out what was to be achieved and show what had been achieved e.g. the final evaluation report showed that repeat victimisation had decreased by 36%.
- 6.10 One of the criteria for leadership and planning involved the extent to which NPD action supported DV harm reduction policy, the development of consistent national information and held areas to account for their performance. Seen from the area perspective there had been some frustration at the time taken to develop and implement accredited programmes. The absence of a research base to establish effectiveness had led to a longer pathfinder stage than with other programmes. Policy development was also delayed because of the need to dovetail with programme implementation and the likely introduction of new legislation. Funding difficulties had also led to delays in the plans for implementation. In order to meet the criteria for this inspection the developments would need to have been more advanced.
- 6.11 Women's safety work was included as an integral part of the accredited programmes. Some areas were struggling with funding this development, as there was no additional money being made available. In most areas access to women's safety work would only be for the victims of perpetrators on the programme potentially leaving a large number of victims without this facility. Thought needed to be given to how WSW development might integrate with, and complement advocacy and outreach services delivered by the voluntary sector and with probation victim contact work, otherwise there was a danger of duplicated and/or fragmented services to victims.
- 6.12 Responsibility for DV policy and practice straddled two departments within the NPD covering programme delivery and public protection. Although there had been close working between the staff from both departments, it was apparent that there needed to be further consideration about how DV integrated into the structure. This became apparent in areas where there was some confusion about where DV cases fitted in MAPPA in the absence of clear national guidance.

**Resource allocation:**

- *The area demonstrates a strategic approach to effective resource allocation for DV work.*

- 6.13 The efficient allocation of resources relies upon clarity about what is to be achieved and a means of prioritising and targeting resources in order to produce results. Most areas partly met this criterion because they had continued to allocate resources to DV work,

even though there had been no national focus or priority given to this. However, expected DV-related results were not well defined and resource allocation was not well thought out.

- 6.14 Under this heading we considered the decisions areas made about the allocation of cases, e.g. whether there was clear guidance about allocation of cases to POs, PSOs and TPOs. An obstacle to clarity was the poor identification of cases. Areas were unable to identify which cases were DV-related partly because nationally developed information systems, until the introduction of OASys, had not facilitated this. In addition, areas did not have clear policies about allocation. In some areas allocation was on the basis of RoH category, so high/very high RoH cases went to POs and medium/low cases generally went to PSOs. We found that 70% of cases were supervised by POs, 14% by PSOs and 7% by TPOs. This may reflect that most of the cases were in their first eight months of supervision and some areas had procedures that involved transfer to a low intensity team, staffed often by PSOs, later in the order.
- 6.15 Our main concern was that the staff holding cases had sufficient knowledge, understanding and skills about DV to properly supervise the case. We did find many examples where this was not so, although this did not break down by grade. It was worrying that some TPOs early in their traineeship were expected to supervise DV cases without having the necessary preparation. Areas were faced with a dilemma of how to give trainees the experience of supervising complex RoH cases at the same time as ensuring the quality of work done with these offenders. The best arrangement seemed to be co-working with an experienced PO where the latter retained overall responsibility for the case.

Criteria	Herts	Essex	Teesside	County Durham	Gwent	South Wales	Staffs
The area demonstrates a strategic approach to effective resource allocation for DV work	NOT MET	PARTLY MET	PARTLY MET	PARTLY MET	PARTLY MET	PARTLY MET	PARTLY MET

**Management and supervision of staff:**

- ***The area's HR policies, strategies and personnel management practices ensure the effective delivery of DV harm reduction work.***

- 6.16 Under this heading we considered staff recruitment, selection, training, supervision and support. Although some areas partly met the criteria, the overall performance in this area was disappointing especially as a critical factor in the assessment and management of individual DV cases is effective staff.
- 6.17 None of the areas had arrangements in place to ensure that those staff supervising DV cases had sufficient relevant knowledge, understanding and skills. It was not surprising therefore that the majority of those interviewed felt that they would benefit from greater input on DV issues. Some case managers acknowledged that their level of knowledge and understanding about DV was below an acceptable level. The level of detailed

knowledge about the specific risk factors relevant to DV cases was of concern. There was, however, a strong sense of commitment to improving practice from all those interviewed.

- 6.18 Most staff reported having regular supervision and appraisal and most line managers operated an 'open door' policy for case managers to consult on difficult cases as necessary. However, many line managers did not have the level of knowledge and understanding about DV in order to help case managers develop their practice and to hold them to account for their work with DV offenders. In addition, most areas did not have a pool of expertise to which case managers could refer if they needed advice on the management of a case.
- 6.19 There was a prospect of improvement through the implementation of the accredited programmes. The associated training plan included: developing a group of staff in each area to train others to use SARA, a validated assessment tool for use with DV perpetrators; training for report writers, case managers and their line managers and briefing for senior managers. After this major national development the level of knowledge and understanding about DV should improve considerably. The improvement needed to be broad based and cover those aspects of DV work that may not be covered in programme-related training, e.g. approaches to working with offenders in denial.
- 6.20 With the roll-out of accredited programmes there should also be more clarity about DV-related outcomes. The NPD and areas should ensure that this development is integrated into their performance management frameworks so that areas, teams and individuals can be held accountable for their work.

Criteria	Herts	Essex	Teesside	County Durham	Gwent	South Wales	Staffs
The area's HR policies, strategies and personnel management practices ensure the effective delivery of DV harm reduction work	NOT MET	PARTLY MET	PARTLY MET	PARTLY MET	NOT MET	NOT MET	NOT MET

**Partnership/contracting out:**

- **Area partnership management ensures effective DV harm reduction.**

- 6.21 We were looking for partnership arrangements that were tied in to probation and multi-agency DV objectives, where contracts had clear objectives and targets and were monitored and reviewed.
- 6.22 Few areas had formal contracts with partner agencies for the delivery of DV-related services. Gwent Probation Area was an exception with a partnership with the NSPCC to deliver programme places for perpetrators. Other areas had less formal arrangements with voluntary sector partners, e.g. South Wales seconded a PO to the Cardiff Women's

Safety Unit and Hertfordshire had an arrangement covering part of the area for the delivery of assessment and treatment services for DV perpetrators. In other areas there were no services being provided by partners, but we considered the extent to which the area had built partnerships within the local multi-agency forums. In most areas there had been considerable effort put into local DV forums.

6.23 There was no example of DV services being subject to a value-for-money appraisal.

***Good practice example:***

Gwent Probation Area had maintained a contract with the NSPCC for the provision of assessments, places on a perpetrator programme and associated victim support services. There was a formal contract which specified expectations clearly and which was subject to quarterly monitoring. The project was able to report a reduced rate of reoffending amongst offenders who had completed the programme.

Criteria	Herts	Essex	Teesside	County Durham	Gwent	South Wales	Staffs
Area partnership management ensures effective DV harm reduction	NOT MET	WELL MET	WELL MET	SATIS-FACTORILY MET	WELL MET	NOT MET	PARTLY MET

**Effective communication with sentencers:**

- ***Area communication with sentencers and justices' clerks supports DV harm reduction.***

6.24 In order to perform well against this criterion areas would have needed a well-developed network of communication with sentencers supported by protocols and a feedback loop so that sentencers were made aware of the effectiveness of DV interventions.

6.25 Three areas had made significant contributions, in collaboration with other agencies, to magistrates' conferences during 2003 specifically aimed at enhancing the level of awareness about DV issues. In other areas specific contributions on DV had been made to regular liaison meetings. In one area all magistrates had been briefed on the availability of, and arrangements for referral to a perpetrator programme. In some areas magistrates' clerks were members of the local DV forums which facilitated their involvement and level of awareness about developments within the probation area.

6.26 There were no specific protocols covering DV, e.g. the suitability of DV cases for SSRs or other short format reports, and no arrangements to feedback to sentencers on the impact of interventions. Communication with sentencers was aimed at magistrates and not the Crown Courts.

Criteria	Herts	Essex	Teesside	County Durham	Gwent	South Wales	Staffs
Area communication with sentencers and justices' clerks supports DV harm reduction	NOT MET	PARTLY MET	PARTLY MET	PARTLY MET	PARTLY MET	PARTLY MET	PARTLY MET

## Overall findings for Quality of DV Management

### Strengths

- Areas had maintained a strategic focus on DV even though there had been little drive through national priorities, targets and performance measures.
- Internal management structures did facilitate a focus on DV issues and there was evidence that senior managers were working with colleagues on an integrated approach.
- The level of engagement of senior and middle managers and others in local DV forums was impressive.

