**HM Prison & Probation Service**

**Chief Probation Officer**

Date: 9th January 2024

**Peter Nieto – HM Senior Coroner for Derby and Derbyshire**

Dear Mr Nieto,

**INQUESTS INTO THE DEATHS OF TERRI LIZ HARRIS, LACEY ELIZABETH BENNETT, JOHN-PAUL JASON BENNETT, and CONNIE ADINE GENT: RESPONSE TO PREVENTION OF FUTURE DEATHS REPORT**

Thank you for your Regulation 28 Report, issued following the inquests into the deaths of Terri Liz Harris, her children John-Paul Jason Bennett and Lacey Elizabeth Bennett, and their friend Connie Adine Gent. I am replying as the Chief Probation Officer of His Majesty's Prison and Probation Service (HMPPS) and on behalf of the Secretary of State for Justice.

I would like to reassert my condolences to all those who have lost loved ones on account of Damien Bendall's terrible crimes, for which he is rightly serving a whole life order. The implementation of learning from this case is my absolute priority. We are grateful for your comments and recommendations for improvement, which we have considered in detail.

In your report you set out a number of concerns, to which I respond below.

| **Probation Service (PS) offender records and documents.** |
|---|
| *The inquests identified that very concerning information regarding Damien Bendall was made known to the PS (including violent assault and injury of a partner, and an incident of possible child sexual abuse) but was not recorded clearly or prominently for subsequent PS practitioners to read and evaluate in risk assessment and decision-making, and indeed was not read at key and critical points. Although this was in part due to the recording made by individual PS practitioners it was also the result of confusing proformas (e.g., the OASys misleading drop-down boxes and the open and closed sections), imprecise arrangements and expectations of how and where such information should be recorded, and where checks should be directed and made when the records needed to be reviewed. The inquests were informed of current PS expectations for recording offender risk information and assessments, but I remain very unsure that there are clear and efficient recording arrangements and systems to ensure that risk information is accurate, prominent, easily seen, and easily updateable by PS practitioners.* |

**Response to PS Offender records and documents**

We accept that the recording of information is complex in various ways and pertinent to this case:

- Concerns were raised in relation to the recording of information not to be disclosed to the offender, how this information is recorded within the Offender Assessment System (OASys), and how that is identified for practitioners to review, given the fundamental principle of our approach to risk assessment which involves the offender in the assessment of his/her risk. We acknowledge the need for further clarity.
- Concerns were also raised about how information relating to an offender's risk is recorded and accessible for practitioners, where that offender has completed a period of supervision and so his case is closed. We acknowledge that we do not have sufficient guidance as to how such information can be stored and accessed.
- Concerns were raised about the current assessment system to ensure information is easily updated and identifiable.
- Prior to the inquests, improvements had been made in Delius to flag information to practitioners; however, we acknowledge concerns regarding practitioner awareness of where to look within a case to identify key information they need to review.

We are committed to making sure we have clear guidance on recording risk information and identifying the key areas for practitioners to access when looking at a case.

The following seeks to address the concerns identified above:

OASys is designed as an open document which can be shared with the offender subject to supervision and whose risk is to be assessed, so that the individual can contribute to the assessment and see the plans in place for their supervision. They would not need to make a subject access request to see the document, so it would not be redacted before they had access to it. There may be circumstances where information needs to be withheld from the offender – for instance, where information cannot be shared under the Data Protection Act 2018 to protect the rights and freedoms of others. OASys makes provision for this by including a section headed *Information Not to be Disclosed to the Offender*. We recognise the challenges this presents for practitioners in relation to risk assessments particularly where the risk cannot be evidenced through a source of information that is disclosable to the offender.

