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INDEPENDENT REVIEW INTO RELEASES IN ERROR

A REPORT FOR THE DEPUTY PRIME MINISTER

DAME LYNNE OWENS

27 February 2026

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Foreword

As I submit this review the words of the father of a 14-year-old victim (known as Victim A) echo loudly in my ears; the re-traumatising effect of the mistaken release of the offender found guilty of sexually assaulting her, Mr Kebatu, was palpable.

At a superficial level, releases in error from any prison establishment or court could be considered an inevitable consequence of a stretched criminal justice service and system. Indeed, as I will go on to explore, there is likely an acceptance, or at least knowledge and tolerance, of this risk. However, as the Kebatu case and others I have examined demonstrate, there are two far more invasive consequences namely:

- Victims and the wider community are exposed to harm, real or perceived; and,
- The administration of Justice fails or is believed to have failed. The rule of law, and the wider principles of Justice, so critical to a functioning democracy, are undermined.

Within this report I have examined the Kebatu case and undertaken a quantitative and qualitative analysis of other cases. I hope you will find an accurate and precise presentation, where the data exists, of the many overlapping issues at hand. These issues are indicative of a whole system that is stretched and where the shifts of demands between organisations are occurring with a narrow or limited vision of the impacts on the public or the different public services affected.

I would like to thank everyone who has spoken to me with candour and passion, and no small degree of frustration, about what is needed to improve the situation. It is my strong proposition that releases in error are simply one symptom of a broken system - not broken by those who work daily to manage risk and protect the public - but by a lack of strategic vision and coherent policy choices, with the necessary funding, where required. This work, like other recent reviews, does not present a 'pick-n-mix' of recommendations, rather it calls for strategic, tactical and operational focus for the public good and to create the environment where public and Crown servants, and private sector colleagues can succeed in delivery of their core functions. Without that, public confidence will diminish and leadership accountabilities will remain hazy.

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It would be foolhardy to suggest that all risk in a highly challenging operational environment can be mitigated or negated, but what is less acceptable is a failure to explain the risk choices that are being made at the most senior levels.

Finally, a plea - this issue spans multiple timeframes and Governments. Now is not the time to throw mud but to consider how Parliament and all those leading the systems can pull together to protect citizens, including those who are retraumatised.

Terms of Reference

This independent review was originally commissioned with a sole focus on the facts that led to the release in error of Mr Hadush Kebatu. In late October 2025, the Deputy Prime Minister, Permanent Secretary and I agreed the following Terms of Reference for the review:

- Establish the facts and timeline of the release in error of Mr Kebatu from HMP Chelmsford.
- Consider whether the relevant protocols around prisoner discharge were in place at His Majesty's Prison (HMP) Chelmsford and whether staff had sufficient experience, training, tools, and technology to apply them appropriately.
- Consider the extent to which the protocols were properly complied with in this case, identifying points of failure.
- Consider what is causing the releases in error across the prison estate, highlighting any systemic factors that require addressing.
- Consider whether the existing protocols and operating procedures that govern prisoner discharges are sufficiently robust.
- Make recommendations on the basis of the above that can be implemented across the prison estate to reduce the likelihood of any such incident occurring in the future.

These terms were published on 5 November 2025. However, following several further high-profile releases in error, the terms for my review evolved and broadened. The Deputy Prime Minister proposed, and we agreed, to incorporate the following additional elements into my Terms of Reference for this review:

- Establish the facts and timeline of the release in error of Mr Kebatu from HMP Chelmsford and **of other relevant cases as deemed necessary by the reviewer.**
- Consider in these cases whether the relevant protocols around prisoner discharge were in place and whether staff had sufficient experience, training, tools, and technology to apply them appropriately.

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- Consider the adequacy of data collected and published on releases in error.
- Consider recommendations for areas that require further consideration as well as any additional areas for enquiry.

My independent review is focused on all these agreed terms of reference. **Where matters outside my terms of reference have been brought to my attention during my review, I have indicated so.** This has been done with the intention of ensuring that the insight and evidence I have gained through this review process on a wide range of systemic and structural issues are not lost.

Methodology

1. Initially, I was asked by the Deputy Prime Minister to lead an independent review into releases in error, including to establish the facts and timeline of the release in error of Mr Hadush Kebatu, who was mistakenly released from HMP Chelmsford on Friday 24 October 2025.
2. At the point of my appointment, an internal investigation into the events that led to this erroneous release was ongoing, led by the Governor of HMP Wandsworth, [REDACTED]. An early draft investigation report was shared with me on 3 November 2025. Ultimately, he issued three reports – a report into the systematic matters and two discipline investigations. I have read all three investigations and visited HMP Chelmsford.
3. At HMP Chelmsford I held four focus groups with officers and staff unconnected from the incident itself. I also spoke directly with the Governor, and observed a release, to familiarise myself with the process as it is undertaken in HMP Chelmsford, noting that it had been revised since the release in error of Mr Kebatu.
4. I later reviewed Human Resourcing information from HMP Chelmsford and requested access to the available CCTV (which I note lacked sound recording, minimising its value). I also met with [REDACTED] myself on 15 January 2026 and followed up in the weeks following, where necessary, with HMP Chelmsford through the Director of East Midlands Prisons Group to ascertain the facts and timeline that led to the release in error of Mr Kebatu.
5. I have striven to present my findings clearly and coherently in **section 1** of this report with commentary and recommendations, as appropriate.
6. In addition, I have engaged widely to gather a range of views on releases in error and the systems within which they occur. I have spoken with civil servants across the Ministry of Justice, His Majesty's Prisons and Probation Service (from hereon HMPPS), His Majesty's Courts and Tribunal Service (from hereon HMCTS) and the Home Office, as well as other justice agencies, including the National Police Chief Council, and the directly affected police services (Essex Police and the Metropolitan Police Service). This engagement has informed my

understanding of the wider operational and policy context within which releases in error occur. Many of those I met also supplied helpful briefings and papers which have informed this review.

7. Most notably, I met with the father of one victim who was 14 years old at the time of Mr Kebatu's offending, as well as their local councillor. This engagement is discussed in more detail on pages 54–56. I sought to engage all victims as part of this review and invited each of them to speak with me about their experiences. It is wholly understandable that some may not want to prolong traumatic incidents through this additional review process.
8. The findings from this engagement have been supplemented by the quantitative and qualitative analysis I have received and undertaken. This is described more fully in **section 3**.
9. The entire process of undertaking this review has allowed me to make judgments on the common reasons for releases in error, including the impact on the public, and to make recommendations to minimise recurrence. As I will go on to explore, the paucity of the data currently collected has inevitably impacted the quality of the analysis undertaken to inform, and again I make recommendations in that regard.
10. Throughout this report, where appropriate, and drawing on my own intelligence background, I have applied the Professional Head of Intelligence Assessment (PHIA) Probability Yardstick¹, to allow me to properly assess and communicate the certainty I have in any assertion or judgement I have made. This assessment is contained in the 'finding' sections of this report, which will usually precede a recommendation. These terms (e.g., 'likely', 'unlikely' 'probable' etc.) should be read alongside the explainer at **Annex A**.
11. Please note that the data used in this report is based on live operational data provided for the purposes of the review, comprise different extracts of data to enable comparisons to the wider offender population and accordingly, they are not intended to match published data.

¹ <https://www.gov.uk/government/publications/explaining-uncertainty-in-uk-intelligence-assessment/explaining-uncertainty-in-uk-intelligence-assessment>

Section 1: The Kebatu Case

12. In this section I provide a detailed account of Mr Kebatu's original offending, his release in error from HMP Chelmsford, and the events that occurred after.
13. After setting out the facts of the Kebatu case and the results of the internal investigation undertaken by HMPPS, I outline the impact that releases in error have on victims, communities, and wider justice agencies beyond the prison service.
14. In writing this section and directing the review, I have never forgotten my meeting with the father of the 14-year-old victim of Mr Kebatu, who was supported by a local Councillor. The retraumatising effect of the release was evident and I sincerely hope, whilst not being able to assuage that pain, this plain and precise analysis answers the questions about how it occurred.
15. More broadly, this section establishes the foundation of my understanding of the issues that contributed to the error and has informed the areas for improvement that I have identified later in my report.

1.1. Facts of the Case

1.1.1. Original Offending

16. Mr Haddush Kebatu is an Ethiopian national and asylum seeker who was housed temporarily at the Bell Hotel in Epping, Essex. Mr Kebatu committed four counts of sexual offending and one count of harassment against two victims² in Epping on 7 and 8 July 2025³ whilst he was housed at the Bell Hotel.
17. Decisions on the housing of asylum seekers are outside the scope of this review, but there were wide reports at the time of protest activity in response to the offending of Mr Kebatu.

² The case involves two victims: one child, referred to in the report as *Victim A*, and one adult, referred to as *Victim B*. There is also a witness who is under the age of 18, referred to as *Witness A*.

³ Sourced from Prison Investigation into Mr Kebatu's release.

1.1.2. Mr Kebatu's Sentence

18. Following his offending, Mr Kebatu was arrested at 17:50 on 8 July 2025 and arrived at police custody at 18:24 on 8 July with the following items in his possession⁴ which were given to SERCO when being transferred to court:
- Wallet containing miscellaneous personal items
 - Necklace
 - Loose foreign change
 - Miscellaneous papers
 - 820 Euro
 - £110
19. When Mr Kebatu entered police custody the clothes he was wearing at the point of arrest were confiscated for evidential purposes. Mr Kebatu was given a grey tracksuit by the police to wear. Mr Kebatu wore this tracksuit to court, and then into custody when he was remanded in HMP Chelmsford on 10 July 2025. He appeared at Chelmsford Magistrates' Court on 23 September 2025 where he was found guilty of five counts and was given 12 months to serve in HMP Chelmsford for four of those counts.
20. The counts were:
- Count 1 – Sexual Assault on a Female, *Section 3 of the Sexual Offences Act 2003*. Sentenced to 2 months, concurrent.
 - Count 2 – Sexual Assault on a Female, *Section 3 of the Sexual Offences Act 2003*. Sentenced to 8 months, consecutive to Count 3.
 - Count 3 – Attempt Sexual Assault on a Female, *Section 1(1) of the Criminal Attempts Act 1981*. Sentenced to 4 months.
 - Count 4 – 18 or over attempt to cause/incite a girl 13 to 15 to engage in sexual activity – no penetration. *Section 10(1)(a), (b), (c)(i) and (3) of the*

⁴ Sourced from Essex Police

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Sexual Offences Act 2003 and section 1(1) of the Criminal Attempts Act 1981. Sentenced to 8 months, concurrent.

- Count 5 – Harassment without violence between 7th July and 8th July, *Section 2(1) and (2) of the Protection from Harassment Act 1997. No separate penalty.*

21. Mr Kebatu received both concurrent and consecutive sentences for his crimes. Concurrent sentences are served at the same time (i.e. they start at the same time and overlap). Consecutive sentences are served directly after each other⁵.
22. As set out in the Warrant for his Custodial Sentence, he received a total sentence of 12 months. The 12-month sentence comes from the 8-month sentence (Count 2) running consecutively to the 4-month sentence (Count 3), with the remaining sentences (Counts 1 and 4) to run concurrently to Count 3. As the offences were sexual in nature, he was required to serve no less than 50% of the total sentence in custody⁶.
23. However, as Mr Kebatu was a Foreign National Offender, he was eligible for the Early Removal Scheme. This scheme allows for Foreign National Offenders to be considered for deportation after serving 30% of their sentence in custody. In Mr Kebatu's instance, he was referred for the Early Removal Scheme by HMP Chelmsford. This was granted on 24 September, 2025⁷, and his deportation date was arranged for 26 October 2025.
24. Had Mr Kebatu not been granted early removal via the Early Removal Scheme, he would have been eligible for deportation from 8 January 2026. In that circumstance, the Home Office would have had to decide whether Mr Kebatu, as a Foreign National Offender, should be detained⁸ under immigration powers or be released into the community on immigration bail under specified conditions whilst he awaited deportation.

⁵ Sentencing Council <https://sentencingcouncil.org.uk/guidelines/totality/>

⁶ See section 244 of the Criminal Justice Act 2003 as modified by the Criminal Justice Act 2003 (Requisite and Minimum Custodial Periods) Order 2024 No.844, paragraph 12 of the schedule.

⁷ Seen on Copy of Mr Kebatu's ERS application approval

⁸ Foreign National Offenders on Licence, PSS and IS91 Policy Framework

1.1.3. Mr Kebatu's Release in Error

25. On 24 September 2025, the Governor of HMP Chelmsford approved the scheduled release and deportation of Mr Kebatu via the Early Removal Scheme authorisation form. A deportation order was made under section 3(5) of the Immigration Act 1971⁹ and then issued and served directly to Mr Kebatu by an Immigration Officer at approximately 10:50 on 25 September 2025.
26. This ordered the deportation of Mr Kebatu and stated that he was not permitted to return to the United Kingdom unless and until the order expired or was revoked.
27. On 23 October 2025, Essex Police dropped Mr Kebatu's belongings off at HMP Chelmsford. This included his clothes that had originally been held by Essex Police for evidential purposes.
28. Mr Kebatu was scheduled to be collected on 24 October 2025 from HMP Chelmsford and transferred to Colnbrook Immigration Removal Centre by Mitie, the prisoner and detainee transport service. He was booked onto a flight for his removal to Ethiopia on 28 October 2025.
29. On the morning of 24 October, Mr Kebatu was collected from his cell in G Wing by an Officer from reception. He was escorted to the prison's reception, where he was placed in the holding cell that is usually used for deportations.
30. On 24 October, the staffing allocation in reception was as follows: one Band 3 Officer on the Front Desk, two Band 3 Officers in the Search Area, and one Band 3 Officer conducting Interviews.¹⁰ Although reception met the minimum Band 3 staffing requirement, there was a shortfall in supervisory cover at Band 4 level. Only one Supervising Officer (Band 4) was available in the limited period between 6:30 and 7:45am. That morning, at an unspecified/unknown time (despite intensive enquiries on my part), one of the Custodial Managers (CM)¹¹, attended reception and enquired how many releases there were for the

⁹ [Immigration Act 1971](#)

¹⁰ Their main duties include interviewing prisoners transferring into the establishment to determine cell-sharing arrangements, completing required documentation for phone credit, canteen access, public protection restrictions and TV compacts, as well as carrying out initial assessments and related administrative tasks.

¹¹ Band 5 Custodial managers are the most senior uniformed officers in a prison. They manage prison activities, often across multiple departments. Responsibilities include managing people and resources.

day. They were advised by reception that there were two, with one being a deportation that reception would manage.

31. At approximately 10:30am that morning, another Custodial Manager attended reception to conduct the two discharges and was told by reception that Mr Kebatu was ready to be processed. The Custodial Manager was provided with a paper file containing the following paperwork:

- **Mr Kebatu's Core record¹², marked in pencil 'ERS Rel – Colnbrook IRC'**. The front page of the core record included a pencil note stating "*ERS Rel – Colnbrook IRC.*" I am advised that this shorthand means "*Early Removal Scheme – Release to Colnbrook Immigration Removal Centre*" and was intended to indicate the expected transfer of Mr Kebatu to Colnbrook Immigration Removal Centre.
- **Prisoner Escort Record (PER), with the 'Not For Release' box ticked.** The Prisoner Escort Record can be digital, or paper based and must be completed for all prisoners prior to **any** escorted external movement or transfer. It provides escort services and receiving establishments information about the prisoner, including identification information, an overview of movements, medical information, and any alerts such as risk of violence, not for release, etc. Prisoner Escort Records are **not** found in the core record where an offender is being released into the community. In Mr Kebatu's instance, this Prisoner Escort Record was for Mitie and the 'Not for Release' box **was ticked**.
- **A Movement Order, authorising Mr Kebatu's movement to Colnbrook IRC for 24 October.** A movement order is produced by the Home Office and this notified the prison of Mr Kebatu's movement details. It stated that Mitie were to transfer Mr Kebatu on 24 October from HMP Chelmsford to Colnbrook Immigration Removal Centre.

¹² A core record (known as an **F2050**) is the primary, official file that contains the full set of key documents relating to a prisoner's custody. It is maintained by establishments and used throughout custody, transfer, and discharge processes.

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- **An authorised Release Licence.** In Mr Kebatu's case, a release licence¹³ had been issued. I was advised that this would have been issued as a precaution in case of failed deportation¹⁴. The licence was formalised, produced on the Digital Prison System and then three hard copies printed. I will consider the appropriateness of the issuing of a licence in this case in section two.
 - **2 Day Checklist, indicating that Mr Kebatu was an immigration removal.** The '2-day checks' are completed 2 days before discharge and are done by a senior case administrator (Band 4) within the Offender Management Unit.¹⁵ This included his sentence calculation check, his release date check, an outstanding warrant/case check, his registration as a sex offender, a check to make sure he was included in the release schedule (which lists all the releases and deportations/transfers of the day) and a check of the Police National Computer (PNC) by the senior case admin to highlight whether there are any outstanding criminal cases to consider.
 - **Sentence Calculation sheet indicating that Mr Kebatu was an immigration removal, dated 23 October.** The sentence calculation sheet was annotated with information on when immigration removal would take place, stating that 'immigration removal' would be on 24 October 2025.
32. At 10:25, Mr Kebatu's release licence was activated, meaning his record had been updated on Digital Prison System by reception staff to reflect his release from custody.
33. Mr Kebatu was issued a gate pass by the discharging Custodial Manager. Gate passes are prepared in advance by reception staff and are populated using information extracted from NOMIS to produce the discharge list. In this case, Mr Kebatu's gate pass recorded his movement as a "Release." I address the implications of this in the conclusion on pages 43-47.

¹³ A release licence sets out the legal conditions an individual must follow when they are released from custody but still serving the remainder of their sentence in the community. It is typically generated by the Community Offender Manager (COM), and depending on the route of release, approved either by a Governor/Director (for automatic or fixed-term recall releases) or the Parole Board/PPCS on behalf of the Secretary of State (for Parole Board-directed releases). It is issued to the prisoner by the discharging Custodial Manager who ensures the prisoner is aware of the conditions within it.

¹⁴ [Foreign National Offenders on Licence, PSS and IS91 Policy Framework](#)

¹⁵ Offender Management Units oversee and manage the sentences and time-served by individuals in custody, whether on remand or following conviction and are part of HMPPS.

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34. Mr Kebatu was escorted from reception by a Custodial Manager and was released in error into the community through the prison gate at 10:35 at HMP Chelmsford. While in reception, he was issued with a physical copy of his licence and given his belongings that had been dropped off by Essex Police the previous day.
35. Mr Kebatu was released wearing, what I understand to be, the tracksuit issued to him by Essex Police after he was arrested. It is my assessment that it is **highly likely** that HMP Chelmsford staff believed the tracksuit to be his own clothing, as this was what he had been wearing on arrival, and therefore provided it to him to change into before release.
36. There are inconsistent accounts about the amount of cash with which Mr Kebatu left HMP Chelmsford. According to Essex Police, he was arrested after his original offending with £110 and 820 Euros which was then given to SERCO¹⁶ when he was taken to court. He arrived from court to HMP Chelmsford on 10 July, however there is no clear record of how much money was placed into his property. When he was released in error from HMP Chelmsford it was recorded that an unknown value of foreign currency was returned to him. By the time he was taken back into Metropolitan Police custody they noted that he had two items on him at the time of arrest, but they were recorded as 'personal' and 'paperwork'. As such, we are unable to ascertain how much money with which Mr Kebatu left the prison. Mr Kebatu was not given any extra money nor a travel warrant¹⁷ by the prison and was not eligible for a subsistence payment.¹⁸
37. After his release, Mr Kebatu returned to the prison gate and spoke to an Operational Support Grade (OSG).¹⁹ Mr Kebatu told them that he believed he should have been collected from the prison for deportation rather than released.

¹⁶ SERCO provides secure prisoner escort and custody services.

¹⁷ A travel warrant is a prison-issued document resembling a cheque that specifies the start and end points of a prisoner's rail journey. Before release, prisoners are asked if they require one; those not being collected or using other transport typically do. The warrant is exchanged at a train station for tickets at no cost to the prisoner, and no price is shown as costs vary by route. If rail travel is unsuitable, a cash amount may instead be provided to cover a bus or taxi fare—usually for short, local, or cheaper journeys. This process is mandated in PSI 72/2011.

¹⁸ A subsistence payment is a payment of £89.52 where the offender is free to spend on what they wish and no accounting of what they spend it on occurs. There are exceptions to receiving this payment and Mr Kebatu was not eligible because he was awaiting deportation or removal from the United Kingdom -Annex B of PSI 72/2011

¹⁹ An Operational Support Grade is a prison support role. It is a varied role, ranging from working on security and searches at the gate, to managing deliveries, supervising visitors, and monitoring phone calls and CCTV.

██████'s investigation found that the OSG tried to get assistance to come to the gate.

38. At 10:49 the first Orderly Officer ('Oscar 1'),²⁰ and two Custodial Managers attended the gate to speak to Mr Kebatu. I did not receive evidence to definitively conclude what was said during this conversation, but the HMPPS' commissioned investigation reported that Mr Kebatu was instructed by Oscar 1 and the two Custodial Managers to go to the train station and to make his way to Harlow probation, as per instruction on his licence.

1.1.4. Notification of Mr Kebatu's Release in Error

39. On 24 October 2025, at 11:00, while Mr Kebatu was back at the gate, the Cashier took a call from the first Orderly Officer 'Oscar 1'²¹ who stated they were at the gate and had a released offender who needed to get to Harlow train station (they did not specify which station in Harlow), and as such were requesting a travel warrant. The Cashier took the offenders details and confirmed it was for Mr Kebatu.
40. The Cashier then raised a concern to Oscar 1 that Mr Kebatu was meant to be transferred to an Immigration Removal Centre and not for release. According to the HMPPS commissioned investigation, Oscar 1 then reportedly said, 'leave it with me', and the phone call ended. It is probable that Mr Kebatu left the prison grounds during that phone call.
41. At approximately 11:19am, Mitie contacted HMP Chelmsford to inform the prison that they were on route to collect Mr Kebatu. The prison did not inform Mitie at that time that Mr Kebatu had in fact already been released.
42. Following the phone call between the Cashier and Oscar 1, the Cashier went to speak to the Business Hub Manager²² about the interaction.
43. At 12:10 the Business Hub Manager informed the Duty Governor of a potential release in error.

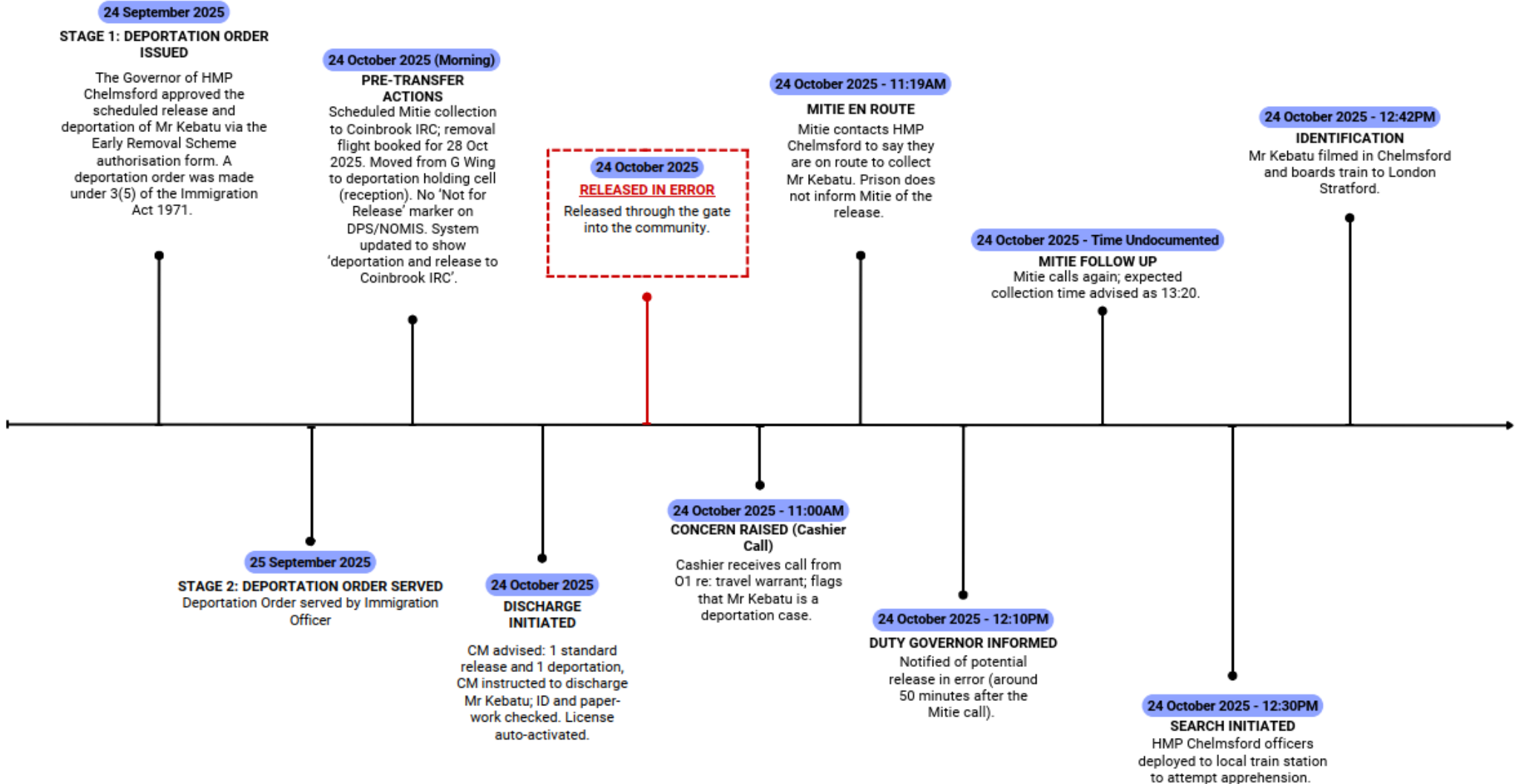
²⁰ Oscar 1 also known as Orderly Officer is a role Custodial Manager grades undertake on a rota basis. In this role Oscar 1 is responsible for ensuring that the establishment's regime is delivered effectively. This can involve making sure staff are effectively utilised and deployed in necessary areas. They are also responsible for ensuring that any operational decisions or incidents are managed in line with contingency plans and where necessary escalating these to the Duty Governor.

²² They are responsible for managing the administrative processes within the People Hub, ensuring that staff are supported through training, detail and all Human resource processes.

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44. A further call from Mitie was received by a reception officer at the prison at an undocumented time, informing the prison that they expected to collect Mr Kebatu at 13:20.
45. At 12:20, the Duty Governor attended the gate, with Oscar 2 and a CM, where they searched the outside area for Mr Kebatu.
46. At 12:30, the Duty Governor briefed the other two HMP Chelmsford Governors.
47. At 12:30, Prison officers from HMP Chelmsford were sent to the local train station to attempt to apprehend Mr Kebatu.
48. At 12:57, HMP Chelmsford notified Essex Police that Mr Kebatu had been released in error.

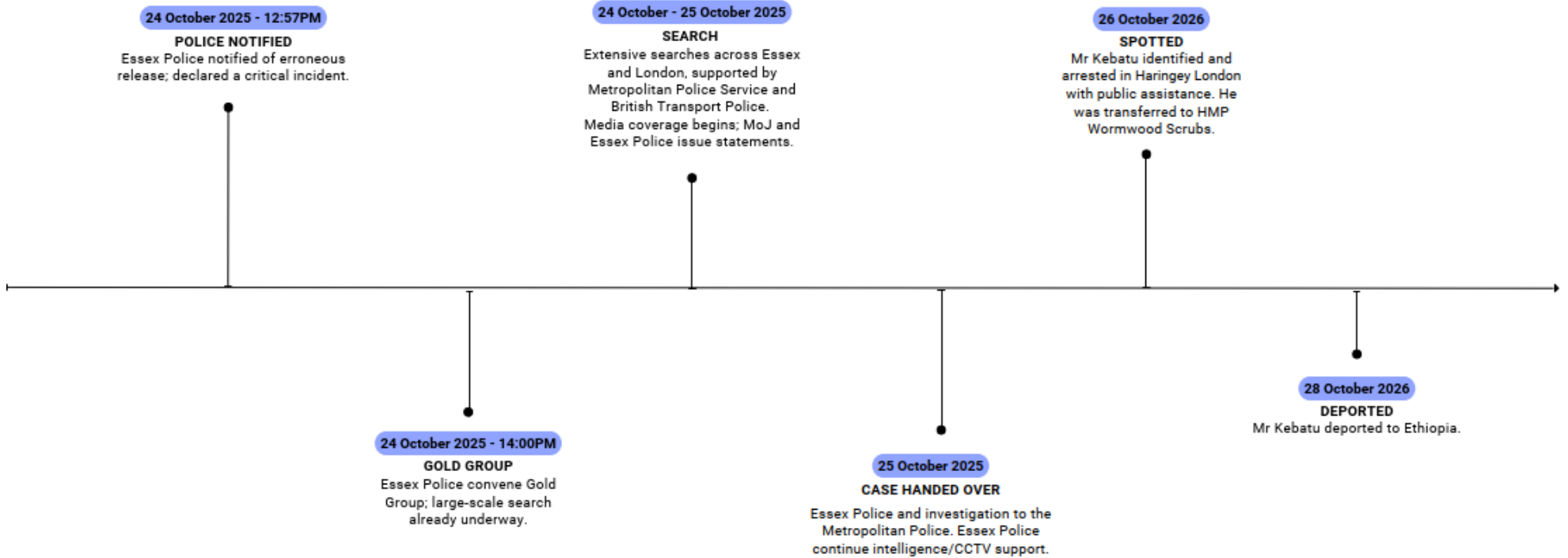
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● **RELEASE IN ERROR (CRITICAL EVENT)**

Prepared for report use. Times shown are local and as provided; one Mitie follow up call time is undocumented.

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1.1.5. Response to Mr Kebatu's Release in Error

49. Essex Police were notified of Mr Kebatu's erroneous release at 12:57. By this time he had already been filmed in Chelmsford and boarded a train (at 12:42) to London Stratford. A critical incident²³ was declared by Essex Police who responded at pace. At 14:00, and with the police search already underway, they convened a Gold Group.²⁴
50. The response indicates that Essex Police immediately recognised the significance of the error, including the public concern already being expressed in the media. They acted to both protect the public and regain public confidence. Extensive searches for Mr Kebatu were launched across Essex and London, supported by the Metropolitan Police Service and the British Transport Police, with covert teams and intelligence units deployed.
51. Media coverage followed the release in error and was contemporaneous with the searches, with the Ministry of Justice and Essex Police issuing public statements in response on the 24 October 2025. On the 25 October, Essex Police handed the investigation to the Metropolitan Police, due to their assessment that Mr Kebatu was now in London, albeit they continued to support with intelligence and CCTV tracing.
52. Mr Kebatu was ultimately identified and arrested, with support from the public, in Haringey, London, on 26 October at 08:30, two days after his release in error. He was transferred to HMP Wormwood Scrubs until his deportation to Ethiopia, which took place on 28 October 2025.

1.1.6. Victim Contact Related to Mr Kebatu's release

53. Unfortunately, the victims of Mr Kebatu were not immediately contacted about the release in error. By the time they were contacted, social media reports had already begun circulating.
54. I have set out below the contact that was had with the victims of Mr Kebatu concerning his release. I make commentary on the adequacy of this contact

²³ Any incident where the effectiveness of the police response is likely to have a significant impact on the confidence of the victim, their family and/or the community.

²⁴ Gold Group is a strategic meeting held by a Gold Commander to ensure coordination of a critical incident.

and related recommendations on page 62, where I specifically consider the impact of releases in error, including on victims.

Timeline of contact with victims

17 October

- The Home Office's Victim Support Team sent an email to the HMPPS Victims Team²⁵ asking if they had had any contact with the victims of Mr Kebatu. They responded the same day and explained that the victims would not have been referred due to them not meeting the criteria on any of the existing statutory contact schemes.²⁶ They therefore would not have a Victim Liaison Officer (VLO).
- The Home Office's Victim Support Team contacted Essex Police to request the victim's details for the purpose of making contact and asking consent to provide details of Mr Kebatu's deportation.

20 October

- The Home Office's Victim Support Team had a call with an Essex Detective Constable who agreed that the police would approach the victims to ask if they would like to be kept informed about the deportation process. This conversation was followed up by email.

21 October

- The Detective Constable at Essex Police confirmed to the Home Office's Victim Support Team by email that the mother of Victim A wanted to be kept informed of Mr Kebatu's deportation status. The mother of Victim A's email address was provided for contact.
- The Detective Constable confirmed that he had been unable to contact Victim B.

²⁵ The HMPPS Victims team lead on the operational policy for the Victim Contact Scheme.

²⁶ [Victim Contact Scheme Policy Framework - GOV.UK](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/674423/victim-contact-scheme-policy-framework.pdf)

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22 October

- The mother of Victim A was contacted by the Home Office Victim Support Team regarding Mr Kebatu's deportation. However, their email could not be delivered
- The Home Office Victim Support Team then emailed the Detective Constable to notify them that they had been unable to reach her and asked that the content of the message, instead, be forwarded onto the mother of Victim A by the police.
- The Detective Constable subsequently sent the content of the email to Victim A's mother in a text message.
- I understand that the parents of Victim A are separated. I was shown this message by Victim A's father when we met, suggesting Victim A's mother had helpfully passed it on.

24 October (the day of Mr Kebatu's release in error)

- At 17:04: Essex Police contacted the mother of Victim A to alert them of the release in error.
- At 17:16: Essex Police rang Victim B. The call was unanswered
- At 17:28: Essex Police rang the mother of Witness A and alerted them of the release in error.
- At 17:59: Essex Police rang Victim B again. When there was no reply, a further email was sent.
- The father of Victim A suggested that Victim A was sent and watched a video on social media of Mr Kebatu out in the community before contact was made with them by the prison or by the police.

25 October

- At 13:35: Essex Police contacted Victim A's mother and provided an update on their enquiry
- At 15:10: Essex Police contacted the mother of Witness A and provided an update.

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- At 15:53: Essex Police Unit attended Victim B in person to provide an update. Essex Police provided a mobile phone to her.
- An email was received from Victim B but not read by the relevant Officer until 27/10 due to them being on rest days.

26 October

- At 08:39: Essex Police updated Victim A and Mother of Witness A, to provide an update that Mr Kebatu had been arrested.
- Victim B did not answer their phone and so a police officer was sent to update in person at 09:44.

27 October

- The mother of Victim A was updated by telephone by Essex Police.
- Contact was first made with the father of Victim A after he texted the case officer directly.
- Further contact was then made with the victims to obtain permission for phone numbers being given to Immigration Team to facilitate direct further contact regarding Mr Kebatu's deportation.
- On the 27 October the Home Office's Victim Support Team received phone numbers for the parents of Victim A, details for the adult Victim B and the mother of the Witness A of Mr Kebatu.
- The parents of Victim A, and the mother of the Witness A were contacted by the Home Office's Victim Support Team and told that the flight to deport Mr Kebatu was imminent.
- The parents of Victim A and the mother of the Witness A were asked if they would like to be informed immediately of Mr Kebatu's departure, explaining the flight would land in Ethiopia in the early hours of the morning. Victim B could not be reached.
- The father of Victim A reported to the Home Office Victim Support Team that they were unhappy that they had not been contacted sooner by the police to inform them of the release in error, but it was explained that this was due to Victim A's mother being the original point of contact during the trial. He

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confirmed that he would like to know when Mr Kebatu had been deported. This was followed up with Victim A's parents by email.