### Areas for improvement

- Although the developments associated with accredited programmes were impressive, the NPD needed to ensure that these were comprehensive and covered all DV-related perpetrator, victim and staff issues.
- Few areas had a comprehensive up-to-date DV policy/plan.
- A lack of consistency of approach to DV work between and sometimes within areas was apparent.
- There were no outcome-focused targets for probation DV work.
- Little monitoring information was available about DV outcomes.
- There was inconsistency and lack of clarity in the allocation of cases to different grades of staff.
- Areas had not ensured that all relevant staff had appropriate knowledge, understanding and skills in DV work.
- Communication with sentencers did not include feedback on DV outcomes.

## **Recommendations**

*The NPD should ensure that:*

- *policy and practice development covers all aspects of DV work undertaken by the NPS*
- *areas develop local policy based on a new national DV policy supported by consistent targets and monitoring.*

*Boards should ensure that:*

- *all relevant staff have appropriate levels of DV-related knowledge, understanding and skills*
- *allocation of cases is based on a clear and consistent policy and procedure*
- *communication with sentencers on DV-related issues includes feedback on the outcome of interventions.*

## 7. QUALITY OF DV ASSESSMENT

7.1 This chapter examines the different criteria that constitute quality of DV assessment. These are, first, the initial screening, supervision planning and identification of suitable objectives, and then the ongoing reviews and records that provide evidence of how well the case is managed overall. The evidence came from the scoring of questions applied to the 152 cases examined in the areas inspected during the seven ESI visits. Evidence also came from the interviews conducted with managers, practitioners, service providers and partners and was in documentation provided in advance of the inspection.

### **Assessment of risk of harm:**

- ***RoH is satisfactorily identified and assessed using approved tools, drawing on relevant assessments, available victim information, previous convictions and knowledge of DV risk factors.***

7.2 The following table shows the results for a range of questions on the assessment of RoH.

Table 4: Assessment of RoH

<b>Criteria</b>	<b>All areas</b>
A satisfactory RoH assessment completed at the start of supervision	31%
Assessment reviewed satisfactorily at least every four months	27%
Assessment following any significant incident that might give rise to concern	27%
Where OASys completed, risk category appropriate	79%
Appropriate additional orders/conditions/requirements and release plans to protect victims incorporated	47%
For high and very high RoH cases risk management plan prepared within five working days	23%
Risk management plan covers DV sufficiently	25%
For high/very high RoH cases appropriate senior or middle manager involvement	39%

7.3 The initial assessment carried out at the start of supervision, often during the PSR stage, was critical to the subsequent management of the case. The overall quality of assessment was up to standard in less than a third of cases. This ranged from 5% in South Wales to 50% in County Durham. Assessments using OASys tended to be more detailed and often, but not always of better quality. Inspectors noticed many cases where previous convictions and witness statements were not available to PSR authors at the time of the initial assessment. In these cases the offender's version was relied upon. When information did become available it was often the case that the original assessment was not updated. This prevented an accurate assessment of the RoH being made.

- 7.4 One of the main problems was the lack of detailed exploration of the DV perpetrator history even in cases where the index offence was DV related. In under half of cases sufficient steps had been taken to ascertain whether an offender had a DV-related history. Only one out of over 600 cases scored excellent on this. There were often signposts in the previous convictions or details of the index offence, e.g. the nature of the offence or victim, which should have led the PSR author to suspect there may be a history of DV-related offending and take steps to confirm this.
- 7.5 Assessments were only reviewed at least four monthly in just over a quarter of cases, although this ranged from 5% in South Wales to 59% in Teesside. This was sometimes because reviews had fallen victim to workload reduction strategies and sometimes because practitioners had not understood the mechanism within OASys for reviewing the RoH assessment.
- 7.6 RoH was not reassessed in nearly three-quarters of cases where an incident had occurred that might give rise to concern. Typically if a DV perpetrator moved back to live with his victim, or if further assaults occurred, steps were not taken by the case manager to review the risk factors and level of RoH.
- 7.7 Over three-quarters of assessments were considered by inspectors to be assigned the correct category of RoH. This had been assisted by the introduction of a common typology with the implementation of OASys. Teesside and County Durham did particularly well against this criterion.
- 7.8 There was variable performance in relation to cases where additional conditions/requirements to orders/licences were called for. It was a general concern that practitioners did not always consider their options for introducing external controls in the form of, for example, exclusion conditions in licences, the use of approved premises or conditions to reside where directed.
- 7.9 There were 53 cases in the sample that at some stage during supervision were assessed as high or very high RoH. Only 23% of these cases had a satisfactory risk management plan prepared within five working days. Only a quarter covered DV sufficiently and nearly two-thirds had insufficient middle or senior manager involvement. Teesside was an exception achieving 88% of cases where senior or middle managers were involved sufficiently.

Table 5: Sources of information

Criteria	All areas
Information sought and used from:	
a) relevant police unit	38%
b) social services	49%
c) other relevant community organisations	48%

- 7.10 The inspection asked specific questions about exchange of information with police DVUs. Every area had links with the relevant police units but these varied to a considerable extent. Some teams had developed close relationships with their local police DVUs and in some cases were in regular contact, whereas other case managers

appeared not to know about this valuable source of information. Inspectors took the view that this source of information, apart from the victims themselves, would give practitioners the most accurate picture in order to be able to make an informed assessment of risk. Too many assessments relied upon the word of the offender.

- 7.11 There was better use of links with social services. Where there were children likely to be affected by the DV we expected there to be routine contact with social services to share information, not just at the initial assessment but throughout the order. There were some excellent examples of very close working between probation and social services in an effort to try to prevent further harm to children. It was of concern that this excellent practice was not widespread with some cases where the RoH to children was overlooked or underestimated.
- 7.12 Where other community organisations were involved, e.g. a Women’s Safety Unit or substance misuse partnerships, there was slightly better information sharing but there was still room for improvement.
- 7.13 Overall the quality of RoH assessment needed considerable improvement.

**Assessment of LoR:**

- ***DV-related criminogenic factors and reoffending probability are identified and assessed using approved tools, drawing on all available information and previous assessments.***

- 7.14 The table below gives the results for criteria relating to the assessment of LoR.

Table 6: Assessment of LoR

Criteria	All areas
LoR and DV-related criminogenic factors have been satisfactorily assessed	41%
Offender history as DV perpetrator ascertained at initial assessment and planning stage (all offenders)	47%
Offender history as DV perpetrator ascertained at initial assessment and planning stage (DV offenders only)	46%
Perpetrator history taken account of in assessment and planning (DV offenders only)	40%

- 7.15 The quality of the assessment of LoR and DV-related criminogenic factors was largely determined by the thoroughness of the completion of OASys or one of its predecessors. The criminogenic factors that appeared most commonly in relation to DV in order of frequency were relationships, thinking skills, alcohol and anger. The least common were financial problems, peer influence and employment. County Durham had been a pilot area for OASys and this showed in more detailed analyses of criminogenic factors, resulting in an achievement of 74% satisfactory assessments. One common mistake was the failure to link the factors that scored highly with the risk of serious harm.
- 7.16 We anticipated that in cases where DV was known, or suspected, that steps would be taken to find out as much as possible about the offender’s history as a DV perpetrator. Good practice would be to find out from the offender as much as possible about their childhood experience of being a victim of DV, their use of violence or other forms of

abuse within current and previous relationships, and to verify this information by using external sources such as the local police DVU. We found that in most cases there was a superficial discussion with the offender that was then not cross-checked against other sources of information, even previous probation records. The most common reason given for this was the lack of time available for proper research.

