Part I

- Executive Summary -

1. The Review Process

1.1 This is a report of a Domestic Homicide Review (DHR) conducted under the terms of section 9 of the Domestic Violence, Crime & Victims Act 2004. It examines the circumstances surrounding the death of LF at the hands of her partner, RC, in November 2014.

1.2 The review considered what has been learned of both LF and RC. Prior to the homicide, RC had come to significant notice as a violent offender and was at the time subject to a Probation Order. LF had been known to the London Borough of Islington (LBI) Social Services since she was a minor. She had previously reported to Police that she had been a victim of domestic violence (though not perpetrated by RC) and had very recently been referred to the Camden & Islington NHS Foundation Trust (CINHSFT) by her GP for treatment regarding panic attacks.

1.3 The key purpose for undertaking any DHR is to assess what, if any, lessons may be drawn from a particular case. Although the couple had not come to notice in the context of domestic abuse (DA), it was felt by the Islington Community Safety Board that a review should be conducted to determine whether this lack of agency awareness, might indicate lessons for the future.

1.4 The review was formally commissioned on 10th December 2014. Prior to the trial of RC, all agencies (see below) were asked to secure whatever material they might have to contribute to the review and, where appropriate, commence their own Individual Management Reviews (IMR).

1.5 RC pleaded guilty to the murder of LF but contested the facts of the killing, as set out by the Crown. At a court hearing to determine the true facts of the incident, the Crown case was accepted. In September 2015 RC was sentenced to life imprisonment with a recommendation that he serve a minimum term of twenty-four and a half years before being eligible for parole. The judge concluded that RC had intentionally fired two shots at LF *"deliberately and with murderous intent."*

1.6 A Review Panel was formed consisting of the following members:

Stephen Roberts, QPM, MA (Cantab) – Independent Chair

Alva Bailey – Community Safety Manager, LBI

Theresa Renwick – Lead Investigator, CINHSFT

Acosia Nyanin – Assistant Director Governance & QA, CINHSFT

Andrew Blight – Assistant Chief Officer, National Probation Service (NPS)

George Howard – Head of Mental Health & Continuing Care LBI and Camden & Islington Clinical Commissioning Group (CICCG)

Det. Sergeant Chris Brown– MPS, Serious & Organised Crime Command

Det. Ch. Supt. Catherine Roper –Islington Borough Commander, MPS

Det. Insp. Julie Willats – Homicide Investigating Officer,MPS

Laura Eden – Children's Social Care Service Manager, LBI

Mary Mason – Chief Exec. Solace Women's Aid (IDVA service provider)

Cllr. Paul Convery – Executive Member for Community Safety, LBI

1.7 Both LF's parents are deceased. LF's brother, DF, was informed of this review before the trial of RC. His Victim Impact Statement was made available to the review as were the police statements of LF's personal friends. All statements were provided with consent. DF's views were sought on the content of the draft report and are reflected in the final version, where appropriate.

1.8 Stephen Roberts, QPM, MA, was appointed by the Safer Islington Partnership as Independent Chair of the Review Panel and Report Author. He is a former Deputy Assistant Commissioner of the Metropolitan Police, now working as a private consultant. He has extensive experience of partnership working at borough and pan-London level. He is a former Director of Professional Standards and Director of Training & Development for the Metropolitan Police. He is entirely independent of the LBI Community Safety Partnership. He has completed training for the role and has successfully chaired and authored domestic homicide reviews for other Community Safety Partnerships.

1.9 The Review Panel met on 24th February 2015 and 21st October 2015.

1.10 The review was guided by the following terms of reference:

- To establish what lessons may be learned from the case regarding ways in which local professionals and agencies worked individually and collectively to safeguard victims.
- To determine how those lessons may be acted upon.
- To examine and where possible make recommendations to improve risk management mechanisms within and between all relevant agencies.
- To identify what may be expected to change and within what timescales.
- To assess whether the relevant agencies have appropriate and sufficiently robust procedures and protocols in place and the extent to which they are understood and adhered to by their staff, including an examination of the metrics and management information mechanisms in relation to risk assessment and management.
- To examine the extent to which the domestic abuse-related aims of the LBI VAWG Strategy 2011 – 2015 have been implemented
- To improve service responses including, where necessary, changes to policies, procedures and protocols.
- To enhance the overall effectiveness of efforts to reduce domestic violence and its impact on victims through improved inter and intra agency working.
- To maximise opportunities for fast time learning and overall partnership improvements as well as medium and longer term enhancements.
- To examine the existence (or otherwise) of any prior intelligence to indicate RC's possession of a prohibited weapon.
- To examine whether there was appropriate dissemination of any intelligence into the MAPPA process.
- To determine what framework exists for the sharing of information between the MAPPA and MARAC processes.