The current Risk of Serious Harm Guidance addresses the issue of using information about behaviour that has not resulted in a conviction to inform risk assessments. To extend this and aid clarity, we are adding specific content to the OASys help text (which practitioners can view as they complete their assessment). This will advise on how to address risk assessment and management where they have information which cannot be used in the main body of OASys.
Established guidance is in place for handling and recording sensitive information. This advocates the 6-step approach that we expect staff to follow using their professional judgement, when considering enquiries or responding to information received relevant to risk, including those received about closed cases. We are working to strengthen our guidance through the following commitments, which will be completed by April 2024:

- We will issue new guidance for practitioners on NDelius recording of closed cases.
- We will update existing guidance in relation to recording, handling sensitive information and OASys help-text to address risk information received on closed cases.
- We will finalise and promote a new Senior Probation Officer (SPO) learning and development package, currently in development, to include support for SPOs on advising practitioners on handling sensitive information.
- We will conduct a review of Information Security Policy Framework to address closed cases.

A new assessment service is in development and aims to present relevant information about risk, needs and strengths back to the practitioner to draw together threads and support holistic and high-

quality analysis of risk. This also aims to reduce cognitive load for practitioners and reduce the likelihood of omitting important information.

The interface of this new assessment service was developed in line with Government Digital Service standards and has tested well with practitioners who stated it is accessible, simple and easy to understand. The service is also designed to be easily updateable, meaning that changes in risk over time are recorded in one place and therefore reflect current circumstances.

The new assessment service will continue to be designed as an open document, whilst facilitating a separate section for recording non-disclosable information. Current timelines aim for the 'Needs analysis' and 'Offence analysis' and sentence plan sections of the new service being available to pilot groups of staff by Summer/Autumn 2024. As further changes are implemented, more staff groups will be onboarded. Expected rollout of the new assessment service to all staff is 2026.

There are 'Registers' within NDelius, the key purpose of which is to alert all staff, including court staff, to key risk information. In response to the concerns raised we will add to existing guidance for practitioners and court report writers on 'where to find risk related information on case records,' covering both OASys and NDELIUS.

**PS domestic abuse (DA) and child safeguarding (SG) checks**

*The inquests identified that DA and SG checks were either insufficient or wholly lacking at various stages of Damien Bendall's offender management. The current evidence is that DA and SG checks remain generally insufficient or are not being done with consequent on-going risks to children and women.*

*Insufficient or absent PS DA and SG checks has been a theme of HM Inspectorate of Probation reports and reviews for at least the last 5 years. On HM Inspectorate of Probation case sampling to determine whether domestic abuse and child safeguarding enquiries were being undertaken when indicated, the HM Inspectorate of Probation Annual Report for 2022/2023 states at page 38: -*

*where inspectors judged that these enquiries needed to be made by the probation practitioner, child safeguarding enquiries were carried out in 55 per cent of cases, domestic abuse enquiries were only carried out in 49 per cent of cases and risk of harm was only properly addressed in 39 per cent.*

*The PS is not currently conducting SG checks in all cases where an offender will live with or have access to children.*

*The PS has mandated that in all cases where a curfew condition is proposed to the court in a pre-sentence report (PSR) DA and SG checks will be conducted prior to the proposal and submission of the PSR: this is not being done in all cases. I am also unclear whether contact to the address homeowner/lead tenant for a potential curfew condition to discuss the suitability of a curfew condition is being undertaken in all cases.*

*Relatedly, although I have not taken evidence on this wider issue, it appears to me that the systems for conducting DA and SG checks are generally severely strained. I say this because as an example the PS has now employed staff to make the checks from police records and has had to do this because the police service itself is unable to check and provide the information to the PS within necessary timeframes.*

**Response to PS domestic abuse (DA) and child safeguarding (SG) checks**

The Probation Service is committed to conducting child safeguarding checks in all cases where an offender will live with or have access to children, and domestic abuse checks in all cases where there are indicators of concern. We are committed to ensuring that DA, SG, and main occupier checks are completed prior to proposing a curfew condition to the court in all cases. Measures to improve performance have been taken since the inquests and are detailed further below.