**Case management:**

- *The case is managed effectively. Supervision plans/CPO assessments incorporate appropriate coordinated and sequenced interventions designed to minimise assessed DV-related risk, address associated criminogenic needs and accommodate relevant victim/diversity issues.*

Table 7: Case management

Criteria	All areas
ISP met national standards on content and timing	44%
Appropriate DV interventions identified	40%
DV-related liaison arrangements specified in ISP	21%
Steps taken to ensure the offender fully understands the order/licence	83%
ISP communicated to the offender	67%
For high/very high RoH cases, ISP integrates MAPPA or other similar RoH/child protection action plan	32%

- 7.17 The content of ISPs tended to be of a better standard when OASys was used. Generally case managers had difficulty framing SMART objectives covering DV. Without the benefit of a detailed assessment, and without an accredited programme, case managers struggled, e.g. a typical objective would be “to reduce the LoR and risk of harm”. This would be achieved through one-to-one supervision with the case manager and would be an ongoing objective throughout the order. Using the programme aims of IDAP it can be seen how objectives could become more specific, e.g. to increase awareness of the range of abusive attitudes and behaviours towards partners and children, etc.
- 7.18 Less than half of ISPs identified appropriate DV interventions. This tended to be better in one area where a Duluth based programme had been retained (Gwent 52%) or where, as an interim arrangement, a one-to-one programme had been designed by a manager who had previously had responsibility for a DV programme (Essex 65%).
- 7.19 Liaison arrangements were ill-defined. A section of OASys prompts the person completing it to specify the nature and frequency of contact. A typical entry in this section would just give the name of the person involved. We expected to find not only names but contact details and the agreed frequency and nature of contact. Rarely was ongoing contact with the police DVU made apparent here.
- 7.20 One criterion, where most areas scored well, was that steps were taken to ensure that the offender understood the terms of the order/licence. Most areas had a standard induction process and asked the offender to sign a pro forma as proof that the order/licence had been fully explained. It was also important for offenders to have been

involved in the preparation of the ISP. Evidence was usually to be found in the section where the offender was asked to sign. The most common failure was where this was not done. For DV cases it is important for offenders to understand the nature and purpose of the tasks that they will be asked to undertake and, in many cases, this will also include an understanding of the restrictive interventions that may be taken by the case manager or others involved in their supervision.

**Documentation:**

- ***All relevant documentation is available, satisfactorily completed and appropriately stored.***

7.21 The table below looks at the quality of the case records and at the recording itself.

Table 8: Documentation

Criteria	All areas
Case records were well organised and complete	61%
Recording was clear and sufficient	76%
Adequate record of DV-related plans and interventions undertaken by other staff/providers	45%
Confidential/third party or victim information stored in a separate, clearly marked section of the file	54%

7.22 With DV cases, many of which were higher RoH, we were looking for files that were kept in a way that made it easy to find key documents and that kept information appropriately. Areas had been given notice of the cases to be included in the inspection and nearly all were presented well. County Durham was to be commended for achieving 100% against this criterion. In other areas many case files were not complete, with one or more important documents missing or difficult to find.

7.23 The accurate and sufficiently detailed recording of contact logs in DV cases was of crucial importance. In three areas (Essex, Teesside and County Durham) nearly all records were clear and sufficient, whereas in others there were, for example, missing or conflicting entries and illegible handwriting or poor typescript.

7.24 We asked specifically if there had been adequate recording of the contribution made by other staff/providers. This was facilitated where area staff in different offices were able to make entries directly onto contact logs. Poor practice focused mainly around the lack of information flowing to and from partner providers, e.g. those providing a substance misuse intervention where this was clearly a DV-related criminogenic factor.

7.25 With DV cases we were looking for best practice in the maintenance of confidential or sensitive third party information. We found considerable variation in practice. CRAMS contact logs were confusing for case managers because a standard entry 'Third Party Information' was used for a range of types of entry, e.g. some case managers used this for confidential information and had the expectation that these entries would be removed if the log was to be shared with the offender, whilst others used it for contacts

involving any person who was not a probation employee. We had serious concerns that information about victims and others at RoH could be accessed inappropriately.

**Good practice examples:**

In Staffordshire every file had a separate, clearly marked folder which contained relevant confidential information.

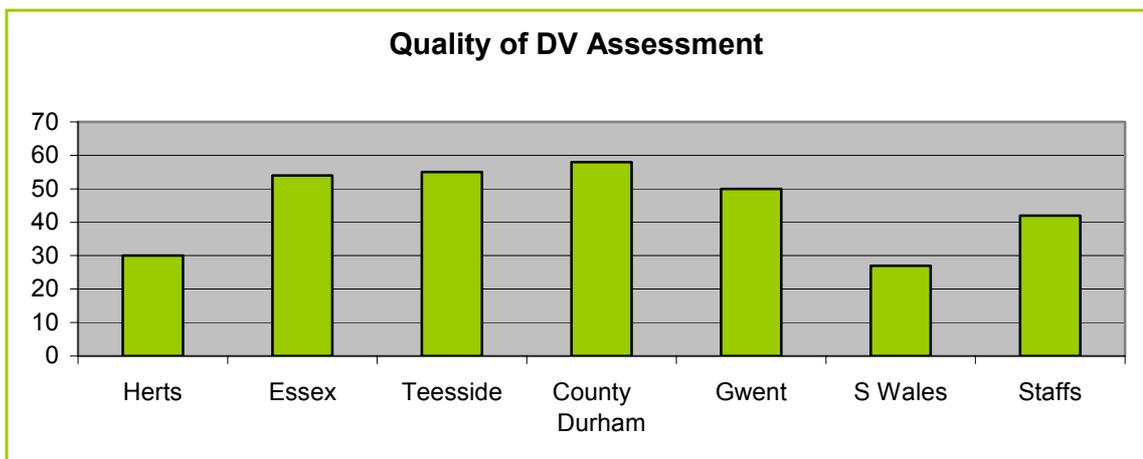
One case manager in another area had a very clear separate folder with confidential third party information and kept a very detailed contemporaneous contact log which contained details of contacts with the victim.

South Wales had very clear instructions for practitioners on what to do to a file before sharing it with an offender.

A VLO in South Wales appended a front sheet to all documents passed on to the case manager that made it very clear that the information attached should not be shared with the offender.

7.26 The chart below shows combined scores for the quality of assessment.

**Overall findings for Quality of DV Assessment**



**Strengths**

- Most cases had been assigned the appropriate category of RoH.
- Orders and licences were fully explained to most offenders.
- Case recording was clear and sufficient in a majority of cases.

**Areas for improvement**

- The quality of assessment of RoH was insufficient and links with police DVUs needed strengthening.
- The LoR and DV-related criminogenic factors were not assessed well in many cases.

- ISPs did not contain SMART DV-related objectives.
- There was insufficient use of additional conditions in orders/licences.
- Risk management plans were not timely or sufficient.
- Confidential information was not being kept safely.

### **Recommendations**

*The NPD should ensure that.*

- *the quality of assessment and risk management planning improves*
- *as part of the roll-out of accredited programmes guidance is issued about appropriate SMART objectives for those on programmes but also for those DV offenders considered unsuitable.*

*Boards should ensure that:*

- *protocols are established with the police to ensure the routine exchange of information about DV perpetrators*
- *confidential information is kept safely.*

## 8. QUALITY OF DV INTERVENTIONS

8.1 This chapter describes work undertaken with offenders, including the extent to which planned DV interventions were actually delivered. The role of case managers in supporting DV work, through preparation, communication and motivation, was also examined. The evidence came from the scoring of questions applied to the 152 cases examined in the areas inspected during the seven ESI visits.

### **Managing attendance and enforcement:**

- ***Contact with the offender and enforcement of the order/licence is planned and implemented to meet DV risk management requirements.***

8.2 The table below shows how well attendance and enforcement were managed.

Table 9: Managing attendance and enforcement

Criteria	All areas
Frequency of appointments arranged conforms to national standards	67%
Type, frequency and location of contacts took into account DV-related concerns	70%
Offender at some stage in supervision has just 'signed in'	11%
Appropriate judgements are made about absences	83%
Breach/recall action within national standards timescale	73%
Prompt compliance and enforcement took into account DV-related concerns	76%
Information about breach of restraining orders or civil court orders passed promptly to relevant authority	47%

8.3 Only two-thirds of cases were offered appointments in line with national standards. Often where offenders were offered the correct number of appointments, the case failed to meet the standard because a home visit had not been carried out. With DV cases home visits can be an essential part of the casework because information can be gleaned and the case manager can get a more rounded picture of the home life of the offender.

8.4 In order to manage workloads some areas had set up reporting schemes where lower RoH offenders in the latter stages of the order were placed on minimal reporting. With DV offenders it was unlikely that this would be a suitable arrangement. It was commendable therefore that in four of the seven areas (Essex, Teesside, County Durham and South Wales) this rarely happened.