- To examine what information was shared between partners in this particular case.
- To determine the appropriateness of the MAPPA Level assigned to RC.
- To determine whether a risk assessment in respect of domestic violence was undertaken re RC's relationship with LF.
- To examine the validity of the risk management plan created for RC.
- To examine the extent to which issues of domestic violence/abuse were addressed during LF's medical and psychiatric treatment.

1.11 The following agencies were asked to participate in the review process, conducting and reporting Individual Management Reviews (IMR) if appropriate:

- The Metropolitan Police (MPS)
- LB Islington - Children's Social Care (CSC), Adult Social Care (ASC)
- The National Probation Service (NPS)
- The Camden & Islington NHS Foundation Trust (CINHSFT)
- The Circle 33 Housing Trust

1.12 Each agency was asked to provide a chronological account of its contact with either LF or RC. The CINHSFT and NPS undertook full formal reviews and submitted detailed reports. Other agencies provided chronologies and full access to whatever information they had on record but due to the limited information held, full IMR were not required. A follow up interview was conducted by the Independent Chair with the reviewer for the NPS in order to explore some aspects of the NPS IMR. Additional interviews and enquiries were conducted by the Independent Chair in an effort to gather the widest possible information.

1.13 Prior to the establishment of this review, RC was charged with murder, possession of a prohibited weapon and possession of an offensive weapon. The MPS granted access to the evidence gathered by its homicide investigation team at various stages of the review. This enabled a more detailed picture to emerge of the background to the tragedy than might otherwise have been possible.

1.14 The following documentary evidence was provided by various agencies to the review:

- **MPS** – A formal letter summarising the incident and background from the police perspective together with relevant witness statements and expert reports derived from the criminal investigation.
- **Circle 33 Housing Trust** – a copy of a "Noise Diary" prepared by a neighbour of RC was provided. The Trust also provided a copy of RC's tenancy file and a file note of an interview by a member of Trust staff with RC's neighbour in relation to the Noise Diary.
- **LBI Children's Social Care –** the full file recording the interaction between Children's Social Care and LF was made available to the Independent Chair.
- **Clinical Commissioning Group** – Copies of NHS GP records for LF.
- **LBI Violence Against Women & Girls Strategy** – copy of the strategy plus recent monitoring and statistical reports on progress.
- **LBI Noise Nuisance Unit** – Copies of the standard process flow diagrams in respect of complaints of noisy neighbours and for noise nuisance cases where there may be DA issues.
- **Minutes of the MAPPA meetings** at which RC was discussed
- **National Probation Service (NPS)–** copies of the National Offender Management Service (NOMS) Domestic Abuse Strategy and the NPS "Guidance to support NPS domestic abuse policy and strategy: assessing and managing risk of harm and the use of interventions" (including a prompt sheet entitled "Working with domestic abuse perpetrators")

1.15 In a further effort to identify the underlying causes of the tragedy, the author of this report attended the trial of RC at the Inner London Crown Court in order to hear the evidence in the case, obtain a copy of the Pre Sentence Report and to note the judge's remarks. This attendance also facilitated contact with witnesses and LF's brother.

1.16 At the conclusion of the trial a written request was made to the judge for a copy of his findings of fact and sentencing remarks – both are included in this report.

1.17 In September 2015 the Independent Chair contacted RC via the Police Prison Liaison service to seek his agreement to an interview. RC refused to be interviewed unless advised to participate by his solicitor. After a discussion between the Independent Chair and the solicitor, it was apparent that RC had been advised not to participate and thus no interview was possible.

1.18 There was no information available to the MARAC in relation to domestic abuse between LF and RC. The recommendations in this report therefore focus on what might be done to enhance information flows and risk assessment and thus minimise the probability of similar incidents.

1.19 Completion of the review was necessarily delayed by the necessity to await the outcome of RC's trial. The Overview and Executive Summary reports were ultimately agreed by the Review Panel on 25th January 2016 and the Community Safety Partnership Board on 22nd February 2016.