- The Home Office's Victim Support Team could not get hold of Victim B via her phone number and several attempts were made. They continued to attempt to keep Victim B informed via email in case she was accessing her email inbox.

28 October

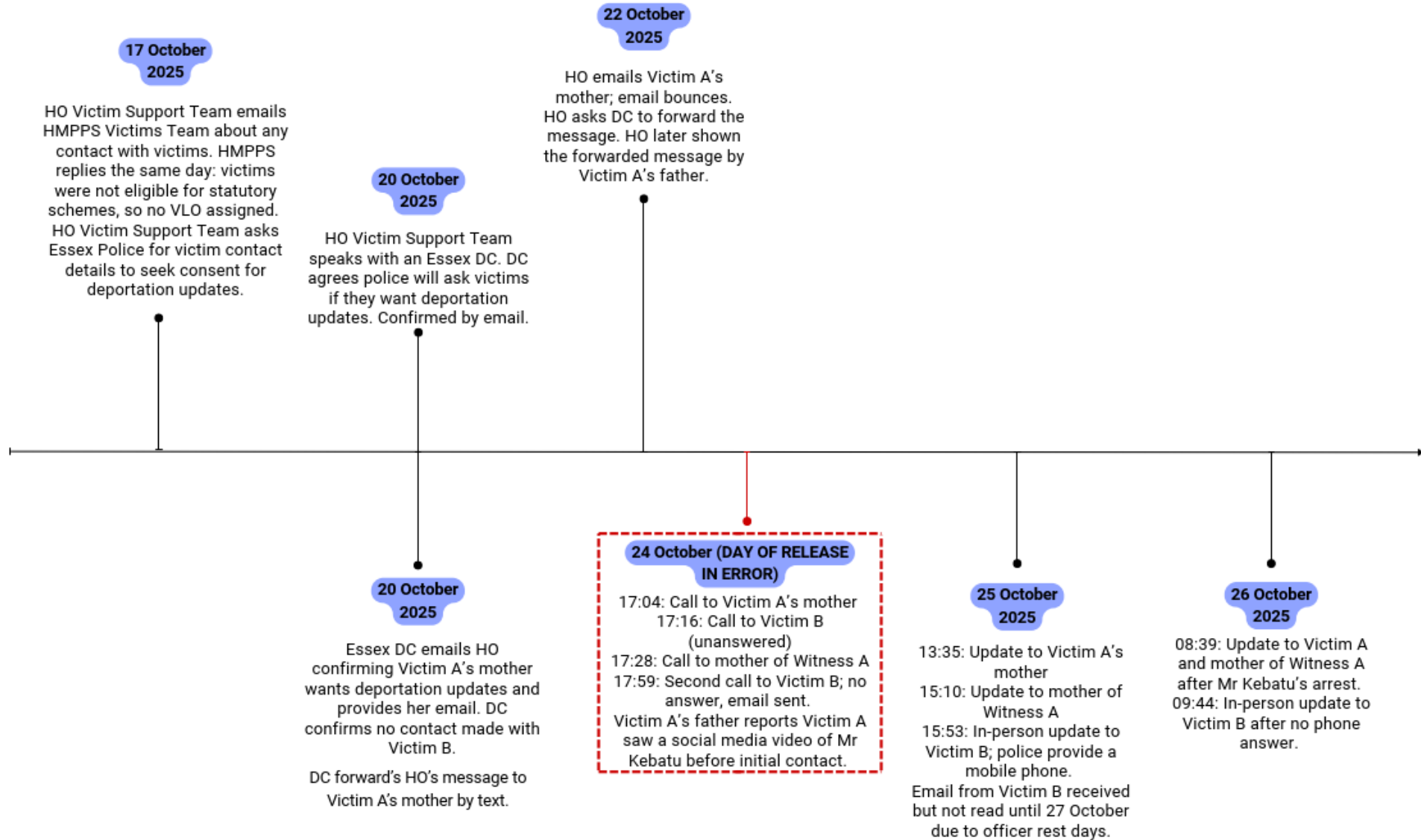
- A victim contact plan was provided to the Chief Superintendent of Essex Police and to the Deputy Director of the FNO Returns Command in the Home Office.

29 October

- Essex Police further contacted all victims to ask whether they were happy to be contacted by HMPPS as part of the investigation/inquiry into Mr Kebatu's release in error.
- At 5am on the 29 of October the Home Office's Victim Support team, following the families specific request, contacted Victims A, B and C using the methods that they had requested (email, text or phone call) to inform them that Mr Kebatu had landed in Ethiopia.

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HOME OFFICE



ESSEX POLICE

OFFICIAL

HOME OFFICE

27 October
2025

HO receives contact details for Victim A's parents, adult Victim B, and mother of Witness A.
HO tells Victim A's parents and Witness A's mother that deportation is imminent.
HO asks if they want immediate confirmation when he departs.
HO continues attempts to reach Victim B via phone and email.

28 October 2025

HO sends victim contact plan to Essex Chief Superintendent and HO FNO Returns Command.

29 October 2025

05:00: HO informs Victims A, B and C (via preferred methods) that Mr Kebatu has landed in Ethiopia.

27 October
2025

Police update Victim A's mother by phone.
First contact with Victim A's father when he texts the officer.
Police ask victims for consent to share their numbers with Immigration.
Victim A's father expresses unhappiness about delayed notification but wants deportation updates.

29 October 2025

Police contact all victims to ask if they consent to HMPPS contacting them for the release-in-error investigation.

ESSEX POLICE

1.2. Investigation into HMP Chelmsford

55. On 25 October 2025, [REDACTED], the Governor of HMP Wandsworth, was commissioned by Sara Robinson, Area Executive Director for the Southeast and Eastern Prisons and Probation Service, to conduct a review into the erroneous release of Mr Kebatu on 24 October 2025. The report was completed on 3 November 2025.
56. [REDACTED] was tasked with investigating:
- Why the paperwork relating to Mr Kebatu's immigration hold was not identified at the point of discharge;
 - Why he was processed for release despite being subject to detention by immigration authorities;
 - Whether all necessary alerts were applied on the Digital Prison System;
 - Whether existing processes for releasing foreign nationals are sufficiently robust to prevent such errors;
 - How the incident was reported and whether the prison acted appropriately upon discovering the error;
 - The adequacy of training provided to Offender Management Unit (OMU) and discharge staff; and,
 - Whether any use of force or complaints by Mr Kebatu indicate wrongdoing. The investigation considered whether any use of force incidents or complaints made by Mr Kebatu indicated potential wrongdoing. HMPPS advised that it is not standard practice to have this in the Terms of Reference. However, in Mr Kebatu's case, he made several allegations to a Sky News reporter during his deportation flight to Ethiopia, including a claim that he had been "*tortured by electric in the prison of Chelmsford.*" The Terms of Reference were therefore expanded as a precautionary measure and to demonstrate due diligence.

57. The investigation identified significant weaknesses in processes, training, and communication at the prison. ██████████ concluded that all of these contributed to the erroneous release of Mr Kebatu. The main findings were:
- The FNO discharge process was unclear;
 - Poor communication between staff;
 - No contingency or escalation procedures in place;
 - Staff lacked training on FNO procedures, Prisoner Escort Record checks, and discharge protocols;
 - Key systems like the Digital Prison Service weren't used properly;
 - There were no contingency plans in place or ability for staff to escalate concerns. Operational staff also did not check alerts/escalate open alerts to seniors.
 - Human error played a role, with the manager not questioning irregularities;
 - Operational practices, such as the coloured tray system used in the discharge process, were inconsistently understood;
 - Limited experience in handling Foreign National Offender and Early Removal Scheme cases; and
 - Compliance was weak: Engagement from the Foreign National Specialist with the HMPPS Foreign National Offender team was low, and issues weren't escalated early enough.
58. I have been told by HMPPS that a disciplinary investigation did take place in respect of two individuals. The ██████████ who authorised the release has appeared before a disciplinary panel.²⁷ The second individual was a ██████████, who did not take any corrective action when notified by the Operational Support Grade at the gate, is awaiting a disciplinary hearing. It is notable that, unlike policing, the fact and outcomes of these processes are not public nor communicated with transparency.

²⁷ The Ministry of Justice and HMPPS were reluctant to share the grades of those under disciplinary action. This is a differing approach to that of the police.

1.2.1. Discussion

59. The prison service has significant responsibility to protect the public, ensure that justice is properly administered and to care for those detained. In a high-risk operational environment, it is not credible to assume that all risk can be mitigated. At every operational level I have seen a desire and determination to improve, within an environment that is resource restrained and managing daily, or even hourly, risks. Investigations are critical to learning lessons and proactively reducing future risks.
60. In reviewing the Mr Kebatu case, I was surprised to observe the internal investigation process in HMPPS. Understandably the need for quick reviews necessitates local input, but the transition from that to more formal investigation and then a conduct enquiry remains unclear. Inevitably, I draw on my policing knowledge and the comparison between the two systems. One (policing) being highly regulated and one not – despite the coercive powers used daily by police and prison officers being similar. I am unclear why the principles of independence and transparency required of the policing system are less identifiably required of HMPPS.
61. Currently, HMPPS does not prescribe how individual incidents must be investigated. Decisions on whether to undertake a lessons-learned review, fact-finding exercise, or formal investigation are made at the discretion of the Governor. In rare cases, Prison Group Directors may commission investigations, particularly where there are serious failings or patterns of concern. I have been informed that learning from investigations is, on occasions, informally shared with HMPPS to inform national learning. Findings may be escalated should there be reoccurring themes or concerns at a systemic level.
62. In the case of HMP Chelmsford, the investigation was undertaken by a Governor from another prison, with an ad hoc team without accredited investigative training. It is to be commended that they are willing to undertake these tasks, in addition to already busy and risky day jobs. Notwithstanding this, it is my view that investigations in cases with such significance as this, require the selection of a standalone team with the professional background

and skills (for example in interviewing) appropriate to investigating such serious matters.

63. It was also concerning to discover that there was no audio recording available in the CCTV footage of Mr Kebatu's release. According to HMPPS, this is because the standard of CCTV equipment in use across the prison estate varies significantly from establishment to establishment. Although systems such as intercoms can capture both video and audio, it is uncommon for prison CCTV to include audio capability. This means that CCTV within prisons provides limited audio evidential value, particularly for the purpose of undertaking investigations.
64. Similarly, the absence of body-worn video among Operational Support Grade staff who interacted with Mr Kebatu at the gate was concerning. Given that body-worn video is intended to provide an objective record of staff-public/or prisoner interactions, it's lack of use and availability to Operational Support Grade staff further limits the evidence available when undertaking investigations. OSG staff would welcome its introduction to their grade, when employed in public or prisoner facing roles, to provide clarity and certainty on interactions. Moreover, the father of Victim A was keen to understand specifically what occurred at the gate and the availability of such evidence would increase confidence in investigative findings in that regard.

1.2.2. Findings

65. Considering the above, I find that:
- It is **possible** that the ad hoc approach taken to investigating errors is failing to get to the systematic root causes, and that the professional, working knowledge of commissioned investigators (e.g. Governor's from the other prisons) may be leading to assumptions being made about the **likely** reasoning for events occurring as they did.
 - The technological capability (or lack of) across the prison estate is **almost certainly** inhibiting HMPPS' ability to fully investigate events or be sufficiently transparent with the public and others as to events taking place therein. The lack of coherence regarding what equipment prisons have and

for what purpose is a critical issue - particularly the absence of audio at key points such as reception and the gate which, in this case, has inhibited a detailed understanding of the events leading up to the release of Mr Kebatu and hampers robust investigation more broadly.

1.2.3. Recommendation

66. I therefore make the following recommendation, that **within three months:**
- **Recommendation 1:** That HMPPS consider extending the use of body worn video to Operational Support Grade staff in public or prisoner facing roles.
67. Investigations of significant events that impact on safety, risk and/or public confidence need professionalisation, with a clear and specific referral criteria (with mandatory and voluntary elements).
68. I therefore further recommend, that **within three months:**
- **Recommendation 2:** That HMPPS and the Ministry of Justice urgently explore and agree a route by which to professionalise the investigation process. Once the investigation process has been agreed it should be **implemented within 6 months**. The options requiring full exploration by HMPPS and Ministry of Justice are:
 - An extension of the Anti-Corruption Command within HMPPS to create a central Professional Standards function, with professional investigators and led separately from individual prison establishments.
 - An escalation route into either the Prisons Ombudsman (with an extension of their current remit) or the option to refer into an already established independent body (e.g. the Independent Office of Police Conduct) in cases meeting a seriousness criterion.
69. I further recommend that **within 12 months:**
- **Recommendation 3:** Considering that the lack of CCTV audio impacted the investigation process and that across the prison estate there are varying standards of CCTV equipment I recommend that HMPPS upgrade CCTV across the prison estate to include audio recording.

1.3. My Conclusions on Mr Kebatu's release in error from HMP Chelmsford

70. In the previous section, I set out the timeline and facts, as reported to me, surrounding Mr Kebatu's case and his eventual release in error. I have also detailed the further investigation that was undertaken and its results. This section provides further detail and a discussion, on the release in error of Mr Kebatu.

1.3.1. Further investigation and discussion

71. In reviewing the Kebatu case, I have identified six areas that warrant further scrutiny. These points were either brought to my attention during my engagement, represent points at which different action might have prevented the release in error, or have raised serious concerns during my review of this case.

72. The six areas are:

- Identifying and responding to the release of high-profile prisoners;
- The use of 'not for release' markers;
- The Early Removal Scheme in the case of Mr Kebatu;
- Incorrect information on the Gate Pass
- The discharge process and production of licence; and,
- Contact made with victims following a release in error.

73. I have provided commentary on each and set out my subsequent findings and recommendations.

1.3.1.1. Identifying and responding to the release of high-profile prisoners

74. An alert identifying Mr Kebatu as a high-public-interest case was applied to his digital record and was live at the point of release. Whilst this information was available on the system, it was not prominent and was missed in a busy operational environment.

75. I was made aware that reception staff at HMP Chelmsford do not routinely check digital alerts prior to releasing a prisoner. I understand that there is, currently, no formal policy requirement to do so, however it was said to me that it is considered best practice. Notwithstanding this, guidance on when and how high-profile flags should be applied appears unclear.
76. I was also alerted to the fact that staff in the Offender Management Unit at HMP Chelmsford were aware of the high-profile nature of Mr Kebatu's case, and the public interest in it. Offender Management Units oversee and manage the sentences and time-served by individuals in custody, whether on remand or following conviction.
77. It was not clear to me whether reception staff at HMP Chelmsford had the same understanding of the high-profile nature of Mr Kebatu's case as the Offender Management Unit were reported to.
78. Notwithstanding this, it is notable that no information about Mr Kebatu's movement, as a person of interest, was included in the staff's morning briefing. The HMPPS commissioned internal investigation into the release in error of Mr Kebatu therefore recommended that prisoner movements of interest should be introduced into morning briefings to ensure all staff are aware of such information.
79. Whilst such briefings could be of help, there is an additional or alternative solution, namely, to systemise the use of the digital alert already provided. The impact of digital alerts not being systemised is they are not mobilised effectively. In Mr Kebatu's case, his digital alert did not prompt additional scrutiny.

Findings

80. In the identification and release of high-profile prisoners, **I find that:**
- Although high profile alerts existed, it is **almost certain** that they were not effectively used in Mr Kebatu's release.
 - Given the high-profile nature of the case and the significant public interest, it is **almost certain** that the application of a high-profile alert on NOMIS/DPS did not trigger any further checks or assurance processes in the Kebatu case, despite its high-profile nature and the significant public

interest. This means that the high alert was **highly likely** not effectively mobilised.

- It is **likely** that this was a missed opportunity to prevent the release in error. For example, had the use of this alert triggered a process of additional scrutiny, the decision to release may have been questioned.
- Further, it is **highly likely** that improving communication between Offender Management Units and reception staff about prisoner' movements and releases would result in greater awareness amongst staff of high-profile cases. It is possible that this could serve to reduce the risk of releases in error in these cases.

Recommendations

81. I therefore recommend the following action **within three months**:

- **Recommendation 4:** That HMPPS clarify operational guidance on what a high-profile alert means, when it should be used, what should happen as a result during the release process and/or other prisoner movements and use, triggering a clear sequence of events.

1.3.1.2. The use of 'Not for Release' markers

82. The discharge process involves reviewing both physical and digital records. Both should be reviewed by the Custodial Manager undertaking the discharge.
83. In the case of Mr Kebatu his records contained conflicting use of the 'Not for Release' marker. Whilst his digital record **did not** have the 'Not for Release' marker checked, his core, physical record **did**. To add to this confusion, the 2-day checklist that was included as part of the paperwork (as a physical copy) had 'N/A' written next to the 'Not for Release' marker. HMPPS advised it was marked as N/A as he was being transferred to immigration authorities.
84. Upon my enquiry into the policy around using 'Not for Release' markers, I was advised that Governors are encouraged to apply 'Not for Release' alerts to both the digital system and the physical file. It was emphasised that this is particularly important for individuals subject to deportation processes or an Immigration Service IS91 authority to detain. An IS91 is a written warrant which allows someone to be kept in immigration detention under the powers of the

Immigration Act 1971. However, at the time of writing this review, there is no mandated requirement for the use of these alerts.

85. It is not difficult to see how three different responses to the same question (i.e., whether Mr Kebatu was marked as 'Not for Release') could lead to errors.
86. Ultimately, it appears that the current policy does not provide sufficiently clear guidance on when these markers should be used or applied to a prisoner's file. I requested sight of the operational policy on 'Not for Release' markers; however, I have quickly concluded that there is little to no formal operational policy in place. Instead, 'Not for Release' markers appear to function as a practice rather than a standardised policy.
87. This ambiguity is compounded by the continued reliance on physical, paper-based records. The use of parallel paper and digital systems makes it significantly harder to ensure that 'Not for Release' markers are applied consistently and are visible at every stage of the release process.
88. This raises a fundamental question about whether the paper-based system should continue to exist at all for functions that directly affect public protection. Reliance on paper records increases the risk of omissions, exacerbate inconsistent record-keeping, and creates gaps between what is held physically and what is recorded on digital case-management systems. This issue is explored in greater detail in future sections of this review (see pages 120-129) as I have observed it as a key and recurring issue.

Findings

89. Regarding the use of 'Not for Release' markers, **I make two findings:**
 - First, it is **highly likely** that there is a widespread lack of clarity at an operational level on the use of 'Not for Release' markers, leading to inconsistent use and introducing confusion. It is **likely** that the mandating of 'Not for Release' markers will help, so long as there is a clear policy and supporting operational guidance on their use.
 - Second, it is **likely** the dual requirement for staff to look at both physical and digital records is introducing risks and/or opportunities for mistakes to be made. I judge that that without eliminating the dual system model, or at

minimum, significantly reducing reliance on physical files, it is **likely** that consistent practice cannot realistically be guaranteed.

Recommendations

90. Considering these findings, it is my recommendation, that HMPPS should **within three months:**
- **Recommendation 5:** Clarify at an operational level when ‘Not for Release Markers’ should be used and mandate the checking of all ‘Not for Release’ markers during release and discharge processes.
 - **Recommendation 6:** Introduce a clear process at operational level by which staff can escalate conflicting use of ‘Not for Release’ markers *before* a discharge or release is authorised.
91. I further recommended that, **within 12 months:**
- **Recommendation 7:** HMPPS, with support from the Ministry of Justice, develop a plan for phasing out the use of paper records in prisons during the release process.

1.3.1.3. Early Removal Scheme in the case of Mr Kebatu

92. The Government operates several schemes that function to relieve pressures on the custodial estate. These are often referred to as ‘early release schemes’ and are abbreviated to ‘ERS’.
93. Removing eligible Foreign National Offenders, via the Early Removal Scheme, is one such mechanism for reducing the prison population. It is unhelpful that the Early Removal Scheme (that was applied in Mr Kebatu’s case) is also shortened to ‘ERS’. It is not difficult to imagine the possible confusion that this could create, especially in a busy operational environment that relies on three letter acronyms.
94. In the case of Mr Kebatu, he was approved for deportation via the Early Removal Scheme, under the Immigration Act 1971 (Conducive Grounds). As I have explained previously, this meant that he was eligible for deportation after serving 30% of his sentence in custody (known as his ‘actual custodial term’).
95. I have variously had policy officials in the Ministry of Justice and the Home Office advise me that the removal of Foreign National Offenders (‘FNOs’) is a

priority for the Government, for both prison capacity and illegal migration purposes. This is evidenced by the recent expansion of the Early Removal Scheme which allows FNOs to be removed up to four years before the earliest release point of their sentence, and the Government's commitment to remove the minimum time they are required to serve before deportation altogether (so that FNOs become eligible for deportation immediately after they are sentenced).

96. The Governor of a prison retains responsibility for authorising early removal via the Early Removal Scheme once an offender has been deemed eligible for removal under this Scheme. However, the policy called Prison Service Instruction 04/2013 from HMPPS is clear that there may be some exceptional cases in which the Early Removal Scheme should be refused, particularly where there are serious concerns about public safety. These exceptional circumstances are:

- Where there is clear evidence that the prisoner is planning further crime, including plans to evade immigration control and return to the UK unlawfully;
- Where there is evidence of violence or threats of violence, in prison, on a number of occasions;
- Dealing in class A drugs in custody;
- Other matters relating to public safety of similar gravity to terrorism offences; and/or,
- **Where early removal under the Early Removal Scheme would undermine public confidence in the criminal justice system.**

97. If a Governor were to decide that one of these criteria applies, they must refer the case to the Early Removal Scheme advice line to determine whether it should then be referred to the Chief Executive of HMPPS for consideration as to whether to refuse an application. The Chief Executive will make the final decision on whether or not early removal is appropriate. During my engagement, it was made clear that such cases would be exceptional, and the number of cases referred to the Chief Executive small.

98. In the case of Mr Kebatu, I raised the question about whether and how the final criteria, the ‘public confidence test’, was applied (highlighted bold above for the purpose of emphasis). I consider it notable that there is no record confirming whether the Governor of HMP Chelmsford considered public confidence in his approval of the Early Removal Scheme application.
99. It does not help matters that there are subtle differences between the Home Office and the Ministry of Justice policies on the Early Removal Scheme²⁸. Whilst the public confidence criteria appear on page 9 of the Home Office policy, it is not in the initial and summary list, as it is on the HMPPS Prison Service Instruction 04/2013 (on section 2, page 7). Whilst I was told that the Ministry of Justice are revising the Early Removal Scheme Policy and associated operational guidance and will consult the Home Office to ensure clarity and consistency with their operational guidance, there remains a lack of consistency, and therefore clarity, across Whitehall departments.
100. Notwithstanding my concerns about the application of the public confidence test, my discussions with policy officials made clear that the decision-making process in Mr Kebatu’s case was complex. Mr Kebatu was from Ethiopia, which is a country to which removals are difficult, and it was explained to me that the Government considered there to be a risk he would raise barriers to his removal had he not been removed under the Early Removal Scheme. It was their view that, as I understand it, based on public mood, the Government should support deportation at the earliest opportunity.
101. I specifically discussed this matter with the father of Mr Kebatu’s victim A and his local Councillor. It was their view that it was “*an insult*” that Mr Kebatu had not served his whole sentence, and they argued that deportation with no consequences in his home country left woman and girls there exposed to potential abuse by a convicted criminal. They asked directly whether the prison Governor could have refused his early removal from the UK.
102. I am clear that the Governor had grounds to make an application to the Chief Executive of HMPPS, applying the public confidence test. He did not.

²⁸ [The Early Removal Scheme \(ERS\)](#)

Findings

103. Regardless of the varying interpretations of public mood around Mr Kebatu's deportation, it remains the case that Mr Kebatu was an extremely high-profile offender, whose offending had resulted in wide-spread societal unrest. In this instance the Governor did not, in practice, apply the public confidence test with rigor.
104. **As a result, I make the following findings:**
- It is **probable** that capacity pressures faced by the system and the subsequent operational focus on relieving these pressures reduced the attention to the public confidence test in this case.
 - It is **almost certain** that the public confidence test should have been applied in this case (albeit I make no judgement on what the ultimate conclusion of the Chief Executive of HMPPS would have been).
 - The current policy position is inconsistent across Whitehall departments, and I find it is **almost certain** that this is making it challenging for hard-working junior and stretched operational staff in prisons and the immigration service to apply it, in a manner which builds both public and victim confidence.
 - It is **almost certain** that the decision to apply the Early Removal Scheme was a contributing factor in Mr Kebatu's release in error.
 - The interchangeable use of the abbreviated 'ERS', is **likely** to have caused confusion in the Kebatu case.

Recommendations

105. I therefore make the following recommendation that **within six months:**
- **Recommendation 8:** The Ministry of Justice and the Home Office develop one, shared policy on the Early Removal Scheme. This should consider:
 - Whether there should be exceptions, and if so what;
 - The process, authority levels and required documentation for the revised Early Removal Scheme;
 - Talk with victims and the victim's sector on the existence and consequences of an early removal policy; and,

- How Early Release Schemes and the Early Removal Scheme can be differentiated when there is an inevitable reversion to the three-letter acronym.

1.3.1.4. Incorrect Information on the Gate Pass

106. Ahead of a discharge from prison, staff at HMP Chelmsford create gate passes using information pulled from the discharge list that is generated from information on NOMIS. These gate passes, ordinarily, reflect the reason for release (e.g., trial, non-custodial sentence, or deportation immigration removal centre), rather than the movement type itself (e.g., transfer, release or court).
107. According to HMPPS, gate processes – including the use of gate passes – serve as a final safeguard and ensure that staff at the gate understand the nature of the release and can confirm the identity of a prisoner is correct, before permitting them to leave the gate.
108. In the case of Mr Kebatu, I was informed that the Custodial Manager undertaking the discharge gave Mr Kebatu the gate pass that had been generated by reception. Whilst the discharge list had noted his reason for release as ‘DEIRC’ (meaning ‘Deport Immigration Removal Centre), Mr Kebatu’s gate pass recorded his movement type simply as ‘release’.
109. It is notable that the internal HMPPS commissioned investigation into the release in error of Mr Kebatu did not explore why this occurred or whether it contributed to the erroneous release.
110. Whilst I accept that the Custodial Manager should have checked the discharge list, I cannot disregard the fact that the gate pass given to the Custodial Manager by reception specifically stated that Mr Kebatu was for ‘release’. It is my view that reception staff should have followed the discharge list and written ‘DEIRC’ on the gate pass - as this was clearly marked on the discharge list as the release reason. I therefore find that the information captured on Mr Kebatu’s gate pass, at best, was missing important information and context, and at worst was incorrect.
111. Since challenging this sequence of events, HMPPS have agreed with my view that - had the gate pass said transferred or deportation via Colnbrook via Mitie

escort services - this may have raised questions at the gate and offered an additional opportunity for the release in error of Mr Kebatu to be prevented.

Findings

112. Regarding the gate pass, I find:

- Had “DEIRC” or “transfer” been recorded on the gate pass, it is **likely** this would have prompted further scrutiny either by the Custodial Manager or at the gate and may have prevented the erroneous release.

1.3.1.5 The discharge process and production of licence

113. Before a prisoner is released or deported under the Early Removal Scheme, the prison must complete the relevant discharge procedures and sentence-calculation checks set out in the relevant Prison Service Instruction. The Prison Service Instruction will set out the mandatory action that must be completed before a prisoner is discharged.

114. In most discharges this includes informing the prisoner about their obligations under any licence or relevant statutory orders; completing an escort risk assessment; verifying the prisoner’s identity using a five-point reference check; conducting a full search; and returning their property.

115. Staff must also prepare all the necessary documentation, including the prisoner’s gate pass, their Prisoner Escort Record and, where required, their release licence. For prisoners being deported via the Early Removal Scheme, the additional documentation is required:

- The Early Removal Scheme authorisation form
- The movement order
- The Immigration Service form IS91, which provides the legal authority to detain an individual for immigration purposes.

116. Staff must check that the discharge date on the Prison National Offender Management Information System (Prison-NOMIS) matches the sentence-calculation sheet provided by the Offender Management Unit and correctly record the discharge. **There is no requirement for staff to check any additional information.**

117. Two of the additional documents outlined above appear to have led to confusion in the Kebatu case. The first, the fact that there *was* a release licence included in his paperwork. The second, is the fact that the IS91 Immigration Service form was *not* present.

The inclusion of a release licence

118. In the case of Mr Kebatu, a release licence **was** included in the documentation provided to the Custodial Manager processing the discharge, even though he was being discharged for transfer to an Immigration Removal Centre, rather than released on licence.
119. On review of this fact, I noted that the HMPPS Licence Conditions Policy Framework²⁹ advises that a release licence is produced as soon as a foreign national offender passes their Conditional Release Date, in case the removal does not take place and the offender needs to be released from the Immigration Removal Centre. HMPPS have informed me that following the erroneous release of Mr Kebau, a security bulletin was issued on 25 October 2025 along with the checklist stating that: 'For Foreign National Offenders remaining in custody under IS91 immigration detention licences must still be issued at Conditional Release Date. Preparation for release into England and Wales must be considered even if deportation is expected '. As I understand it, this is because these removal centres are unable to produce their own licences so they must be produced in a prison.
120. However, throughout my engagement and review, across the Ministry of Justice and with officials in HMPPS, I observed significant uncertainty about whether a release licence should or should not have been produced for foreign national offenders being transferred to an Immigration Removal Centre (IRC) for deportation. It became clear that there is no shared operational understanding of the correct approach in cases like Mr Kebatu. At the time of writing, there still appears to be no consistently agreed position.
121. This lack of clarity appears to arise from contradictory policy frameworks. Indeed, it is confusing that the guidance on producing licences is variously

²⁹ [HMPPS License Policy Framework](#)

explained in policy documents. The guidance on the use of licences in documents associated with the Early Removal Scheme is set out below:

- A. The Early Removal Scheme policy:³⁰ *There is no guidance on the public confidence test.*
- B. Prison Service Instruction 04/2013: Release of Foreign National Prisoners:³¹ *'Prisoners who are removed prior to the half-way point of sentence...do not need to be issued with a licence, but must be issued with the ERS Authorisation Form'*
- C. Foreign National Offenders on Licence, PSS and IS91 Policy Framework:³² *'Where an FNO enters the licence production window, a release licence must be produced as normal.'*

122. My discussions with staff during visits to prisons confirmed that, on the front-line, this means there is no consistent understanding of how policy should be applied in these circumstances.
123. It appears that the guidance relies on a front-line interpretation of whether a prisoner's deportation is "*imminent*" (the critical word in the policy) at the point of discharge, as to whether a licence should or shouldn't be produced. However, none of the policies referenced above provide a definition or parameters for what "*imminent*" means, whether this refers to a matter of days, weeks, or longer. As a result, the policy relies entirely on individual judgement, creating avoidable variation in decision making and an approach that is neither clear nor appropriate for such a process.

The lack of an Immigration Service form IS91

124. An IS91 is also referred to as an Immigration Warrant. This provides the legal authority under the powers of the Immigration Act 1971 to detain someone after the prison part of their sentence has ended. Immigration detention under IS91 is a Home Office power to prevent release into the community where there is a realistic prospect of deportation within a reasonable timeframe.

³⁰ [The Early Removal Scheme \(ERS\)](#)

³¹ [Prison Service Instruction 04/2013: Release of Foreign National Prisoners](#)

³² [Foreign national offenders of Licence, PSS and IS91](#)

125. In Mr Kebatu's case, the IS91 was received by the Offender Management Unit on 22 October but was not present in the core record on the day of Mr Kebatu's release in error - even though this would have been needed by Mitie as authorisation to detain in custody. The internal investigation commissioned by HMPPS suggests that this is because the Offender Management Unit were concerned about dual detention and did not believe the IS91 was needed for Mr Kebatu's discharge. The HMP investigation suggests that this did not significantly impact the subsequent release in error.
126. I am not convinced that this can be concluded so concretely and have instead formed the view that it is possible that the absence of paperwork relevant to the deportation, when conjoined with the inclusion of a licence for release into the community contributed to the erroneous release of Mr Kebatu.

Findings

127. On consideration, **I find:**
- That there is no consistent or shared understanding of how to manage Foreign National Offenders at the point of discharge under the Early Removal Scheme. Staff are required to navigate contradictory policies, rely on local interpretation, and make subjective judgements, such as determining what constitutes "*imminent*" without adequate guidance. This lack of clarity was evident in the Kebatu case, where gaps in professional curiosity and limited understanding of discharge processes contributed to key documents being either missing or accepted without question, despite this being inappropriate for the circumstances.
 - That the lack of coherent policy supported by clear operational guidance is **likely** to have contributed directly to the operational error.

Recommendations

128. I therefore recommend that, **within six months:**
- **Recommendation 9:** The Ministry of Justice and HMPPS should review the policy on Release License. The aim should not be to determine retrospectively which interpretation was 'correct', but to recognise that frontline staff cannot be expected to interpret contradictory or opaque

policies, especially where the stakes are high. Operational staff require clear-cut, easily applicable rules. This review should therefore consider:

- The loose term of “*imminent release*”; and
- Issue explicit guidance that states when a Release License must be produced and when it must not.

1.3.1.6. Contact made with victims following a release in error

129. I have already provided a factual overview of the contact that was made with the victims of Mr Kebatu following his release in error from HMP Chelmsford (at pages 24-27). Although the Essex Police Gold Commander made an early and pragmatic decision that the victims needed to be updated, this occurred approximately four and a half hours after the release in error. By that point, social media reporting had already reached at least one of the victims.
130. This led me to consider the existing processes and Government schemes for making victim contact during a release in error, including the adequacy of those processes as well as the risks to victims when they fail.
131. It appears to me that there are three existing routes by which victims may receive contact regarding an offender in custody.
132. The first is the probation service **Victim Contact Scheme**, which is provided for in legislation and operated by HMPPS. It applies to victims of serious violent, sexual or terrorism offences, **12 months or more** or an equivalent hospital order.
133. The second is the HMPPS operation **Victim Notification Scheme**, which applies to victims of specified stalking and harassment offences, regardless of the length of the custodial sentence.
134. The third is a **Home Office-operated contact scheme** that is operated by an internal Home Office team. This scheme is provided for in the Victims’ Code and entitles victims to receive information regarding whether deportation action is being pursued, the outcome of any appeal, and when an offender is released from immigration detention, and when deportation has taken place. Victims of sexual offences committed by Foreign National Offenders who are sentenced to imprisonment may receive information through this scheme about

deportation, regardless of sentence length. Where victims are not eligible for the Victim Contact Scheme, or have opted out, they retain the right to request updates directly from the Home Office Victim Support Team providing they fall under the remit of the Victims' Code. It is unclear to me how they would know that this entitlement exists. In the absence of systematic awareness-raising, the availability of the service alone may be insufficient to ensure meaningful access.