8.5 It was also creditable that in three areas (Essex 94%, Teesside 100% and County Durham 95%) case managers were making appropriate decisions about the acceptability of offenders' reasons for absence. In the small number of cases where breach action was required, it was disappointing that this was only achieved in three-

quarters of cases within ten days. This ranged from 17% in South Wales to 100% in Essex. Inspectors expected to find case managers giving some thought to RoH issues before taking enforcement action, e.g. the victim safety plan may need to be strengthened before an offender is told that he/she is in breach of an order/licence. It was disappointing therefore that there were just under a quarter of cases where this was not done.

8.6 There were a small number of cases where a civil court order or restraining order was in place. In these cases we expected to find that the case managers had full details of the nature and length of the order and where they received information about any breach of this order that this was immediately passed to the relevant authority. Unfortunately case managers often failed to find out the details of the order, e.g. whether it had powers of arrest and then failed to pass information on promptly. Performance ranged from 100% in Gwent to 0% in Hertfordshire, Essex and South Wales.

**Delivering appropriate supervision:**

- ***Interventions are delivered and coordinated to ensure supervision and risk-reduction objectives are met.***

8.7 The table below outlines the extent to which DV interventions were delivered appropriately.

Table 10: Delivering appropriate supervision

<b>Criteria</b>	<b>All areas</b>
Supervision plan objective reviewed in line with national standards	45%
Appropriate DV interventions carried out	36%
Case manager motivated offender and reinforced the work of others	62%
Case manager actively liaised with others providing DV-related interventions to offender	56%
Supervision plan reviews integrate MAPPA or other similar action plans	30%
Additional interventions incorporated if RoH increased	45%
DV interventions consistent with DV harm reduction objectives	61%
Specialist resources made appropriate use of	44%
Specialist resources monitored, recorded and reviewed	44%

8.8 A significant number of supervision plans were not reviewed every four months. This ranged from 17% in Essex to 77% in County Durham. Case managers often cited high workloads as a reason for not completing reviews within the national standard timescale.

8.9 Without the benefit of an accredited programme all areas struggled to deliver appropriate DV interventions. In one area, Gwent, a DV programme run by the NSPCC was maintained as a legacy programme. In other areas legacy programmes had been discontinued and interim one-to-one programmes introduced. In three areas no specific intervention was offered. Some supervision plans included anger management and one-

to-one general offending behaviour work. Referral to an accredited general offending behaviour programme was also used where offenders met the targeting criteria. Of these options only the Duluth based programme in Gwent fully addressed the criminogenic needs of DV offenders as well as taking into account victim issues.

- 8.10 Some practitioners evidenced a good awareness of the power and control issues underlying DV and the offender's propensity to minimise their violence and attribute its cause to the victim's behaviour. They demonstrated persistent efforts to address these issues in their individual work with offenders. Others however lacked this awareness and persistence, and were often inclined to take perpetrator accounts at face value. There were examples where practitioners had undertaken joint meetings with perpetrators and victims and, whilst in some cases this had enabled them to gain a better picture of the offender's controlling behaviour, which they had subsequently confronted, in other cases inappropriate joint relationship counselling had been attempted or advocated.
- 8.11 In most cases where the offender had an alcohol problem associated with DV, referrals had been made to partner agencies for this issue to be addressed. The quality and relevance of services provided by such agencies was very variable. Some appeared to have a good understanding of DV issues and used a range of services, methods and tools to address alcohol dependency, others appeared to operate to a stress model which attributed both DV and problem drinking to external factors such as the state of the relationship, unemployment or financial problems. They sometimes provided unfocused counselling or strayed into other areas such as trying to sort out the offender's debts.
- 8.12 Case managers often did not motivate the offender to address their offending. Sometimes this resulted from a failure to fully address DV issues during supervision. Performance ranged from 45% in Hertfordshire to 82% in County Durham.
- 8.13 The quality of liaison with those providing DV-related interventions to the offender varied, with County Durham achieving a creditable 89%, whereas Hertfordshire only in a quarter of cases.
- 8.14 In high or very high RoH cases any action plan arising from MAPPA should have been integrated into the review. This was achieved in less than a third of cases, although this ranged from 100% in Teesside to 0% in Hertfordshire and Staffordshire.
- 8.15 We expected to find that if RoH increased, e.g. when an offender moved back to the DV victim, that additional interventions would be incorporated into supervision or at least considered. Even in the best performing area (Teesside) nearly a quarter of case managers failed to do this.
- 8.16 There were more than a third of cases where DV interventions were not consistent with DV harm reduction. Sometimes this was because the planned interventions were not considered effective for DV offenders, e.g. a range of anger management exercises used one to one by the case manager. In other cases it was because the interventions failed to address DV issues at all.
- 8.17 There were few examples of specialist DV resources in use. In Gwent the DV programme run by NSPCC, in Essex the use of an expert SPO as a consultant, and in

South Wales the Cardiff Women’s Safety Unit were examples. It was a matter of concern that for most case managers there was no specific resource for them to use for expert advice on how to manage DV cases. Where use was made of a specialist resource, it was monitored, recorded and reviewed in less than half of relevant cases.

**Responsivity:**

- *Offender characteristics, learning style, motivation and capacity to change are taken into account in the intervention plan.*

8.18 The table below shows the criteria covering responsivity and pre-release work.

Table 11: Responsivity

Criteria	All areas
Consideration was given to using methods and personnel most likely to manage and reduce DV RoH	50%
Pre-release work had been done to address DV-related risk, criminogenic need, motivation and capacity for change (licence cases only)	21%

8.19 It was expected that case managers would take into account responsivity issues when considering the nature and delivery of interventions. At its simplest, this meant that case managers would consider how they should engage with the offender in one-to-one sessions. At a more complex level, this could have included a detailed psychological profile that would indicate which methods were positively or contra-indicated. Co-working was considered by practitioners to be a valuable method, but rarely was this used because of workload issues. The gender of the case manager was also rarely considered as a case management choice. It was not surprising therefore that in only half of cases was sufficient consideration given to responsivity issues.

8.20 There were only 24 cases where pre-release work would have been expected and in only five cases was the quality of work undertaken of sufficient standard. Only Staffordshire achieved 100%. For DV cases the RoH assessment and management work done at the pre-release stage can be critical to the protection of victims throughout the licence period. Workload problems were often cited as a reason for not working actively with the offender before release. In other cases the offender had not been allocated to the supervising officer until immediately before release.

**Management of RoH:**

- *Risk of harm is actively managed in collaboration with others.*

8.21 The table below covers criteria that referred to the management of RoH.

Table 12: Management of RoH

Criteria	All areas
DV interventions appropriate to manage level of RoH	44%
Changes to RoH identified and managed	45%
Good quality RMP	21%
RMP properly executed	34%
RMP appropriately reviewed	24%
Interventions address risks to children if any at RoH	59%
Appropriate involvement in child protection arrangements (child protection cases only)	62%
Management oversight in line with national/area policy (high/very high cases only)	42%
Home visit taken place (high/very high cases only)	68%

- 8.22 We expected to find that consideration had been given to restrictive and constructive interventions designed to reduce the RoH to victims or potential victims. It was disappointing that we found this in less than half of cases. Even the best performing area (Teesside) failed to do this in more than a third of cases.
- 8.23 During supervision of a DV case robust and continuous RoH assessment needs to be undertaken. In less than half of cases were changes to RoH identified and managed. This often centred upon whether or not the offender was seeing an ex-partner or perhaps developing a new relationship. Any changes should have triggered a reappraisal of the level of risk and changes to the RMP.
- 8.24 It was of significant concern that the quality of risk management planning was so poor. Only in Teesside was there sufficient planning in over half of cases. Nowhere did we find an excellent RMP. This is an area of practice that requires urgent attention.
- 8.25 Where there were plans it was often unclear from records whether and how these had been executed and in less than a quarter of cases were they appropriately reviewed.
- 8.26 The fallout from DV often profoundly affects children either as direct victims or indirectly as witnesses. The long-term emotional impact of experiencing violence in the home has been emphasised by recent research. We would expect care to be taken by probation staff that any RoH to children is fully assessed and steps taken, in collaboration with other agencies, to reduce the risks. In only one area, Gwent, did this reach an acceptable quality of practice.
- 8.27 Where there were children subject to registration under child protection procedures, it was anticipated that there would be an appropriate level of involvement by the supervising officer in case conferences and, if appropriate, core group meetings. In three areas, Hertfordshire, South Wales and Staffordshire, involvement was an unacceptably low level. Essex was to be congratulated however for an appropriate level of involvement in all its relevant cases.