2. Key Findings

2.1 There was not sufficient information or intelligence *actually* available to any agency to justify intervention to avert the tragic death of LF. Neither did the Safer Islington Partnership as a whole have the capability to collate all the information *potentially* available to it. The review therefore focused on measures which offer an opportunity for enhanced information gathering and better integrated collation which may offer the opportunity to avert future tragedies.

2.2 The current LBI Violence Against Women & Girls Strategy is well developed and fit for purpose: it includes innovative approaches to persistent offenders and seeks to achieve a broad ethnic base of reporting to reflect the diverse population of the borough. Prior to the inception of this review, the Community Safety Manager had already expressed some concerns about the effective *implementation* of the strategy and initiated work to improve matters. The IDVA provider (SOLACE) generates quarterly monitoring reports albeit on the evidence provided, the statistical analysis is somewhat unsophisticated (e.g. suggesting improving trends based on only very few data points) and therefore risks flawed inferences at the strategic level.

National Probation Service (NPS) Issues

2.3 Perhaps the most obvious cause of concern in this case is the assessment and management of RC by the National Probation Service in the months between his release from prison and the murder of LF. During this period he was on licence and under the supervision of the NPS. At various times, RC had been assessed both in prison and on release as presenting a high risk of harm to the public. It was also well established even before his release that the triggers for his violence included the use of alcohol and drugs. Examination of the minutes of the pre-release MAPPA meeting about RC reveals that compliance with requirements for addressing his alcohol and drug habits was an explicit condition of his licence. Minutes of subsequent meetings confirm that his supervision by the NPS should have included a focus on these issues. Unfortunately, despite the decision of the Camden MAPPA meeting of 13th June 2013 that RC's risk level should be reduced from high to medium and that he should be managed by the NPS alone, RC's probation officers failed to implement the specific decision of the meeting that he be referred to alcohol services. There is evidence that in the months and weeks prior to the killing, he was drinking and subsequent interviews show that he was also using cocaine. It was unavoidable that the supervision of RC by the NPS was undertaken by a succession of different officers but it is clear that at various times information was available to his supervisors that he was drinking and yet there is no indication that any effort was made to address the issue.

2.4 This case illustrates the fact that the inevitable changes in supervising officer are critical moments in the overall period of supervision – they are potentially opportunities for a new officer to "take a fresh look" at a client but also a moment at which key issues may "fall between the cracks". Recommendation 7 is aimed at maximising the opportunities and minimising the risks at this critical juncture.

2.5 The fact that RC was reclassified as medium risk by the Camden MAPPA (at which the NPS was represented) only four days after his OASys had classified him as presenting a high risk appears to indicate some confusion in the overall management process. The definition of "high risk" used within the prison and probation services and in MAPPA refers to a high risk of *imminent* harm, i.e. the definition addresses both the level of risk and its immediacy. Thus even with the benefit of hindsight, the rapid downgrading of RC's risk level from high to medium in June 2013 was correct in that he did not in fact cause harm to anyone for a further 16 months.

2.6 The NPS IMR suggests that whatever the root of the apparent confusion over RC's risk assessment, in practice, the level would have made little if any difference to

the way in which he was managed. The fact, however, that RC was assigned to a place in Approved Premises strongly suggests that he was considered to be at the upper end of the spectrum of medium risk.

2.7 The more substantial concern is the fact that, especially once RC had left the Approved Premises to live in his own flat, more proactive supervision would have benefited the management of the case. In particular, there is evidence that a client of another Probation Officer had seen RC in Holloway somewhat the worse for alcohol. Despite the fact that alcohol use was a previous trigger for his offending, no action was taken and he was not asked about drug use.

2.8 The NPS IMR concludes that because there was no previous history of domestic violence, it was correct that such violence was not the focus of risk management or other work undertaken with RC. However, given that his offending history was characterised by violence, controlling and intimidating behaviour both in relation to his offending and his behaviour towards statutory agencies, his supervising officer should have explored his new relationship with LF. Had this happened, it is *at least possible* that their actual lifestyle (which included significant alcohol and drug consumption) *might* have become clearer thus triggering the imposition of some constraints. Despite the fact that RC told his supervising officer about the turbulence in the relationship, she seems to have accepted the relationship as a protective factor and evidence that RC was "settling down". The NPS have already implemented increased supervision by Senior Probation Officers, requiring the routine audit of two cases prior to each of their regular supervision sessions with each Probation Officer. In addition, Senior Probation Officers have been given the task of reviewing the training and developmental needs of the Probation Officers under their authority.