135. According to the Ministry of Justice, as Mr Kebatu was not sentenced to 12 months or more imprisonment for a single specified offence, the two victims in this case **did not** qualify for Victim Contact Scheme or Victim Notification Scheme and so were not contacted regarding his release in error via this route. However, following a retrospective review of the case, the witness care unit in Essex Police ultimately concluded that a Victim Contact Scheme referral should have been made for one of the victims because the offending resulted in two custodial sentences totalling 12 months. The difference of view between the policy department and the operational is indicative of the confusion between these over complicated schemes.
136. It is notable that the victims of Mr Kebatu **did** receive contact from the Home Office's team regarding the arrangements for deportation of Mr Kebatu – both before and after his release in error (see pages 23-29). The Home Office advised that, due to intense media reporting, the Victim Support Team took the unusual step of proactively contacting the victims to inform them of Mr Kebatu's deportation at the earliest opportunity.
137. Ultimately, the victim contact issues that arose during the Kebatu case have highlighted a lack of policy coherence around what victims can reasonably expect - both following a release in error, and more generally. It appears to me that the complexity of eligibility criteria across these arrangements contributed to uncertainty among frontline staff about whether notification should occur and, if so, which agency is responsible for notifying victims in any or every circumstances. This is the result of an overly complex landscape of multiple schemes intended to serve the same purpose.

138. Perhaps more fundamentally, the release in error of Mr Kebatu also raises questions about the suitability of using the existing schemes to dictate the suitability of contact with victims in cases where an offender has been released in error. Whilst I appreciate that there may be releases in error in which contact with victims would not be appropriate, I encourage the Government to think more flexibly about the scenarios in which a victim *should* be contacted – regardless of their eligibility to an existing scheme.
139. In addition to engaging directly with the victims of Mr Kebatu, I sought broader views from sector organisations that support victims and witnesses. In December, I presented an update at the Ministry of Justice’s Victims, Sector, and Witness Group ³³ and welcomed further correspondence on the matter. I followed that up with direct conversations with the Victim Commissioner and the Domestic Abuse Commissioner and spoke to another leader of a third sector organisation who reached out proactively.
140. All concurred that the issue of releases in error was not well known or understood by victims, until the high profile Kebatu case. They were unsurprised that there was a lack of clarity on who, when, where and by who notification would be given to victims in specific cases as, from their perspectives, this was indicative of issues that apply to contact with victims in relation to ‘*all releases, full stop.*’ In effect, the issues highlighted by releases in error, particularly the absence of clear guidance and limited victim awareness, were seen by them as being pervasive across the wider victim’s policy landscape.
141. They can see, both for reasons of risk and to be assured justice is being served, that victims should be contacted. They recognised that the detail of how that should be done would need a more thoughtful examination and engagement with the victim sector than is possible within the review timescales.
142. However, in discussions with policy officials, I was concerned by what I perceived to be an overly narrow distinction between risk, viewed as a policing responsibility, and communication, assigned to probation and immigration

³³ This group includes representatives from across Whitehall departments, the police, courts and prisons, the Victims’ Commissioner, and a wide range of victim support organisations.

partners. I do not consider this division to reflect the realities of victim experience, and the third sector may provide an alternative solution, albeit I see the need for careful consideration of how sensitive information and data is shared.

143. Having seen the impact on Mr Kebatu's victim and family and recognising that similar harms could arise if other victims were to become aware of releases in error in their own cases, it is my view that this needs resolution.

Findings

144. On consideration of the Kebatu case, the contact that was had with his victims after his release in error, and following my wider engagement, **I find that:**

- There is a myriad, of unconnected arrangements and schemes dictating victim contact that are **almost certainly** unclear to both victims and operational staff.
- There is no formal policy framework establishing responsibilities, expectations, or minimum standards for victim communication when releases in error occur.
- This means that, in practice, it is **highly likely** that there will be further instances such as the Kebatu case where a victim may be made aware of a release in error via social media rather than through considered contact by an appropriate professional.

Recommendations

145. In response, I make the following recommendation, that **within six months:**
- **Recommendation 10:** The Ministry of Justice and the Home Office urgently talk with victims, victims' sector and cross-service partners to develop a clear policy and protocol on contact around releases (broadly on releases and, specifically, 'in error.'). This should establish:
 - Who is responsible for notifying victims,
 - In what cases victims should be notified,
 - What support will be available them,
 - When notification should take place,

- And by what means,
 - It should also address the distinction between cases identified immediately and those discovered at a later stage, and the differing requirements for victim contact that may necessarily be required. This is of particular importance considering known data limitations, which I will come onto in more detail in subsequent sections three and four.
146. To be clear, I do not consider this to be a matter that can be resolved through a simple transfer of responsibility to policing and I heard evidence from the victim sector that such route may not be a victim's preference in any event.
147. Finally, I acknowledge that existing arrangements, and those anticipated under forthcoming legislation of the Victim and Courts Bill, have been shaped by affordability, proportionality, and ministerial direction I would have liked to see them amended based on the findings of this review. I am advised that it is too late to amend the legislation, which would have been my preference. As such, and in the absence of that **I further recommend that within three months:**
- **Recommendation 11:** The Ministry of Justice ensures that the findings of this review are carefully and precisely interpreted into the regulations that will accompany the Victims and Courts Bill.
148. And further, that within 12 months following their implementation:
- **Recommendation 12:** These measures are reviewed by the Ministry of Justice on whether they have addressed the issues outlined in this review regarding victim contact, or whether the scope of the Victim Contact Scheme needs to be updated.

1.4. Conclusion: How and why was Mr Kebatu released in error?

149. For the sake of clarity, here I have consolidated and summarised my findings and conclusions with regard to Mr Kebatu's release in error – as explored in greater detail in the previous sections.
150. After considering the timeline and facts shared with me, I find that Mr Kebatu was released in error because:

- The early removal under the Early Removal Scheme was authorised by the Governor without consideration of Prison Service Instruction 04/2013, which states at section 2 that early removal should not proceed 'where early removal under the Early Removal Scheme would undermine public confidence in the criminal justice system'. In my view, this exception should have been considered and referred to the HMPPS Chief Executive. This did not occur.
- Simultaneously, a Release Licence was included within the paper file. There are conflicting views among HMPPS staff (Governor, Custodial Manager, OMU staff both at Chelmsford and elsewhere) about whether the production of the licence was correct. The inclusion of this licence confused the [REDACTED].
- The [REDACTED] applied all their attention to the licence and, in human error, disregarded the deportation paperwork. This matter was subject to a HMPPS discipline process as decided by Governor, [REDACTED].
- Whilst there was a 'Not For Release' (NFR) marker on the physical Prisoner Escort Record (PER), this was not on the digital record. This created inconsistencies on critical paperwork.
- The gate pass incorrectly stated 'release', meaning that an opportunity to prevent the release in error at the gate was missed.
- There was an opportunity to correct Mr Kebatu's mistaken release when he returned to the gate and told officers he should not have been released. This opportunity was not taken. Despite the impressive efforts of junior grades at the gate and in administrative functions the on duty and present [REDACTED] [REDACTED] did not take the necessary action. This matter is subject to a HMPPS discipline process as decided by Governor [REDACTED].

151. In addition, and as outlined in the previous section, I have found that:

- Although high profile alerts existed, it is almost certain that they were not effectively used. Without clear guidance on the use and management of high-profile alerts, it is **likely** that a high-profile alert would only prevent a

release in error in cases where professional curiosity prompts further scrutiny of a release.

- The absence of clear, consistent 'Not for Release' process contributed to the erroneous release.
- Policy ambiguity and inconsistent practice on licence production, and discharge processes for FNOs being detained under IS91 contributed to the error.

1.5. The Impact of Releases in Error

152. What has become explicitly clear throughout this review is that the impact of releases in error is widely felt. This section deals with this specifically and emphasises the importance of concerted action to reduce releases in error.

1.5.1. The Impact on Victims

153. As part of my review, I sought to consult with the victims of Mr Kebatu. In early December, I met with the father and the local councillor of the 14-year-old female victim to discuss their experience. I was deeply grateful for their honesty and straightforward manner in communicating the impact of the release, what they wanted from the review, and their views on what they wanted to see done differently. I promised them similar candour in this report.

154. In addition to wanting to better and more clearly understand what had occurred (my conclusions to which are detailed above), they raised the following specific questions:

- **Why was Mr Kebatu released in prison issued clothing – was this special treatment?**
 - During the process of undertaking this review, Victim A's father asked me why Mr Kebatu was released wearing prison issued clothing, specifically as to whether this was standard practice, or evidence of Mr Kebatu being treated differently by HMP Chelmsford. During my investigation, I was advised that when Essex Police originally arrested Mr Kebatu, they had seized Mr Kebatu's clothing for evidential purposes and they had provided him with a grey tracksuit to wear.

- I do wish to note, that it was difficult to get HMP Chelmsford to confirm the position, but it is my understanding that this police tracksuit was returned to him prior to his release in error and this was therefore the clothing he was discharged in. Therefore, whilst it initially appeared that he was wearing prison-issued clothing, I am led to believe that he was in fact wearing the police-issued tracksuit provided to him after his initial arrest.³⁴
 - Considering the available evidence, I find that **it is almost certain** that, although it initially appeared Mr Kebatu was released in prison-issued clothing, he was in fact discharged wearing the tracksuit he had entered HMP Chelmsford in. This tracksuit had been provided by Essex Police, as the clothes he was arrested in were confiscated for evidential purposes.
 - **Could the prison Governor have refused his early removal from the UK?**
 - This question is explored on pages 39-41.
155. They also questioned the reports that Mr Kebatu received a payment of £500 to leave the UK, noting that this appeared he was rewarded for the crimes he had committed. The provision of discretionary payments to prisoners falls outside the scope of my review.
156. Ultimately, it was clear from this meeting that, in addition to the original offending, the release in error of Mr Kebatu had a profound and detrimental impact on both the victim and her family. They described the experience as “*retraumatising*.” Victim A’s father described the fear he had knowing that Mr Kebatu, on mistaken release, could have encountered his daughter and what could have occurred.
157. It was clear that social media amplification had played a part in the distress caused; it is hard to discern the distinction between concerns on that platform being legitimately expressed and deliberate provocation.

³⁴ To note, according to HMPPS, had Mr Kebatu been transferred to an Immigration Removal Centre, he would have been issued with the clothing he entered the prison in and would therefore have been likely to wear the same outfit he was ultimately released in.

158. A social media analysis conducted by the Ministry of Justice shows that between 24–29 October 2025, releases in error, and particularly Mr Kebatu's release in error, was a dominant driver of online conversation. There were 33.5k posts mentioning Mr Kebatu on X (formerly Twitter) during this period.
159. Notably, and appallingly, Victim A learned of Mr Kebatu's release in error from social media, underscoring the scale and speed at which information, and potentially misinformation, can spread online.
160. It was also brought to my attention that there was social media reporting that recorded suggestions Mr Kebatu was *deliberately* released in error, to impact Government policy. These statements had been seen by the father of Victim A and had understandably concerned him. The HMPPS' Counter Corruption Unit undertook further enquiries and confirmed to me that they hold no information in relation to corrupt staff involvement in any release in error at HMP Chelmsford or other HMPPS sites.
161. I wish to be clear that, throughout the course of my review, I found **no evidence** to support the social media assertion that the release was a deliberate or planned act to disrupt Government policy.

1.5.2. Impact on Communities

162. The release in error of Mr Kebatu was a high-profile incident that generated significant public concern, amplified by extensive media and social media coverage. Prior to his release, a protest at the Bell Hotel in Essex had already heightened community tensions around asylum seekers. The release in error of Mr Kebatu also undermined confidence in the criminal justice system. Indeed, although the Metropolitan Police assessed the actual risk posed by Mr Kebatu as lower than public perception, their consultation with victims, victim groups and media analysis show that the incident seriously undermined confidence in the criminal justice system.
163. Mainstream media coverage was immediate and intensive, with rolling updates and prominent front-page reporting throughout the two-day manhunt, recapture and subsequent deportation. Coverage was dominated by alarm and condemnation, with victims' families, local MPs and Ministers expressing strong criticism. Commentary quickly broadened to systemic issues, using the case to

highlight weaknesses across prisons, deportation processes and immigration policy.

164. The incident heightened public anxiety and, in some cases, prompted protests. Prior public awareness of releases in error was **likely** low, and understanding of the scale and nature of these risks appeared limited.
165. Such a public misadministration of justice can, inevitably, impact community confidence and cohesion. Analysis by the Ministry of Justice found that the case prompted widespread outrage online. High-engagement social media posts - several receiving over 1,000 reposts - often came from accounts with large followings and framed the incident in highly emotive or political terms, linking it to broader debates about criminal justice and immigration.
166. I found it notable that the concept of public confidence featured less in the lexicon of HMPPS, its leaders and frontline staff, than I may have imagined. I consider this in further detail in the 'Culture' chapter later in the paper.

1.5.3. Impact on Other Services

167. Releases in error place significant operational, financial and organisational strain on other resources that are required to respond. Responses to unanticipated errors can have consequences for public safety, risk management and wider activity.

1.5.3.1. Policing

168. Police have operational responsibilities set out in national protocols for responding to releases in error. There is a protocol between HMPPS and the National Police Chiefs Council (NPCC) which outlines each agencies' responsibility upon a release in error, including communication with the public. I found that awareness about the protocol was low beyond the National Police Chiefs Council leads. It was suggested that the protocol had not been revisited since it was first signed. The police and HMPPS recognise a gap in the protocol when it comes to victim contact and public (including media) communication. I agree that it could be improved with this addition.
169. Following discussion, the NPCC undertook an analysis to better understand the communication functions involved in release in error cases. Whilst the

findings were not representative, the survey indicated that, overall, notification of releases in error appear to be an infrequent occurrence for most police force communication teams. Where it does arise, there appeared to be no consistent mechanism for how communications teams within forces are informed of the incident; albeit this varied according to local practices.

170. As policing have a responsibility to protect the public from harm, the impacts on them can be significant when a release in error occurs. The response to the release in error of Mr Kebatu was impressive, involving three police forces who, with the help of the public, secured his arrest. However, this level of response required the declaration of a critical incident³⁵ by both Essex and the Metropolitan Police Services, and the mobilisation of substantial leadership, front line officer, specialist crime, covert capability and public order resources. This inevitably drew officers and staff away from routine and priority policing functions. Specialist teams were redeployed at the expense of their normal portfolios, implicitly leaving risk elsewhere in the system.
171. The specific impacts of the incident on the two primary police forces involved in the Mr Kebatu release in error are outlined in Annex A and B. Suffice to say it generated considerable direct financial costs with a wide variety of officers, staff and specialists deployed over multiple days at a total cost running into tens of thousands of pounds. It should be noted that many officers were kept on duty at short notice with the corresponding human impacts too.

Essex Police

172. As part of the response to Mr Kebatu's erroneous release, a significant number of officers were retained on duty for extended hours. This response necessitated a significant adaptation of the policing of Chelmsford and the wider County. Namely:
- Local Policing Teams, which had started their shifts at 06:00 and were due to finish at 16:00, remained on duty until between 20:30 and 23:00. This included one Police Sergeant and 20 Police Constables, as well as 12 officers from Neighbourhood Policing Teams.

³⁵ A Critical Incident is any incident where the effectiveness of the police response is likely to have a significant impact on the confidence of the victim, their family and/or the community.

- At 06:00, the Chief Superintendent assumed the role of Gold Commander, providing overall strategic oversight of force operational delivery and leadership of any critical or major incidents. At the same time, the Superintendent commenced duty as the Local Policing North Duty Officer, acting as Silver Commander with responsibility for operational delivery across the North Local Policing Area and critical incident management. The average hours recorded relate solely to time dedicated to the manhunt of Mr Kebatu. All officers referenced concluded duty after 23:00, and the Superintendent received further calls overnight with updates and tasking requirements.
- Intelligence Teams, which began work at 08:00 and were scheduled to conclude at 16:00, were also retained until between 20:30 and 23:00. This group comprised one Detective Sergeant and nine Detective Constables. The Chief Inspector, who began duty at 07:00 in their role as District Commander responsible for response and neighbourhood policing across the Chelmsford and Maldon area, likewise remained on duty beyond the planned finish time.
- The Serious Organised Crime Team, including one Detective Chief Inspector, one Detective Inspector, two Detective Sergeants, and four Detective Constables, extended their duty from the planned 16:00 finish to 23:00.

173. In summary, most officers worked an additional five to seven hours beyond their scheduled shifts.

174. The total additional cost to the force as set out was estimated to be just over £80k.

The Metropolitan Police Force (the Met)

175. Similarly to Essex, the Met responded with diligence and urgency. They reported to me that numerous officers and staff were mobilised as part of the initial response. The covert operations suite was opened and resourced with additional officers aligned to a serious crime in action model.

176. Proactive teams from Specialist Crime (SC), consisting of 18 officers, were also redeployed from other operations to support significant covert tactics and methodology. As the operation progressed, the Mets specialist public order teams (the Territorial Support Group) was required over two shifts.
177. Strategic management of the incident (Gold) was undertaken by the on-call Commander, supported by Silver, a Detective Chief Superintendent. A Management Board member retained oversight throughout. Of note is that this response pulled the organisation out of shape. Resources had to be abstracted from their normal business, and limited specialist teams were redeployed to focus on this operation leaving risk elsewhere.
178. Operationally 1178 officer/staff hours were used on the manhunt at a cost of £72k.
179. The evidence provided above demonstrates the significant operational, financial and organisational costs arising from these errors, and the consequent risks to wider policing activity.

1.5.3.2. Probation

180. The Probation service does not collect data on cases of release in error, which means there is no clear evidence base to quantify or analyse the scale of the impact that releases in error have on the probation service. They had no direct role in the case of Mr. Kebatu. As a result, the findings are based on narrative accounts rather than robust data, limiting the ability to draw definitive conclusions.
181. During my engagement with the Chief Probation Officer, I was made aware of the view that releases in error can impact staff working within probation, particularly Victim Liaison Officers within the Victim Contact Unit. Victim Liaison Officers are responsible for informing victims who are registered with the Victim Contact Scheme of case developments, including release decisions. In cases involving a release in error, this may require them to communicate unexpected and distressing information and to manage victims' understandable anger, shock, and loss of confidence in the justice system.
182. Victim Liaison Officers often bear a disproportionate emotional and practical burden following releases in error, despite not being responsible for the

decisions that led to them. However, the overall impact on their workload is limited, as the number of releases in error incidents requiring victim contact is currently low and represents only a very small proportion of the wider caseloads of victims eligible to be contacted via the Victim Contact or Notification Schemes, which at any one time consists of tens of thousands of active cases. Whilst individual releases in error can carry heightened emotional complexity, the tasks required are broadly consistent with the difficult and sensitive communications VLOs already manage, and guidance is now in place setting out the steps they should take when responding to such incidents. Nonetheless, I recognise that there have been occasions where VLOs have been the first point of contact and primary source of information for victims, and I fully acknowledge how challenging and distressing this can be for them when it occurs.

183. It is possible that there may be releases in error that are first identified by Probation staff during routine case activity. When this occurs, Probation staff are left to manage the immediate consequences, which includes alerting the police and the releasing prison, communicating the situation to the individual, and coordinating their return to custody. This places staff in a challenging position, as they may have to inform an offender that they must go back to prison and organise circumstances for which they can be returned. In the rare circumstances this occurs, this places significant stress on the officers and disrupts the functioning of the unit.

1.5.4. Findings

184. **I find that:**

- Releases in error have serious and far-reaching impacts, retraumatising victims and families and undermining trust in the criminal justice system.
- Taken together, this evidence shows that such errors **almost certainly** place acute strain on police capacity and undermine the ability of forces to carry out other essential tasks, reducing resilience, delaying other investigations and increasing exposure to operational risk across the policing landscape.

- It is **probable** that a lack of clarity in roles and responsibilities between the Ministry of Justice, HMPPS and policing arises in two areas: responsibility for victim contact, and public communication. This will lead to poor public communication or conflicts between elements of the public sector occurring during a live incident. This is then compounded by the challenges of social media outlined previously.
- Both public and departmental understanding of the varying risks posed by releases in error is **almost certainly** limited and inconsistent; clearer recognition of this risk spectrum is needed.

1.5.5. Recommendations

185. What is clear is that releases in error have wide-reaching impacts. This report makes recommendations to address these errors and therefore reduce this impact. However, for the purpose of addressing the points raised from considering the impact of the Kebatu case specifically, I recommend that, **within three months:**

- **Recommendation 13:** The Ministry of Justice, HMPPS and Policing (via the NPCC) update their protocol to consider victim notification and broader communication responsibilities.

Section 2: Operational Context

2.1. Background

186. Throughout this review – both via my analysis of cases and my conversations with many dedicated people – it has become evident that, ultimately, some errors are the result of human mistakes. That is, for the most part, not a consequence of individual laziness but far more because the system is stretched, processes designed in isolation of one another and where staff are operating without the right tools, training and technology to ensure success or, at the least, to minimise errors.

2.2. System Pressure

187. It is evident that the prison system has faced sustained pressure for several years. Between October 2022 and August 2024, the adult male prison estate operated at 98-99.7% capacity. I witnessed firsthand the impacts of this on the wider justice system during my time as Deputy Commissioner of the Metropolitan Police Service.

188. Increased demand is a symptom of changing threats and the hard work of colleagues in policing/prosecution. Shifting political priorities over the past decade have seen new criminal offences created and sentences increased. However, the justice system is inherently that: a system, albeit it currently operates as a series of systems, each element with their own priorities and financial restraints. The fact that prison capacity reached a crisis of such proportions suggests that planning for increased demand has either, historically, not been adequately revisited and/or it has been carried out but decisions have been made to not prioritise the necessary funding. In her August 2025 Independent Review into Prison Capacity, Dame Anne Owers expertly summarised the issues that have led us to this point:

'In 2007-08, the last Labour government faced a capacity crisis, due to the mismatch between the number of available prison spaces and the demand created by legislation...The then Lord Chancellor had to introduce an early release scheme... to avoid the system collapsing. During the austerity

measures in the Coalition government between 2010 and 2015, the Ministry of Justice (MoJ) offered up savings based on the assumption that the prison population would reduce but did not take any measures to reverse the inbuilt drivers of population increase. Eighteen expensive, mostly smaller, prisons were closed and only two new prisons were opened; overall prison officer numbers were reduced by 27%, with a significant loss of experienced staff; maintenance and capital budgets were cut or transferred to plug holes in running costs. By the summer of 2017, there were only around 900 prison spaces left, and real risks of a system collapse...The 2022-24 capacity crisis... is therefore only the latest among a succession of crises, though it was probably the deepest and longest, described by many of those who lived through it as an 18-month 'permacrisis'. It affected the prison service at every level, as well as much of the rest of the criminal justice system. As recent events have shown, it is far from over, as recent prison capacity figures show.³⁶

189. Whilst outside the terms of reference for this review, but based on the above and other reviews, it is likely that the ongoing capacity crisis be considered a result of a lack of long-term planning and a mismatch between the funding secured and delivered into the prison service verses the demand forecasted. This is replicated for other partners in the system.
190. Prison staff in Offender Management Units (OMUs) are particularly impacted by these changes, as they must frequently grapple with the implementation of new policies, whilst simultaneously delivering capacity management measures (such as moving prisoners to different parts of the estate), all of which contribute to a high-pressure environment. With staff operating under greater strain and at increased risk comes higher propensity for errors, particularly with limited access to the right technology tools, which I will come to.
191. Elsewhere and simultaneously, Sir Brian Leveson noted in his July 2025 Independent Review of the Criminal Courts, Part 1³⁷ that '*criminal justice is in crisis*', and that '*the open caseload in the Crown Court has now reached a*

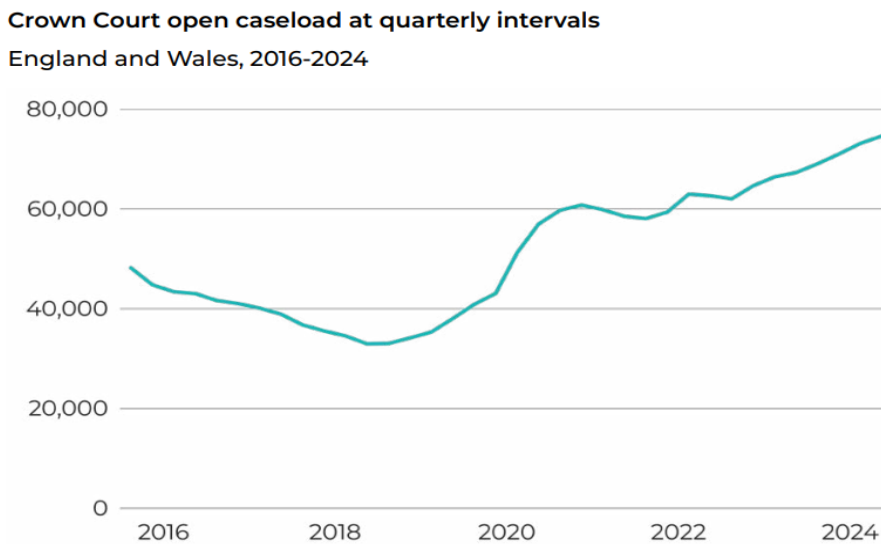
³⁶ https://assets.publishing.service.gov.uk/media/6890b2b4dc6688ed508783d5/independent-prison-capacity-review-report_.pdf

³⁷ [Independent Review of the Criminal Courts - Part 1](#), Page 4.

record high...more than double the numbers in 2019, and trials are being listed as far ahead as 2029.'

192. He goes on to say that the reasons for this include *'long-term constraints and reductions in funding and investment in criminal justice over many years ... a considerable maintenance backlog in the court estate and a smaller and less experienced workforce. This has been exacerbated by the disconnect between different agencies within the criminal justice system.'* This aligns with my own findings, that no part of the Criminal Justice System can be examined nor fixed in isolation or silo, nor without consequence somewhere else in the system.

Figure 3: Crown Court Caseload



Source: Criminal court statistics quarterly, October to December 2024

2.3. Complexity

193. The ongoing prison capacity crisis has required the Government and HMPPS to bring forward rapid and successive policy and operational changes. Every change requires updated guidance and recalculations of eligibility and release dates. The cumulative effect is a complex policy and operational environment, with layers of changing operational guidance. Front-line staff are required to interpret this changing guidance, which might overlap, shift, or apply only in narrow circumstances.

194. For example, between March 2023 and November 2025 there were 20 capacity-related legislative and policy changes that the OMUs had to implement. See **Annex B** for breakdown.
195. The primary key point to note is that each of these changes was implemented at pace. For example, Offender Management Units who are responsible for calculating sentences in prisons commented that initially they felt they were not given sufficient notice to implement End of Custody Supervised Licence (ECSL), a scheme related to early supervised release from custody.
196. In my conversations with them, HMPPS agreed that whilst the pace of release policy changes was swift, that they had been communicated in good time for implementation. Instead, they suggested there was a disconnect between the policy documents (and how they had been envisaged to work) and how that was then translated into operational practice on the ground – meaning frequent clarifications and corrections were needed.
197. Ultimately, the introduction of 20 policy changes within the same many months meant that the system has had little time to refine operational guidance and recalibrate to each change. Overall, it is **likely** that the pace of change required to respond to the acute capacity pressures have outstripped the system's ability to consolidate and simplify this change. This ultimately means that hard pressed operational officers and staff are now operating in a landscape that is more complex than any time in recent history.

2.4. Outdated systems

198. I have already emphasised what I believe is too frequently forgotten - the justice system should be, fundamentally, a system. Those less familiar with the detail of the justice system would not be misguided in presuming that the operation of this system has a joined up and modern infrastructure to support it. However, as any who have worked in the justice system know, the underlying infrastructure of the justice system remains fragmented and, in most parts, technologically outdated.
199. Core systems used across prisons, courts, probation, and the police are not designed - or able - to communicate with one another. This means that critical

information is often manually entered into multiple systems, creating duplication, likely slowing down processes, and introducing opportunities for human error. In a high-pressure environment faced with constant and frequent changes, the technological limitations of the justice system risk becoming a point of failure.

200. Additionally, a significant challenge is that aging systems are harder and slower to change than modern architectures. This means that rapidly changing processes and policies (as mentioned in the previous section) do not get codified digitally resulting in work arounds, paper processes and ultimately inconsistencies.
201. Staff on the front-line are reliant on manual workarounds. In most cases this is because they don't have the technological capacity to do otherwise. In others, it is because the technological solutions simply do not work and/or are not *trusted* within the operational reality within which they are introduced.

2.5. Impact

202. Risk is inherent to the justice system. However, an effective justice system should effectively mitigate and manage this risk or be clearer with the public about what risks are being tolerated. Without this, the pressure of any errors sits with the most junior people. After undertaking this review, I am unconvinced that the operational context, as is, enables these risks to be effectively mitigated.
203. The recently introduced Sentencing Act and the recommendations of the Independent Sentencing Review together present an opportunity to simplify aspects of the current framework and address some of the pressures driving system complexity. The proposals aimed at reducing short sentences, improving clarity around release points, and creating more consistent sentencing structures may help reduce operational burden within one part of the justice system over time. Notwithstanding this, I remain cautious about the 'burden shunt' into policing.
204. Fundamentally any benefits will only be realised if implementation is carefully managed. Rapid or poorly sequenced change risks compounding existing

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issues - particularly given the outdated systems and fragmented processes currently in place. Any reforms designed to improve clarity or support capacity must therefore be introduced with a deliberate focus on the capacity, training and technological upgrades needed to support those reforms. Otherwise, changes introduced with the intention of reducing errors may instead increase them. I cover the wider systemic change I have found necessary to reduce release in errors in full detail in section four of this review.

205. Finally, in evidence of the impact of the issues raised above, several additional matters were also raised directly with me during the course of my review. These are outside the scope of my review, however those raising them were compelling in their presentation, such that I am minded to bring them to the Government's attention for awareness and consideration. They are as follows:

- The distribution of drugs within prisons was raised as an issue for prison officers, and they suggested some insightful ways to tackle the issue when prisoners bring drugs in but are still able to distribute them during segregation.
- The prevalence of drones around prisons was raised as a significant challenge, allowing criminals to smuggle drugs, mobile phones, and weapons directly into prisons as there are no security systems to stop them.
- The illegal use of phones by prisoners undermines safety and security, enabling organised crime to continue from behind bars. This places significant pressure on staff, increasing both workload and personal risk.
- The current issues with electronic monitoring were mentioned due to delays in fittings tags, poor breach management, unreliable data sharing and inconsistent enforcement, all of which can allow offenders to abscond reoffend, or breach restrictions without timely intervention.

Section 3: Causes of Releases in Error

206. When the Deputy Prime Minister extended my terms of reference, it was evident that I needed a process to include other cases in my analysis of the issues. This chapter includes that analysis (outlining the gaps in the data), my findings and corresponding recommendations.

3.1. Quantitative analysis of releases in error

207. At the outset of this review, I asked the Ministry of Justice to provide a quantitative analysis of data covering releases in error. This would necessarily require an analysis of the data available and a summary of the statistical trends. I also asked that they provide an assessment of the risk presented by releases in error.

208. The quantitative analysis I received used administrative and operational data collected on release in error incidents reported between 1 April 2020 and 4 December 2025. This covered time series, offence types, reoffending, risk scores, nationality status, prison establishment and time spent out of HMPPS custody, amongst other variables. I asked for a summary of the main findings and implications which is attached at **Appendix D**.

209. I found the three points set out below the most substantive, considering the limitations of the data:

- **Reported incidents of releases in error have been increasing since 2022** with a further spike recorded in 2024 (Figure 4).³⁸ The current view in HMPPS is that this spike reflects specific, time-limited operational and policy pressures, rather than a sustained change in the underlying rate of releases in error. I understand this to be an operational judgement, rather than a conclusion following a full causal analysis.

A particularly notable increase in reported incidents can be seen in September 2024 (Figure 5). I am advised that this increase can be attributed to a specific issue that was identified in September 2024, and which saw 38³⁹ offenders released in error through outdated legislation relating to

³⁸ Between April 2024 – March 2025.

³⁹ This was originally reported as 37 cases. One additional case was identified following the initial investigation.

breaching restraining orders, under the first tranche of the Government’s implementation of a change to standard determinate sentences to relieve prison pressures (known as ‘SDS40’).⁴⁰

Figure 4: Annual releases in error – FY 2006-07 to FY 2024-25

Source: The Ministry of Justice published statistics

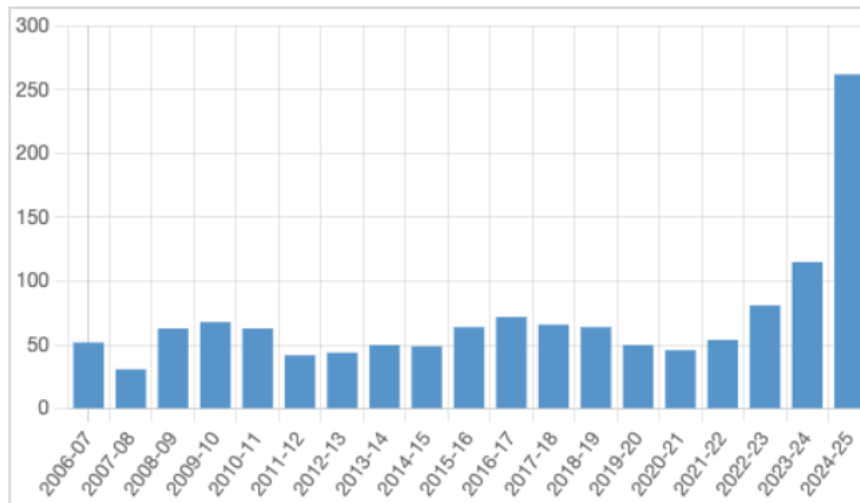
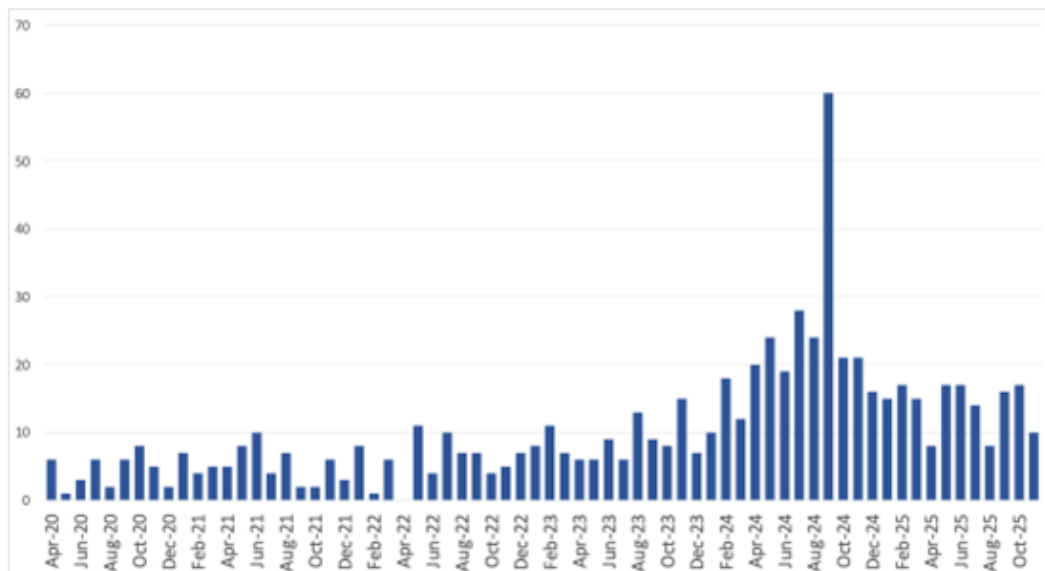


Figure 5: Monthly releases in error - April 2020 to November 2025

Source: NOMIS Incident Reporting System: Live operational data, subject to change.