8.28 Management oversight of cases was sufficient in less than half of cases. This figure masks wide variations in performance, with some areas (Essex and Teesside) performing reasonably well and others being sufficient in less than half of cases.

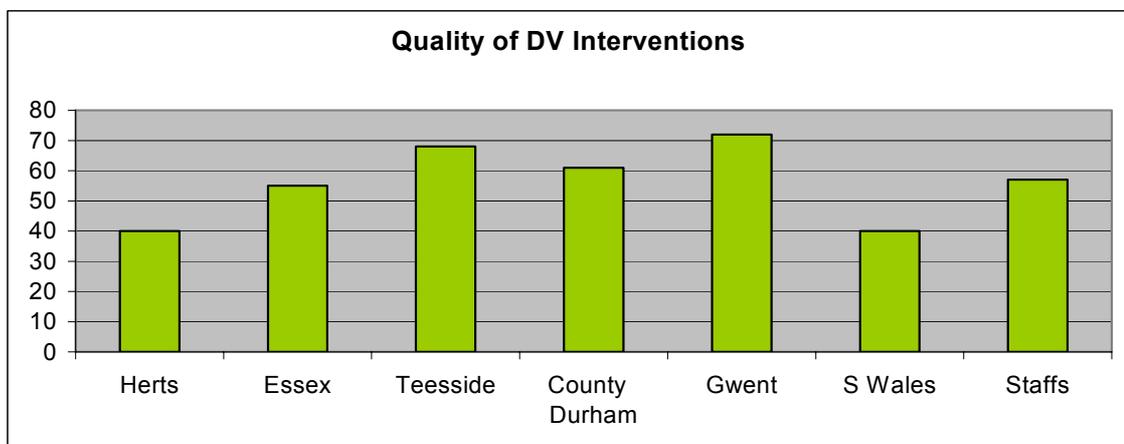
***Good practice example:***

In Teesside there was widespread use of a stamp by the SPO as part of routine case recording. This made it clear when the record had been scrutinised by the line manager and was usually accompanied by a comment on the case. This made it very plain how much middle manager involvement there had been.

8.29 Although home visits were required by the national standard in all cases, we asked specifically about high/very high-risk cases. One was not done in a just under a third of cases, although in one area (Teesside) a home visit was done in every case and in Hertfordshire in no cases.

8.30 Overall the quality of RoH management was very disappointing. Although all areas had arrangements in place covering the management of cases considered to present a RoH to the public, there were many inconsistencies and the quality of individual practice needed considerable improvement.

**Overall findings for Quality of DV Interventions**



***Strength***

- Judgements about the acceptability of absences were mostly appropriate.

***Areas for improvement***

- There was a lack of appropriate interventions for DV offenders to address their specific criminogenic needs.
- Breach action was not always taken within national standards timescales.
- Information about breach of civil court or restraining orders was not passed promptly to the relevant authorities.

- There was a lack of specialist resources available to assist case managers.
- The quality of pre-release work was poor.
- Insufficient was done to respond to changes in the RoH status.
- The quality of risk management plans was poor.
- The RoH to children from DV was not addressed sufficiently.

### **Recommendations**

*The NPD should ensure that:*

- *urgent action is taken to improve the quality of risk management plans.*

*Boards should ensure that:*

- *DV cases that require breach action are dealt with promptly*
- *there are local specialist resources available to advise case managers on DV cases*
- *case managers take appropriate action in relation to civil court and restraining orders*
- *pre-release work with DV offenders is improved*
- *action is taken in every case to address the risks to children from DV.*

## 9. QUALITY OF INITIAL DV OUTCOMES

9.1 This chapter assesses the outcome of the supervision plan and interventions for each offender. It should be noted that most of the cases in the sample were about eight months into their period of probation supervision. Hence this was a measure of *initial outcomes*. The evidence came from the scoring of questions applied to the 152 cases examined in the areas inspected during the seven ESI visits. Evidence also came from the interviews conducted with managers, practitioners, service providers and partners and was included in documentation provided in advance of the inspection.

### **Interventions are delivered with the desired outcomes:**

- ***DV harm reduction objectives are achieved and RoH/reoffending is demonstrably reduced.***

9.2 The table below shows the initial outcomes achieved during the first part of probation supervision.

Table 13: Initial outcomes are achieved

<b>Criteria</b>	<b>All areas</b>
Reconviction since commencement of order/licence	25%
Progress made on first priority criminogenic factors	54%
Evidence of learning outcomes/skills applied	33%
Offender attended all or nearly all DV-related appointments	70%
Offender complied with DV-related conditions	55%
Confirmation by police of no further callouts	25%
At least some progress on external DV RoH reduction	32%
At least some progress on internal DV RoH reduction	34%
At least some progress on DV-related criminogenic factors	47%
Measurable improvement in DV-related attitudes and beliefs	11%
At least one measurable DV-related objective achieved during supervision	28%

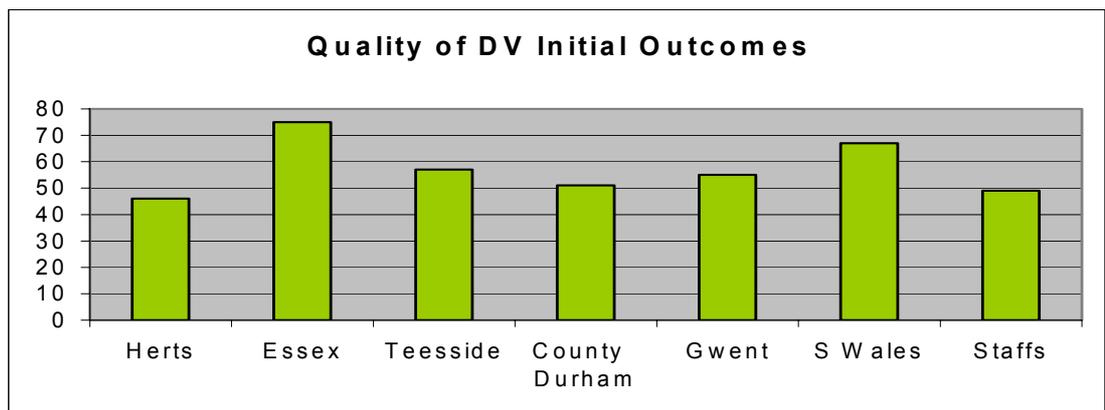
9.3 A quarter of offenders had been reconvicted since the commencement of the order/licence, although this included all types of offending rather than just DV related. There was a wide range between areas, with Hertfordshire at 36% the highest and Teesside at 11% the lowest. In addition some offenders had further DV-related charges pending which had not yet received a court disposition. It was a not uncommon practice for offenders to lodge or indicate pleas of not guilty as a delaying tactic in the hope that the victim would retract their statement or be deterred by the prospect of giving evidence in a full trial. Variations in areas' reconviction rates in the nine month

supervision period may well partly reflect local differences in the speed at which cases come to trial.