2.9 The NOMS Domestic Abuse Strategy acknowledges the importance of addressing domestic abuse and illustrates it's prevalence with various statistics drawn from the OASys – most notably that 27% of all male offenders are perpetrators of domestic abuse and 44% of offenders classified as 'high/very high risk of serious harm' are perpetrators of domestic abuse. At section 2.1 the strategy specifies the overarching aim that *".... issues of domestic abuse are embedded into the assessment and management of offenders in custody and in the community."* The primary focus of both the Domestic Abuse Strategy and its guidance notes is the importance of dealing with those offenders who have been convicted of offences which were committed within the context of domestic abuse. The strategy and guidance are far less specific about the need and possible interventions to address the behaviour of those, convicted of offences in other contexts but who may be at risk of perpetrating domestic abuse once

back in the community. In this case there is no evidence that the issue of domestic abuse was considered, despite the fact that RC's NPS supervisors were aware that he had a partner living with him.

2.10 All National Probation Service staff are now required to complete two e-learning modules on Domestic Abuse and Child Safeguarding. These are to be followed up with a two day classroom-based training session which will include a DHR case scenario. Dates for this training are currently being rolled out.

2.11 In considering the adequacy of NPS management of RC, it is noteworthy that it took place in the context of the national restructuring of probation services consequent on the Transforming Rehabilitation agenda[1]. Whilst both RC and his Probation Officer remained within NPS, his officer would have been allocated a number (anything up to 20) of new cases, all of which would have been classified as high risk and/or MAPPA. This would inevitably mean that the officer would have prioritised her time on trying to gain an understanding of and developing a relationship with these new cases. Given the fact that by this time, RC was assessed as medium risk, in employment and in a relationship (wrongly) regarded as perhaps protective, the lack of proactivity is at least understandable.

LBI Issues

2.12 Whilst RC's Probation Officers were in possession of only limited information regarding his lifestyle and domestic circumstances, the LBI Noise Nuisance Unit were in *potential* possession of more information. There is no record in the Unit of the initial complaint of noise from RC's neighbour. This may be attributed to the unusual circumstance that the approach was made by a fellow employee and in person rather than by the usual routes via telephone or e-mail. It is evident, however, that there was no lack of interest in the Unit, that there was an awareness of potential domestic violence issues and a willingness to take the matter further on the neighbour's behalf. His problems were even subject to an informal follow-up enquiry. Whilst in itself, a simple noise complaint could not and should not generate action (i.e. a MARAC referral) in respect of domestic violence, in the six months immediately prior to the killing, a neighbour was aware of angry shouting and door slamming within RC's flat. The process flow diagram to guide Unit staff how to deal with complaints about noisy neighbours is attached (see Appendix B of the Overview Report). The guidance makes

[1] Transforming Rehabilitation is the Ministry of Justice (MoJ) paper 'Transforming Rehabilitation: A Strategy for Reform', issued in May 2013

specific reference to the possibility of a noise complaint being an indication of domestic violence and directs Unit staff to a second process flow diagram to guide their actions if this is suspected (see Appendix C of the Overview Report). In this case, whilst Unit staff appear to have taken the complaint regarding noise from RC's flat seriously, it is clear that they departed from the guidance. Moreover, there is no explicit mention in the guidance of the practice of issuing officially produced Noise Diaries or the need, where one has been issued, to record the fact or to make follow-up enquiries (or simply to invite the complainant to re-contact the Unit if the nuisance continues). In fact, as identified in this review, the official use of Noise Diaries has lapsed and hence the absence of any mention of them either in the process flow diagram or indeed on the LBI website offering advice re noisy neighbours. It seems highly likely that NH was dealt with on a very informal basis simply because he was a caller in person and an LBI employee – whilst there appears to have been no absence of will to take his concerns seriously, it seems that he simply was not recognised as a "complainant" within the meaning of the standard procedures of the unit. Though it must be a matter of speculation, it is entirely possible that had the information from the neighbour been available to RC's Probation Officer, this might have been the additional trigger necessary to stimulate a more proactive management of the case, including attention to his turbulent domestic circumstances.