*The PS is not currently conducting SG checks in all cases where an offender will live with or have access to children.*

The requirement to undertake enquiries with Children's Services in all cases where an offender lives with children, will have contact with children, or who is identified as posing a risk to children, is set out in the Child Safeguarding Policy Framework. Compliance with this requirement is carefully monitored.

We continue to see positive advances in our performance of DA and SG checks and we have strengthened the messaging to practitioners through a statement issued by the Chief Probation Officer which outlines the expectation of compliance. This will include direction to ensure that court reports must not have proposals for curfews when DA, SG and main occupier checks have not been completed.

*The PS has mandated that in all cases where a curfew condition is proposed to the court in a pre-sentence report (PSR) DA and SG checks will be conducted prior to the proposal and submission of the PSR: this is not being done in all cases.*

A gatekeeping process is mandated to check every report before it goes to court so that any such recommendation can be changed *before* the report is submitted to court if the information from enquiries is not available. We have taken further steps since the inquests to add assurance through weekly regional meetings to review the data to assure that all cases where a curfew is recommended are informed by checks and this is further backed up by a monthly report for senior leaders.

*I am also unclear whether contact to the address homeowner/lead tenant for a potential curfew condition to discuss the suitability of a curfew condition is being undertaken in all cases.*

The national *Domestic Abuse and Safeguarding Enquiries Practitioner Guidance* was revised and relaunched August 2023. It is explicit in relation to the expectations of main occupier checks and we have amended systems to add assurance that the main occupier has been contacted to discuss the curfew. Work is underway to explore options to develop standardised recording and reporting mechanisms to enable senior managers to be assured that this is happening in every case.

*Relatedly, although I have not taken evidence on this wider issue, it appears to me that the systems for conducting DA and SG checks are generally severely strained. I say this because as an example the PS has now employed staff to make the checks from police records and has had to do this because the police service itself is unable to check and provide the information to the PS within necessary timeframes.*

We are committed to working with partner agencies such as the police and children's services.

With our input to update the Prison and Probation sections, the Department for Education published the new Working Together to Safeguard Children 2023 (published on 14 December 2023 on the GOV.UK website). This statutory guidance helps us protect and promote the welfare of children. It applies to all organisations and agencies who have functions relating to children, including HMPPS.

The changes will help to strengthen the arrangements which the Probation Service has with Children's Services, particularly in relation to responding to child safeguarding enquiries and collaborating to improve outcomes for children at risk of abuse or neglect.

The Chief Probation Officer meets regularly with the Police to progress joint working in relation to domestic abuse through the National Police Chiefs' Council lead for domestic abuse.

**PS PSR reports**

*There is no evidence that DA and SG checks were made by the PS practitioner in respect of Damien Bendall's PSR report. Via the report the court was informed that checks had been conducted. The PS practitioner put forward a curfew provision as appropriate and the report was written in such a way to indicate that the report writer had checked the suitability of the curfew address, when she had not in fact done so. Had the court not been misled it is unlikely that the court's disposal would have included a curfew requirement.*

*The inquests heard that PSRs written by the same PS practitioner, reviewed before her submission of Damien Bendall's PSR, and reports reviewed after the murders, also lacked evidence of DA and SG checks having been made even though they were stated to have been done in the reports.*

*Evidence from senior PS staff was to the effect that failing to undertake the checks and failure to make this explicitly clear in a PSR might be dealt with by management feedback to the PS practitioner but is an unlikely to be a disciplinary matter. This leads me to question whether, given the potentially very disastrous outcomes in terms of public protection, the PS is failing to grasp the seriousness of the issue, to make this explicit to PS practitioners, and ensure that there are commensurate penalties for staff where these professional duties have been breached.*

**Response to PS PSR reports**

The Probation Service does grasp the seriousness of this issue and has policies to respond as detailed below.