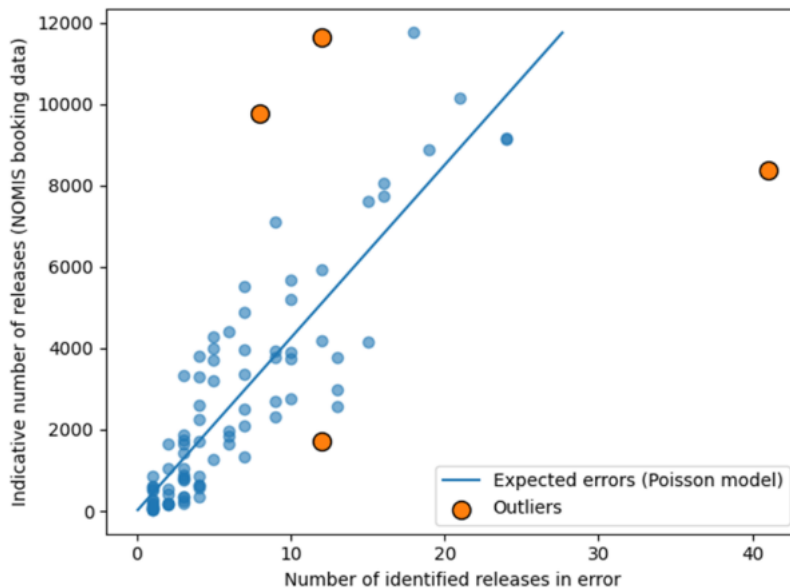
- **Releases in error are widely distributed across the prison estate, with no evidence of persistent geographic clustering (Figure 6).**

⁴⁰ The policy-change excluded offenders in custody for breach of a restraining order from being released early. Despite this, 38 offenders were released early and in error because of being in custody under a repealed offence. I am told that the issue was corrected via a legislative amendment, and all individuals released in error as a result, returned to custody (albeit I have not received evidence to confirm this).

Establishments with higher number of releases in error tend, to be those with higher volumes of releases overall, and the variation observed is more likely linked to throughput and the scale of an establishment, often related to their category/type, rather than location itself. Notwithstanding this, four statistical outliers were identified (HMP Doncaster, HMP Forest Bank- with fewer releases in error than might be expected, HMP Leicester & HMP Pentonville- with more).⁴¹ The Department may wish to undertake further analysis to understand the reasons for variation in these establishments.

Figure 6: Geographic Statistical tracking

Source: NOMIS Incident Reporting System. This is live operational data and is subject to change.



- **The sentence status of those released in error (e.g. remanded or sentenced) does not appear to substantially influence the likelihood of a release in error.** The trends seen amongst the sentence status of the release in error cohort broadly maps onto the sentence status of the wider prison population.

⁴¹ Pentonville and Leicester are the outliers to the right of the line – i.e., with more releases in error than would be expected given their release volumes.

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210. Unfortunately, current data and collection methods on Release in Error are limited and subject to a number of caveats. It thus became difficult to draw any further or more meaningful conclusions than those I have outlined above.
211. These caveats limited the usefulness of the analysis for two primary reasons. Firstly, the process by which this data is collected (proformas) relies purely on operational input which may vary substantially from incident to incident and cannot be relied on to accurately or reliably capture the full circumstances that led to the release in error. Secondly, and perhaps most concerning, the data captured is representative only of those that were known about and therefore reported.
212. Indeed, the most alarming realisation on receiving this analysis was the, seemingly, well-known and widely accepted, fact that the data collected is only the *minimum* number of releases in error. This is because the data is derived from incidents that are proactively reported to the Prison Incident Reporting Service, i.e., after an incident has occurred. Often, errors are only identified when an individual is returned to custody, recalled, or otherwise comes back into contact with the criminal justice system.
213. The fact that the Department's understanding of the true extent of releases in error is the minimum of what is likely to be the case was not my only point of alarm. The immediate concern I had was that the Ministry of Justice and HMPPS seemed to explicitly accept that the data is not representative of the 'true' picture of releases in error and yet had no means by which they were regularly quantifying the level of inaccuracy and therefore the level of extant risk of harm to the public. Without an established level of 'accepted' inaccuracy and risk, nor a regular means by which to check this, my concern thus became that the Government has historically and ongoingly accepted an outstanding and unquantifiable risk to the public.
214. To be very clear, I received no evidence to suggest that this was an explicit decision taken. Instead, I suspect this is an example of an implicit decision taken to deprioritise further interrogation into releases in error to concentrate on other pressing issues, supported by the fact that the known numbers in the

dataset indicates *low* volumes of releases in error compared to the volumes of all releases per year. I return to this point substantively in section 4 of this report.

215. On recognition of both points, I wrote to the Deputy Prime Minister on 10 November 2025 to outline my concerns about the lack of a built-in systematic process by which historic releases are checked. I made clear in my letter that the data the Department reports on releases in error, and which is relied upon in the House of Parliament and relevant Select Committees, are the minimum number that there could in fact be. Considering this lack thereof, **I made an urgent recommendation for the Ministry of Justice and HMPPS to seek to quantify the risk to the public to enable mitigation if necessary.**
216. In response, the Ministry of Justice and HMPPS conducted a random dip-sample. The purpose of the dip sampling exercise was to identify the potential scale of previously unidentified releases made in error –in order to calculate, the ‘true rate of releases in error’. The Department’s published figures capture known releases in error; however, the exercise sought to assess whether additional releases in error were occurring that were not being identified through routine reporting.
217. To do so, the Ministry of Justice and HMPPS randomly sampled 386 regular releases (i.e. releases from prison where an error had not already been identified). The sample consisted of 193 random cases from the first 6 months of 2024 and 193 random cases from the first 6 months of 2025. These cases were then manually checked for errors.
218. In this pool, four releases in error were immediately identified because the Ministry of Justice and HMPPS were already aware of these errors (i.e., they had already been reported), and so they made the decision to resample and replace these four cases with another random four. This provided them with a sample of 386 releases; none of which were already known releases in error. The final report is set out in **Annex E**.
219. It is notable that the Ministry of Justice and HMPPS admitted that they would have needed to stratify the sample of releases by characteristics that are known to make releases in error more likely (e.g., sentence complexity) to achieve a more statistically accurate and precise estimation on the ‘true’ volume of

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releases in error. The Department were clear that this would have required a manual check of thousands of cases, with several months of operational resource needed. It was their judgement that this operational requirement would affect ongoing sentence calculations checks, potentially increasing the risk of releases in error. However, without stratifying the sample, it is **likely** not enough cases with the characteristics that can increase the likelihood of errors were reviewed – limiting the reliability of the Department’s estimation on the ‘true’ rate of releases in error.

220. Notwithstanding these limitations, the Department’s review of 386 cases still identified two releases in error that had, until that point, been undetected. This constituted around 0.5% of the sample. Of the two releases in error identified: One was released 2 days early due to a sentence miscalculation; the other was released five days early due to miscalculation of remand. The Department’s review of 386 cases also discovered 14 individuals who had been unlawfully detained prior to the release. In half of these cases the individual had been detained unlawfully for one day, but the longest period of unlawful detention detected was 12 days.
221. Following this exercise, the Department concluded in both their quantitative summary report and dip-sample report (Annexes D & E) that despite the limitations of the sample size, and *"while there may be releases in error that go undetected, there is not a large-scale issue of unidentified releases in error"*. They set out that *"based on the dip sample and published statistics, the overall proportion of releases in error (including detected and undetected releases in error) is likely to be less than 1%"*.
222. They subsequently determined that: *"Further sampling work would be required to reduce this uncertainty and provide greater confidence in the estimated prevalence. This statistical assessment forms one component of the overall view of prevalence and should be considered alongside operational understanding of how releases in error are identified in practice. On this basis, releases in error are uncommon when compared to the total volume of releases but can have serious consequences when they occur."*

223. On receipt of the Ministry of Justice's conclusions from their dip-sample exercise, I contacted the Office for National Statistics and engaged them on the methodology used. We agreed that this exercise has limitations:
- Firstly, as the Department analysis notes, a random sample of releases will not account for the factors that are likely to make the likelihood of a release in error far higher. For example, a release in error may be more likely if an individual is on remand, if they have multiple, complex sentences, or if they reside in an establishment where the flow of prisoners in and out is higher.
 - Secondly, concerns were also raised about the four 'known' detected releases in error in the initial sample. The Office for National Statistics noted that this would be substantially more than would be expected in a random sample of 386, given management information from the Ministry of Justice indicates the 'known' rate of detected releases is around 0.17%. Detecting four cases in a sample of 386 is therefore highly improbable (around a 0.4% probability chance).
224. Both of these considerations mean it is challenging to draw inferences about the number of *unknown* releases in error from this sample. In combination with the noted methodological limitations, it is therefore not possible to conclude firmly that the true overall rate of releases in error is below 1%, as it may exceed this level
225. It is also notable that officials in the Ministry of Justice and HMPPS' concluded that an "*under' 1% error rate does not represent a 'large scale' issue*" – despite their own suggestion of a 0.5% rate of unknown releases in error. Whilst I do not consider the Department's dip-sample exercise to be a reliable indicator of the true rate of releases in error, I still struggle to agree with the definitive conclusion they drew from their findings. Had the results been more reliable and genuinely indicated a 0.5% unknown error rate, this would imply that, annually, more than twice as many individuals may be released in error into the community than the Government is currently aware of.
226. Of course, my central point is that the exercise appears so limited and uncertain that further analysis is essential before any firm conclusions can be drawn. However, I would urge the Government, before undertaking additional work, to

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reflect on what level of error they consider sufficient to constitute a '*large-scale*' issue.

227. Indeed, it is also notable that this exercise did not strive to quantify in concrete terms the Ministry of Justice and HMPPS' assessment of the risk presented by releases in error, despite this being a fundamental part of my urgent recommendation. The assessment on risk that I did receive (included in their quantitative analysis of the available data as per **Annex D**) provided a narrow interpretation - focused on comparing reoffending rates of those released in error against the broader cohort. To me this fundamentally misses the point that these individuals should not have been released at this point. The risk arises because they are unlawfully in the community.
228. It is equally concerning that this risk assessment was not an established or readily accessible product, with an assessment agreed by Ministers, that was easily provided to me. Instead, it required additional bespoke analysis, which took the Department several weeks to provide. I reflect in more detail on the impact of this to risk-management in a dedicated chapter in section four of this review on governance, audit and performance (pages 135-143).
229. It is likely that, while I am focussed on risk, officials are applying pragmatism on volume. This may explain why the Department has not, at the point of writing this report, made the proactive decision to link data on releases in error with that held on the Police National Computer (PNC) and get the necessary data sharing agreements to do so. This would provide a better understanding of the criminal histories of those who are released in error and the risk that they present. It is my view that this understanding is essential to tackling the offending behaviours and repeat victimisation that is associated with crimes such as domestic abuse and violence against women and girls.
230. Overall, I have been disappointed by the inability of the Ministry of Justice to provide, in a comprehensive and timely manner, a quantitative analysis on which I can rely.
231. In conclusion, the limit of the Department's understanding on releases in error is concerning, not least because the data reported currently being provided to

Ministers and therefore Parliament as a means by which to make definitive rather than indicative commentary on releases in error.

3.1.1. Findings

232. Ultimately, the analysis I received from the Department revealed the stark limitations of data that is collected by the Ministry of Justice and HMPPS on releases in error. Whilst further work was undertaken to quantify the ‘true’ rate of releases in error in response to my urgent recommendation, it has been difficult to reconcile the Department’s conclusions reached with my own. **I therefore find:**

- That the release in error figure has been stated as factual rather than indicative.
- It is **likely** that the limitations of the data are impacting the Department’s understanding of the root causes of releases in error. Without understanding this, strategic, policy and operational interventions to prevent reoccurrence are likely to be impeded. I make recommendations to address the limitations of the data as currently collected in a dedicated chapter on data and transparency, in section 4, page 130-134.
- It is **likely** that the absence of any meaningful analysis until very recently (see the fish tail analysis at the end of this section) is indicative of the diminished attention that releases in error were given prior to the release of Mr Kebatu. The lack of scrutiny also indicates an implicit acceptance of the risk that releases in error may present as a result.
- The rate of releases in error cannot yet be firmly concluded as under 1%. The evidence does not rule out a prevalence of more than 1%.
- I do not consider the Ministry of Justice nor HMPPS’ analysis of risk to adequately quantify the risk presented by these releases in error.

233. **I make full recommendations on the position of data on page 134**

3.2. Case File Review: A more detailed look at the causes of releases in error

234. Releases in error can arise from complex and multi-stage issues, errors, and breakdowns in processes. Case-by-case analysis using the available operational data can help to better understand contributing factors and identify issues. In my first section of this report, I used this operational data to analyse and outline the causes of Mr Kebatu's release and provide connected findings and recommendations.
235. However, with the limited quantitative analysis that was provided to me at this stage I was unable to establish, on a wider scale, the causation across the whole release in error cohort. To meet this aim and the terms of reference for this review, I made the decision to undertake a more detailed review of a select sample of 35 cases. To supplement my own review and observations, I also commissioned the Ministry of Justice to undertake a thematic analysis; the methodology for this, as well as for my selection of 35 cases, is set out in **Annex E**. This combined approach helped me to identify and categorise the most typical and recurring 'types of errors', as well as identify some drivers for those errors and other contextual factors.

3.2.2. Findings from Thematic Analysis

236. The thematic analysis considered the available operational data to identify **four overarching 'types of error'** associated with early releases. These were:
1. **Sentence miscalculation:** Cases where the release date for an individual has been miscalculated.
 2. **Missed information:** Cases where necessary information has not been sent or received by the relevant parties – for example, an email being missed or a warrant not being received.
 3. **Incorrect outcome:** Cases where an incorrect outcome for an individual was recorded for an offence. For example, where bail has been recorded rather than remand.

4. **Mistaken identity:** Cases where an individual has been released in error due to mistaken identity – for example, because two individuals share the same name or because an alias has been overlooked or names spelt variously/incorrectly.
237. Whilst these types of error can be considered distinct, they were not considered mutually exclusive. Multiple conclusions can therefore often be drawn from individual cases; for example, an incorrect outcome being recorded could lead to sentence miscalculation, but sentence miscalculation could also occur for other reasons.
238. Alongside these types of error, the thematic analysis also identified three **overarching drivers of error** which applied across all error types and frequently occurred in combination with each other or otherwise interacted. All the cases reviewed involved at least one of the following drivers. The drivers identified were:
1. **System-level issues with the process, guidance or checks in place:**
This involves cases driven by what were determined to be system-level issues. This category includes errors that related to issues with technology or IT systems but could also involve more substantial breakdowns in processes or lack thereof.

In some cases, these drivers were directly identified in the proformas reviewed. In others, the respondent did not directly refer to a system-level issue but subsequently identified possible improvements to local processes.
 2. **Human-level issues or oversight:** This includes cases where proformas refer to ‘processes not being followed correctly’, implying that clear or appropriate processes are in place but that there was human oversight or error in following them. This could include incorrect information being uploaded onto a system, emails being received but not read or other ‘unforced’ or ‘unexplained’ errors.

As I’ve made clear in section 2, it is important to note that the propensity for human errors can be increased by system-level issues.
 3. **Staffing or resourcing issues:** The operational information available contains insufficient evidence to make definitive judgments on the impact of

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staffing levels on releases in error. Notwithstanding this some proformas did refer to staffing levels or resourcing concerns and so I have included reference to this in the analysis. In the cases where staffing or resourcing was mentioned, this included reference to periods of unusual or unexpected high demand (e.g. due to result of multiple releases being required in one day) or periods of low staffing (e.g. limited resource over the Christmas period). In some cases, proformas also referred to staff training, either by specifically stating that lack of suitable knowledge or training contributed to an error or by noting further training as an action following the release in error.

239. In addition to the drivers of error identified, the thematic analysis identified several further **contextual factors** which may have been related to releases in error in given cases. These factors were not framed as drivers of error but may merit further consideration. They were:
1. **Remand:** Some proformas discussed calculation of remand time, remand warrants being missed or remand being incorrectly accounted for as contributing to releases in error.
 2. **Home Detention Curfew (HDC):** The sample included cases in which errors related to HDC (e.g. HDC being incorrectly granted), with some proformas identifying a need for further checks or training in relation to HDC.
 3. **Recall:** In some cases, recall was identified as a factor that may have related to release in error. For example, proformas discussed changes in recall length or the incorrect recall length or type being recorded.
 4. **Foreign National Offender (FNO):** In some cases, the FNO status of the released individual was coded as a contextual factor – for example, where the release in error related to immigration processes.
 5. **Multiple offences:** In some cases, an individual having multiple offences or sentences may have contributed to releases in error because of complexities in sentence calculation or because of increased likelihood of information being missed.

240. These contextual factors were noted only where they appeared to contribute directly to the release in error – for example, remand cases were only noted where involvement of remand appeared directly relevant to the error.
241. **Annex F** captures the final themes identified through this thematic analysis process, including the number of times each theme was identified in the sample.

3.2.6. A Risk-Based Approach to Determining the 'Gravity of Release in Error'

242. Having reviewed these cases in more detail, it became clear to me that the published data captures both minor administrative issues that are resolved quickly, as well as serious cases where further offending following a release in error could be tracked. As such, I also have considered the *impact* – or the 'gravity of the release in error' - in each case and determined whether the release in error can be considered a more minor administration of justice related error, or a more substantive error with associated risk presented to the public. As a result, I have judged whether the release in error can be shown to have created an identifiable public protection risk.
243. I have considered the distinction between administrative and substantive release in errors as per the below:
- **Administrative release in errors** are those cases involving limited early releases of less than two weeks before an individual's normal release date and where the offender remains subject to standard risk management from probation.
 - **Substantive release in errors** involve cases where an offender is released from remand and therefore lacks the normal risk management provided by probation, and/or where the offender is released a significant period before their proper custodial release date, and/or where the release in error has enabled further offending in the community. Substantive errors therefore represent instances where the error inevitably produces a demonstrable increase in public protection risk.

244. **Annex G** sets out my methodology for determining this in each case, and **Annex H** provides a compendium of all cases considered and the conclusion I reached for each. It is noteworthy that 80% of cases I reviewed ultimately constituted a substantive release in error. Whilst I cannot draw statistical significance from this small sample size, the high proportion of cases that I deemed to be a ‘substantive release in error’ demonstrates the impact of releases in error. Indeed, rather than merely constituting minor administrative discrepancies in sentence calculation, the results of my analysis suggest that releases in error should be considered, primarily, as a systemic issue with associated risks to the public and tackled as such.

3.3. Identified Issues

245. In this section I have considered in more detail the four types of errors that were identified through the Ministry of Justice’s thematic analysis outlined above and make corresponding findings and recommendations to address these issues. I have used case-studies and included timelines where those cases were not remand cases to illustrate the impact of these errors,

246. In the process of undertaking this review, I have also identified wider systemic problems that are compounding the likelihood of these issues occurring, and releases in error. These problems are set out in more detail in section four of this report. Without addressing these systemic problems, I expect that the Government’s ability to address these issues will be limited. **All recommendations made in this section should therefore be considered in the knowledge that releases in error are unlikely to be fully mitigated without sustained and strategic focus on the wider issues I have set out here and in section four.**

3.3.1. Sentence Miscalculation

247. When an individual is convicted of an offence, a judge will set the sentence length and determine whether any other sentences received run concurrently or consecutively, as well as whether any additional orders should be made. The law then determines how much of the sentence is to be served in custody and what deductions must be applied. This is a complex process involving the

assessment of remand time, curfews and other factors, with responsibility for different calculations sitting with different organisations.

248. For example, following sentencing, HMCTS staff are responsible for deducting qualifying curfew time before issuing a warrant. This is then passed to specialist staff within each prison's Offender Management Unit⁴², who calculate the exact release date. The Offender Management Unit – whose role it is to oversee and manage sentences and time served by individuals in custody – then calculates key dates, such as the Conditional Release Date, Sentence Expiry Date, and any relevant parole dates.
249. This calculation determines the precise day on which the individual must be released, usually onto licence, although in some cases the release point may be affected by additional days added for disciplinary reasons, extending the time the individual remains in custody. It is frequently calculated manually by Offender Management Units; although I am aware that some calculations are automated via the Calculate Release Data Service (see paragraph 335).
250. The Offender Management Unit will then also complete all necessary documentation for release, whether at the end of a sentence or when a court directs the release of someone held on remand.
251. Accurate release dates depend *entirely* on these calculations. Therefore, any mistake can have serious consequences. If the date is calculated too early, a person may be released before the law allows. If it is calculated too late, they may be kept in prison longer than they should be, which means they are being held unlawfully.

Discussion

252. The operational information available on the 35 cases I reviewed indicates that sentencing miscalculations can stem from human error, system-level issues or a combination of the two.

⁴² There is an Offender Management Unit in every public and private sector prison, except for HMP Thameside, a private prison run by Serco, where the Offender Management Unit is operated by Catch22, a third sector organisation.

253. The further engagement that I have conducted for this review indicated that there are several events that can lead to sentences being miscalculated. These include:

- **Calculations beginning from the wrong information base:** Essential sentencing data such as updated warrants, custodial history, or corrected entries may be missing or inaccurate. When the starting information is incomplete or wrong, the calculation begins from the wrong baseline, which in turn shortens the sentence and can lead to early, unlawful release. These mistakes may arise because of staff misinterpreting court orders or because they are working with incomplete or outdated information to begin with - often due to weak communication between courts, prisons, and probation. The disconnected technology systems across the criminal justice system do not enable early or automatic resolution of these issues.
- **Time served in custody is allocated incorrectly:** Remand may not be split properly across different custodial periods, Added Days may be recorded wrongly, and tagged bail or detention days may be applied inaccurately. These errors can serve to give prisoners more credit in custody than they are entitled to, shortening the custodial period and increasing the risk of an unlawful early release. Errors can also arise from misinterpreting sentencing or recall rules. For example, the wrong recall type may be applied, SDS40/SDS50 may be miscalculated, licence requirements misunderstood or Fail to Return (FTR) days incorrectly applied. When the wrong rules are applied, the system produces an incorrect release date.
- **Administrative mistakes contribute to miscalculations:** Staff can make seemingly simple, administrative errors that directly distort the final release date. For example, they may enter data incorrectly, miscount days, or fail to reconcile time served when individuals move between prisons.
- **Complexity of sentencing:** The sentencing regime is inherently complicated and changed to meet Government priorities. More recently, substantive changes to sentencing frameworks have been introduced to reduce demand on the custodial estate. This complexity exacerbates the likelihood for error. To make matters more complicated, courts give

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sentences in days, weeks, months, and years. This makes recording and working out the exact length of a sentence more complicated. Months and years do not always have the same number of days, which can lead to confusion. It is probable that it would reduce the risk of these errors if it were exclusively expressed by all parts of the system in days and weeks, as per my **recommendation 14**.

254. All the possible points of failure outlined above go to show how a sentence miscalculation can occur at multiple points across the justice system. Whilst some errors result in offenders spending shorter periods in custody than intended, others involve serious offenders being released months or years early and, therefore, failing to serve significant parts of their sentences.
255. As well as releases in error, miscalculations can also result in a person being unlawfully detained where they spend longer in prison than they are legally required to do so, something I touch on again later in the report.
256. Ultimately, these miscalculations can expose the public to risk, lead to operational disruption, and undercut confidence in the justice system's ability to administer justice fairly.

Impact: Case Study Examples

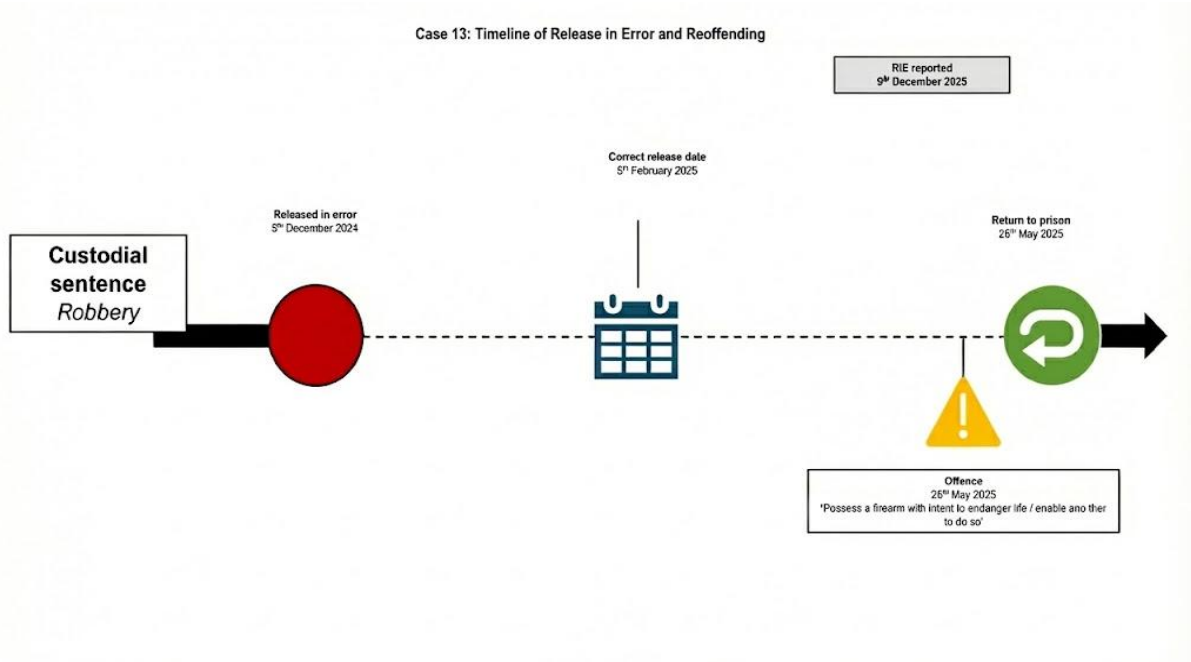
Case 13: ██████████

The offender received a four-month custodial sentence on 16 May 2022. He was subsequently sentenced for further offences, including a seven-year term imposed on 16 January 2023. The Offender Management Unit did not notice this previous sentence on NOMIS which meant his remand time was not correctly apportioned between the two sentences. This led to an incorrect and excessive application of remand credit, which brought forward his calculated release date and resulted in an unlawful early release on 5 December 2024.

The offender, who had been sentenced for robbery, conspiracy to commit robbery, and handling stolen goods, remained unlawfully at large for 174 days. During this period, he committed an additional offence - possession of a firearm with intent to endanger life/enable another to do so.

Figure 7: Case 13 timeline

Timeline reflects the index offence for which the offender was released in error, correct release date, date of release in error and date of further offence committed while unlawfully at large



Case 19: [REDACTED]

In this case, the offender was released on Home Detention Curfew (HDC) on 16 July 2025. He failed to turn up at the Approved Premises at which he was required to live under his probation terms, so was recalled back to prison. As he was returned to prison under a standard recall he should have only be released with Parole Board approval or at his sentence end date. However, his return to prison was wrongly recorded as an HDC curfew breach, rather than as a standard recall, so the prison treated him as eligible for routine release on 11 September 2025, leading to his mistaken release. The error only became apparent when he was recalled a second time for failing to comply with his licence conditions and returned to custody, revealing the Offender Management Unit (OMU) calculation mistake.

The offender who was originally sentenced for wounding and inflicting grievous bodily harm without intent was unlawfully at large for 9 days, during which no further offences were committed.

3.3.2. Missed Information

257. The precise and correct recording and sharing of information is integral to the administration of justice. Currently, information management in the justice system relies on multiple case-management systems (which are disconnected from one another), and on the timely and accurate manual input of data by operational and administrative staff.
258. Accurate releases depend on complete information being passed to the correct team for processing if key data is missing, outdated, or incorrectly directed, this can variously lead to releases in error. For example, missing information can lead to sentences being miscalculated, warrants not being actioned, or recall details being inaccurate.

Discussion

259. As it currently operates, the justice system relies on multiple unlinked case-management systems holding accurate information. The table I have included at pages 121-124 shows the range of case management systems in use across the criminal justice system and the lack of join-up across these.
260. The lack of join-up between case management systems creates inevitable weaknesses in the timely and accurate passing of information between different agencies. Indeed, through the process of reviewing cases in further detail, I identified three predictable weak points in the flow of information between courts and the Offender Management Units in prisons. who receive large volumes of important information from a wide array of justice agencies.
- Firstly, Offender Management Units receive large volumes of important information from a wide array of justice agencies which they manually triage. A study into the efficiency of Offender Management Units completed for consultants in HMPPS in September 2024 highlighted the sheer abundance of information received. It found that staff in Offender Management Units face substantial inefficiencies caused by overloaded inboxes that require constant triaging, heavy administrative work including the printing and organising of prisoner files, and time-consuming checks across multiple databases such as Common Platform, NOMIS, and NDelius. It found that in one prison (HMP Hull) the courts inbox received over 60 emails in just a 2-

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hour period and that nearly 40% of staff time was spent searching for emails, updating NOMIS or sorting paperwork. The requirement to manually triage such an abundance of information, on a daily basis, most likely increases the risk that warrants, orders, or other critical documents are sometimes overlooked or misrouted.

- Secondly, courts often send documentation late in the working day - sometimes close to or after 16.30. Critically, Offender Management Unit staff do not monitor inboxes beyond standard hours, typically 17:00. This is **likely** to be reducing the propensity for Offender Management Units to seek clarifications where necessary and is increasing the likelihood that information is missed or not actioned. Put simply, these divergent working patterns are **likely** to be undermining the necessary communication that is needed to support effective information management and cross-agency collaboration.
- Third, the redirecting of information or case details from one team or system to another adds further risk. For example, on account of capacity pressures on the prison estate, courts often send prisoners and their paperwork to prisons outside their normal catchment area. This increases the chance that documentation is sent to the wrong Offender Management Unit. If that Offender Management Unit does not action the incorrect redirect promptly, then this information is not processed in a timely manner. Worse, I have noted instances where Offender Management Units who have received an incorrect redirect have failed to take any remedial action.

261. Under sustained pressure, these weak points become failures and lead to releases in error.

Impact: Case Study Examples

Case 6: [REDACTED]

In this case an offender had multiple concurrent sentences, where one the outcomes was missed at his time of remand into prison.

During a bail information review, the Community Offender Manager identified that a custodial sentence issued on 06 March 2023 was not recorded on NOMIS when the offender arrived at HMP Altcourse on 07/03/2023, meaning two custodial outcomes (a 7 day Post Sentence Supervision breach and an 8week sentence) were never activated. This should have been picked up by the team responsible for warrant processing at the prison.

There was a breakdown in information flow between the court and the offender Management Unit. He was therefore released 36 days early due to not taking into account these sentences on his calculated release date. The offender who was originally sentenced for theft, burglary with intent to steal, and driving while disqualified was released in error and remained unlawfully at large for 579 days during which time a further offence was committed.

Case 11: [REDACTED]

At HMP Humber, following a separate release in error, staff were instructed to review the Offender Management Unit mailbox checking for any emails related to further sentences and lodged warrants. They discovered in this inbox an unactioned lodged warrant for a consecutive 45 day term that had not been actioned in this offender's case. This had not been served at the time of release, resulting in the offender being released early.

The fact that this error was only caught upon the prompting of a separate release in error incident indicates, that there are systematic issues with the monitoring of lodged warrants. The fact that this error was only caught upon the prompting of a separate release in error incident indicates, that there are systematic issues with the monitoring of lodged warrants and communications between courts and offender management units.

3.3.3. Incorrect Outcome Recorded

262. Some errors can occur even before the offender has left the dock and started their sentence. In the cases I reviewed in detail, this at times occurred because of the incorrect recording of outcomes. Amongst the cases I reviewed, I found examples of where outcomes being incorrectly recorded had serious and significant consequences.
263. Court clerks play a pivotal role in sentence proceedings and are responsible for recording sentence outcomes onto several case management systems, including some legacy systems.⁴³ Each system requires a different entry format and process, and the clerk is responsible for recording this complex information accurately on each system, every time for all the relevant parties.⁴⁴
264. There is a formal process for verifying with the judge that the recorded sentence is accurate. When a judge imposes an immediate custodial sentence the court clerk records the details of the sentence in the court log. This is shared with the judge and advocates, in writing on the Crown Court Digital Case System where the judge confirms accuracy, also in writing. Once the sentence is confirmed, the court clerk must then finalise the sentence on Common Platform to issue any warrants. This process has been in place since 2018 and is set out in guidance available to court clerks. During my visit to Woolwich Crown Court, a court clerk showed me this process in more detail.
265. Critically, on Common Platform, there is no audit function for a court clerk to check whether there are any errors with the outcomes or warrants. This means that, where mistakes are made, there are limited opportunities for quick resolution. For example, when a court result is amended it is done so from the system it was originally recorded on and the prison is notified by way of an amended warrant.

⁴³ Libra and Xhibit remain in use as legacy systems and are used for cases that predate the introduction of the Common Platform.

⁴⁴ On Xhibit, the clerk simply draws and signs the order gain – it then goes automatically down the Xhibit portal. On Common Platform, a process called amend and reshare is followed where the original result entry is amended and then the outcomes reshared with the prison (including a new warrant) On Libra, a note is added to the courts register and then this amended register (depending on the size of amendment) or a new manual warrant is sent to the prison.

Discussion

266. I am grateful to those at Woolwich Crown Court – the Judiciary and court staff – who allowed me to observe the process by which outcomes are recorded. Here I noted the significant time pressures that court clerks are under to process and record outcomes promptly (e.g. to get to Offender Management Units for processing). The fact that clerks must communicate data between DCS (the Judges case system) and Common Platform (the court system) for the purpose of checking outcomes is plainly problematic, and more so when we consider this time-pressure to record outcomes and complete warrants and orders as they happen.
267. These conditions increase the potential for error. Indeed, court clerks at Woolwich Court shared with me directly that in a time pressured environment ‘*errors are inevitable*’, and they often feel ‘*set up to fail*’. With the current pressures on court time, I am unclear what work, if any, has been done to establish if the expectation on court clerks is reasonable. I subsequently make recommendations to address the problematic working model between courts and prisons later in this chapter.
268. My engagement suggested that Common Platform intensifies the pressures on clerks. For example, clerks described Common Platform as slow, unreliable and lacking the features needed to support accurate case resulting.⁴⁵ Many preferred legacy systems such as Xhibit which allowed the resulting of cases- the process of formally recording the court’s decisions, outcomes, and updates in the case management system- to be completed in stages. Instead, Common Platform requires clerks to result every aspect of the entire case every time, even when the information has not changed which creates further duplicative work.