- 9.4 The most frequently occurring criminogenic factors were relationships, thinking skills, alcohol and anger. It was encouraging that at least some progress had been made in over half of cases on the risk factor considered the most important focus. Typically this would include a reduction in alcohol consumption, the use of strategies to avoid DV starting, recognition by the offender that they had a problem, reduced levels of violence. The evidence was often based on self-report by the offender.
- 9.5 Evidence of the application of learning outcomes/skills was poor, with progress in only a third of cases. Case managers often found it difficult to think of examples of what an offender might be doing differently and how this related to work that had been undertaken with them. This ranged from 19% in Hertfordshire to 54% in Essex.
- 9.6 DV offenders proved relatively compliant, with 70% attending all the DV-related appointments made for them. Just under half of offenders failed to comply with DV-related conditions, although this varied from 20% in County Durham to 83% in South Wales. This may have depended partly upon the quality of risk management practice, e.g. the better the RMP the more likely it would be that infringements would be identified.
- 9.7 One way of double-checking the impact of supervision is to ask the police DVU whether there had been further callouts. Apart from direct information from the victim it is the most reliable way of determining the extent to which an offender has made progress. Unfortunately, in many areas, it was not a routine part of case managers' practice. In many cases it was not clear whether there had been confirmation of no further callouts. Only 25% of cases showed clear confirmation that the offender had not come to police notice for DV-related behaviours. Of those cases where there was clear information, in 65% of cases there had been further DV-related behaviour. This underlines the frequency of repeat victimisation for this type of offence.
- 9.8 One way of RoH being reduced is for the victim of the DV to move away out of the reach of the offender or, preferably, for the offender to move. This type of case we referred to as external RoH reduction. There were just under a third of cases where this was true, although this improvement may be temporary, e.g. with the offender in prison for a short period.
- 9.9 Internal RoH reduction referred to changes within the offenders themselves, e.g. improved use of strategies to prevent DV incidents starting, which led to a reduced level of risk. This was true in just over a third of cases. We also looked for improvements in DV-related criminogenic factors. This was so in nearly half of cases, typically a reduced level of alcohol consumption. Finally, we looked for measurable changes in DV-related attitudes and beliefs. This was problematic because of the lack of use of specific tools for measuring change. As a result, only one in ten cases was able to demonstrate improvement.
- 9.10 Very few DV-related objectives were achieved. For some cases it was too early to judge, and in others the wording of the original objective had not been SMART and so progress was not measurable.

9.11 It is apparent from the summary bar chart below for scores on initial outcomes that some areas that scored well on assessment and intervention scored less well on initial outcomes. It is true however that accurate assessment and more effective interventions are likely to result in more DV offenders being held to account for their behaviour and for continuing DV behaviour to be identified more readily. Caution should therefore be used in making assumptions based on the bar chart. It provides us if anything with more questions to ask.

### Overall findings for Quality of Initial DV Outcomes



#### Strengths

- Over half of offenders had made progress on relevant criminogenic factors.
- Most offenders had attended all or nearly all of their DV-related appointments.

#### Areas for improvement

- Most evidence of progress relied upon offender self-report.
- Lack of clarity about what was to be achieved led to lack of clarity about what had been achieved.

#### Recommendation

*Boards should ensure that:*

- *steps are taken to gather independent evidence of progress.*

## 10. CURRENT EMERGING ISSUES

---

- 10.1 The previous four chapters set out the findings from the inspection of seven probation areas. Arising from this and other aspects of the inspection, this chapter explores some of the key issues in more depth and makes recommendations aimed at addressing them.

### Local management

- 10.2 In the absence of a national priority for DV, local developments had depended upon the commitment and drive of local managers. In many areas this had kept DV on the local strategic agenda, in others it had either fallen into abeyance in anticipation of the roll-out of a new national policy and accredited programmes or had taken a back seat to other priorities which had a national impetus.
- 10.3 Most areas did not have a comprehensive up-to-date policy, although some had developed guidance for staff. The expected publication of the NPS DV policy should enable areas to develop local versions that are both consistent with the national policy and tailored to local circumstances.

#### ***Good practice example:***

Teesside had developed, as an interim measure, a set of Quality Standards for DV work that had been introduced to all relevant staff through a series of team briefings.

Darlington and County Durham DV Strategy Group had produced an impressive practice guidance reader and resource directory for practitioners. It was particularly strong on its focus on the specific risks to, and needs of children and on diversity issues.

- 10.4 HR issues including recruitment, criminal records checks, assignment, induction, training and other development, supervision and appraisal were rarely shown to address specifically the delivery of effective harm reduction work with DV offenders and victims.
- 10.5 At appointment all members of staff, likely to have contact with offenders, victims and their families, should be subject to criminal record checks. This involves a check being made to see if there is a history of convictions for criminal offences and if recent and/or serious this might prevent a candidate being appointed. These checks never extended to looking up their history of DV callouts.
- 10.6 Without this check being done probation areas will probably be appointing staff who are current DV perpetrators and who are therefore a current RoH to both adults and children. Without a conviction this is a very difficult scenario to deal with. However it should be clear to all that someone who is a current perpetrator of violence within the home would not be a suitable person to work with offenders.

- 10.7 Many practitioners told us that they did not feel properly equipped to assess and manage the RoH posed by DV offenders. Even very experienced POs felt that they needed to be updated on the latest practice initiatives. There had been recent promising developments. Every probation area in the country had nominated staff to attend a training course that would enable them to train others in the use of SARA. Every report writer, case manager and programme tutor should be trained in the use of this tool. This should result in a more informed body of staff involved in assessment and interventions.
- 10.8 Further training for those involved in delivering programmes and supervising those offenders taking part in programmes will further add to the body of collective knowledge. Once this round of training has been completed an audit should be undertaken to ensure that all those involved in any way with the supervision of DV offenders or work with their victims has the relevant knowledge, understanding and skills to undertake their role. Relevant staff also need to be familiar with risk/vulnerability factors not specifically covered by SARA, e.g. victim pregnancy, disability, and other victim-related diversity issues.
- 10.9 It seems likely that a better informed workforce will more accurately identify a greater number of DV offenders, resulting in an increased demand for effective assessment and interventions. Those who have a role in supervising DV offenders, who are not immediately involved in the delivery of programmes, will also need to improve their awareness, understanding and skills, e.g. those assessing the RoH represented by offenders on CPOs.
- 10.10 Communication with sentencers was a key area for improvement. It is important that the NPS ensures that sentencers have confidence in the interventions being proposed in PSRs. Although many areas were able to show that there had been events aimed at raising awareness about the nature and extent of DV, none were able to demonstrate fully that sentencers in both magistrates' and Crown Courts had been provided with sufficient information and were confident about the interventions being offered by the NPS. The implementation of accredited programmes provides an opportunity to address this.
- 10.11 The NPS, in collaboration with other community safety partners, should develop a shared understanding about the relative effectiveness of community and custodial sentences in addressing DV offending. There also needs to be clear guidance to practitioners on the effective use and monitoring of restraining orders following their wider availability as a result of new legislation.
- 10.12 Finally, there were some examples of short format reports being used for DV cases. It was not a suitable option because of the need to explore fully the RoH issues involved in a case. The shortened investigative process and the reduced availability of full information make short format reports a poor means of ensuring an appropriate proposal for disposal is made. Guidance should be issued aimed at ensuring that the RoH presented by DV offenders is fully assessed and taken account of in reports to court.

## Assessment

- 10.13 With the introduction of OASys there had been an improvement in the quality of assessment of DV issues. However there were still major shortcomings. Assessment is the foundation of probation practice. In order to be fully effective a programme of constructive and restrictive interventions should be tailored to address the specific assessed needs and risks of each offender. For many of the cases we saw the assessment was superficial and based on what the offender chose to reveal rather than a more balanced assessment. With more information available from research about the factors underlying DV which can be used to predict the LoR and RoH, it underlines the importance of a thorough well-informed assessment. The findings from the reviews of serious further offending also support this because of the cases of violence which were considered to have been predictable and those where high RoH went unrecognised.
- 10.14 Another shortcoming was the problem of accuracy. With a significant number of cases being initially assessed without the benefit of a list of previous convictions and/or the witness statements, this calls into question the accuracy of assessments and particularly the RoH category assigned to an offender. Where this information was available we came across examples where it had not been properly taken into account – staff rarely made enquiries with anyone other than the offender as to who was the victim of past assaults, and critical risk related information, such as use of weapons, was sometimes not extrapolated from these documents. There were examples of cases where a history of DV formed the context to an assault on another person (e.g. police officer, or friend or new partner of a DV victim) yet this had not been picked up. Even where information became available later, assessments were often not reconsidered. With eOASys this could mean inaccuracies built into the database. This needed to be addressed.
- 10.15 OASys assessment begins with the completion of a screening document, with an optional next step of a full RoH assessment in cases that meet certain criteria. This is particularly important with DV cases because the full assessment is a critical part of preparing for an effective RMP. We found a number of cases where a decision had been made not to proceed with a full assessment for insufficient reasons.
- 10.16 Thresholds for categorisation of RoH status appeared variable. OASys has fairly clear definitions of the four categories of RoH but even so there was confusion. When asked about the difference between medium and high risk some practitioners told us that to be considered high the RoH would have to be imminent. The definition of very high RoH in the OASys manual makes it clear that imminence is a threshold factor for that category. Many DV cases attracted the comment “something could happen at any time”. The timing was unpredictable but the occurrence inevitable. Some detailed work needs to be done on categorising RoH in DV cases. Part of the solution to this problem is better RoH assessment. The more accurate the information that goes into the assessment, the more likely it is the risk categorisation will also be accurate. This is of the utmost importance because the category of RoH normally determines the amount and type of resource going into managing a case.
- 10.17 There was also some confusion about the assessment of RoH of an offender whilst in prison. Whilst in many cases this would reduce the risk to victims, in others DV perpetrators reach through the prison wall to continue to harass and otherwise victimise

people. The RoH assessment and RMP should take into account and address all possible risks.