2.13 There appears to be a lack of clarity in the standard procedures of the Noise Nuisance Unit and/or some disparity between the implementation of those procedures and actual working practices. Specifically, it is necessary to provide certainty for Unit operators as to whether Noise Diaries are to be issued or not – if they are to be issued, clear guidance should be formulated about the circumstances under which they should be issued and the processes that should follow, including initial recording, follow-up, evaluation and dissemination of the information derived from them. Formulation of the guidance should be followed by training in the new procedures and the opportunity taken to re-emphasise the importance of recogising the relevance of information to either child or adult safeguarding procedures.

Police Issues

2.14 Islington Police had no record of any problems at RC's flat. His possession of a shotgun was unknown and there was no identifiable intelligence about the gun or its provenance. Thus the MPS had nothing to contribute to an overall picture of RC's circumstances. Since part of the purpose of this review is to identify possible improvements in the partnership arrangements to prevent domestic abuse, further

enquiries were made about the information available to front line police officers when they interact with MAPPA subjects.

2.15 When police officers are assigned to attend an incident at an address, standard procedures require that local intelligence officers research the address and its occupants (if known) using the various indices available to them; the principal databases being the Police National Computer (PNC) and the MPS database which holds criminal intelligence, known as CRIMINT. They may also have reference to a jointly administered system known as ViSOR (Violent & Sex Offenders Register). An important role of the probation services is to create records of offenders who fall within various MAPPA categories in the ViSOR system. Once a person is recorded on the ViSOR system, a flag is automatically created on the PNC system and thus information on the two systems is cross-referenced. The MAPPA Guidance does not require all Level1, Category 2 offenders to be so recorded (Category 2 because they have received a custodial sentence of 12 months or more for a violent or sexual offence and remain under the supervision of Probation. Level 1 because they merit management in the community by only a single agency). RC in fact was recorded on ViSOR even before he was released from custody but not all such individuals would be recorded on a routine basis. Given the importance of police officers being equipped with as much information as possible prior to their arrival at an incident, and the need for information to flow back to whichever agency may be managing a MAPPA subject, it is recommended that details of all Level 1, Category 2 subjects be recorded on the PNC (see Recommendation 4)

2.16 The key issues, set out above demonstrate that whilst no individual agency had sufficient information to trigger an intervention which might have directly prevented the killing of LF, the following items of information were either *actually* or *potentially* available:

- RC, previously considered to present a high risk of harm to the public, was resident at his home address with only limited supervision (i.e. MAPPA level 1 management by NPS consisting of monthly meetings).
- RC's offending history was characterised by significant violence, controlling and intimidating behaviour, apparently triggered by drugs and/or alcohol.
- RC was known to be drinking alcohol. Had appropriate enquiries been made it would have become apparent that his consumption of alcohol was increasing

(neighbours were aware of the fact that beer bottles/cans could often be seen outside RC's flat).

- RC was in a volatile relationship and intermittently living with LF, a person with a troubled background dating back to her teenage years.
- Noises suggestive of domestic turbulence and anger frequently emanated from RC's flat.

3. Conclusions & Recommendations

3.1 The psychological phenomenon known as "outcome (or hindsight) bias" is a common feature of the way in which those analysing a sequence of events allow their knowledge of the outcome to influence their beliefs about the correctness of decisions prior to that crisis point. The phenomenon might be expected to apply with particular force in a case such as this, where a death has occurred. In reviewing the appropriateness and adequacy of the decisions and actions actually taken, this review has focused only on what was known at time to those making decisions. What is indicated, however is that there are potential improvements in the systems available to the Safer Islington Partnership to improve the probability of avoiding future tragedies.

3.2 The overall conclusion of this review is that there was not sufficient information or intelligence *actually* available to any agency to justify intervention to avert the tragic death of LF and that the Safer Islington Partnership as a whole did not have the capability to collate all the information *potentially* available to it. Whilst it must be a matter of speculation, it is at least possible that had all the relevant information been collated and available to RC's Probation Officer, more robust supervision of RC (specifically, compelling him to attend drugs and alcohol interventions) could have been pursued even to the extent of his licence being revoked if he failed to comply with its conditions.

3.3 Standard NPS operating procedures require that where a client commits a serious further offence, an internal review should be undertaken. Such reviews focus both on the correctness of individuals' actions and on systemic issues. As a result of this NPS review, it was identified that RC's supervisor should be provided with additional support, training and mentoring from an NPS Practice Development Officer and be relieved of some of her additional responsibilities. The systemic issues from the NPS review have informed this DHR process.