⁴⁵ Resulting is the process by which a court clerk records the official outcome of a hearing or court event into the court’s digital systems.

Impact: Case Study Examples

Case 12: [REDACTED]

In March 2025, an offender was released in error from Bexleyheath Magistrates Court. The individual appeared before the court on a 'no-bail' warrant for breach of a suspended sentence originally imposed on 22 August 2024. During the hearing, the judge activated the suspended sentence and imposed a custodial sentence of 20 weeks' imprisonment. The offender should have been transferred to a nominated prison - likely HMP Belmarsh - and taken into custody.

However, the duty clerk recorded the outcome, incorrectly, as a non-custodial sentence. As a result, the offender was released from court on the same day rather than being remanded into custody as ordered.

On the same day, a remand warrant was received by Bexleyheath Magistrates mailbox from Common Platform for the Suspended Sentence for 18 months imposed by Southeast London Magistrates Court. The Duty Custodial Manager did not see this email alerting them to the release in error at this time or thereafter.

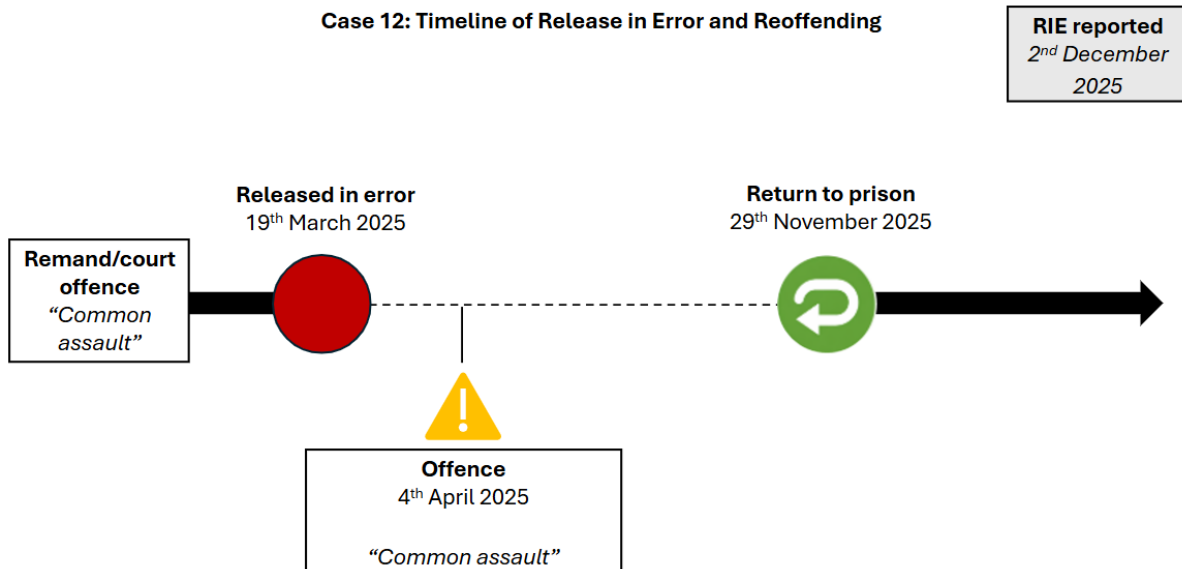
At the same time, this email was sent to the wrong custody team to action, HMP Thameside, which is not aligned with Bexley Magistrates Court. HMP Thameside OMU neither acted on the request nor forwarded the email to the appropriate OMU team to action.

The error was eventually discovered in December 2025 after the offender appeared at Bromley Magistrates Court in November 2025 for a further offence of 'assault by beating'. On that occasion, they were remanded into custody at HMP Belmarsh pending a December 2025 hearing at Bexley Magistrates' Court. By the time the error was realised, the offender had been unlawfully at large for 255 days, during which they had committed an additional offence. Crucially, had the offender not committed a further offence, it is likely the error would have remained undetected.

This case highlights the serious consequences of incorrect outcomes being recorded, in this case, because of human error and the impact of poor ineffective communication between agencies which allowed the error to remain undetected for such a long time.

Figure 8: Case 12 timeline

This timeline reflects the index offence for which the offender was released in error, date of release in error and date of further offence committed while unlawfully at large. There is no correct release date represented as the offender was released directly from court, before a sentence calculation had been completed.



Case 17: [REDACTED]

In this case, an offender was scheduled to appear via video link at Norwich Crown Court from prison on 30 October 2025 for two cases involving 'sending communication threatening death or serious harm'. The hearing did not proceed because the defendant refused to leave their cell. At the time, the offender was on technical bail for one case and remanded in custody for the other.

The court clerk 'resulted' the case on Common Platform incorrectly, recording the result as conditional bail for both cases instead of maintaining technical bail and custody. As a result, the offender was released in error from HMP Peterborough on 31 October 2025, with no probation contact or community risk plan in place. On 28 November 2025, 28 days after the release in error, the Crown Prosecution Service notified the court that the offender was no longer in custody. The police were subsequently informed. The offender remained unlawfully at large for 40 days. The defendant in this case was considered vulnerable and there had been concerns regarding their ability to understand the proceedings. They had also been deemed not fit to plead in the Magistrates' Court. The offender was released while remanded in custody and without any probation contact or risk management plan. Therefore, their release may have presented risks to the public, and themselves.

3.3.4. Mistaken Identity

269. As an offender moves through the criminal justice system - from arrest, to court, to prison, and then probation - their personal details are transferred between multiple, separate systems including, but not exclusively, individual police force custody systems, the court's case management systems (full list at pages 121-124), and the Digital Prison Service/ NOMIS. Because prisons still rely heavily on outdated technology, additional information is often recorded on paper or emailed to overloaded Offender Management Unit inboxes.
270. Misspelling of names, the use of aliases (where someone uses multiple or slightly different names), and rare occasions where offenders with the same name - for example, family members – are held in the same establishment, can all lead to inaccurate records and, consequently, releases in error.
271. Inevitably, the spelling of names must therefore be monitored closely by all staff responsible for creating or updating records. The multiple and disparate systems that are operationalised by staff across the justice system means that information about offenders must be inputted manually and accurately at multiple stages. It is almost certain that the chance of mistaken identities, particularly where aliases are used, is compounded, not rectified, by the technology in place as a result.

Further investigation and discussion

272. Throughout this review, I have observed the importance of accurate records to the proper and fair administration of justice. Just as mistaken identities can result in releases in error, they may also lead to unlawful detentions.
273. The cases I have reviewed show that mistaken identities can arise from simple human-errors (such as misspelling), because aliases are not identified, and due to identifying information on warrants being missed (e.g., date of births). In busy operational environments, there is an increased risk that documentation or instructions intended for one individual are applied to another - particularly in cases where aliases are used.

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274. Whilst I have observed, first-hand, the pressures that operational staff are under in the current creaking system, there must be fail-safes in place to prevent mistaken identities.
275. For example, my engagement with prison officers at HMP Chelmsford made clear the limited technological means available to identify prisoners. Prison staff rely on observed physical characteristics – many of which may change substantially during a custodial sentence - and ask prisoners to quote their personal prisoner number during the release process.
276. Technology should also be maximised to support operational and administrative staff in prisons and courts to mitigate the risk of mistaken identities. I have provided further commentary on the tools and technology available throughout the justice system and made recommendations for improving these to reduce releases in error in a future dedicated chapter of this report.

Impact: Case Study Examples

Case 39: [REDACTED]

On the 5th of May 2023 the offender came into Custody on a remand warrant. In this case, the offender was scheduled to be presented at court for a battery offence. Further appearances were made under the same case number on the 10 May, and 7 June 2023 each time a further remand order was issued. On the 22nd June 2023 a discontinuance notice was received from the CPS leading to the offender being released.

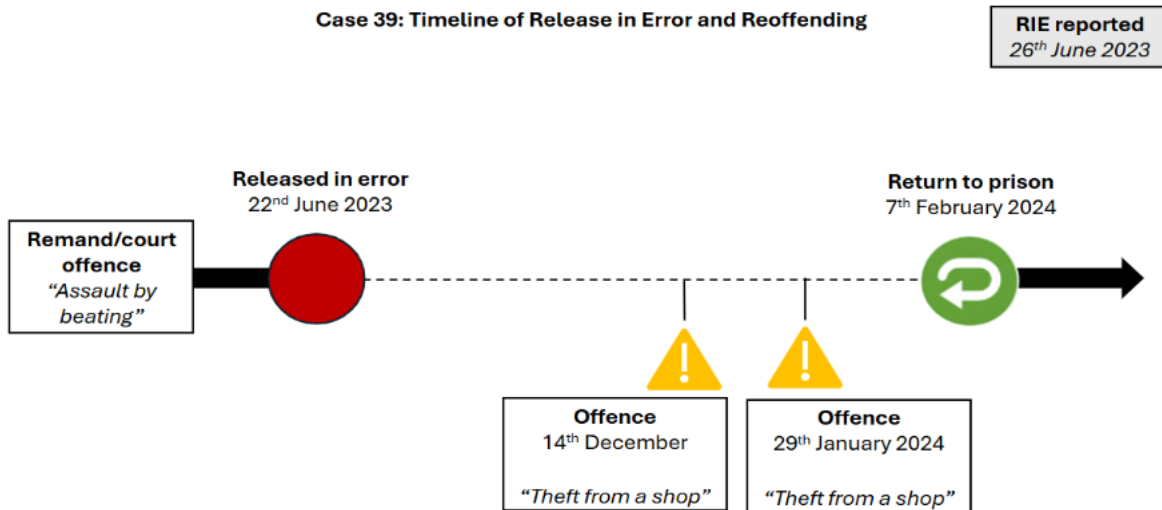
However, the next day on June 23rd the releasing establishment received a call from Mold Crown Court, to inform them the offender was required at court on the 19th of July under his birth name. It became apparent he had been released under an aliased name, although these aliases were known at the time they were not reflected on the remand warrant issued by the court.

Further investigation revealed that the remand warrants issued under the offender's birth name had not been received by the prison and no notification had been received from the Xhibit system.

The offender who was originally charged with battery, engaging in controlling/coercive behaviour in an intimate/family relationship, disclosing/threatening to disclose private sexual photographs and films with intent to cause distress and theft from a dwelling was released in error and remained unlawfully at large for 230 days during which he committed a further offence - theft from a shop.

Figure 9: Case 39 timeline

Timeline reflects the index offence for which the offender was released in error, date of release in error and date of further offence committed while unlawfully at large. There is no correct release date represented, as the offender was due to be on remand at time of release.



Case 2: [REDACTED]

In this case, it was determined that a release in error happened as a result of the misspelling of the surname, but also, because of missing information about an alias recorded.

The offender was recalled under the name [REDACTED] but on the imprisonment order the name was recorded as [REDACTED] and this was not recorded as an alias. As a result, it meant that when the two-day check was being completed, an additional imprisonment order was not picked up as it was under a different spelling of his surname. A thorough check of common platform should have been conducted checking for aliases, but this was not undertaken. The offender who was sentenced for breach of criminal behaviour i.e. theft from a shop was released in error and remained unlawfully at large for 15 days during which time no further offence was committed.

Case 1: [REDACTED]

In this case the release of co-defendants, who were father and son with the same name, were mixed up by the prison due to the prison not identifying the correct date of birth on bail paperwork sent by the court.

The court e-mailed HMP Elmley paperwork showing that bail had been granted in the name of the offender. However, this referred to the son in this case who was the co-defendant and shared the same name. The bail paperwork referenced the date of birth of the son which was the identifier of who should have been released, however, this was missed by the prison and so they ended up releasing the father. Whilst there is an element of human error of the date of birth not being picked up when paperwork was being reviewed, the prison was not helped as both individuals in this case had the same case number and the same name which made it challenging to identify the correct individual to be released. The offender who was sentenced for robbery and burglary remained unlawfully at large for 5 days, no further offences were committed.

3.4. Further Analytical Work

277. During my review The Ministry of Justice Digital Team shared the below '*fish tail*' analysis with me (**Figure 10**). This provides a more detailed and extensive analysis than I had previously received on the causes for releases in error. I found this a helpful addition to my own findings. In sharing this with me they were explicit and clear that this was based on:

- Unvalidated and unpublished data;
- It was not completed until December 2025; and
- It had not yet been discussed with leaders in HMPPS, Courts or The Ministry of Justice.

278. I was keen to include it in this report however because:

- It shows the *recent* determination of those in The Ministry of Justice to understand the issues surrounding releases in error.

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- It supports my identification of wider systemic problems, and the issues identified via my own case-file review process.
- It indicates how analysis can support a staged and sensible system redesign of technology solutions and working practises.

279. I commend the Department for this work, and it supports my recommendations made in a later section of this report regarding the need to better grip and understand the issues behind releases in error.

280. There has been considerable reticence in some areas of The Ministry of Justice for me to share this work. This is seemingly based on concerns, allegedly emanating from the Office of National Statistics about how departments use data. I wish to stress that I totally understand why unvalidated data, used clumsily or deliberately may have been used inappropriately in the past and thereby impacting on confidence in the Government.

281. However, that cannot transition to be a reason to minimise the use of analysis to understand problems, with the purpose of establishing strategic and operational solutions and, in some cases, public transparency may be necessary.

282. It should be noted that the data is based on live operational data provided for the purpose of my review, it comprises different extracts of data to enable comparisons to the wider offender population and accordingly, they are not intended to match published data.

3.5. Findings

283. The issues identified by the case-file analysis go to show how a seemingly ‘small’ administrative error – often at the court/prison interface – can have significant consequences. For example, we saw how the inaccurate recording of an outcome led to an offender being unlawfully at large for 255 days.

284. Throughout this review I have found that unnecessary complexities (both in policy and operational practice/guidance), a lack of integration between different case-management systems and agencies, and an ongoing need for data to be manually inputted into outdated systems increases the burden on administrative staff and the propensity for errors.

285. **As a result, I find:**

- The current method of recording sentences in years and months creates inconsistency when calculating sentences. In addition, it is **highly likely** that the combination of a complex and changing sentencing regime, with limited supporting and connected technological capability for staff to undertake these calculations, is currently increasing the likelihood of sentence miscalculations. I comment more fully on the usefulness of digital sentencing tools that are in development in a later dedicated chapter on tools and technology (pages 120-129).
- It is **highly likely** that insensible working arrangements between courts and prisons are increasing the likelihood that key information is missed and reducing the likelihood of errors being resolved promptly. Without urgent rectification, I am **almost certain** that substantial errors will persist. This issue was first highlighted in 2021, and yet there has been extremely limited progress since.
- It is **highly likely** that the pressures currently facing court clerks is increasing the propensity for human errors, and that spotting these errors currently relies on proactivity from the prison.
- Rather than help the situation, it is **likely** that the introduction of new technological systems – such as Common Platform – which are designed to simplify processes and encourage join-up between agencies are creating

additional drains on operational staff's time and serving to prevent join-up between courts and prisons.

- It is **almost certain** that the automated linking of systems between the courts and prisons would reduce this burden, and the risk of human errors.
- The process of undertaking a thematic analysis showed that these issues cannot be considered in isolation. Indeed, it ultimately proved challenging to distinguish between the 'type' of error in many cases, and **Annex F** highlights the cases in which I determined there were multiple 'types' of errors at play in individual cases. For example, just as outdated and disconnected case management systems and working practices lead to missed information, so too can these issues lead to mistaken identities, and prevent sentence miscalculations and incorrect recording of case outcomes from being identified.

286. Considering these identified issues together, then, I further find that:

- It is **highly likely** that there have been releases in error which could have been prevented through more connected and modernised technology. As noted in Sir Brian Leveson's review⁴¹ technology is essential to the effective functioning of a modern criminal justice system. For example, if biometrics were used consistently, offenders could be identified through their fingerprints at every stage - from arrest to prison. This would provide an additional safeguard for identifying individuals throughout the justice system.
- It is **almost certain** that the accuracy of information input into systems (whether that's case-management systems or digital sentence calculation tools) will be critical to reducing sentence miscalculations and releases in error.

3.6. Recommendations

287. Considering my findings, I make the following recommendations to address these identified issues.

288. First, to address complexities, inconsistencies, and a lack of join-up leading to errors, I recommend that **within three months**:

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- **Recommendation 14:** The Ministry of Justice, in conversation with the judiciary and supported by the Judicial Office, to explore options for agreeing standardisation of days, weeks, months (consistently either 28 days, 30 days or 31 days), and years (52 weeks) with the purpose of simplifying sentence calculations.
 - And/or exploring the feasibility of judges setting out the release date at the point of sentencing,
 - And/or suggesting alternative solutions to simplify sentence calculations.

289. I further recommend that, **within six months:**

- **Recommendation 15:** The Ministry of Justice with HMPPS & HMCTS develop a shared target operating model for working together, including on communicating sentences and sharing critical information, without which I am almost certain it will be impossible to bring the number of releases in error down. This should consider:
 - Information shared about prisoner production and appearance.
 - The modernisation and integration of Offender Management Unit & court working practises to include roles, responsibilities, grading and working hours.
 - Introducing sentence calculation as a specialist operation within each Area Executive Director region, rather than across every prison at a local level.
 - The capacity of one court clerk sitting alone to complete all the tasks required and their ability to resolve inaccuracies or ambiguities, including out of hours.
 - Necessary improvements to Common Platform to reduce additional administrative burdens on court clerks.

290. I further recommend that **within 12 months:**

- **Recommendation 16:** This new model of operation should be agreed between the Ministry of Justice, HMPPS and HMCTS and then implemented.

291. The recommendations above serve to address complexities and a lack of join-up – both of which I find to be contributing to releases in error. However, further work is necessary to improve the technological systems that support staff and agencies to accurately track information (and offenders) and administer justice. Ultimately, sustained strategic investment is required to address this lack and tangibly reduce releases in error.
292. I comment in more detail on the technological lack in my dedicated chapter on tools and technology (pages 120-129).
293. In the second part of his review, Sir Brian Leveson recommended establishing a single, shared vision for the criminal justice system to strengthen collaboration across the system.⁴⁶
294. I support his recommendation and further recommend that **within 12 months:**
- **Recommendation 17:** A plan for developing a clear cross agency strategy for the criminal justice system is agreed and driven by Government. This must include a complementary technology and data strategy with specific actions to make substantial and connected changes to the technology provision directly and determinedly creating systems that interact with one another or are overlaid with tools that facilitate this and reduce the need for multiple data entries. This should include a plan for developing an interface that links the court system for recording sentences to the prisons systems. Tools that are currently being tested, and which I outline in further detail in my section on tools and technology (pages 120-129) should be considered for inclusion in this strategy depending on the outcomes of a thorough evaluation.
295. I further recommend that **within six months:**
- **Recommendation 18:** That this strategy considers the effectiveness of the current separate Courts, HMPPS and Justice Digital transformation programmes, which may be creating unnecessary and counter-productive system divide. The Ministry of Justice's Permanent Secretary, with system

⁴⁶ [Independent Review of the Criminal Courts – Part II: Volume 1](#)

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leaders, should examine whether structural changes could aid the ambition to have a joined-up technology approach across the criminal justice system.

- **Recommendation 19:** Alongside this, the Ministry of Justice and Home Office should develop a plan for the consistent use of biometrics, both in prison and across the whole system. This should allow offenders to be tracked from the point of arrest to release and will be critical to ensuring the correct individual is being released into the community.

Section 4: Wider Areas for Improvement

296. In the previous sections I reviewed the facts and timelines surrounding Mr Kebatu's release in error (section one), explored the wider operational context (section two), and undertook an analysis and case file review to identify recurring 'types' of error (section three). All of this has helped me to make findings and recommendations to address releases in error.
297. Throughout, I have identified wider systemic factors that are almost certain to be increasing the risk of releases in error. The areas explored in this section are:
- People and experience;
 - Tools and technology;
 - Data and transparency;
 - Governance, performance, audit and risk; and
 - Culture.
298. This section explores these wider areas and makes clear why they are of relevance to the Government's aim to reduce releases in error. Where possible, I have made recommendations to address these issues and/or highlighted where further consideration is required.
299. A strategic approach that addresses these wider, systemic issues will be critical to reducing releases in error incidents. It is my ongoing view that piecemeal reform without an overarching vision will always stunt progress.

4.1. People and Experience

300. In the second section of this report, I provided background on the wider, operational context within which releases in error occur. In doing so, I made clear that most releases in error are not a consequence of individual laziness, but far more because the system is stretched, processes designed in isolation of one another and with staff operating without the right tools, training and technology to ensure success or, at the least, to minimise errors.
301. Here I have focused on the roles, responsibilities, recruitment and training of those who work in prisons, specifically the impact that both may have on the propensity for errors. I find that the right training is essential and critical to public safety, making recommendations to improve staffing structures and training to set staff up to succeed.

4.1.1. Roles, Responsibilities & Pay

302. Appropriate staffing structures are critical to the effective and efficient running of organisations, whilst clear roles and responsibilities help to avoid duplication and empower staff. Transparent and achievable pathways for progression help to retain talent, reduce turnover and build institutional memory.

4.1.1.1. Background

303. Prison officer roles are varied and encompass a wide-range of tasks - from maintaining discipline, dealing with daily basic needs of prisoners, to processing releases.
304. The staffing structure in prisons uses grades to denote both experience and expertise. Higher grades have more responsibility and are, generally, expected to manage more risk. Pay in prisons is dictated by these 'bands'; with progression and increased remuneration usually requiring promotion through these formal graded bands, rather than increasing with specialism or time-served in the role.
305. The pay bands are recommended by the independent Prison Service Pay Review Body, and approved by the Chief Executive Officer of HMPPS, the Lord Chancellor and, eventually, the Prime Minister.

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306. Currently, the prison staffing structure in public prisons consists of 10 graded 'bands' (see Figure 13). Bands 3-5 are the key operational grades and include 'prison officers' (band 3), specialist roles and supervising officers (band 4), and Custodial Managers (band 5). The most senior bands are (bands 9-12). Prison governors (band 7-9) are the senior operational manager and have overall responsibility for the running of their prison. Prison Group Directors (band 12) are responsible for the operational and strategic oversight of multiple prisons within a defined area and are considered senior leaders in HMPPS.

Figure 11: Operational grading structure:⁴⁷

Band	Job Title(s)	Pay Bands (Public Prisons)
Band 2	Operational Support Grade (OSGs)	National - £24,527 Outer London - £27,842 Inner London - £29,568
Band 3	Prison Officer	National - £28,122 - £29,611 Outer London - £31,271- £32,926 Inner London £32,911- £34,652
Band 4	Supervising Officers; Physical Education Instructors; Specialist Roles	National - £33,275 Outer London - £36,590 Inner London - £38,316
Band 5	Custodial Managers	National - £36,151 - £37,887 Outer London - £39,315 - £41,202 Inner London - £40,962 - £42,928
Band 7	Head of Function (will include management of a function defined as complex).	National - £52,316 Outer London - £55,631 Inner London - £57,357
Band 8*	Deputy Governor; Head of Group Office	National - £55,457 - £61,003 Outer London - £58,471 - £64,318 Inner London - £60,040 - £66,044

⁴⁷**Operational grading structure:** *Some more complex sites will also have Band 8 staff members as Heads of Function.

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Band 9-11 ⁴⁸	Deputy Governor and Governing Governor grades that have overall responsibility for the running of a prison	£71,027 - £102,329
Band 12	Prison Group Director	National - £121,644 Inner London - £124,959 Outer London - £126, 685

307. Offender Management Units operate within prisons but have a slightly different grading structure to other parts of the prison estate (Figure 12).

Figure 12: Offender Management Unit grading structure

Band	Job Title(s)	Pay Bands (Public Prisons)
Band 2	Records Clerk	National - £24,527 Outer London - £27,842 Inner London - £29,568
Band 3	Case Administrator	National - £28,122 - £29, 611 Outer London - £31,271 - £32,926 Inner London - £32,911 - £34,652
Band 4	Senior Case Administrator; Prison Offender Manager (will include some operational and non-operational posts)	National - £33,275 Outer London - £36,590 Inner London - £38,316
Band 5	OMU Hub Manager	National - £36,151 - £37,887 Outer London - £39,315 - £41,202 Inner London - £40,962 - £42,928
Band 7	Head of OMU Services; Head of OMU Delivery	National - £52,316 Outer London - £55,631 Inner London - £57,357

308. Governing Governors are selected through a selection panel which is conducted at Prison Group Level and not at establishment level. To be eligible

⁴⁸ Some smaller sites (i.e. those with Band 10 Governors) have Band 8 Deputy Governors.

to sit the Governing Governor selection panels the candidate needs to have gained accreditation. This would include accreditation through the Silver Commander⁴⁹ (incident management) process and the Governor Assessment Centre.

4.1.1.2. Observations/Discussion

309. Through my engagement, visits and review of Mr Kebatu's release in error, I have identified two immediate areas of improvement: (A) Line management structures, and (B) Routes for progression/specialism. I consider improvements in these areas necessary to mitigating the risk of releases in error and/or ensuring my recommendations made in the previous section of this report have maximum impact.

Line management structures

310. Leadership at all levels is essential to shaping a positive prison culture and visible line management is necessary to supporting front-line staff. Line management structures should provide both support and routes for escalating concerns. In the context of a prison, staff must feel safe to raise questions and/or concerns and know the appropriate routes for doing so. This is critical to the management of risk.

311. However, during my engagement with prison staff I observed limited visible line-management, and I was told directly by Operational Support Grades that they did not know who their line-manager was. Equally, Custodial Managers, who are the first-line managers in an establishment, made clear that their line-management responsibilities (which can range from 18-30 direct reports), are so broad that their ability to actively supervise junior grades is limited.

312. I was advised by the Prison Learning and Delivery team in HMPPS that this was consistent with the findings of exit surveys, where they understood poor line management capability as one of the primary exit reasons. On examination of the survey results the broader topic of leadership has persisted as one of the three primary reasons people provide for exiting the prison service. It is not specific on the line management point. Based on the significant direct feedback

⁴⁹ The Silver Commander plays a pivotal role in major incidents, as the senior member at the scene, in charge of coordinating the available resources to respond to the incident.

to me I assess it is **likely** to be contributory to the recorded exit outcome. At HMP Chelmsford, where Mr Kebatu was released in error, staff reported feeling comfortable raising process-related issues but were more hesitant about challenging colleagues' behaviour or holding one another to account. This is where visible line management structures should support junior staff.

Progression and specialism

313. The current staffing structures in prisons do not consistently incentivise staff to develop within their role, not least because pay increases are driven by promotion rather than by increasing specialism in the role.
314. For example, staff in Offender Management Units undertake specialist roles and rely on skills and experience to undertake complex tasks daily. However, as currently structured in public prisons, staff in Offender Management Units receive no standardised reward or recognition for developing specialisms or building experience.
315. In private prisons, I have seen an alternative structure that has been designed to reward specialism and experience. For example, HMP Peterborough has implemented different pay grades for staff in Offender Management Units based on experience rather than 'fixed bands'. This sees progression look like:
- A new starter is paid a case administrator salary of £24,570 and within 3 months is expected to complete an online introductory course and Basic Sentence Calculation training. Once completed, their salary will increase to £25,817.72.
 - Within six months from starting in role, a case administrator will then complete their Advanced Sentence Calculation training. Once complete, their salary will increase to the equivalent senior administrator salary of £27,065.90.
 - Case administrators with two to three years' experience may be determined as Custody Administrator Specialists and will see their salary increase to £30,000.

4.1.2.3. Findings

316. Considering the evidence described. **I find:**

- It is **highly likely** that the staffing structures in prisons provide insufficient visible line management to operational support grades. Specifically, the ratio of Custodial Managers to prison officers is so broad that it is **highly likely** they are unable to provide active and effective supervision.
- For staff that work in Offender Management Units, I find it **highly likely** that the units are not structured in a way that adequately reflects the complexity of the work they undertake, and the requirement for them to become specialists in this area
- I find it is **probable** that current structures have led to Offender Management Unit staff working under high pressure, which has resulted in releases in errors. This needs to be considered in accordance with recommendation 15 in section three regarding the Offender Management Units operating model. I am unconvinced that there is a requirement for the sentence calculation specialism in every prison.

4.1.2.4. Recommendations

317. Effective supervision and channels for prison staff to raise concerns are critical to identifying and addressing potential errors before they lead to serious incidents.

318. Therefore, I recommend **within six months**:

- **Recommendation 20:** That HMPPS and the Ministry of Justice examine the balance between their operational model within prison establishments and what resources are based centrally or regionally. The aim should be to:
 - Not replicate services with the Ministry of Justice (department)
 - To maintain nationally or regionally the HMPPS specialist services that may be best placed there (for the purpose of this review to consider regionalisation of sentence calculation and centralisation of Professional Standards). As above, this should be considered in line with recommendation 15 to review the current Offender Management Unit operating model.

- To ensure a focus on the frontline resources within a prison to examine and improve supervisory ratios and enabling an investment in the right place.

4.1.2. Recruitment, Training, & Experience

319. Recruitment and staff training are essential for developing an effective and resilient workforce – regardless of the organisation. Prison staff consistently take on some of the toughest and riskiest jobs in the public sector, and are vital to keeping prisons safe, secure, and focused on rehabilitation.
320. It follows that the recruitment and ensuing training of prison staff should be at the forefront of this Government's efforts to both increase confidence in the justice system and reduce the likelihood of releases in error.

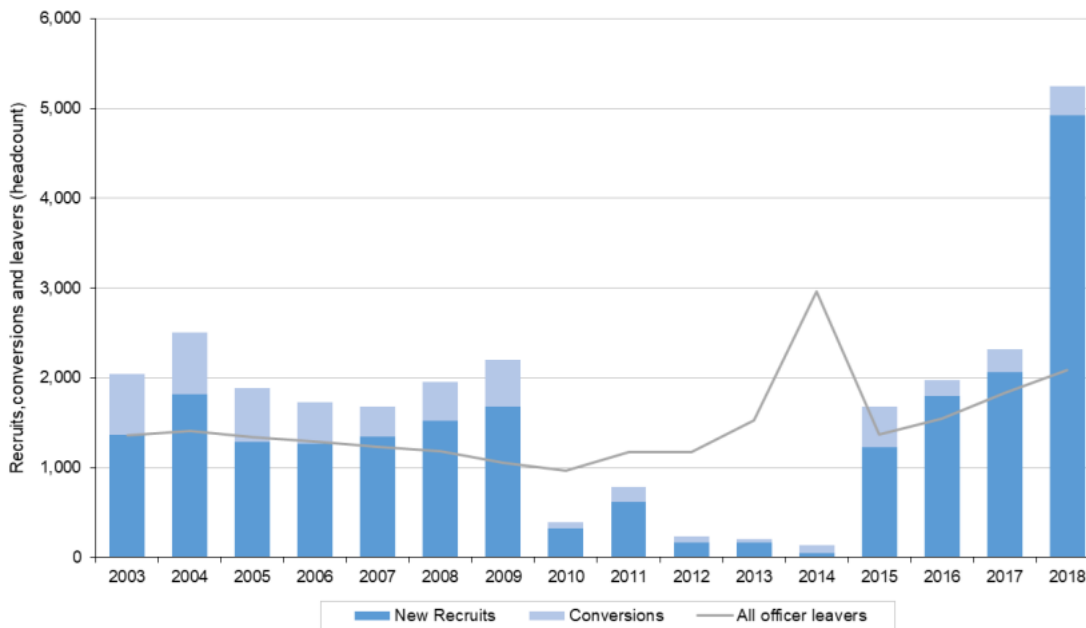
4.1.2.1. Background

Recruitment

321. In 2009 the Prison Service was subject to overarching reform including the introduction of staffing benchmarks. This saw annual intake of prison officers fall, whilst attrition rose from 4.1% in 2010 to 10.0% in 2018 (see Figure 13). In response, in November 2016, the then-Government committed to recruiting an additional 2,500 officers by the end⁵⁰ of 2018 to address safety concerns and support the roll-out of the key worker scheme. To meet this ambition, recruitment was automated and oversight of high-volume campaigns was centralised.

⁵⁰ Prison Safety and Reform, November 2016: <https://assets.publishing.service.gov.uk/media/5a80aa1040f0b62302694ceb/cm-9350-prison-safety-and-reform- web .pdf>

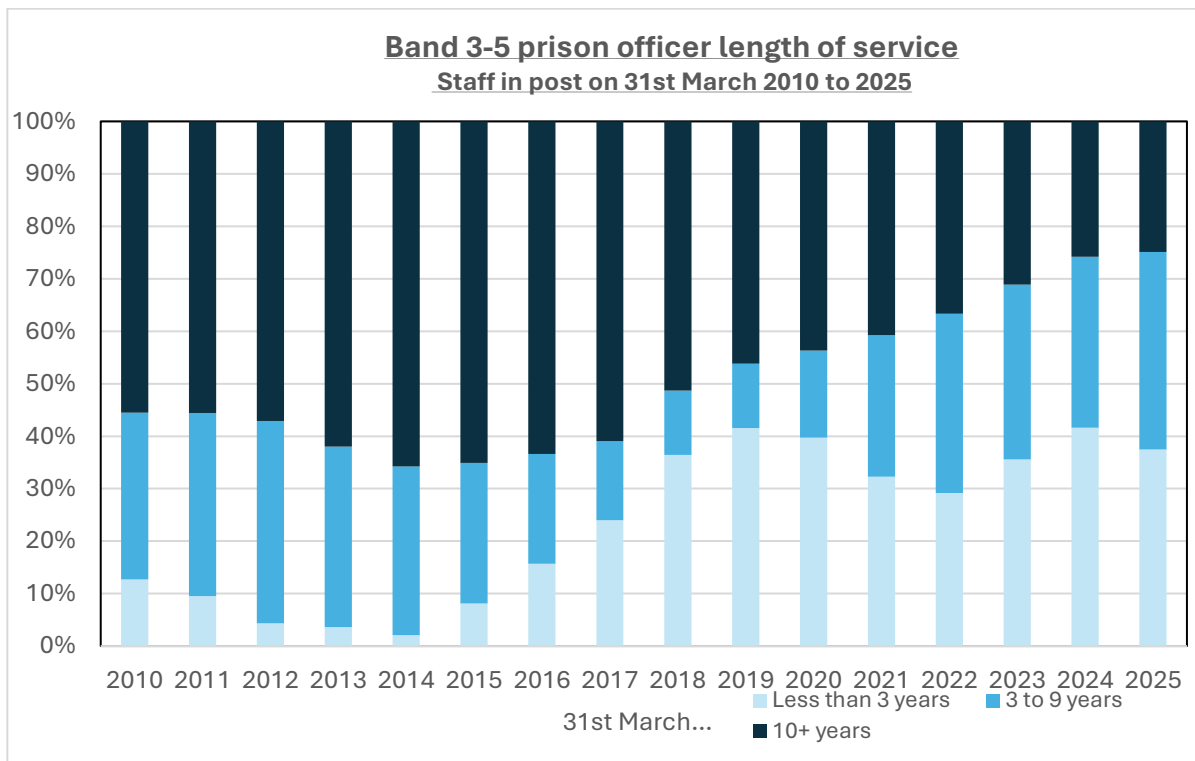
Figure 13: Recruits, conversions and leavers at prison officer level between 2003 – 2018.