10.18 Finally in this section, we came across some cases that were subject to transfer. This was triggered for various reasons – offenders moving house, POs leaving, an offender completing an intervention, reduced or raised RoH status. There were a few cases where the transfer took place at a time when stability would have been more helpful. One example was an offender who had reached the end of the second quarter of supervision. The area operated a reporting centre where low and medium-risk cases were supervised for the last part of the order/licence – this however coincided with the offender moving back with the victim, clearly a need to reassess the RoH. There was a strong argument in favour of deferring the transfer. This was an example of the RoH taking second place to organisational systems requirements.

10.19 In order to summarise aspects of best practice in assessing DV offenders, we have included this list of actions to improve the quality of assessment.

#### ***Improving Assessment of DV Offenders***

- *Train report writers and others involved in assessment to understand the RoH factors associated with DV.*
- *Make sure a list of previous convictions and the CPS package are available to PSR writers and that they are carefully read.*
- *The person making the assessment should establish, as early as possible, whether victims are still at risk from the offender – by asking simple questions about the offender's living circumstances and current relationships.*
- *Report writers should ask the offender to explain each of their court appearances, including those that may appear not relevant.*
- *Offenders should be asked whether the police have ever been called out to an incident at their home or the home of a partner/former partner.*
- *The offender should be asked about their experience of violence in the family. Experience of DV as a child is a predictive risk factor.*
- *Checks should be made with police DVUs where there is any history of relationship conflict or of violence to anyone.*
- *Once a DV history is established, the offender should be asked detailed questions about their history of relationships.*
- *If there are any children or young people associated with the offender, contact should be made with social services.*
- *Where a history as a DV perpetrator is indicated, SARA should be used.*
- *Where there is a RoH to a known victim, care should be taken at every step of the assessment phase to ensure that RoH is minimised and not raised by the assessment process – this may involve a decision not to take one or more of the steps outlined above.*

## Constructive interventions

- 10.20 Constructive interventions are those aimed primarily at reducing the LoR. For DV offenders this might be inclusion on a DV perpetrator programme and, if applicable, addressing alcohol misuse through treatment. The absence of a nationally accredited DV programme had led to a significant gap in provision for many areas. With the accreditation and roll-out of IDAP and CDVP a DV programme should be available in every area in the country by the end of 2005. The implementation of the programme brings with it the impetus to develop more consistent and robust inter-agency partnerships as well as services for victims. In addition, a large proportion of practitioners and managers will become more knowledgeable about DV offending in general as a result of the training associated with the roll-out of the programme and SARA. Areas will need to consider how they plan to tackle and prevent the high rates of attrition associated with DV programmes. Appropriate case manager preparatory and motivational work will be critical, along with concurrent action to address any substance misuse problems that may compromise attendance and full participation.
- 10.21 Probably a minority of DV perpetrators on a probation caseload will attend and complete a DV programme. This is because some will be in denial and others will recognise their problem but be unwilling or unable to address it. In many cases the period of supervision will be too short to make attendance at a programme realistic. It is therefore critical that the NPS not only develops comprehensive arrangements for those on programmes but also for the rest.
- 10.22 There are also constructive interventions to address criminogenic factors associated with the DV offending which might not be covered in a DV programme. In many cases this would concern substance misuse and particularly alcohol misuse. It is important not only that relevant constructive interventions are available but also that those delivering the interventions understand the DV-related issues associated with a particular offender in order to target their efforts and crucially to contribute to any RoH management issues. It was positive that part of the training plan for accredited programmes addressed the training of partner agencies. It would be helpful if further thought could be given by the NPS programme development team about making more explicit the links between the substance misuse programmes and DV offenders.
- 10.23 One of the reasons for attrition is a failure to engage offenders early enough. We found many cases where there was a gap between an order being made or an offender being released on licence and their first meeting with their case manager and the start of a DV-related intervention. Many areas used a generic form of induction which meant that offenders were seen quickly by someone, but this needed to be backed up with a quick follow-up meeting with the case manager including contingencies in the event of leave. Prompt implementation of an effective, comprehensive supervision plan is critical given that the risk of further assaults is greatest in the first few months following the last assault.

## Restrictive interventions

- 10.24 By restrictive interventions we mean those designed primarily to reduce the RoH to the minimum level feasible. The range of restrictive interventions available extends much

wider than those delivered by the NPS, e.g. the use of technical equipment installed by the police to reduce offenders' access to victims. A good quality RMP will make use of the full range of these interventions where necessary. We found that quite a narrow range of options was considered by probation staff, e.g. little use was made of conditions of residence or approved hostels. Many case managers had insufficient awareness of the full range of the external controls available. This should be addressed.

***Restrictive interventions include:***

- *civil orders – non-molestation orders, occupation orders, both can have powers of arrest attached*
- *restraining orders*
- *conditions in licences, e.g. exclusion zones and non-contact clauses*
- *curfew orders*
- *conditions in community orders, e.g. to reside as directed*
- *residence in an approved hostel as part of a community order/licence or as a bail option*
- *police monitoring and in very high-risk cases surveillance*
- *the collection and use of intelligence, e.g. during a period in custody and prior to release; home visits by probation staff*
- *electronic monitoring to curb stalking, etc.*

10.25 The quality of RMPs was a matter of serious concern. Not only did many DV cases not have a RMP at all but those that were in place were often not comprehensive and rarely took the victim's perspective. There was some confusion about whether a RMP should be done when the RoH status was assessed as medium or low. Case managers sometimes told us that the written RMPs were not a good representation of the quality of information sharing and discussion that underpinned them. It is beyond question however that the quality of the RMPs needs urgent attention. In the box below is a list of the elements that inspectors looked for when judging the sufficiency of a plan. One of the questions we suggested case managers ask themselves when appraising their own plans was 'If I was the victim in this case would I feel safer as a result of reading this plan?'

***What makes a satisfactory RMP?***

*To be deemed of satisfactory quality the RMP should:*

- *be clearly based on and refer to risk assessment(s) and integrate, where relevant, any victim safety plans*
- *state clearly who is at risk, of what, in what circumstances and from whom*
- *outline DV risk factors, triggers and any action that may reduce the RoH*
- *define action to be taken by whom and by when and the date of the next planned review*
- *specify inter- and intra-agency information-sharing and liaison arrangements*
- *state if there are children involved in the domestic arrangements who may witness or be otherwise affected by DV and include details ensuring their safety*
- *define both restrictive and constructive interventions, where relevant.*

## **Recommendations**

*The NPD should ensure that:*

- *guidance is issued for practitioners on DV-related civil and criminal court orders*
- *the policy on the suitability of different types of court report for DV cases is clarified*
- *guidance is developed for practitioners on RoH thresholds for DV cases and the links between alcohol misuse and DV.*

*Boards should ensure that:*

- *action is taken so that CPS documentation is available for initial assessments.*

## 11. FUTURE DEVELOPMENTS

---

11.1 This final chapter looks at future areas for development: the strategic focus on DV, the multi-agency context, and the impact of the creation of NOMS.

### The strategic focus

11.2 Effective probation work with DV offenders has to take place within a multi-agency context where all the participants in the process of reducing reoffending are committed to common goals and have a shared understanding about the key processes involved. Although multi-agency working was outside of the scope of this inspection, evidence from area visits led us to the view that the current strategic framework had not resulted in the development of a fully coherent inter-agency approach. The recent HMIC/HMCPsi report on DV highlighted a number of recommendations at a strategic level, e.g. the development of a common definition of DV for both operational and monitoring purposes. Similar strategic issues need addressing in offender management.