The Performance Management and Conduct and Discipline Policies provide options for dealing with staff employed in the Probation Service who fail to meet the required personal and professional levels of conduct. Where the failure to maintain standards is through a lack of knowledge, skill or ability, this should be dealt with under the Managing Poor Performance Policy. Where standards of behaviour fall below what is expected to meet required standards, and the employee has the relevant knowledge, skills and ability that they should reasonably be expected to have, this could constitute misconduct and should be dealt with under the Conduct and Discipline Policy.

The decision to commence a disciplinary process should not be made purely on the consequences of the incident but rather should be based on the seriousness of the practice failing and whether it would amount to misconduct or gross misconduct. It is important that decisions about whether the threshold for a disciplinary investigation are met are made consistently and have been investigated under the disciplinary procedure irrespective of whether there is a SFO or not. However, the consequences of the practice failing will be relevant when assessing the seriousness of the offence and appropriate sanction.

The actions of each member of Probation staff involved in this case have been considered against both the Performance Management and Conduct & Discipline Policies. This has resulted in a member of staff being dismissed and recommendations being made for the additional training and supervision of others.

HMPPS recognises that managers need further support to determine when a practitioner's failure to comply with policies or manage cases to an acceptable standard reaches the threshold for formal action to be taken under the Service's Capability or Disciplinary Procedures. Human Resources will issue interim guidance to address this matter ahead of a fuller review of the Conduct and Discipline Policy scheduled for 2024.

## PS DA and SG training

*A significant issue in the inquests was the fact that the very inexperienced staff who were (wrongly) allocated Damien Bendall's case on transfer to the East Midlands PS region had insufficient DA and SG training. The PS states it has introduced more robust DA and SG training, but it is unclear whether PS practitioners are receiving this before cases are allocated to them to manage.*

**Response to PS DA and SG training**

The Case Allocation Policy Framework clearly sets out the expected training that must be completed prior to allocation. It also requires Senior Probation Officers to record the rationale for their allocation decisions. Cases with DA and SG concerns are not allocated to practitioners prior to their completion of the domestic abuse, child safeguarding and adult safeguarding training.

The training expectations prior to allocation of cases are detailed below.

Professional Qualification in Probation (PQIP – i.e., trainee Probation Officers) and Probation Service Officers (PSO) are required to undertake a minimum level of training/learning before they are allocated appropriate cases. This learning includes induction, NDelius, OASys, core skills and key concepts, risk assessment and management and sentence planning e-learning, and safeguarding e-learning (child protection and safeguarding, domestic abuse awareness and adult safeguarding). The completion of the minimum learning ensures that practitioners are equipped with the awareness, knowledge and understanding of the core skills for practice. Once all of this learning has been completed, appropriate cases can be allocated which would be low risk of serious harm, and no cases involving safeguarding concerns.
Domestic abuse, child safeguarding and adult safeguarding training is completed after the initial learning described above. It is only after successful completion of this learning and also the advanced core skills and key concepts and risk assessment, risk management and sentence management learning that cases with safeguarding and domestic abuse concerns can be allocated.
'*Allocate A Case,'* the new digital tool which has been rolled out to regions, enhances the allocation framework by providing in a single place all information necessary to support the SPO to make a defensible allocation decision, including risk of serious harm, risk of reoffending and risk registrations, and individual workloads. The SPO is required to consider the capabilities of the practitioner and record their allocation decision.

## Reporting concerns to the PS by the Electronic Monitoring Service (EMS)

*Damien Bendall made the comment "if this relationship goes bad I'll murder my girlfriend and the children" to the EMS field operative who fitted his tag and monitoring equipment but this was not reported back by the field operative to her manager nor to the PS. EMS has stated that it has introduced relevant training but the inquests heard evidence from the field operative that comments made by offenders which can be interpreted as potentially posing risk are currently routinely not being reported back by EMS field operatives.*

*The inquests examined the relevant contract terms between the Ministry of Justice and Capita (EMS) relating to reporting concerns and there did appear to be lack of clarity on reporting mechanisms and issues to report.*

**Response to Reporting concerns to the PS by the Electronic Monitoring Service (EMS)**

We accept the concerns that there was a lack of clarity within the service contracts and have put measures in place to rectify this for the current and future contracts.