Experience

322. Inevitably, the sustained focus on high-volume recruitment in combination with high rates of staff attrition has had a knock-on impact on the experience of the workforce. There has been a decline in the length of service across bands 3-5 in public prisons since 2010 - despite these bands making up the core operational capability of prisons. As of 30 September 2025 (**Figure 14**), 35.7% of band 3-5 prison officers have **fewer** than 3 years of experience (23.0 percentage points higher than March 2010), whilst just under a quarter (24.9%) have 10 years or more service (30.6 percentage points lower than 2010).

Figure 14: Prison officer length of service 2010-2025



Training

- 323. Declining experience makes training even more important. At present, the centralised Prison Learning and Delivery team in the Ministry of Justice is responsible for the design and delivery of training for operational staff in prisons. Courses are delivered both centrally and locally, with 93 courses currently available to HMPPS staff, including initial prison officer training, role-specific training (such as for staff in Offender Management Units) and specialist training (e.g. on specific skills).
- 324. Training for new Prison Officer recruits consists of a seven-week course which introduces them to some of the core principles of the role, such as control, restraint and adjudications. There is currently no pass mark to the foundation training – individuals most simply successfully undertake all the practical elements to finish the programme.⁵¹ Since 2025, first-time Governors can access a structured induction programme which includes sessions with subject matter-experts, mentoring and coaching.

⁵¹ I was advised by Prison Learning and Delivery team that if an individual does not complete all their training, the prison to which they are be deployed may choose to re-grade the individual (e.g., into a non-operational role) or seek to support them to return to training to complete all elements.

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325. For specialist roles there may be additional training required. For example, staff who work in Offender Management Units and who require specialist skills to carry out their roles in the release process are expected to complete additional and mandatory training courses at each grade, including gaining a 'licence to operate' on sentence calculations. For other roles, such as working on reception, staff have the option to undertake additional training, but this is not a requirement. The table below sets out some of the relevant training available to staff in Offender Management Unit and those who work on reception.

Figure 15: Training requirements

Course	Mandatory Training Required	Optional
Sentence Calculation – Licence to Operate: mandatory for staff supporting complex sentence calculations, recalls and adjustments.	Case Admin, Hub Manager and Head of Offender Management Service	
Reception Officer Duties: practical course covering the core processes for prisoner reception and discharge. Staff will learn how to verify warrants, complete essential documentation, assess and manage risks, and process releases accurately.		Reception Officers and staff working in prison reception areas
Defensible Decision Making: training on making sound, defensible decisions during routine operations and emergencies. It ensures decisions are lawful, transparent, and accountable, following the Incident Management Framework.		Orderly Officer

326. Responsibility for training staff largely sits with prison leaders. Custodial Managers, Governors and other senior leaders are expected to identify both their own and their staff's training and development needs and book the

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appropriate training course. The Prison Learning and Delivery team have no central oversight of take up of training locally.

327. Despite sentence calculation training being considered essential for Offender Management Units, self-reported data on training indicates that in November 2025 an estimated 70% (736 out of 1,044) Case Administrators and Senior Case Administrators in post had completed their Sentence Calculation training, and only 57% had completed their advanced sentence calculation course. See figure 16 below.

Figure 16: Rates of Training OMU⁵²

Offender Management Unit staff in post	Totals
Case Admin – Target Staffing Figure	1032
Case Admin – Staff in Post	891
Senior Case Admin – Target Staffing Figure	232
Senior Case Admin – Staff in Post	153
Sentence Calculation Trained – In Post	736
Advanced Sentence Calculation – Staff in Post	600
Additional Staff – Sentence Calculation Trained	181
Additional Staff – Advanced Sentence Calculation Trained	145
Sentence Calculation Trained – Out of Date	142

4.1.2.2. Observations/Discussion

328. Whilst I am aware that HMPPS is piloting an alternative training model for new Prison Officers (including a 15-week course which blends theory with onsite practice and an assessment on suitability), the current view is that the training is lacking. Indeed, from junior prisoner officers to Governors, as well as amongst the Prison Officers Association who I spoke with, the strong feedback

⁵² Figures included in the table showing OMU rates of training have been rounded to the nearest whole number as previously they were presented in full-time equivalent (FTE), so decimals reflect part-time staff or posts funded at less than 1.0 FTE.

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was that the current training provision fails to sufficiently prepare new recruits for the complexities of the job. Added to this, high attrition means new officers have less opportunity now to draw on the expertise of long-standing prison officers.

329. Formal training around discharge procedures has not been available nationally since the introduction of the Custodial Manager role, instead the discharge-related training is embedded within wider courses such as Reception Officer training and Defensible Decision Making. This is despite the process being inherently risky and complicated. I heard first hand from Custodial Managers that they felt ill equipped to conduct release processes and that the requirement to sign off on processes they did not understand left them feeling exposed. This view was confirmed by the Prison Officers Association.
330. In addition to poor provision, there is no means by which, centrally, the Prison Learning and Delivery team can understand or assess whether staff are appropriately trained. The team has limited oversight of the take-up of training across the prison estate, with little understanding of where gaps in capability may exist in different local areas. Instead, training is left entirely to the discretion of prison leaders who are responsible for identifying the training needs of their staff.
331. I have been told that, in times of increased pressure and when resources are stretched, training is often the first thing to go. Last minute cancellations are common. This inevitably presents challenges and associated costs to central teams who must plan the commissioning of training courses in advance.
332. Too often, as a result, training is limited to shadowing, informal coaching and self-directed learning for those who take initiative. This risks leaving staff without the depth of knowledge they need to confidently perform critical and often high-risk tasks.

4.1.2.3. Findings

333. **I find:**

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- That the current training model for prison staff is **highly likely** to be leading to significant gaps in experience and capability across the prison estate. It is **likely** that this has operational and cultural repercussions.
- It is **highly likely** that the lack of training for Custodial Managers, who enact the release process, reduces their ability to be a point of assurance in the process and, instead, increases the likelihood of releases in error.
- The officer engaged in that case, a Custodial Manager, had no formal training and simply had the opportunity to shadow. This is plainly insufficient for such an important task where public safety or public confidence can be jeopardised and was **almost certainly** a contributory factor in Mr Kebatu's release in error.
- It is **likely** that there is insufficient central oversight of training uptake across the HMPPS. Governors will always need an element of discretion (so that they can manage risks within their estate), but they should be provided with products to help them understand who is trained and who is not.

4.1.2.4. Recommendations

334. As action is taken across the service to reduce releases in error, I encourage HMPPS to proactively consider the skills and experience that will be required by staff to take forward these processes confidently.

335. Accordingly, I recommend that **within three months:**

- **Recommendation 21:** That a Custodial Managers course is designed, delivered, and made mandatory for all Custodial Managers, and subject to pass/fail assessment before deployment in role. I recognise that staggering of the course may be necessary at initial implementation, but the medium-term objective should be central oversight and sequencing.

336. I further recommend that **within six months:**

- **Recommendation 22:** HMPPS review their approach to the balance between centralised and localised design, provision and implementation of training.

4.2. Tools and Technology

337. The process of this review has brought into stark realisation the limitations of the tools and technology available in prisons and the wider criminal justice system. In section one, I demonstrated how technological limitations restrict the ability to properly investigate the incidents when they occur. For example, the lack of CCTV audio capability hindered the investigation into the release of Mr Kebatu. In section three, I explored further how the lack of integrated systems contributes to errors.
338. This section explores the impact of this, and the development of new tools designed to mitigate the risk of releases in error in more detail.

4.2.1. Background

Technological capability

339. Against logic, the criminal justice system relies on information that is held on multiple disconnected data management systems; with staff remaining reliant on bundles of paper and manual workarounds in a bid to keep the system functioning. During my site visits, I observed the piles of paperwork that accumulate in busy prison office spaces.

Figure 17: HMP Wormwood Scrubs – Paper document storage



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340. Staff on the front-line are required to move these paper documents around the prison estate to keep pace with prisoners as they transfer between establishments. It is easy to imagine how this lack of digitisation can make a simple process time consuming, inconsistently completed and vulnerable to error.

341. The table below sets out the multiple systems that hold information on offenders, and which are used by different agencies expected to work together across the justice system.

List of Offender case and management information systems

System	Functionality	Used by (Prisons, Courts, Police)
The Police National Computer (PNC)	The Police National Computer (PNC) is a crime information centre and database used by police and is updated when an offender is released from custody.	Police OMU staff cannot directly access PNC, but there is a need for them to have access to these reports from the database.
Police National Database (PND)	The Police National Database (PND) is a national information management system used by police. It allows the Police Service to share, access and search local information electronically. It informs risk assessments and post release management but plays no direct role in authorising or carrying out a release.	Police only
ATLAS	Atlas is the new case working system for managing immigration and asylum applications for the Home Office. It replaced Case Information Database (CID) in 2025, though there are still occasions where the legacy database (CID) is used for information. In the release process this system is used by the Home Office to confirm if an offender is to be deported or if they are still of interest of the Home Office.	Home Office OMU (HMPPS) staff within prisons can access Atlas.
XHIBIT Portal	The XHIBIT Portal is the authorised method for communication of crown court results and bail conditions between HMCTS, police, probation,	Courts, police, probation and prisons

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	prisons and CPS. It allows the criminal justice system partners to access information when it is created by the court to then save or enter on to their own systems. Information is available on the portal for 300 days.	
XHIBIT System	The XHIBIT system is a case management system used by court staff in every crown court in England and Wales to record events and outcomes of the court. The date from XHIBIT is also passed to the XHIBIT Portal, for it to be available to users.	Courts Only
LIBRA	Libra is the Magistrates' Court case management system. It records sentencing and courts outcomes and details of defendants, court cases and outcomes as well as handling the enforcement of fines. It was first introduced in 2003 and is being replaced by Common Platform.	Courts, Police and OMU access OMU staff within prisons can access
Common Platform	<p>Common Platform is a digital case management system developed by HMCTS for the Crown and magistrates' courts in England and Wales. It has brought together different legacy case management systems under a single platform.</p> <p>Police do not have edit case capability on Common Platform; they can only contribute information. Case information is only edited by HMCTS users.</p> <p>In the magistrates' courts judiciary, solicitors and barristers will use the system to view information for their cases but cannot edit case information.</p> <p>Judiciary and barristers in the Crown Court do not use Common Platform, as they use the Digital Case System.</p> <p>Prison OMU staff have access to Common Platform and can see case information and case materials such as warrants and bail documentation.</p>	Courts, Police, and Prisons.
Digital Case System	The Crown Court Digital Case System is used to manage, prepare and present information on cases in the crown court. It is used by HMCTS, the Judiciary and professional court users, including defence solicitors and barristers to	HMCTS, judiciary and professional court users.

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	prepare and manage case files. It contains all case material, and a trial record sheet is uploaded to the Digital Case System as part of the court record Criminal Procedure Rules 5.4.	
Digital Prison System	HMPPS Digital Prison Service provides access to information across prison and probation services; Supports probation officers with better data and case management systems. The first version of this system was first introduced in 2016 and has been updated since. The Digital Prison System is used by staff to record when a prisoner is released, recalled, or transferred, updating the custody status across HMPPS systems. The Digital Prison System also shares release details with probation systems such as NDelius so community supervision can begin as soon as an offender is released. The Digital Prison System will show the critical sentence and release information.	Prisons OMU staff all have access to DPS
NOMIS	In 2004, the National Offender Management Service (NOMS) initiated the creation of the National Offender Management Information System (NOMIS). NOMIS was intended to be a single offender management IT system across prison and probation, replacing existing prison and local probation case management systems with one integrated system. The initiative to introduce a single offender management database was ultimately unsuccessful. NOMIS is an operational database which holds details relating to the offenders which includes type of offence, the type of custody and other relevant personal information. In the release process staff will use NOMIS which holds the sentence structure and lawful release date, confirms eligibility for release and checks for legal barriers, records the release event (type, date, time), changes custody status from in custody to release, drives updates to probation system and the Police National Computer (PNC). The intention is for NOMIS to be replaced by the Digital Prison System in all prisons.	Prisons OMU staff all have access to NOMIS
ViSOR	ViSOR was introduced nationally in 2005 and is a national 'Official Sensitive' database that	Police, Probation and Prison staff

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	<p>supports public protection by facilitating effective sharing of information and intelligence on violent, sexual, terrorist and other dangerous offenders between the three MAPPA Responsible Authority agencies, namely the Prison and Probation services and Police Service (including Counter Terrorism Police). ViSOR also contains records of other nominals such as Serious Organised Crime (SOC) and Potentially Dangerous Persons (PDP) and is used by associated partner agencies including NCA (National Crime Agency) and MOD (Ministry of Defence). There are a limited number of licences to access ViSOR per prison which involves enhanced vetting. These are held by OMU staff and some operatives working in Security departments within Prisons. Before the release of a prisoner agencies use visor to share risk assessments, licence conditions, and supervision plans.</p>	<p>who have a licence to access ViSOR.</p>
<p>NDelius</p>	<p>NDelius, which stands for National Delivery of Information for Users, is a browser system that was introduced in 2012 and is used by the Probation Service as their case management toolkit.</p> <p>It was developed to streamline the flow of information including details relating to pre-sentence assessments, community orders, custodial sentences and post release supervision.</p> <p>Prior to release NDelius records sentence details, risk assessments, licence conditions, and resettlement plans. At release it activates the case in the community, transfers responsibility to a community offender manager, and records release details. used to manage licence supervision. If someone is recalled the details are updated on NDelius which is then shared with other prison systems.</p>	<p>OMU staff within prisons can access NDelius.</p>

342. The casefile review in Chapter 3 evidenced that the simple lack of connectivity and modernisation can lead to an increased risk of error. I have recommended

that a comprehensive and cross-justice system technology strategy is necessary (see pages 104-105).

Tools

343. In addition to technology, staff require the right tools to undertake their duties effectively. Chronic underinvestment has left them with few reliable tools to deal with the demands of their jobs, or to overcome the lack of technological capability.
344. I have identified two notable tools directly linked to the Ministry of Justice and HMPPS' efforts to reduce errors.
- **Calculate Release Date Service:** Introduced in 2024, this tool calculates release dates from data that is inputted by staff into NOMIS. It is an attempt to reduce repetitive manual calculations and address the complexities involved in calculating release dates for prisoners. Officials reported to me that the tool has removed 45% of manual paper calculations that were previously performed by Offender Management Units, and that the tool can support most complex sentence calculations. Roughly 1.5% of the prison population's sentences are not currently covered by the tool. It was reported to me that, based on the bugs reported, the engine's accuracy was 99.996%. However, I was made aware that it is currently used *alongside* paper-based calculations to ensure accuracy and continuity. I understand that the plan is to develop an end-to-end automated digital service.
 - **Release checklists (paper):** Release checklists were updated after Mr Kebatu's release in error and provided to prison staff to complete during the release process. The original revised checklist was designed by HMP Chelmsford in the aftermath of Mr Kebatus' release in error. It was consulted on by HMPPS, and I am aware that there have been two revisions since. It is notable that staff at HMP Chelmsford fed back to me that the checklist included a lot of 'irrelevant' questions and caused further confusion. Whilst the checklist was intended to be implemented nationally, I observed

variations in other prisons I visited. HMP Wormwood Scrubs, for example, insisted that their revised checklist was far better.

345. I was also made aware, during my review, of new tools in development and/or in the pilot stage. These include:

- **A smart inbox:** This is intended to enable AI-assisted routing of court warrants to the appropriate establishment and is designed to assist with the manual triaging of large volumes of information that is currently undertaken by Offender Management Units. Early testing of the smart inbox at HMP Wandsworth identified 15 warrants that had been sent to the wrong establishment per day during the first full week of testing.
- **Alias checker:** This aims to improve the accuracy of offender identification by detecting duplicates, known aliases or misspellings across prison-record systems and flagging them to frontline staff. There are plans to expand this beyond prison systems and to link the checker with Common Platform. This would remove the need for staff to manually search Common Platform for each alias.
- **Secure AI chatbot:** This will provide instant guidance on current sentencing policy to support Offender Management Units with their work. I understand the chatbot has been evaluated by a set of sentence calculation experts and is in the process of being refined and its accuracy improved ahead of a wider rollout.

4.2.2. Observations/Discussion

346. The technological deficit has created an ongoing problem that is simple enough to understand: The justice system relies on staff to deliver accuracy within a system built from old, unlinked platforms, paperwork and requiring repeated manual data entry. The Internal Government Audit review into the prisons and courts interface in November 2025 described exactly this issue – multiple systems including legacy in play and with no interface between them, whilst the same facts are inputted repeatedly with limited checks or validation of this data. Enabling staff with the right tools and technology to function in the current operating context is essential to addressing releases in error and equally

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provides opportunities to increase the efficiency with which services are delivered.

347. When questions are being asked publicly it is understandable that emergency action is taken to try and prevent reoccurrence. However, rather than addressing the underlying problem of an unintegrated technology system, what I have observed is the adoption of short-term fixes that do not resolve the core issues, and in some cases, add further complexity to an already complicated release process.
348. For example, staff reported that the new release checklist created confusion rather than clarity and was disempowering. Whilst I recognise that there have been anecdotal accounts given of where the prompts on the checklist helped to spot risk – including claims that they prevented separate releases in error of Foreign National Offenders at HMP Pentonville and HMP Onley, the overall effect appears, to be to shift solutions to the end of the process.
349. The introduction of the Calculate Release Date Service is an attempt to reduce repetitive manual calculations and systemise complexity, and a step in the right direction. However, as the service remains limited by its reliance on manual data entry into NOMIS, its accuracy will only ever be as good as the data entered. At the time of writing this report, I have not received persuasive evidence that the tool is yet serving to reduce errors. Instead, it appears to me that whilst the tool may be helpful it should not be considered a substitution for a fully integrated system that provides Offender Management Units with reliable data.
350. The additional pilot work I have outlined above are green shoots of innovation. However, I anticipate that all these tools will provide only incremental progress without an overarching strategic approach taken to address the current lack of technological capability (as per my recommendation 17, see above paragraph 265). I see all these tools as sticking plasters until the wider systemic issues I outline in full in this report are addressed in earnest.
351. For example, the smart inbox may provide a pragmatic and temporary solution, at least until a more sustainable solution to manage unwieldy Offender

Management Unit inboxes and to improve joint-working between the HMCTS and HMPPS is identified (as per recommendation 15).

352. The alias checker addresses another common point of failure. However, I expect that the success of this tool will rely on it being accessible across the breadth of systems that hold information on offenders. I anticipate that the value of this tool would grow exponentially if it was extended immediately beyond prisons and, eventually, becomes the spine for tracking single identities across the entire justice system - from arrest to release (as per recommendation 19 regarding the use of biometrics across the system). Finally, whilst the secure AI-chatbot may serve to provide quick and consistent advice on complicated sentencing policy, I suggest that efforts should be focused first on implementing my recommendations to reduce sentence miscalculations as set out in the third section of this report, rather than on providing operational staff yet more advice.
353. Taken together, the rising will I have observed to develop technological solutions is encouraging. However, the path to truly reducing the likelihood of releases in errors is **not likely** to be more checks and balances. Instead, it will inevitably rely on facilitating connected technology and deliberately designing join-up between systems.

4.2.3. Findings

354. **Considering all the above I find that:**

- Whilst I understand why emergency actions were taken and why a paper checklist may have seemed sensible in the absence of strong digital solutions, I find it is **likely** that these are giving false reassurance as neither Governors nor Custodial Managers are expert in the complexity of sentence calculation.
- The development of the new tools I have explored will **likely** offer some clear benefits and reduce releases in error.
- However, I consider them to be short-term, narrowly focussed solutions. I find it is **almost certain** that they do not address the fundamental issue: the lack of digitalisation and interconnectivity of systems across the criminal justice system.

- It is **highly likely** that without innovation in technology and a broader, system wide approach, these measures risk being incremental and helpful sticking plasters rather than transformative.

4.2.4. Recommendations

355. As a result, I make the following recommendations that should be implemented **within six months**:

- **Recommendation 23:** That the further development or rollout of new tools to plug gaps in current technological capability of the estate are continued only as part of a longer-term and over-arching technology and data strategy as per my recommendation 17. This includes the development of the CRDS tool and any AI solutions that the Ministry of Justice chooses to rollout more widely.
- **Recommendation 24:** It is my belief that the need for a checklist will diminish if the other recommendations within this report are acted upon at pace. I therefore recommend that, HMPPS establish, with candour, the value of Governor checks. A better use of their time may be to concentrate on developing a '*getting it right first time*' culture.

356. I further recommend that:

- **Recommendation 25:** The Ministry of Justice accelerator funding should continue to focus on identifying if AI can provide a temporary solution to the more effective management of unwieldy inboxes in Offender Management Units.

4.3. Data and Transparency

357. In any service accurate information, data and analysis is essential. This is particularly the case in public services that have the responsibility to keep the public safe and secure the administration of justice. Senior operational leaders need data to help them, strategically, tactically and operationally, to understand if they are performing well in the provision of their public service. In the same vein, good quality products help to inform leaders and the Government on the risk they are holding - enabling strategic choices on matters, ranging from resourcing, technology or even risk acceptance or tolerance. Published data also informs the public and is an important part of transparency and accountability.

358. Notwithstanding this, section three of this report was explicit in my view that the data on releases on error, as stands, is starkly limited. In undertaking this review, it has become clear that the data available is both:

- Limiting the Ministry of Justice and HMPPS's full understanding of the extent of releases in error, the root causes, and the systemic issues that are facilitating these errors.
- Preventing the Ministry of Justice and HMPPS from properly ascertaining the risk that these errors present to the public.

359. As per my terms of reference, this section tackles the collection and publication of data on releases in error in more detail and makes recommendations for improvements.

4.3.1. Background

360. When a prison identifies a release in error, they must report the incident in three ways:

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- To the National Incident Management Unit telephone reporting line;
 - Via an Incident Reporting System inbuilt into the National Offender Management Information System (NOMIS); and
 - By completing a standardised proforma which is sent to the Release Accuracy Support Unit in HMPPS for any further necessary investigations.
361. The information collected via the Incident Reporting System is then published annually in the HMPPS Annual Digest. This publication provides performance data across prisons and probation over a 12-month period,⁵³ and includes monthly management information on the number of releases in error reported by prisons. It does not include data on releases in error identified and subsequently apprehended at the court stage. Equally, and as I have already made explicitly clear, this data only provides a picture on the releases in error that are reported and captures the minimum that there may, in fact, be.
362. The data published in the Digest is accompanied by a narrative that summarises the trends and provides a brief assessment of the issue. In the publication of data on releases in error reported in the 12 months to March 2025, the publication stated:
- “Releases in error remain infrequent. The rise [in this year] is believed to be linked to the requirement of Offender Management Units to digest and implement a range of operational and legislative changes. The rise in this year also partly reflects a number of offenders who were released in error in the first tranche of SDS40 due to an issue with a repealed Breach of Restraining Order offence, which was swiftly identified and corrected with legislation.”*
363. I have been told that this data is published in full compliance with the principles set out in the Code of Practice for Statistics. However, whilst I was reassured that the data is reviewed by operational and policy leads to “*ensure accurate and consistent messaging*”, the process by which the accompanying narrative is agreed and signed off at senior levels remained opaque.
364. Where considered necessary, the Department may also publish ad hoc data on releases in error. There was an ad hoc data publication most recently in

⁵³ HMPPS Annual Digest; where data on releases in error is published [HMPPS Annual Digest 2024 to 2025 - GOV.UK](#)

November 2025, following the Deputy Prime Minister's statement to the House of Parliament on releases in error.

365. Whilst consideration of unlawful detentions is outside the scope of my terms of reference for this review, it is notable that data on unlawful detentions is not currently disaggregated from the information collected via the Incident Reporting System. This data is therefore not published in the Annual Digest.

4.3.2. Observations/Discussion

366. I have already been clear on the limitations of the data as currently published and, specifically, the lack of built-in systematic processes to audit releases.
367. It is important to reiterate here, in this chapter on data and transparency, my concern about the Government's continued reliance on published data on releases in error – particularly when using it to make public statements about the scale of the issue. Drawing conclusions from ad-hoc data should be approached with caution; otherwise, the Government risks the perception of selectively choosing periods to support a preferred narrative. Relying on data that is fundamentally ill-suited to providing an understanding of either prevalence or trends ultimately undermines, rather than supports, genuine transparency.
368. Beyond the limitations of the data for providing an accurate picture of the extent of releases in error, the data as currently collected also allows no meaningful route to analysing the causes, and thus the issues leading to releases in error, nor the gravity of those errors.
369. As I explored in my case-file review, not all errors carry the same level of risk or gravity: some are substantive with clear potential for harm, whilst others are administrative and pose less concern (albeit they are still a fundamental misadministration of justice). The data as currently collected does not allow for these distinctions to be made and, instead, collapses this nuance into a single headline figure.
370. This prevents meaningful analysis of patterns, underlying causes, or levels of public exposure to different risks because of releases in error. Without the ability to break the data down by type, seriousness, contributing factors, and

operational context, the system - and therefore senior decision-makers – may be largely unaware of the areas of greatest concern. This will inhibit senior leaders' ability to identify solutions and assess their impact.

371. It is possible that, as a result, the main feedback received about any measures implemented to tackle releases in error and relied on for future decision-making will be solely operational and anecdotal, rather than data-backed evidence. This may be limiting the ability of leaders to make effective decisions and to neutrally assess frontline feedback on any action taken.
372. The dataset also provides no way of capturing or analysing the converse issue: unlawful detentions. These cases are the direct counterpart to releases in error and carry their own significant impacts- both financial and legal. ⁵⁴Any credible effort to improve transparency and oversight must necessarily include both sides of the coin, to ensure that action taken to reduce releases in error does not inadvertently increase the other.
373. I wish to be clear that the alternative cannot lay more reliance on the current system of proformas - standardised free text forms that are completed by individual prisons (**Annex I**). The quality of these forms varies significantly and is, frequently, based on an individual interpretation of what went wrong.

4.3.3. Findings

374. Considering all I have outlined above, **I find:**
- That there is currently no proper understanding of the true extent of risk presented by releases in error.
 - The absence of high quality, reliable and consistent data as it relates to releases in error is, **highly likely** to have influenced the lack of attention to it and limited the Department's understanding. As a result, it is almost certain that releases in error remain managed at an operational and tactical level with well-meaning but often minor or ineffective tweaks, with inefficient strategic, cross system attention to the issues detailed in this report as requiring urgent attention.
-

- That unlawful detention and release in error are two sides of the same coin. It is **highly likely** that unlawful detentions present material financial and reputational risks for HMPPS because compensation claims under Common Law and the Human Rights Act can result in substantial payouts. Data on unlawful detentions should therefore be considered with the same scrutiny as releases in error.

4.3.4 Recommendations

375. In light of my above findings, I recommend that **within six months**:

- **Recommendation 26:** As the current statistics do not adequately reflect the totality of releases in error, the Ministry of Justice, HMPPS and the Office for National Statistics should undertake a wider piece of work on the data on releases in error and come forward with a proposal to ensure that statistics provided to Ministry of Justice seniors, Ministers and the public are reliable and assured. This will need to consider what ongoing investment is required to improve the quality of data collection. Data on unlawful detentions should be included as part of this proposal. In full, this proposal should address:
 - A methodology to quantify the **likely “true” rate of release**
 - Transparency: Being clear with the public on any limitations.
 - Data Analysis: How the data is disaggregated to assess the risk.
 - Release Audit: The frequency of this and by whom it is undertaken.
 - Categorisation: I have been clear that there is a distinction between errors that present public risk of harm and errors that could be considered administrative error. Any project should draw formal definitions for each and consult on them, including with the victim sector.
 - Risk to public: The Government should also consider how best and frequently to communicate to the public how many offenders who present a public risk remain at large.
 - Demographic data: to better understand if there is any systemised bias.

4.5. Governance, audit and performance

376. Together, the Ministry of Justice and HMPPS serve to administer justice, punish and rehabilitate offenders, and protect the public. Releases in error undermine this function and, thus, constitute both a risk and an issue. Used effectively, audit and performance processes in combination with governance arrangements should serve to monitor risks and issues, and direct mitigatory action where necessary. As part of this review, I have examined these processes and considered their effectiveness for monitoring and mitigating releases in error.
377. Understanding the processes by which the Ministry of Justice and HMPPS undertake governance, audit and assess performance has not been easy. Overwhelmingly I have observed a cobweb of interdependent and duplicative governance frameworks across both the Ministry of Justice and HMPPS - many of which are differentiated by membership rather than purpose. The breadcrumb trail of minutes and inconsistent terms of reference that I followed, inevitably, made it difficult to gain full clarity on these processes. This section speaks to what I have gathered from this exercise.

4.5.1. Background

378. Audits, performance frameworks and inspections help to identify operational failures and to highlight and address poor performance. Accepting that not all risks can be completely mitigated, it may be unrealistic to expect that all releases in error will be prevented.
379. However, this makes it more important - not less - to have clear governance arrangements, supported by performance monitoring and audit processes. This is essential to ensuring oversight of releases in error, and to keeping the level of error within an accepted and agreed tolerance level. This is basic performance and risk management - both of which are fundamental functions of any large, operational organisation and, considering its purpose, *core* to the running of HMPPS.

Performance Frameworks

380. Prison performance is formally assessed via the Prison Performance Framework,⁵⁵ which is owned and managed by HMPPS. The framework consists of 34-outcome focused measures across six domains: Safety, security, respect, purposeful activity, preparation for release, and organisational effectiveness. Most measures operate on a 'performance against target' basis. Each prison then receives an overall performance rating derived from a weighted aggregation of all measures, with total weights summing to 100%. Performance is then rated on a four-point scale, from serious concern (1) to outstanding performance (4).
381. Release in error is measured through this framework (code CU118) and under the security domain. However, it is weighted at 0% for all prison-types, meaning it does not affect an establishment's overall rating. Whilst the HMPPS year-end moderation process now allows elevated release in error scores to be considered, I understand that no prison has been moderated down a performance rating based on release in errors alone. I appreciate that the Prison Performance Committee, who are responsible for the Prison Performance Framework, have discussed releases in error periodically.

Audit

382. The material I have received to inform my review shows that the last significant consideration of releases in error occurred in May 2021, when the then Prison Group Director for East Midlands, led the aforementioned 'Root Cause Analysis Review' into releases in error. This followed a serious incident in which an individual who was released in error went on to commit sexual offences whilst in the community. The review made 26 recommendations (set out in Annex J) and a 'Release in Error' project group was established to implement the recommendations.
383. Whilst some changes were pursued, many of the systemic concerns raised in the Root Cause Analysis (e.g., data quality, clarity and oversight) remain issues, as is evident in the findings of my review. It is notable that the project was

⁵⁵ [Annual Prison Performance Ratings Guide 2024/25 - GOV.UK](#)

moved into 'business as usual' activity in March 2023. Key risks remained outstanding, initially transferred to the East Midlands Area Executive Director's risk register⁵⁶ and since to the Risk Register managed by Director General of Operations in HMPPS.

384. In November 2025, the Government Internal Audit Agency issued a joint HMCTS and HMPPS audit of warrants and sentence calculations. The audit found that the heavily manual and non-integrated process at the interface between courts and prisons was driving errors in a pressurised operational context. It noted the likelihood for errors was further exacerbated by high amendment rates to imprisonment orders, the requirement for relatively junior staff to undertake high-risk tasks, and poor data collection on incidents. The Government Internal Audit Agency determined that the audit provided 'limited assurance' and identified significant weaknesses that mean the system could be, or could become, ineffective. Many of these weaknesses have been drawn out already in this report, and I have provided precise recommendations to address them. See Annex K for the Government Internal Audit Agency's full recommendations.

Inspections

385. Prisons are subject to a mix of internal HMPPS-led audits and external, independent scrutiny by His Majesty's Inspectorate of Prisons, as well as the Prisons and Probation Ombudsman and the Independent Monitoring Boards. HM Inspectorate of Prisons inspects all prisons once every five years (or more frequently where risk is considered higher) and assesses performance against the standards that the HM Inspectorate of Prisons considers essential ('expectations').
386. Releases in error do not currently appear to form a part of the inspection regime. To date, neither HM Inspectorate of Prisons, nor the Prisons and Probation Ombudsman have specifically focused on the release process or

⁵⁶ The Release in Error Project Closure Report from December 2023 sets out that Release in Error was transferred to the East Midlands Area Executive Director's risk register. It has been confirmed that following the scheduled Q1 July 2025 review Release in Error was escalated to the Lord Chancellors Quarterly Recess Risk Register managed by DG Operations.

releases in error as a sustained line of inquiry.⁵⁷ The Independent Monitoring Boards operate under the National Monitoring Framework which is agreed by Ministers and currently has no oversight of release in error.

Governance and risk-management

387. Governance should connect the processes and outcomes of inspection, audit, and performance management. It should ensure that these processes run regularly, translate findings or 'scores' into operational change, and provide a line of accountability.
388. At the top of the Ministry of Justice and HMPPS' governance structures sits the Ministry of Justice Departmental Board which is chaired by the Lord Chancellor and attended by senior leaders across the Department, including the Chief Executive Officer of HMPPS. The board has responsibility for checking progress against delivery of the Ministry of Justice's performance indicators and seeking assurance from the Department's sponsored bodies.
389. **Figure 18** sets out the governing structure of HMPPS. To summarise: The overall performance, delivery and financial management of HMPPS is overseen by the HMPPS Leadership Team - who meet bi-monthly to address issues and makes decisions on matters likely to have a significant impact on the core business over the medium to long term. The Audit and Risk Assurance Committee⁵⁸ reviews risk, governance and controls quarterly, whereas the Prison Performance Committee supports the HM Inspectorate of Prisons Urgent Notification process and has authority to make day-to-day decisions regarding prison performance.
390. Alongside this, HMCTS and HMPPS have established the Joint Criminal Courts Improvement Board to review issues at the court-prison interface. Regionally, Areas Executive Directors (introduced in October 2023) are expected to make devolved decisions that impact frontline service deliver. I discussed the introduction of the Area Executive Director model and associated governance structures directly with Governors during a roundtable I held and the feedback

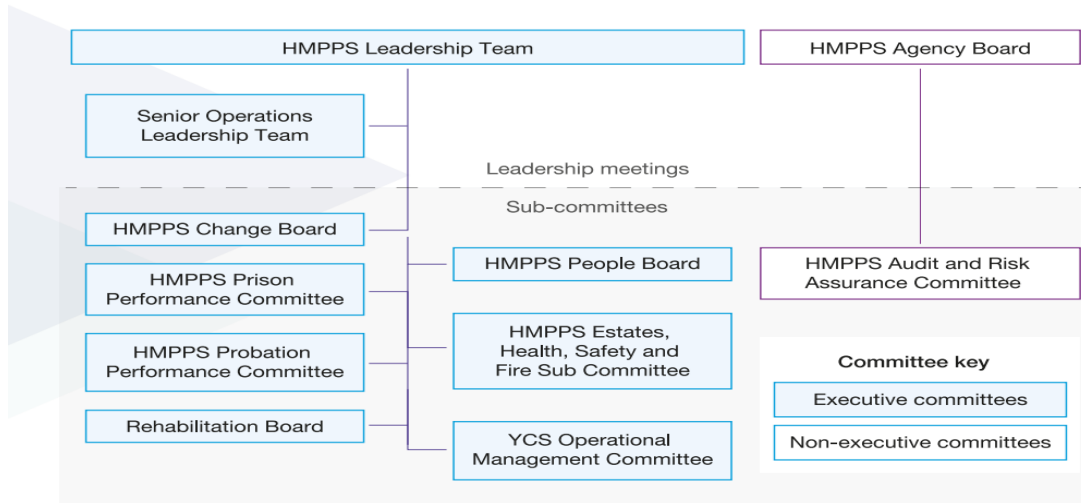
⁵⁷ Although HMIP have not specifically focussed inspections on releases in error they have previously highlighted concerns in relation to the operation of Offender Management Units, Releases in Error and Unlawful Detention. In one notable case this contributed to the awarding of an Urgent Notification at HMP Pentonville.