11.3 We looked for the following in the multi-agency context:

- an inter-departmental strategic framework with outcome-focused targets and performance measures
- a departmental strategic delivery plan with shared objectives, e.g. reduced repeat victimisation. These delivery plans would be put into action nationally, regionally and locally
- local multi-agency structures such as DV Forums, CDRPs, LCJBs, ACPCs, and MAPPsMBs with clear roles and responsibilities in the achievement of the targets
- managers in local agencies understanding the role they had to play in bringing offenders to justice, protecting victims and reducing reoffending
- front line staff geared up to fulfilling their roles and responsibilities, which would be designed to contribute to the achievement of the outcome-focused targets
- comprehensive monitoring and review systems that enabled anyone in the system to assess how effective they were and prompt improvements where necessary.

11.4 Although we often found elements of these in place and signs that national developments were addressing some of the gaps, there was still a need for a more consistent and comprehensive approach. In order to protect victims and their children better we viewed this as a crucial focus for future national and local efforts.

## The multi-agency context

- 11.5 Another unresolved strategic question was the place of DV in the field of public protection and children's safeguards. Within any probation area there are a number of multi-agency arenas where DV issues should be addressed. Principally these are:
- DV forums – both at area level and in local districts
  - CDRPs – which sometimes oversee the work of DV forums
  - MAPPA – including SMBs, levels 1-3 arrangements
  - ACPCs – with responsibility for children harmed by DV
  - LCJBs – increasing the effectiveness of criminal justice agencies dealing with DV.
- 11.6 We found that probation involvement in these forums varied from no active participation to probation managers being the driving force. In most probation did play a significant role in contributing to the development of DV forums and frequently took on the role of Chair or Vice Chair. Their full contribution was often hampered however by their inability to bring to the table an effective way of addressing DV offending within their own sphere of responsibility.
- 11.7 These multi-agency arenas enable agencies to develop a shared understanding of DV and how to tackle it. The tension between national prescription and meeting local needs and circumstances inevitably leads to variation. For some aspects of DV provision this is appropriate, e.g. a rural area may need different service delivery methods to an inner city area. However there are some variations that are unhelpful, e.g. using different definitions of DV makes it difficult to collect comparable information. It would be helpful to have clear guidance setting out what aspects of DV work need to be the same throughout England and Wales and those that can be tailored to meet local needs and circumstances.
- 11.8 This guidance should be agreed within and between agencies, e.g. in a number of areas police colleagues had developed risk assessment tools to be used by those involved in dealing with DV incidents, these needed to be compatible with SARA. Probation developments will require the support of other agencies in order to be effective, e.g. the police in providing information about DV perpetrator histories and the voluntary sector as women's safety work develops.
- 11.9 Differences and anomalies emerged in the way that DV cases were dealt with by MAPPA in the areas inspected. There were normally three levels of multi-agency arrangements – at the lowest level where RoH had been identified cases were managed locally by one or possibly more agencies. At the next level cases were brought before a local panel of agency representatives. At the highest level, for the very high-risk cases needing additional local and possibly national resources, a MAPPP was convened often involving senior managers.
- 11.10 The broad range of risk categories for DV cases resulted in a range of approaches to the management of RoH. In many cases this involved only the case manager, sometimes others providing interventions, sometimes in collaboration with police DVUs, sometimes with other agencies through various levels of MAPPA. Whilst this range may

be appropriate in order to respond to the level of RoH, in fact it varied not according to the actual RoH but often according to the organisation's approach to DV. In Cardiff where the Women's Safety Unit had led to the development of a comprehensive approach, e.g. there was an automatic multi-agency meeting three months prior to a DV prisoner's release in order to develop a victim safety plan. In other areas offenders with similar risk profiles were just managed by the case manager. We came across many cases where a multi-agency approach should have been adopted but was not. Every case should involve cooperation with the local police DVU at the very least.

- 11.11 The position of DV offenders within the public protection agenda was problematic. MAPPA had often developed within areas with the aim of addressing the protection of the public from sex offenders. DV offending sometimes seemed to sit uncomfortably in the MAPPA forums. In South Wales an interesting development involved setting up MAPPA specifically to deal with DV cases. Although work still needed to be done to improve risk assessment and management planning, this approach showed some promise. It provided an opportunity to develop expertise, target information sharing and it threw a sharper spotlight on specific offenders. There were potential problems to overcome, e.g. complex cases that straddled the responsibilities of the DV MAPPA and those dealing with other cases.
- 11.12 There was evidence from the case scrutiny that DV cases were often accorded a lower status than other sexual/violent offenders. The cliché 'it's only a domestic' appeared still to be part of some peoples thinking. Although there were exceptions this view was supported by the lack of availability of constructive interventions, the lack of use of restrictive interventions, the under assessment of DV cases and the failure to work these cases on a multi-agency basis. If compared to the approach to managing sex offenders in the community there was a marked difference in the seriousness with which they were treated.
- 11.13 Findings from the sample of DV cases indicated a need to improve the recording of MAPPA meetings. We found examples of case managers being unaware of the actions arising from MAPPA because of a delay in the minutes reaching them. In relation to MAPPA, work needed to be done to improve the quality of action plans resulting from MAPP meetings. It would be helpful for work done in the multi-agency arena to improve action plans to be congruent with that done by probation to improve RMPs.

### **Offender management in the future**

- 11.14 The inspection took place during the initial stages of the development of NOMS. With the overarching aim of developing more effective ways of reducing reoffending, this presented both opportunities and risks for the future of DV work. The findings of this inspection in relation to pre-release work with DV offenders demonstrated that there was much work to be done to achieve a fully coordinated approach. There was an opportunity to place DV work in a new integrated organisation. Some important joint prison/probation initiatives had already been started – the development of OASys and the roll-out of a common accredited programme (CDVP). Further consideration needed to be given to making the assessment and interventions fully congruent whether delivered in prison or in the community.

- 11.15 There were potential pitfalls as well. Against the backdrop of major organisational and operational change with NOMS development and the implementation of the Criminal Justice Act 2003, it will be a challenge to implement the recommendations of this report. There are however many rewards if DV offending was tackled more effectively – fewer victims of repeat offending, less demand on health and other public services and, importantly, fewer children harmed by their experience of domestic abuse in the home.

### **Recommendation**

*The NPD should ensure that:*

- *work is undertaken with other departments and agencies to develop a more consistent and coherent approach to the management of DV cases.*

## 12. PROFILE OF THE DV SAMPLE

<b>Total sample</b>	152
<b>Gender</b>	95% Male; 3% Female
<b>Race and ethnicity</b>	Black and Asian 5%; White 82%
<b>Employment status</b>	Unemployed 50%; Employed 38%
<b>Disability</b>	17% of the total sample had a disability, of these 44% were physical; 40% mental health; 8% dyslexia
<b>Index offence</b>	Violence against person 72%; Acquisitive offences 9%; Sexual offences 3%; Burglary 3%; Drugs 3%;
<b>DV related Index offence</b>	66%
<b>DV perpetrator history</b>	86%
<b>Victim contact involvement</b>	11%
<b>Offender still living with victim</b>	33%
<b>Children as victims of DV</b>	54%
<b>Order/Licence</b>	CRO 68%; CPRO 11%; Licences 20%
<b>Offender in approved premises</b>	6%
<b>RoH categorisation</b>	Very High 6%; High 33%; Medium 48%; Low 14%
<b>Ever been on area's high RoH register</b>	Yes 18%
<b>Child protection case</b>	24%
<b>OGRS scores</b>	Under 40 66%; 41 and above 35%
<b>OASys scores</b>	Under 40 36%; 41 and above 64%
<b>Number of cases managers from commencement</b>	One 55%; Two 31%; Three 11%; Four +3%
<b>Grade of case manager</b>	PO 70%; PSO 14%; TPO 7%
<b>Type of criminogenic factors</b>	Relationships 89%; Thinking Skills 80%; Alcohol 63%; Anger 56%; Mental Health 26%; Accommodation 24%; Drugs 22%; Employment 16%; Peer Influence 9%; Finances 8%

HM Inspectorate of Probation is an independent Inspectorate, funded by the Home Office and reporting directly to the Home Secretary. The Inspectorate retains its independence from both the policy making and operational functions of the National Probation Service for England and Wales.

HMI Probation  
Room 217  
Ashley House  
2 Monck Street  
LONDON  
SW1P 2BQ

Tel: 020 7035 2207 Fax: 020 7035 2237

Web address:

[www.homeoffice.gov.uk/justice/probation/inspprob/index.html](http://www.homeoffice.gov.uk/justice/probation/inspprob/index.html)