EMS have reviewed and amended its safeguarding policy and procedures, recognising that allowing discretion for Field Officers (FMOs) to assess and decide what to report has led to some inconsistency and a lack of clarity. They have therefore amended their instructions to, and training for, FMOs so that they are required to report any concerns to Probation, regardless of the FMO view of how serious the tagged person was when they made the comments or actions. This has already been implemented. Where the offender does not have a Supervising Probation Officer (for example, where an offender is subject to a stand-alone curfew requirement), such risk of harm information should be reported to other agencies (such as the courts, prison and/or police) as appropriate.

This has also been reflected in a change to the contract, to remove any lack of clarity.

We have also reviewed the Future Service contracts due for implementation in 2024. The providers will commence service delivery under the new contracts in July 2024. The new contract will be clear about risk reporting requirements with the expectation that the FMO report what they observe and hear to the probation practitioner.

**Notification of missed substance misuse appointments to the PS**

*In Derbyshire, the substance misuse services provided to offenders where there is a court-imposed sentence requirement for such services is provided under the auspices of Derbyshire Healthcare NHS FT. Damien Bendall was subject to an alcohol treatment requirement. The precise number is not clear on the records, but he missed 4 or 5 appointments with the service between 21 July and his first attended appointment on 17 September 2021, but the required proforma attendance/non-attendance forms were not sent by the substance misuse service to notify the PS. Such non-attendance is non-compliance with the court-imposed alcohol treatment requirement and should be considered by the PS practitioner for referral back to the court as a breach of the court order. Clearly it is vital that non-attendance is formally and quickly notified to the PS practitioner especially where there is a relationship between use of substances and violent offending.*

**Response to Notification of missed substance misuse appointments to the PS.**

Existing HMPPS guidance sets out that the responsibility relating to information sharing sits with both Probation and the Treatment Provider (TP), and that collaborative working is required to ensure appropriate supervision and treatment options are provided. The national guidance sets out that inter-agency local protocols should be agreed, confirming responsibilities and actions to be taken where, for example, an offender is non-compliant with, or absent, from treatment and that Probation should then make decisions regarding breach of conditions based on the information provided to them by treatment providers, combined with their own assessment.

We are in the process of updating guidance on Drug Rehabilitation Requirements (DRR) and Alcohol Treatment Requirements (ATR) but the existing guidance, explicitly states that:

- The ATR may only be used where the offender gives consent to this sentence option. Implicit in this consent is the agreement to have information shared between the Community Rehabilitation Company (CRC) or National Probation Service (NPS) and the Treatment Provider. Therefore, the CRC or NPS and alcohol treatment providers must ensure they work together in such a way as to provide the relevant supervision and treatment options, supporting the offender and each other in the process.

- Local protocols should be agreed to ensure appropriate risk management of offenders and clarity of agreed roles and responsibilities of the health and criminal justice contributors. This will require that inter-agency protocols are agreed which specify the responsibilities and actions taken in cases where for example an offender is non-compliant with treatment or absent.

On 1 August 2023, the newly developed joint working arrangements, which detail the roles and responsibilities of both the PS and TPs in the provision of Alcohol Treatment Requirements (ATR) and Drug Rehabilitation Requirements (DRR), were launched in the East Midlands in Derby and Derbyshire. The arrangements detail the expectations of practitioners and administrators from all partners at all stages of the process, including information sharing.

Governance of these arrangements occurs through regular meetings of the DRR/ATR Working Group and the Community Treatment Requirement steering group which is chaired by the Probation Service Deputy Head.

At a strategic level, updates are provided to the Derbyshire Reducing Reoffending & Offender Health Board and the Derbyshire Drug and Alcohol Strategic Partnership.

Yours sincerely

**Chief Probation Officer**
**HM Prison and Probation Service**

**cc:**