⁵⁸ The Audit Risk and Assurance Committee is chaired by an Independent External Chair usually appointed for an initial period of three years (with ability for extension of up to three years if agreed by the Chief Executive HMPPS)

on their effectiveness was mixed. Prison Group Directors report to Area Executive Directors and oversee Prison Governors - who are responsible for leading and managing their senior management teams at establishment level.

Figure 18: HMPPS Governance Structures

The key governance structures in place as of 31 March 2025 are shown below.



391. I was advised that there are formal bilateral governance processes in place, intended to address performance issues at a local level. These governance arrangements are meant to include monitoring and responding to risks such as release-in-error incidents, alongside wider operational challenges.

392. In practice, it appears that release in error has been raised intermittently across these forums. Notably, the Audit and Risk Assurance Committee discussed release in error on 4 November 2025, after Mr Kebatu’s high-profile release.

4.5.2. Discussion/Observations

393. I’ve been clear that an effective combination of audits, performance frameworks and governance arrangements should provide assurance to senior leaders on performance, monitor the implementation of improvements, and ensure active management of risks and issues.

394. The Ministry of Justice and HMPPS appear to have all the structures in place - inspection, performance, audit processes and governance - but, at present, I do not believe they are effectively converging to provide oversight of releases in error.

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395. For example, whilst the current inspection regime of prisons considers many important matters that are integral to the safe and secure running of the custodial estate, it does not routinely examine the release process. If the release process is never inspected, assurance on its suitability will remain reactive. The current performance framework tells a similar story. Releases in error are measured but the ranking carries no weight in the Prison Performance Framework. Even with the adjusted moderation route, no prison has been moderated down because of releases in error alone. This appears confused - the framework at once acknowledges releases in error as an issue, and yet does nothing to incentivise improvements.
396. Similarly audits undertaken by the Department have been sporadic and, seemingly, prompted by high-profile cases rather than proactive attempts to grip and monitor the issue. The Ministry of Justice and HMPPS' attention has not remained consistent on addressing these issues. The transfer of the Release in Error project that followed the 2021 Review into business-as-usual activity in March 2023 served to lower the profile of the issue and strategic attention to it. This move, in combination with the Release Accuracy Support Unit transfer to Area Executive Director oversight, transitioned the Department's action to the operational/tactical end of what must also be considered a strategic and systemic problem - without the analytical capacity or cross-system levers to address it.
397. And, finally, whilst much governance exists and meets regularly, upon my own investigation I found that releases in error tend to surface as sub-items on broader agendas rather than as specific, dedicated topics for consideration. Indeed, the attention of HMPPS' Audit and Risk Committee turned to the issue on 4 November appeared to follow the release in error of Mr Kebatu. The subsequent action for the Release Support Accuracy Unit to "*monitor the effectiveness of measures being put in place to restore release in error levels to historic error rates*" and to "*add this topic to the Audit and Risk Committee forward view for later review*" implies that release in error was not actively considered before this point.
398. The Criminal Courts Improvement Board focused on the interface between courts and prisons, where I have noted a high propensity for errors to occur

throughout the course of this review, is a welcome addition to the governance flora. However, I remain unconvinced that the Board is appropriately positioned to deliver the meaningful change required. In particular, it lacks the strategic authority and senior leader buy-in needed to resolve long standing issues - namely the persistent communication gaps between the prisons and courts.

399. In section three of this report, I found that neither the Ministry of Justice nor HMPPS have undertaken any meaningful analysis to quantify the risk presented by these releases in error. Ultimately, I expect that most governance will be ineffective considering the current lack of a quantified level of risk. Without an understanding of the risk presented by releases in error, the Ministry of Justice and HMPPS have no means by which they can properly judge the severity of the issue, agree a tolerated risk level, and then hold the system accountable to progress.
400. This all matters for the purpose of providing accurate and timely briefing to Ministers and enabling them to assure themselves that strategic risks - particularly those where there is an associated risk to the public - are being appropriately managed. Indeed, I have had access to several briefing notes from HMPPS into Ministerial offices in which release in error was described, factually, as a risk arising from different early release schemes, rather than as the result of wider systemic issues.
401. For example, in December 2024 a lengthy briefing note was supplied to the Minister of State for Prisons, Probation and Reducing Reoffending at the request of the Director General of Operations on the narrow topic of releases in error.⁵⁹ It was a factual update that sought no decisions, nor did it draw out the requirement for Ministerial or inter-Governmental attention to the more strategic issues this review has highlighted, although it did outline the activity underway to mitigate the risks of releases in error and that: *“releases in error can be discovered some time after the actual release date therefore data can fluctuate”*. In response, the Minister asked for a quarterly update on releases in error trends. There was a later written briefing on the 7 February 2025. This note is recorded as *“for noting”* and, whilst candid, appeared to present the

⁵⁹ The briefing is an internal document provided by the Release Accuracy Support Unit to the Minister of State for Prisons, Probation and Reducing Reoffending.

issue through a narrow lens. Despite Ministerial interest and the right questions being asked, this did not apparently lead to an exploration of the cross-system issues that would be necessary to affect the needed reduction in releases in error.

402. The Ministry of Justice and HMPPS will want to reflect on their reticence to provide more explicit advice that addresses the cross-system issues. I have neither found nor been supplied with any briefing material that appears to have informed or asked Ministers about their tolerance for risk in respect of release in error.

4.5.3. Findings

403. **I find that:**

- **It is likely that**, whilst releases in error are a known risk within HMPPS and the Ministry of Justice's profile, the attention it received has diminished over time. I can find no Ministerial involvement in that deprioritisation and, when the Minister of State for Prisons, Probation and Reducing Reoffending was provided with a fuller briefing its careful tone and narrow framing could have been interpreted as the matter being fully in hand.
- On account of the fact that neither the Ministry of Justice nor HMPPS have undertaken any meaningful analysis to quantify the risk presented by releases in error (as per my finding in the analysis section of the review on page 77), **it is highly likely** that neither have they agreed a 'risk level' for the purpose of active risk-management processes nor sought to gain Ministerial agreement on a tolerated 'level' of risk.
- I am struck by the unclear line of responsibilities between the Ministry of Justice and HMPPS with some replicated functions that **are likely** to lead to inefficiency and ineffectiveness. **It is likely** that these structural issues, lead to gaps in strategic oversight and responsibility.

4.5.4. Recommendations

404. To resolve these issues, I recommend that **within 12 months:**

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- **Recommendation 27:** Once the Ministry of Justice and HMPPS have agreed a more considered and reliable plan for collecting and using the data on releases in error (as per recommendation 26), the Ministry of Justice should seek to quantify the level of risk that this presents to the public as a result. This should be presented to Ministers, who should agree a ‘tolerable’ level (both in terms of volume and gravity) of releases in error (and unlawful detentions), and what escalation routes should be utilised if that risk level is approaching or breached. Notably the advice should reflect on the views of victims and communities who may have a likely low tolerance for any risk.

405. And I further recommend within **six months**:

- **Recommendation 28:** Pending a fuller Criminal Justice System strategy, Government should revisit the performance framework for HMPPS and assure themselves it reflects their current priorities AND that well analysed data products exist to support it.

406. And I further recommend that within **three months**:

- **Recommendation 29:** The Ministry of Justice and HMPPS should review their internal audit capacity to provide assurance including direction against the prison performance framework.
- **Recommendation 30:** The Ministry of Justice and HMPPS to consider, with HMIP, whether RIE and unlawful detention should be part of the inspection regime.

4.6. Culture

407. In the case of Mr Kebatu's release in error we saw directly how, whilst concerns were raised with a senior, this did not result in the right course of action. This prompted me to consider the culture of the prison service. Feeling able to speak up and express concerns is often indicative of an organisation's internal culture.
408. I take culture to mean the implicit and explicit factors that shape accountability, communication, learning, structures and senior decision making, as well as the day-to-day realities of frontline work. It dictates the operational context - what gets attention, what gets delayed, what gets escalated - and it is shaped by that context in return.
409. In the context of the criminal justice system, where the risks are high and the pressure is constant, this two-way traffic between culture and the operational context serves either to build resilience or bake in vulnerability.

4.6.1. Background

410. In 2023, HMPPS acknowledged that cultural weaknesses were undermining professional standards and commissioned Jennifer Rademaker, a Non-Executive Director, to review organisational culture and propose reforms.
411. The report, which was commissioned October 2023 and finalised October 2024, reported: bullying, harassment, discrimination (BHD) and victimisation, fear of speaking out and perceived retaliation, normalisation of poor behaviour, and power imbalances that were seen to inhibit fair process.
412. Whilst all recommendations were accepted, ultimately implementation has taken time. For example, the update to sexual harassment guidance is expected to be implemented towards the end of March. Whilst I acknowledge that some have questioned the value and uptake of the national staff survey, the early 2025 results suggest limited improvement has been made.

4.6.2. Discussions/Observations

413. First, I want to make explicitly clear that at every level of the system I have observed a willingness to engage in the issue. Whilst senior leaders across the Ministry of Justice and HMPPS have varied in their assessment of the

seriousness (influenced, in no small part, by the dearth of data and analysis), all have made clear their desire to protect the public and ensure the proper administration of justice.

414. Frontline staff at HMP Chelmsford, in particular, were candid about the embarrassment and public concern caused by Mr Kebatu's release in error, and clear in their desire to do better. Many of them live in the vicinity and found it hard to justify their pride in their profession in this context. Their commitment is not in doubt. What releases in error reveal, however, is a culture under strain. Throughout my review I observed the patterns outlined in this chapter recur.

A culture of scarcity

415. The criminal justice system operates in a context of tight fiscal, capacity and capability constraints. The consequence of scarcity is that decisions are necessarily triaged and prioritised. Through this review I have seen examples such as training deferred and analytical support focussed in other areas. Alongside this, and in the context of technology, scarcity has shown up as a continued reliance on unconnected legacy systems and paper files.
416. This appears to have led to the growing sense that errors are unavoidable in the operating context. Indeed, throughout the process of undertaking this review I repeatedly heard a variation of the phrase "there is no money". Not all solutions need new monies and there are leadership responsibilities to corral resources at disposal in any event. The Department appears to have focussed on what they considered to be the most significant risk, namely the prison capacity crisis. I am concerned about the consequences of this cultural response for two reasons - firstly it means I cannot find the strategic decision to resolve or tolerate the risk of releases in error (within the bounds of reasonableness) and secondly, this may be encouraging a complacency. Poor performance can be accepted as the norm and, over time, the apparent impotence is minimising escalation of the right issues.
417. This is not to ignore that the justice system is creaking under the sustained pressure of increased demand or suggested underinvestment. The critical point I am making is that a culture of scarcity risks staff - from the frontline to senior decision makers - feeling that improvement is futile and risks the organisation

becoming self-limiting. This ultimately increases the likelihood that systemic weaknesses remain unaddressed, elevating risk to public safety.

A culture of reactivity

418. Throughout this review I have observed a reactive rather than proactive culture - with the frontline feeling this keenly.
419. Attention at governance forums increased after high-profile incidents such as the release in error of Mr Kebatu; checks are implemented at the end of a process; and the weak and limited dataset is acknowledged but not proactively improved to enable targeted improvements. Focusing on disciplinary measures after incidents occur rather than implementing systemic prevention and improvement strategies perpetuates operational weaknesses and increases the risk of releases in error
420. Overarchingly, I have observed the response to releases in error tilt towards quick, immediate fixes, with limited success or potential, as opposed to long-term planning which will lead to sustainable resolution. To be clear, this is not to criticise individuals working hard within the system rather to highlight a culture of reactivity and short-termism.

A culture of risk tolerance

421. I have observed over the course of this review an instinct to reassure. It has been said to me that there are concerns about causing public alarm, with implications for confidence. Exposure to risk - such as HMPPS is daily - can lead to increased tolerance. However, a low number of high-risk incidents should not be confused with a conclusion that releases in error present a low total risk. It is integral that the Government attempts to openly quantify the current risk presented by releases in error and agree thresholds of tolerance.
422. Quantification of risk should not be focused too narrowly. Indeed, I have been surprised at the lack of attention to the impact of these errors on 'public confidence' in my discussions with seniors across the system. An overly narrow focus on 'risk' defined via reoffending rates misses that public confidence in the justice system is equally integral to its functioning.

423. Thorough analysis and comprehensive briefings are integral to enabling Ministers to confidently assure themselves on the totality of risk and enable the prioritisation of limited resources across the system. This report presents the opportunity for the Ministry of Justice and HMPPS to proactively engage Ministers openly and frankly on longstanding issues.

Impact

424. Put together, these explicit and implicit cultural dynamics create a loop: A culture of scarcity drives reactivity which, in turn, encourages risk tolerance. Taken together these dampen the case for change, resulting in more scarcity.

425. Releases in error sit inside this loop. I hope that this review has made explicitly clear that they are a signal of the systemic failures within the operating context and the cultural conditions that creates, as much as they are the result of individual human error.

4.6.3. Findings

426. I find that:

- A culture of scarcity is **likely** to be stalling improvements and leading to reticence to 'do more'.
- A culture of reactivity is **highly likely** to be preventing strategic decisions and focusing attention on downstream fixes rather than the systemic issues.
- It is **possible** that a culture of risk tolerance is undermining risk management and ministerial assurance.

4.6.4. Recommendations

427. As a result, I recommend that, **within three months:**

- **Recommendation 31:** That the Ministry of Justice and HMPPS leadership team actively discuss the cultural issues unearthed by this review focussing on their teamwork and collaboration to set the right direction on the highest risk issues.

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- **Recommendation 32:** That HMPPS communicate out to all staff action that has been undertaken as a result of this review, to showcase positive action and encourage improvements.

428. And that **within 12 months:**

- **Recommendation 33:** That HMPPS and the Ministry of Justice undertake a systematic review of all culture related recommendations (both in this review and others) to assess whether they are delivering the intended improvements. Any actions that are not achieving measurable progress should be refined, strengthened, or escalated.

Section 5: Findings and Recommendations

This section sets out the totality of my findings and the recommendations I make to mitigate the likelihood of releases in error. To reiterate, I encourage the Government to consider the recommendations holistically.

Section 1: The Kebatu Case

In section one I outlined the facts and timeline that led to the release in error of Mr Kebatu and explored the internal HMPPS investigation into the matter. I then made conclusions on the release in error of Mr Kebatu with further scrutiny paid to six areas of policy and/or operational process. Finally, I outlined the impact of releases in error on victims, the community, and other services. My subsequent findings and recommendations on each are set out below.

The HMPPS Investigation into HMP Chelmsford

I made two findings related to both the HMPPS investigation into HMP Chelmsford and the process by which HMPPS investigate incidents more broadly. I found:

- It is **possible** that the ad hoc approach taken to investigating errors is failing to get to the systematic root causes, and that the professional, working knowledge of commissioned investigators (e.g. Governor's from the other prisons) may be leading to assumptions being made about the likely reasoning for events occurring as they did.
- The technological capability (or lack of) across the prison estate is **almost certainly** inhibiting HMPPS' ability to fully investigate events or be sufficiently transparent with the public and others as to events taking place therein. The lack of coherence regarding what equipment prisons have and for what purpose is a critical issue - particularly the absence of audio at key points such as reception and the gate which, in this case, has inhibited a detailed understanding of the events leading up to the release of Mr Kebatu and hampers robust investigation more broadly.

I therefore made the following recommendations:

- **Recommendation 1:** That HMPPS consider extending the use of body worn video to Operational Support Grade staff in public or prisoner facing roles.

Timescale (recommendation 1): Within three months

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- **Recommendation 2:** That HMPPS and the Ministry of Justice urgently explore and agree a route by which to professionalise the investigation process. The options requiring full exploration by HMPPS and Ministry of Justice are:
 - An extension of the Anti-Corruption Command within HMPPS to create a central Professional Standards function, with professional investigators and led separately from individual prison establishments.
 - An escalation route into either the Prisons Ombudsman (with an extension of their current remit) or the option to refer into an already established independent body (e.g. the Independent Office of Police Conduct) in cases meeting a seriousness criterion.

Timescale (recommendation 2): The options for this professionalised investigation process should be analysed within three months. Once agreed it should be implemented within six months.

- **Recommendation 3:** Considering that the lack of CCTV audio impacted the investigation process and that across the prison estate there are varying standards of CCTV equipment I recommend that HMPPS upgrade CCTV across the prison estate to include audio recording.

Timescale (recommendation 3): Within 12 months

My conclusions on Mr Kebatu's release in error from HMP Chelmsford

Identifying and responding to the release of high-profile prisoners

I made four findings related to the identification and release of high-profile prisoners. I found:

- Although high profile alerts existed, it is **almost certain** that they were not effectively used in Mr Kebatu's release.
- Given the high-profile nature of the case and the significant public interest, it is **almost certain** that the application of a high-profile alert on NOMIS/DPS did not trigger any further checks or assurance processes in the Kebatu case, despite its high-profile nature and the significant public interest. This means that the high alert was **highly likely** not effectively mobilised.

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- It is **likely** that this was a missed opportunity to prevent the release in error. For example, had the use of this alert triggered a process of additional scrutiny, the decision to release may have been questioned.
- It is **highly likely** that improving communication between Offender Management Units and reception staff about prisoner' movements and releases would result in greater awareness of high-profile cases. It is possible that this could serve to reduce the risk of releases in error in these cases.

I therefore made the following recommendations:

- **Recommendation 4:** That HMPPS clarify operational guidance on what a high-profile alert means, when it should be used, what should happen as a result during the release process and/or other prisoner movements and use, triggering a clear sequence of events.

Timescale (recommendation 4): Within three months

The use of 'Not for Release' markers

I made two findings regarding the use of 'Not for Release' markers in the case of Mr Kebatu. I found:

- It is **highly likely** that there is a widespread lack of clarity at an operational level on the use of 'Not for Release' markers, leading to inconsistent use and introducing confusion. It is **likely** that the mandating of 'Not for Release' markers will help, so long as there is a clear policy and supporting operational guidance on their use.
- It is **likely** the dual requirement for staff to look at both physical and digital records is introducing risks and/or opportunities for mistakes to be made. I judge that that without eliminating the dual system model, or at minimum, significantly reducing reliance on physical files, it is **likely** that consistent practice cannot realistically be guaranteed.

I therefore made the following recommendations:

- **Recommendation 5:** HMPPS should clarify at an operational level when 'Not for Release Markers' should be used and mandate the checking of all 'Not for Release' markers during release and discharge processes.

Timescale (recommendation 5): Within three months

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- **Recommendation 6:** Introduce a clear process at operational level by which staff can escalate conflicting use of 'Not for Release' markers *before* a discharge or release is authorised.

Timescale (recommendation 6): Within three months

- **Recommendation 7:** HMPPS, with support from the Ministry of Justice, develop a plan for phasing out the use of paper records in prisons during the release process.

Timescale (recommendation 7): Within 12 months

Early Removal Scheme in the case of Mr Kebatu

I made five findings regarding the application of the early removal scheme in the case of Mr Kebatu. I found:

- It is **probable** that capacity pressures faced by the system and the subsequent operational focus on relieving these pressures reduced the attention to the public confidence test in this case. It is **almost certain** that the public confidence test should have been applied in this case (albeit I make no judgement on what the ultimate conclusion of the Chief Executive of HMPPS would have been).
- The current policy position is inconsistent across Whitehall departments, and it is **almost certain** that this is making it challenging for hard-working junior and stretched operational staff in prisons and the immigration service to apply it, in a manner which builds both public and victim confidence.
- It is **almost certain** that the decision to apply the Early Removal Scheme was a contributing factor in Mr Kebatu's release in error.
- The interchangeable use of the abbreviated 'ERS', is **likely** to have caused confusion in the Kebatu case.

I therefore made the following recommendation:

- **Recommendation 8:** The Ministry of Justice and the Home Office develop one, shared policy on the Early Removal Scheme. This should consider:
 - Whether there should be exceptions, and if so what;
 - The process, authority levels and required documentation for the revised Early Removal Scheme;

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- Talk with victims and the victim's sector on the existence and consequences of an early removal policy; and,
- How Early Release Schemes and the Early Removal Scheme can be differentiated when there is an inevitable reversion to the three-letter acronym.

Timescale (recommendation 8): Within six months

The Incorrect Information on the Gate Pass

I made one findings regarding the use of the gate pass in the case of Mr Kebatu

- It is **likely** that reception staff did not understand the meaning of “DEIRC” on the discharge list, leading them to assume that Mr Kebatu was being released into the community. Had “DEIRC” or “transfer” been recorded on the gate pass, it is **likely** this would have prompted further scrutiny either by the Custodial Manager or at the gate, and may have prevented the erroneous release.

The discharge process and production of licence

I made two findings regarding the discharge process and the production of licences during the release process. I found:

- That there is no consistent or shared understanding of how to manage Foreign National Offenders at the point of discharge under the Early Removal Scheme. Staff are required to navigate contradictory policies, rely on local interpretation, and make subjective judgements, such as determining what constitutes “imminent” without adequate guidance. This lack of clarity was evident in the Kebatu case, where gaps in professional curiosity and limited understanding of discharge processes contributed to key documents being either missing or accepted without question, despite this being inappropriate for the circumstances.
- The lack of coherent policy supported by clear operational guidance is **likely** to have contributed directly to the operational error.

I therefore made the following recommendation:

- **Recommendation 9:** The Ministry of Justice and HMPPS to review the policy on Release License. The aim should not be to determine retrospectively which interpretation was ‘correct,’ but to recognise that frontline staff cannot be expected to interpret contradictory or opaque policies, especially where the stakes are high.

Operational staff require clear-cut, easily applicable rules. This review should, therefore consider:

- The loose term of “imminent release”; and
- Issue explicit guidance that states when a Release License must be produced and when it must not.

Timescale (recommendation 9): Within six months

Contact made with victims following a release in error

I made three findings regarding contact made with victims following a release in error. I found:

- There is a myriad, of unconnected arrangements and schemes dictating victim contact that are almost certainly unclear to both victims and operational staff.
- That there is no formal policy framework establishing responsibilities, expectations, or minimum standards for victim communication when releases in error occur.
- This means that, in practice, it is **highly likely** that there will be further instances such as the Kebatu case where a victim may be made aware of a release in error via social media rather than through considered contact by an appropriate professional.

I therefore made the following recommendations:

- **Recommendation 10:** The Ministry of Justice and the Home Office urgently talk with victims, victims’ sector and cross-service partners to develop a clear policy and protocol on contact around releases (broadly on releases and, specifically, ‘in error’). This should establish:
 - Who is responsible for notifying victims,
 - In what cases victims should be notified,
 - What support will be available to them,
 - When notification should take place,
 - And by what means.

- It should also address the distinction between cases identified immediately and those discovered at a later stage, and the differing requirements for victim contact that may necessarily be required.

Timescale (recommendation 10): Within six months

- **Recommendation 11:** The Ministry of Justice ensures that the findings of this review are carefully and precisely interpreted into the regulations that will accompany the Victims and Courts Bill.

Timescale (for recommendation 11): Within three months

- **Recommendation 12:** These measures are reviewed by the Ministry of Justice and assessed on whether they have addressed the issues outlined in this review regarding victim contact, or whether the scope of the Victim Contact Scheme needs to be updated.

Timescale (for recommendation 12): Within 12 months

The Impact of Releases in Error

I made four findings regarding the impact of the release in error on the victims, the communities, and other services. I found:

- Releases in error have serious and far-reaching impacts, retraumatising victims and families and undermining trust in the criminal justice system.
- Taken together, this evidence shows that such errors **almost certainly** place acute strain on police capacity and undermine the ability of forces to carry out other essential tasks, reducing resilience, delaying other investigations and increasing exposure to operational risk across the policing landscape.
- It is **probable** that a lack of clarity in roles and responsibilities between the Ministry of Justice, HMPPS and policing arises in two areas: responsibility for victim contact, and public communication. This will lead to poor public communication or conflicts between elements of the public sector occurring during a live incident. This is then compounded by the challenges of social media outlined previously.
- Both public and departmental understanding of the varying risks posed by releases in error is **almost certainly** limited and inconsistent; clearer recognition of this risk spectrum is needed.

I therefore make the following recommendation:

- **Recommendation 13:** The Ministry of Justice, HMPPS and Policing (via the NPCC) update their protocol to consider victim notification and broader communication responsibilities.

Timescale (recommendation 13): Within three months

Section 2: Operational Context

In section two, I outlined the operational context within which releases in error occur. I did not make findings or recommendations in this section, although was clear that the current operating context makes the risk of releases in error difficult to mitigate.

Section 3: Identified Issues

In section three, I set out the limitations of the quantitative analysis provided to me by the Ministry of Justice. I then discussed, in detail, the key issues I identified through the process of undertaking a case file review on 35 cases. My subsequent findings and recommendations made in this section are set out below.

Quantitative analysis of releases in error

I made five findings regarding the quantitative analysis supplied by the Ministry of Justice and the stark limitations of data that is collected by the Ministry of Justice and HMPPS on releases in error. I found:

- That the release in error figure has been stated as factual rather than indicative.
- It is **likely** that the limitations of the data are impacting the Department's understanding of the root causes of releases in error. Without understanding this, strategic, policy and operational interventions to prevent reoccurrence are **likely** to be impeded. I make recommendations to address the limitations of the data as currently collected in a dedicated chapter on data and transparency, in section 4.
- It is **likely** that the absence of any meaningful analysis until very recently is indicative of the diminished attention that releases in error were given prior to the release of Mr Kebatu. The lack of scrutiny also indicates an implicit acceptance of the risk that releases in error may present as a result.

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- The rate of releases in error cannot yet be concluded as under 1%. The evidence does not rule out a prevalence of more than 1%. I do not consider the Ministry of Justice nor HMPPS analysis of risk to adequately quantify the risk presented by these releases in error.

Identified issues

I made seven findings regarding my analysis into what causes releases in error such as missed information, incorrect outcome or mistaken identify. I found: The current method of recording sentences in years and months creates inconsistency when calculating sentences. In addition, it is **highly likely** that the combination of a complex and changing sentencing regime, with limited supporting and connected technological capability for staff to undertake these calculations, is currently increasing the likelihood of sentence miscalculations. I comment more fully on the usefulness of digital sentencing tools that are in development in a later dedicated chapter on tools and technology (pages 120-129).

- It is **highly likely** that insensible working arrangements between courts and prisons are increasing the likelihood that key information is missed and reducing the likelihood of errors being resolved promptly. Without urgent rectification, I am **almost certain** that substantial errors will persist. This issue was first highlighted in 2021, and yet there has been extremely limited progress since.
- It is **highly likely** that the pressures currently facing court clerks is increasing the propensity for human errors, and that spotting these errors currently relies on proactivity from the prison.
- Rather than help the situation, it is **likely** that the introduction of new technological systems – such as Common Platform – which are designed to simplify processes and encourage join-up between agencies are creating additional drains on operational staff's time and serving to prevent join-up between courts and prisons.
- It is **almost certain** that the automated linking of systems between the courts and prisons would reduce this burden, and the risk of human errors.
- The process of undertaking a thematic analysis showed that these issues cannot be considered in isolation. Indeed, it ultimately proved challenging to distinguish between the 'type' of error in many cases, and Annex F highlights the cases in which I

determined there were multiple ‘types’ of errors at play in individual cases. For example, just as outdated and disconnected case management systems and working practices lead to missed information, so too can these issues lead to mistaken identities, and prevent sentence miscalculations and incorrect recording of case outcomes from being identified.

Considering these identified issues together, then, I further find that:

- It is **highly likely** that there have been releases in error which could have been prevented through more connected and modernised technology. As noted in Sir Brian Leveson’s review⁴¹ technology is essential to the effective functioning of a modern criminal justice system. For example, if biometrics were used consistently, offenders could be identified through their fingerprints at every stage - from arrest to prison. This would provide an additional safeguard for identifying individuals throughout the justice system.
- It is **almost certain** that the accuracy of information input into systems (whether that’s case-management systems or digital sentence calculation tools) will be critical to reducing sentence miscalculations and releases in error.

I therefore made the following recommendations:

- **Recommendation 14:** The Ministry of Justice, in conversation with the judiciary and supported by the Judicial Office, to explore options for agreeing standardisation of days, weeks, months (consistently either 28 days, 30 days or 31 days), and years (52 weeks) with the purpose of simplifying sentence calculations:
 - And/or exploring the feasibility of judges setting out the release date at the point of sentencing,
 - And/or suggesting alternative solutions to simplify sentence calculations.

Timescale (recommendation 14): Within three months

- **Recommendation 15:** The Ministry of Justice with HMPPS & HMCTS develop a shared target operating model for working together, including on communicating sentences and sharing critical information, without which I am **almost certain** it will be impossible to bring the number of releases in error down. This should consider:
 - Information shared about prisoner production and appearance.

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- The modernisation and integration of Offender Management Unit & court working practises to include roles, responsibilities, grading and working hours.
- Introducing sentence calculation as a specialist operation within each Area Executive Director region, rather than across every prison at a local level.
- The capacity of one court clerk sitting alone to complete all the tasks required and their ability to resolve inaccuracies or ambiguities, including out of hours.
- Necessary improvements to Common Platform to reduce additional administrative burdens on court clerks.

Timescale (recommendation 15): Within six months

- **Recommendation 16:** This new model of operation should be agreed between the Ministry of Justice, HMPPS and HMCTS and then implemented.

Timescale (recommendation 16): Within 12 months

- **Recommendation 17:** A plan for developing a clear cross agency strategy for the criminal justice system is agreed and driven by Government. This must include a complementary technology and data strategy with specific actions to make substantial and connected changes to the technology provision directly and determinedly creating systems that interact with one another or are overlaid with tools that facilitate this and reduce the need for multiple data entries. This should include a plan for developing an interface that links the court system for recording sentences to the prisons systems. Tools that are currently being tested, and which I outline in further detail in my section on tools and technology (pages 120-129) should be considered for inclusion in this strategy depending on the outcomes of a thorough evaluation. The plan should align with Sir Brian Leveson's recommendation for a single shared vision for the criminal justice system.

Timescale (recommendation 17): within 12 months

- **Recommendation 18:** That this strategy considers the effectiveness of the current separate Courts, HMPPS and Justice Digital transformation programmes, which may be creating unnecessary and counter-productive system divide. The Ministry of Justice's Permanent Secretary, with system leaders, should examine whether structural changes could aid the ambition to have a joined-up technology approach across the criminal justice system.

Timescale (recommendation 18): Within six months

- **Recommendation 19:** Alongside this, the Ministry of Justice and Home Office should develop a plan for the consistent use of biometrics, both in prison and across the whole system. This should allow offenders to be tracked from the point of arrest to release and will be critical to ensuring the correct individual is being released into the community.

Timescale (recommendation 19): Within six months

Section 4: Wider Areas for Improvement

In section four I outline the wider systemic factors that I identify as increasing the risk of releases in error. I cover: People and experience, tools and technology, the collection and publication of data; Governance, audit and performance, and culture. My subsequent findings and recommendations on each are set out below.

People and Experience

- I made eight findings regarding staffing structures, training, recruitment and the experience of staff involved in the release process. I found:
- It is **highly likely** that the staffing structures in prisons provide insufficient visible line management to operational support grades. Specifically, the ratio of Custodial Managers to prison officers is so broad that it is **highly likely** they are unable to provide active and effective supervision.
- For staff that work in Offender Management Units, I find it is **highly likely** that the units are not structured in a way that adequately reflects the complexity of the work they undertake, and the requirement for them to become specialists in this area.
- It is **probable** that current structures have led to Offender Management Unit staff to work under high pressure, which has resulted in releases in errors. This needs to be considered in accordance with recommendation 15 in section three regarding the Offender Management Units operating model. I am unconvinced that there is a requirement for the sentence calculation specialism in every prison.
- The current training model for prison staff it is **highly likely** to be leading to significant gaps in experience and capability across the prison estate. It is **likely** that this has operational and cultural repercussions.

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- It is **highly likely** that the lack of training for Custodial Managers, who enact the release process, reduces their ability to be a point of assurance in the process and, instead, increases the likelihood of releases in error.
- The officer engaged in that case, a Custodial Manager, had no formal training and simply had the opportunity to shadow. This is plainly insufficient for such an important task where public safety or public confidence can be jeopardised and was **almost certainly** a contributory factor in Mr Kebatu's release in error
- It is **likely** that there is insufficient central oversight of training uptake across the prison estate. Governors will always need an element of discretion (so that they can manage risks within their estate), but they should be provided with products to help them understand who is trained and who is not.

As action is taken across the service to reduce releases in error, I encourage HMPPS to proactively consider the skills and experience that will be required by staff to take on these processes confidently.

I therefore made the following recommendations:

- **Recommendation 20:** That HMPPS and the Ministry of Justice examine the balance between the operational model within prison establishments and what resources are based centrally or regionally. The aim should be that to:
 - Not replicate services with the Ministry of Justice (department)
 - To maintain nationally or regionally the HMPPS specialist services that may be best placed there (for the purpose of this review to consider regionalisation of sentence calculation and centralisation of Professional Standards). As above, this should be considered in line with recommendation 15 to review the current Offender Management Unit operating model.
 - To ensure a focus on the frontline resources within a prison to examine and improve supervisory ratios and enabling an investment in the right place.

Timescale (recommendation 20): Within six months

- **Recommendation 21:** That a Custodial Managers course is designed, delivered, and made mandatory for all Custodial Managers, and subject to pass/fail assessment

before deployment in role. I recognise that staggering of the course may be necessary at initial implementation, but the medium-term objective should be central oversight and sequencing.

Timescale (recommendation 21): Within three months

- **Recommendation 22:** HMPPS review their approach to the balance between centralised and localised design, provision and implementation of training.

Timescale (recommendation 22): Within six months

Tools and Technology

I made four findings regarding the tools and technology available to prisons and the criminal justice system. I found:

- Whilst I understand why emergency actions were taken and why a paper checklist may have seemed sensible in the absence of strong digital solutions, I find it is **likely** that these are giving false reassurance as neither Governors nor Custodial Managers are expert in the complexity of sentence calculation.
- The development of the new tools I have explored will **likely** offer some clear benefits and reduce releases in error.
- However, I consider them to be short-term, narrowly focussed solutions. It is **almost certain** that they do not address the fundamental issue: the lack of digitalisation and interconnectivity of systems across the criminal justice system.
- It is **highly likely** that without innovation in technology and a broader, system wide approach, these measures risk being incremental and helpful sticking plasters rather than transformative.