3.4 Information known to the LBI Noise Nuisance Unit has the potential to contribute to better preventive measures. Whilst nuisance from loud music, late night parties etc. may have no wider significance, sounds indicative of anger etc. may be the first and perhaps the only indication of domestic violence (and/or child abuse). This review has found evidence that the processes of the Unit need to be reconsidered and training given in the revised arrangements. Specifically, the use or otherwise of Noise Diaries must be clarified. If diaries are formally reintroduced, procedures must be developed and documented for their issue, follow-up, evaluation and dissemination. Unit operators should be trained in the revised procedures and the opportunity taken to emphasise the importance of fully detailed recording practices. Additionally, training should be given about assessing the significance of incoming information and the crucial importance of the appropriate dissemination of that information into the child or adult safeguarding mechanisms which already exist within LBI. **(Recommendation 1)**

3.5 At present, the information flow processes for adult and child safeguarding are separate and require officers (in the Noise Nuisance Unit and elsewhere in the LBI) to recognise which route is appropriate for the information they receive. Whilst the additional training referred to above should improve the reliability and consistency of these decisions, in the longer term, LBI and its partner agencies should consider the potential benefits of using an enhanced Multi Agency Safeguarding Hub (MASH) as a single information nexus for all safeguarding information. A MASH brings together statutory and non-statutory safeguarding professionals to share and collate information with a view to identifying where vulnerable people may be at risk. The Islington Partnership already operates a MASH in respect of child safeguarding. There is, however scope to extend the remit of the arrangements to encompass domestic abuse and other adult safeguarding aspects. The MASH could thus deliver an information product on an individual or family based on the entire safeguarding partnership's collective knowledge. Thus risks may be identified earlier even where no single agency has enough information to reach its own threshold for referral into MARAC, or to trigger more assertive action by one or more partner agencies – in this case, the NPS **(Recommendation 2)**

3.6 There is no evidence that LF's allegation that she was sexually abused as a child, whilst visiting Eire in about 1990 was ever passed to An Garda Siochana (the police service in the Republic of Eire). It is recommended **(Recommendation 3)** that this information is now provided in an appropriate form.

3.7 Front line police officers are a valuable source of information but only if they are able to be aware, as a matter of routine, of the interest of other partner agencies.

Additionally, officers are better able to deal with incidents in safety if they have access to information about addresses and occupants before they arrive. It is thus recommended **(Recommendation 4)** that NPS provides a list of all Level 1, Category 2 MAPPA subjects to the Islington Jigsaw team to enable details to loaded into CRIMINT. It is further recommended **(Recommendation 5)** that provision of the details of all new MAPPA subjects at this level becomes a standing item at monthly MAPPA meetings.

3.8 The NOMS Domestic Abuse Strategy and its guidance notes do not adequately address the issue of offenders who are under supervision for non-DA index offences but who may, after release from custody, perpetrate domestic abuse. In this case, the failure to consider the potential for abuse within the relationship between LF and RC at an early stage was the responsibility of a single officer, whose training requirements are being addressed. The NPS IMR concludes that because RC had no history of domestic abuse, it was correct that the risk of it in relation to LF would not have been the primary focus of his supervision. This conclusion, taken together with the lack of focus within the National NOMS Domestic Abuse Strategy is significant evidence of the need for the NPS to give greater prominence, strategically and during training, to the risks of abuse from clients with no known history of domestic abuse. The case thus highlights the need for the Domestic Abuse Strategy to be reviewed by NOMS to ensure that adequate focus is given to assessing the risk of domestic abuse from offenders such as RC, whose previous convictions had no connection to domestic relationships. The amended strategy should then be inserted into the continuous professional development programme. This review may provide a suitable case study in the training. **(Recommendation 6)**

3.9 The NPS has already introduced enhanced formalised supervision by Senior Probation Officers (SPO) of their subordinate staff. With immediate effect, each month each SPO will select at least two cases to audit in preparation for the regular supervision meetings with each Probation Officer. Given the critical importance of the quality of work when cases are handed over from one officer to another, it is recommended **(Recommendation 7)** that all handover cases should be subject to this formal level of audit as soon as possible after the event.

Stephen Roberts QPM, MA (Cantab)

Independent Chair & Report Author