I therefore made the following recommendations:

- **Recommendation 23:** That the further development or rollout of new tools to plug gaps in current technological capability of the estate are continued only as part of a longer-term and over-arching technology and data strategy as per my recommendation 17. This includes the development of the CRDS tool and any AI solutions that the Ministry of Justice chooses to rollout more widely.

Timescale (recommendation 23): Within six months

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- **Recommendation 24:** It is my belief that the need for a checklist will diminish if the other recommendations within this report are acted upon at pace. I therefore recommend that, HMPPS establish, with candour, the value of Governor checks. A better use of their time may be to concentrate on developing a 'getting it right first time' culture.

Timescale (recommendation 24): Within six months

- **Recommendation 25:** The Ministry of Justice accelerator funding should continue to focus on identifying if AI can provide a temporary solution to the more effective management of unwieldy inboxes in Offender Management Units.

Timescale (recommendation 25): Ongoing

Data and Transparency

I made three findings regarding the collection and publication of data. I found:

- That there is currently no proper understanding of the true extent of risk presented by releases in error.
- The absence of high quality, reliable and consistent data as it relates to releases in error is, **highly likely** to have influenced the lack of attention to it and limited the Department's understanding. As a result, it is **almost certain** that releases in error remain managed at an operational and tactical level with well-meaning but often minor or ineffective tweaks, with inefficient strategic, cross system attention to the issues detailed in this report as requiring urgent attention.
- That unlawful detention and release in error are two sides of the same coin. It is **highly likely** that unlawful detentions present material financial and reputational risks for HMPPS because compensation claims under Common Law and the Human Rights Act can result in substantial payouts. Data on unlawful detentions should therefore be considered with the same scrutiny as releases in error.

I Therefore, made the following recommendations:

- **Recommendation 26:** As the current statistics do not adequately reflect the totality of releases in error, the Ministry of Justice, HMPPS and the Office for National Statistics should undertake a wider piece of work on the data on releases in error and come forward with a proposal to ensure that statistics provided to Ministry of Justice seniors,

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Ministers and the public are reliable and assured. This will need to consider what ongoing investment is required to improve the quality of data collection. Data on unlawful detentions should be included as part of this proposal. In full, this proposal should address:

- A methodology to quantify the likely “true” rate of release
- Transparency: Being clear with the public on any limitations.
- Data Analysis: How the data is disaggregated to assess the risk.
- Release Audit: The frequency of this and by whom it is undertaken.
- Categorisation: I have been clear that there is a distinction between errors that present public risk of harm and errors that could be considered administrative error. Any project should draw formal definitions for each and consult on them, including with the victim sector.
- Risk to public: The Government should also consider how best and frequently to communicate to the public how many offenders who present a public risk remain at large.
- Demographic data: to better understand if there is any systemised bias.

Timescale (recommendation 26): Within six months

Governance, audit and performance

I made three findings regarding the current governance, performance, and audit structures used to manage releases in error. I found:

- I find that it is **likely** that, whilst releases in error are a known risk within HMPPS and the Ministry of Justice’s profile, the attention it received has diminished over time. I can find no Ministerial involvement in that deprioritisation and when the Minister of State for Prisons, Probation and Reducing Reoffending was provided with a fuller briefing its careful tone and narrow framing could have been interpreted as the matter being fully in hand.
- On account of the fact that neither the Ministry of Justice nor HMPPS have undertaken any meaningful analysis to quantify the risk presented by releases in error (as per my finding in the analysis section of the review on page 77), it is **highly likely** that neither

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have they agreed a 'risk level' for the purpose of active risk-management processes nor sought to gain Ministerial agreement on a tolerated 'level' of risk.

- I am struck by the unclear line of responsibilities between the Ministry of Justice and HMPPS with some replicated functions that are **likely** to lead to inefficiency and ineffectiveness. It is **likely** that these structural issues, lead to gaps in strategic oversight and responsibility.

I therefore made the following recommendations:

- **Recommendation 27:** Once the Ministry of Justice and HMPPS have agreed a more considered and reliable plan for collecting and using the data on releases in error (as per recommendation 26), the Ministry of Justice should seek to quantify the level of risk that this presents to the public as a result. This should be presented to Ministers, who should agree a 'tolerable' level (both in terms of volume and gravity) of releases in error (and unlawful detentions), and what escalation routes should be utilised if that risk level is approaching or breached. Notably the advice should reflect on the views of victims and communities who may have a **likely** low tolerance for any risk.

Timescale (recommendation 27): Within 12 months

- **Recommendation 28:** Pending a fuller Criminal Justice System strategy, Government should revisit the performance framework for HMPPS and assure themselves it reflects their current priorities AND that well analysed data products exist to support it.

Timescale (recommendation 28): Within six months

- **Recommendation 29:** The Ministry of Justice and HMPPS should review their internal audit capacity to provide assurance including direction against the prison performance framework.

Timescale (recommendation 29): Within three months

- **Recommendation 30:** The Ministry of Justice and HMPPS to consider, with HMIP, whether RIE and unlawful detention should be part of the inspection regime.

Timescale (recommendation 30): Within three months

Culture

I made three findings regarding the culture across MoJ and HMPPS. I found:

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- A culture of scarcity is **likely** to be stalling improvements and leading to reticence to 'do more'.
- A culture of reactivity is **highly likely** to be preventing strategic decisions and focusing attention on downstream fixes rather than the systemic issues.
- It is possible that a culture of risk tolerance is undermining risk management and ministerial assurance.

I therefore made the following recommendations:

- **Recommendation 31:** That the Ministry of Justice and HMPPS leadership team actively discuss the cultural issues unearthed by this review focussing on their teamwork and collaboration to set the right direction on the highest risk issues.

Timescale (recommendation 31): Within three months

- **Recommendation 32:** That HMPPS communicate out to all staff action that has been undertaken as a result of this review, to showcase positive action and encourage improvements.

Timescale (recommendation 32): Within three months

- **Recommendation 33:** That HMPPS and MoJ undertake a systematic review of all culture related recommendations (both in this review and others) to assess whether they are delivering the intended improvements. Any actions that are not achieving measurable progress should be refined, strengthened, or escalated.

Timescale (for recommendation 33): Within 12 months

This review is one of a recent number that seek to improve the criminal justice system. The Ministry of Justice should consider these recommendations in the round and sequence activity to improve performance from the system.

Conclusion

I want to conclude this review by acknowledging all who have spoken to me with candour about releases in error, their causes and effects. To thank the small team of officials from the Ministry of Justice who have supported the work to develop these coherent findings/recommendations. Most importantly, to replicate the passion shown by the father of Victim A in stating that the risk, or perceived risk, of harm and the impact on public confidence in the justice system cannot and should not be underestimated.

It is likely that some will find my findings surprising, whereas for others working at junior levels in the criminal justice system, they are simply indicative of their day-to-day reality.

Releases in Error were highlighted in the public arena through the mistaken release of a convicted sex offender. In many ways the facts of that case are specific and the recommendations there stand alone, written with an intent toward speedy resolution.

All my recommendations, when taken together, will make a difference but without a **precise and determined strategic focus on recommendations 2, 10, 14, 15, 16, 17, 18, 19, 26 and 33**, releases in error are likely to continue to rise and other risks are **likely** to emerge.

I commend this review to you, with thanks for the opportunity.

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Glossary

Glossary Acronym	Definition
HMPPS	His Majesty's Prison and Probation Service
HMCTS	His Majesty's court and Tribunal service
OMU	Offender Management Units - Prison teams that manage sentence information and ensure lawful release.
FNO	Foreign National Offenders – People in prison who are not British nationals and whose cases may involve immigration processes alongside their criminal sentence.
IRC	Immigration Removal Centres – Secure centres used to hold people for immigration purposes before removal from the UK
Yardstick	Yardstick is a framework for using standardised probabilistic language to express uncertainty in intelligence assessments. Because such assessments rely on incomplete or conflicting information and involve subjective judgement, the Yardstick ensures that readers clearly understand the assessed likelihood of a judgement being true and the associated level of uncertainty. It sets out probability terms and their approximate numerical ranges, helping analysts communicate uncertainty consistently and avoid implying artificial certainty. Further detail on Yardstick can be found here
Critical Incident	As per the college of policing, a critical incident is any incident where the effectiveness of the police response is likely to have a significant impact on the confidence of the victim, their family and/or the community.
Concurrent	If you're sent to prison for 2 or more crimes, you'll usually get a sentence for each crime. The judge or magistrate will tell you whether your prison sentences will be served concurrently or consecutively. If your sentences are concurrent, it means you will serve them at the same time. For example, if you get one 6-month sentence and one 3-month sentence, the total sentence will be 6 months. This is because you will serve the 3-month sentence at the same time as the 6-month sentence.
Consecutive	If you're sent to prison for 2 or more crimes, you'll usually get a sentence for each crime. The judge or magistrate will tell you whether your prison sentences will be served concurrently or consecutively. If your sentences are consecutive, it means you will serve them one after the other. For example, if you get one 6-month sentence and one 3-month sentence, the total sentence will be 9 months. You will serve the first sentence, then you'll serve the second sentence after that.
ERS	Early Removal Scheme - A scheme that allows some non-UK citizens to be removed from the country before completing their prison sentence, where the law permits and public safety is considered.

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PNC	Police National Computer - A national police database used to store and check information about people, vehicles and property to support policing and public safety.
VLO	Victim Liaison Officer - A professional who supports victims by keeping them informed about an offender's sentence and release and acts as their main point of contact.
NPCC	National Chief's Police Council - This is a national group of police chiefs who work together on issues affecting policing across the UK.
HDC	Home Detention Curfew – An early release scheme that allows some people to leave prison early and serve part of their sentence at home under strict conditions, including electronic monitoring.
CRDS	Calculate Release Date Service - A secure computer system used in prisons to manage information about people in custody, including where they are held and when they are released.
DPS	Digital Prison Service - The Digital Prison Service is the computer system prisons use to keep and manage information about people in custody.
NOMIS	National Offender Management Information System - A national computer system used by prisons to keep records about people in custody, including their sentence details and release dates.
IS91	Immigration Service detention authority form - A Home Office form issued by Immigration Enforcement that provides the legal authority to detain a person under immigration powers.
PHIA	Professional Head of Intelligence Assessment - The senior role that oversees standards, skills and professional development for people working in intelligence.

Annex A: Yardstick explanation

How do I use the Probability Yardstick?

- You should first determine whether the event has a more or less than 50% chance of occurring (or of having occurred, if considering past or present events).
- Once you have judged which half of the scale your judgement lies within, attempt to determine which quarter, i.e. more or less than 25% or 75%.
- If you determine that your probability sits within a certain numerical range, e.g. between 50% and 75%, then you should use the appropriate term from the Yardstick to describe it, e.g. likely or probable.
 - If you cannot be more precise than above or below 50%, then be explicit, e.g. "there is less than 50% chance that X will achieve A in the next year", or "it is more likely than not that Y perpetrated a cyber-attack on B in 2018".
 - If you can be *more* precise in your judgement then do so, e.g. "we assess that there is an approximately 60-70% chance of X occurring by Y date".
 - If you can *legitimately* assess that event has an even chance of occurring, say so, e.g. '50/50 chance', or 'even chance'.
- If you have complete certainty in a judgement, then appropriate language should be used, e.g. "has" or "will not".
- Neither 0% nor 100% are within a range.

What should I check before I issue my product?

- Does your final product include the Yardstick?
- Has the Yardstick terminology been used to express probabilities in all your judgements?
- Do all Key Judgements use the same probabilistic language as that used in the body of your assessment? A judgement must not be 'almost certain' if in the body of the assessment it says it is 'highly likely'. This also applies to an executive summary.

What should I *not* do?

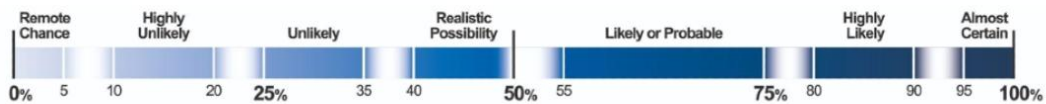
- **Do not** provide judgements without any qualifying Yardstick terms as it fails to convey any level of uncertainty, which will confuse the customers.
- **Do not** use may/could/might/can in place of probabilistic language - this suggests that you expect your customer to assign their own understanding to your meaning.
- **Do not** use probability language multiple times in one sentence - craft your sentences in a way that assigns the correct level of probabilistic term whilst remaining easy for your customer to read.

If you have any questions relating to this paper please contact your departmental professions lead, or the PHIA team via phia@cabinetoffice.gov.uk

PHIA Probability Yardstick

The intelligence assessment community use terms like unlikely or probable to convey the uncertainty associated with intelligence judgements. These terms are used instead of numerical probabilities (e.g. 55%) to avoid interpretation of judgements as being overly precise, as most intelligence judgements are not based on quantitative data. A Yardstick establishes what these terms approximately correspond to in numerical probability. This ensures that readers understand a judgement as the analyst intends. The rigorous use of a Yardstick also ensures that analysts themselves make clear judgements and avoid the inappropriate use of terms that imply a judgement without being clear what it is (e.g. “if X were to occur then Y might happen”).

The Professional Head of Intelligence Assessment (PHIA) Probability Yardstick splits the probability scale into seven ranges. Terms are assigned to each probability range. The choice of terms and ranges was informed by academic research and they align as closely as possible with an average reader’s understanding of the terms in the context of what they are reading. Below is an example of how the Yardstick appears in intelligence assessments.



- >0% - ≈5%: Remote Chance
- ≈10% - ≈20%: Highly Unlikely
- ≈25% - ≈35%: Unlikely
- ≈40% - <50%: Realistic Possibility
- ≈55% - ≈75%: Likely or Probable
- ≈80% - ≈90%: Highly Likely
- ≈95% - <100%: Almost Certain

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**Annex B: Breakdown of costs associated with the police response to Mr
Kebatu's release**

Essex Police

DAY 1	Hourly	Officers	Av Hours	Approx
	NORMAL	Assigned	Worked	Cost
PC	73.81	68	10	£50,191
PS	92.84	7	10	£6,499
PI	84.98	1	11	£935
CI	90.09	1	11	£991
SUPT	119.19	1	11	£1,311
CSUPT	127.62	1	11	£1,404
Control	48.79	2	11	£1,074
Media	84.89	1	10	£849
Overtime Cost to date				£2,791
Total				£66,045

DAY 2	Hourly	Officers	Av Hours	Approx
	NORMAL	Assigned	Worked	Cost
PC	73.81	6	10	£4,429
PS	92.84	3	10	£2,785
PI	84.98	1	8	£680
CI	90.09	1	4	£360
SUPT	119.19	1	6	£715
CSUPT	127.62	1	6	£766
Media	84.89	1	5	£424
Overtime Cost to date				£0
Total				£10,159

DAY 3	Hourly	Officers	Av Hours	Approx
	NORMAL	Assigned	Worked	Cost
PC	73.81	4	6	£1,771
PS	92.84	2	6	£1,114
PI	84.98	1	4	£340
CI	90.09	1	2	£234
SUPT	119.19	1	3	£270
CSUPT	127.62	1	3	£383

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Media	84.89	1	4	£340
Overtime Cost to date				£0
Total				£4,452

Metropolitan Police

Rank	Number	Cost per person per day*	Total Cost (two days)
Assistant Commissioner	1	£1,701.06	£3,402.12
Commander	1	£983.14	£1,966.29
Detective Chief Superintendent	1	£872.87	£1,745.74
Inspector	4	£579.16	£4,633.28
Sergeants	9	£472.68	£8,508.25
			£47,026.45
Constables	60	£391.89	
Analysist / Researcher	8	£300.00	£4,800.00
Total Staff:	84	£5,300.80	£72,082.46

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Annex C: List of updates to release processes

Date	Schemes implemented
March 2023	Temporary presumptive Recategorization Scheme (TPRS) introduced
June 2023	Home Detention Curfew (HDC) extended to 6 months
September 2023	Restricted Open Estate Transfers (ROET) activated for a 4-week period
October 2023	End of Custody Supervised Licence (ECSL) launched in several prisons which released male prisoners 18 days early.
January 2024	Early Removal Scheme (ERS) extended to deport Foreign National Offenders 18 months early
February 2024	ECSL implemented across all adult male prisons in England and Wales
March 2024	ECSL extended from 18 days to 35 days
April 2024	Fixed Term Recall mandated for short sentences
May 2024	ECSL extended to 70 days
June 2024	HDC extended to sentences of over 4 years
July 2024	TPRS12 introduced (extension to TPRS for up to 12 months)
September 2024	Standard Determinate Sentence (SDS 40) changes implemented (tranche 1) Certain prisoners were released after serving 40%
October 2024	SDS 40 changes tranche 2
November 2024	Standard Regime added to TPRS
December 2024	Additional offences excluded from 40% release
March 2025	TPRS extended to 24 months
June 2025	HDC expanded to 12 months
June 2025	TPRS extended to 36 months
September 2025	Fixed Term Recall 48 starts implementation, ERS extended
November 2025	FTR48 Implementation continues

Annex D: The Ministry of Justices' Summary of Quantitative Analysis on Releases in Error

Title: Releases in Error – Summary of Evidence and Implications

Overview

1. The Ministry of Justices' data directorate was commissioned to provide data and analytical support to the independent review of releases in error including quantitative analysis and narrative assessment of the available data.
2. This summary draws together different analyses of releases in error including quantitative analysis of historic cases, assessment of the 35 cases examined as part of the independent review, and the results from a dip sample assessing the potential scale of unidentified releases in error. It focuses on the scale of RiE, what drives it, and the implications for managing risk at a system level.

Scale of releases in error

3. Between April 2020 and November 2025, there were 707 identified releases in error, an average of around 50 incidents per year until an increase beginning in 2022–23 and reaching over 250 incidents in 2024–25. HMPPS's current assessment is that the recent increase reflects specific, time-limited operational and policy pressures, rather than a sustained change in the underlying rate of releases in error, based on informed operational judgement rather than a full causal analysis.
4. These figures reflect identified releases in error only. Some releases in error incidents are only identified long after the release, often when an individual returns to custody, meaning recent years **likely** appear lower than the true underlying position.
5. To assess the potential scale of unidentified releases in error the Department conducted a random dip sample of routine releases. This random sample included 4 RiEs that had already been previously identified; as such, these were replaced by new random cases to ensure the sample the department was dip sampling focused only on *unidentified* releases in error, as commissioned.

6. From this, two previously undetected releases in error were identified, equivalent to around 0.5% of the sample (approximately 1 in 200 releases). Historic published data show that on average 0.3% (between 0.1% and 0.5%) of releases are identified as releases in error⁶⁰. Taken together and allowing for the likelihood that some of these cases could have been identified subsequently, this indicates that the overall prevalence of releases in error is **likely** to be below 1% of releases. It remains the case that any release in error is of concern and we refer at the end of the paper to the measures that may be required to continue to address the issue.
7. Whilst this analysis focuses on releases in error, as commissioned, it is important to note that 14 unlawful detentions were also identified in the same dip sample. The root causes of releases in error and unlawful detentions are often the same, and HMPPS take the consequences of both types of incidents as seriously as each other. We have never combined or calculated the totality of release inaccuracy through our data streams in the past; however, our commitment is to addressing overall accuracy of our sentence calculations.
8. However, despite the limitations of the sample size, the results do provide some reassurance that there is not a large-scale issue of unidentified releases in error, and that the published statistics offer a reasonable indication of overall scale. Further sampling work would be required to reduce this uncertainty and provide greater confidence in the estimated prevalence. This statistical assessment forms one component of the overall view of prevalence and should be considered alongside operational understanding of how releases in error are identified in practice.
9. On this basis, releases in error are uncommon when compared to the total volume of releases but can have serious consequences when they occur. Further reductions are therefore **likely** to depend on addressing cross-system complexity and data flows, rather than focusing solely on local process improvements.

What drives releases in error

10. There is no single, comprehensive dataset that reliably captures the root causes of releases in error. Identifying root causes requires detailed case-level review,

⁶⁰ [Prison and Probation Performance Statistics - GOV.UK](#) and [Offender management statistics quarterly: October to December 2024 - GOV.UK](#)

drawing on multiple paper and digital records. The available evidence therefore comes mainly from prison-reported causes and RASU insights.

11. Across these sources, a consistent set of issues emerges. These include errors in release date calculation, miscalculated remand or additional charges, issues arising from court results, and the application of eligibility rules for different release schemes. Taken together, these indicate that releases in error most often arises at points of interaction between court outcomes, data flows, and prison-level processes. In many cases, the issue is that information is incorrect, incomplete, or not available in time, rather than being incorrectly applied. These risks are exacerbated where staff have limited capacity to check, follow up, chase missing information, or double-check complex cases under operational pressure.

Risk and outcomes

12. To understand the risk associated with releases in error, the analysis focuses on outcomes for identified releases in error cases. This allows exploration of whether there are indications that the identified RiE cohort differs from the wider released population in terms of observed risk.
13. This analysis is subject to important limitations. It only relates to releases in error cases that have already been identified, and releases in error are more likely to come to light following recall or reoffending. This identification bias means the analysis is likely to over-represent more negative outcomes, such as proven reoffending. Also, consistent data on when individuals should have been released is not available across the historic dataset, meaning it is not possible to assess how far through their sentence individuals were released in error. As a result, the analysis cannot capture the potential impact of early release on access to rehabilitation or other interventions.
14. For the 379⁶¹ identified releases in error cases between April 2020 and June 2025 that could be linked to outcomes data, outcomes at six months post-release were compared with a broader cohort of individuals released between January and June 2024.
15. Within the identified releases in error cohort:
 - 31.4% reoffended, 7.5 percentage points higher than the comparator cohort

⁶¹ Outcome data could be linked only where individual release events could be reliably matched across datasets; in some cases, this was not possible due to limitations in how criminal justice outcome information is recorded across systems.

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- 40.6% were recalled, 20.6 percentage points higher
- 2% had an ongoing court case, slightly lower than the comparator cohort
- 25.9% had no reoffending, recall or court case, substantially lower than the comparator cohort

16. Taken together, these figures show poorer observed outcomes for the identified RiE cohort compared with the wider released population, consistent with the identification bias described above.

17. Case-level review highlights the potential severity of risk when reoffending does occur. Out of the 35 cases examined as part of the Independent Review's qualitative assessment, 10 individuals released in error went on to commit offences while they should have been in custody. These included non-compliance with sexual offender notification requirements and violent offences.

18. Of course, some individuals do go on to reoffend even when released at the correct point of their sentence. However, release in error still exposes the public to risk during a period when those individuals should have remained in custody; where individuals convicted of more serious offences or subject to close supervision are involved, that risk increases.

19. The duration of time spent out of custody following a release in error varies considerably. Across the historic data, the median time before the offender returns to custody is around 14 days. Return to custody does not necessarily mean that the release in error had been identified, as individuals may have returned for other reasons. Case reviews show that further offending can occur within days of release in error, meaning that even short periods out of custody can carry risk. Operational insight would suggest this is broadly in line with reoffending trends. There is also a long tail, with a small number of individuals remaining out of custody for much longer periods, in some cases extending to years, suggesting they have not been rearrested for any reoffending.

Implications for the system

20. There is a clear need for more consistent and better-quality data and analysis on releases in error. While existing data provides insight into the overall scale of releases in error and some of the risk, it is more limited in what it can tell us about the underlying causes of errors and how early in a sentence individuals are released.

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21. More consistent data capture and analysis would strengthen understanding of why errors occur, support our assessments of the risk to the public and enable more effective targeting of preventative and system-level interventions.
22. The findings indicate that reducing releases in error would require more than incremental, local process improvements. Further progress is **likely** to depend on stronger end-to-end data and digital systems linking courts and prisons, reducing reliance on manual processes and fragmented information. In particular, a clearer and more reliable transfer of offender information across the criminal justice system would help reduce complexity, improve visibility, and lower the risk of error at key decision points.

Annex E: The Ministry of Justices' Release in Error Dip Sample Methodology and Findings

Title: Release in Error Dip Sample Analysis Report

Summary and Highlights

1. This paper addresses the findings from the dip sampling exercise to assess the true volume of releases made in error. These findings are based on a sample of 386 releases that were not already within known releases in error datasets.
2. This dip sampling exercise was completed through an urgent recommendation to the department from Dame Lynne Owens. The purpose was to assess the true volume of releases made in error – the published figures capture known RiE, raising concerns around whether further releases in error were not being identified.

Analytical Findings

3. Our findings, based on the dip sample and published statistics, is that the overall proportion of releases in error (including detected and undetected releases in error) is likely to be less than 1%. Additionally, the analysis suggests that while there may be RiE that go undetected, there is not a large-scale issue around unidentified releases in error and the department's published statistics provide a reasonable broad sense of scale around releases made in error.
 - A. The dip sample considered 386 routine releases⁶² where releases in error had not already been identified. We identified 2 previously undetected releases in error in this sample. This constitutes around 0.5% of the sample, equating to around 1 in 200 releases made in error.
 - B. The department's published statistics on known releases in error, indicate that on average⁶³, around 0.3% (range 0.1% to 0.5%), or 1 in 300, releases are made in error⁶⁴.
 - C. Taking together these proportions of known and previously undetected RiE, and allowing for uncertainty due to the sample size, as well as the likelihood

⁶² This analysis only includes releases from prisons (e.g., this would exclude releases from court and the Home Office. It also excludes releases classified as release on temporary licence (to make checks more practical in time available), and escape, abscond, administrative release for merge, and died (as these cannot lead to an RiE). This selection of release codes is an approximation to the opportunities for a release in error to occur, rather than a direct comparator.

⁶³ Considering 4 years' worth of data. The range is 0.1% to 0.5%

⁶⁴ [Prison and Probation Performance Statistics - GOV.UK](#) and [Offender management statistics quarterly: October to December 2024 - GOV.UK](#)

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that some of the undetected cases could have been identified subsequently, this indicates that the overall prevalence of releases in error are likely to be below 1% of releases.

Operational Findings

4. 386 cases have been checked. 2 releases in error have been found through the checks, as well 14 individuals who had been unlawfully detained prior to the release. In half of these cases the individual had been detained unlawfully for one day, the longest period of unlawful detention detected was 12 days.
5. Of the 2 releases in error identified in the dip sample:
 - A. One individual is confirmed to be currently unlawfully at large. They were released in error three days early following the completion of a recall and have not been supervised by probation as there was no remaining licence period to serve. The release in error was due to the miscalculation of a consecutive chain of sentences due to the issue surrounding days/months/weeks/years that was flagged by RASU to the review team as a systemic cause of releases in error. Advice has been provided to the Deputy Prime Minister on whether to return any individual deemed unlawfully at large because of this exercise.
 - B. The second individual releases in error was released via the End of Custody Supervised Licence Scheme (ECSL) five days early due to a miscalculation of remand. Any release via ECSL was done on compassionate grounds in line with prison capacity challenges, The Ministry of Justice lawyers have confirmed that individuals would not be deemed unlawfully at large therefore they do not need to return to custody.
 - C. Neither individual has ever returned to prison custody since their release in error.
6. SST have also checked whether the Calculate Dates Release Dates Service (CRDS) was used to verify the calculations for the sample cases. The tables below summarise the findings.

Total number of cases checked by SST	386
Unsentenced prisoners that did not require a calculation	94
Sentence types unsupported by CRDS	12
Cases calculated on CRDS at either the 14 or 2 day check point (or both)	145
Cases not calculated on CRDS	135

Cases not calculated on CRDS	135
SST are unable to confirm as the individual has since returned to custody and the digital service cannot perform the calculation that was correct at the point of release as information has changed	93
CRDS calculates an incorrect release date but this is due to data entry errors on NOMIS	4
CRDS has calculated the same date as SSTs manual calculations	38

- *To note some of the cases where a calculation has not been performed in CRDS may be due to the date of release being prior to the roll out of CRDS to all prisons in July 2024.*

Analytical Methodology

7. The department conducted a review of a random sample of 386 releases⁶⁵ to assess whether the releases were made in error. The distribution of release reasons and prisons in this random sample mirror that in the wider set of releases that the sample was drawn from.
8. The random sampling approach used does not confer statistical accuracy or precision, and there are limitations to what can be inferred, (for example identifying 0 releases in error in a sample of 386 does not mean there are no releases in error across the whole set of releases). However, this random sampling approach is not uncommon outside of formal research studies. The method used and justification for this approach are below:
 - i. We used a statistical power calculation to estimate that 386 cases would need to be assessed to achieve a reasonable estimate of the releases in error volume.
 - ii. We randomly selected 193 cases from the first 6 months of 2024 and the first 6 months of 2025 respectively. This random sample included 4 releases in error that had already been previously identified; as such, these were replaced by new random cases to ensure the sample the department was dip sampling focused only on *unidentified* releases in error, as commissioned.

⁶⁵ This only includes releases from prisons (e.g., this would exclude releases from court and the Home Office. It also excludes releases classified as release on temporary licence (to make checks more practical in time available), and escape, abscond, administrative release for merge, and died (as these cannot lead to an RiE). This selection of release codes is an approximation to the opportunities for a release in error to occur, rather than a direct comparator.

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- iii. We completed manual checks on the information held for each release in order to calculate the correct release date and ascertain if this was the date on which the release occurred. Manual checks were required as the digital tool used to calculate release dates can be affected by information flow issues (further details below) that can lead to releases in error. Please see the Operational Methodology section below for further detail on the checks completed.
9. In order to achieve a highly statistically accurate and precise releases in error volume, the department would have needed to stratify the sample of releases by characteristics that make releases in error more likely, such as sentence complexity and release reason. Without accounting for these, it is possible that the sample did not count enough cases where these factors existed to give us a more reliable sense of how many errors there were.
10. However, this approach would have required the department to draw a significantly larger sample size (thousands of cases). The manual checks required to assess a sample of this size would require several months of operational resource, and would affect ongoing sentence calculations checks, potentially increasing the risk of releases in error. For this reason, it was decided that a random sample of 386 releases be considered, and further sampling be considered if a significantly different proportion of releases in error was found.
11. The CRDS (a digital system used to calculate release dates) operates at over 99.9% accuracy rate, however there are currently some limitations with its use. At present, the service is reliant on warrant information manually entered by Case Administrators into NOMIS (a legacy IT system). This data is not automatically transferred from the court's digital systems to the prison's digital systems. This has been identified as a priority for the Ministry of Justice, with work already underway through the £10m package of investment the DPM announced in November 2025. Therefore, outputs are only as accurate as the data inputted into NOMIS, and sometimes this is incorrect. Manual calculations are still performed alongside CRDS to double-check that the warrant information has been correctly transcribed into NOMIS.
12. CRDS can generate release dates for 98.5% of the current prisoner population who are serving determinate sentences. Prisoners with sentence types that are not accommodated require manually calculated release dates. The CRDS team are in

the process of increasing the coverage by accommodating different sentence types. This work needs to be carried out in parallel with legislative change updates and is therefore a secondary priority.

Operational Methodology

13. The random sample of 386 cases were assessed by the department's Release Accuracy Support Unit and carried by OMU Specialist Support (SST) Advisors who are trained at an advanced level in sentence calculation with a Licence to Operate. Their role is to be a centralised expert on calculation processes. The checks are based on the documentation provided by HMCTS to HMPPS. We cannot account for any errors that may have gone undetected because the warrant documentation may be incorrect.
14. The process carried out by the SST was as follows:
 - i. The SST Manager split the list and allocated cases randomly across four SST advisors. Each advisor was responsible for checking their own allocated cases.
 - ii. They checked these cases against NOMIS data entries and performed a manual calculation to confirm the release date, which took account of any periods of remand, added days (following an adjudication) and all sentences and their types.
 - iii. This was then cross referenced to NOMIS movements and the Book a Secure Move (BASM) system to check for any remand discrepancies, and then against available warrants and other paperwork on Common Platform, Xhibit, Delius and PPUD.
 - iv. If all information aligned with the release date on the spreadsheet no further action was taken as the release date was confirmed as correct.
 - v. If there was a discrepancy, the SST Advisor contacted the releasing establishment to request scanned copies of paperwork that could prove or disprove the discrepancy. For example, there may have been a discrepancy in the amount of remand recorded on NOMIS, which may have been due to information being digitally unavailable to SST, as Xhibit cases are archived after 300 days.

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- To assist in their confirmations SST requested supporting paperwork in 56 cases, two of these cases were found to be RiE, four were unlawful detentions.
- 50 of the cases were confirmed to have been lawful releases.

15. Once requested paperwork was received from the establishment, the SST Advisor then performed their calculation and where this matched the initial spreadsheet the release date was proven.

16. A second advisor then performed a '*blind check*' calculation to verify the outcome of the calculation.

Annex F: Thematic Analysis Methodology and Findings

This sets out the methodology for undertaking a thematic analysis of case files for the review into releases in error.

Whilst findings from individual cases cannot be considered statistically representative, they nevertheless provide practical insight into how errors occur in practice and can be used to inform precise recommendations to minimise reoccurrence.

Methodology

Identifying a sample

1. A sample of 42 cases was initially selected for further review:
 - 24 cases were selected via purposive stratified sampling. This sampling approach means that the sample was non-random and is not statistically representative.
 - Initially, the reviews terms of reference was focused narrowly on the Kebatu case and its surrounding circumstances. However, the terms of reference were broadened on the 24 November to cover the wider causes of releases in error across the justice system. This required consideration of the most up to date cases to provide an accurate picture of how the system was currently operating, particularly in light of the immediate changes introduced by the Lord Chancellor after Kebatu's release to prevent releases in error. As a result, a further 18 cases were added to the sample after being released in error between 11 November and 15 December 2025.
2. Of the 42 cases selected, 7 were ultimately excluded from the qualitative analysis:
 - One because the case was considered too old to be relevant;
 - Three because the proformas were not available for analysis;
 - Two because after consideration by the review team it was determined that the case did not refer to a release in error; and

- One because it is already covered in depth in this report (Mr Kebatu's case)
3. Further and more detailed examination was therefore conducted on a final sample of 35 cases.

Data analysed

4. Operational data contained in 'proformas' was used to undertake this qualitative analysis. A proforma is a standardised form completed by a prison, after a release in error is identified. The precision with which the proforma is completed is often limited, and the reasons recorded in proformas reflect what staff *believe* at that early stage to be the cause of the release, rather than a confirmed or fully evidenced explanation.

Limitations

5. These proformas were not designed for qualitative analysis, and there was inconsistency in the level and type of detail they contained. This means that relevant case details or complexity may not have been captured in this analysis. For example, while some proformas referred directly to staffing or resourcing issues, further evidence of these were not necessarily provided. Conversely, absence of reference to staffing or resourcing issues in a proforma does not necessarily mean these did not contribute to the Release in Error.

Findings

6. The following table captures the final themes identified through the analysis process and provides counts for the number of times each theme was identified in the sample. It is important to note that:
 - The themes provided here are not mutually exclusive and multiple codes may apply to a single case: counts do not therefore sum to the total number of cases.
 - The themes identified are intended to express the range and complexity of issues related to release in error: they do not provide evidence about the wider prevalence or relative importance of issues.
 - Findings are not generalisable to the wider population. In particular, counts cannot be scaled up to draw wider quantitative conclusions.

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Theme	Count
Types of error	
Incorrect outcome recorded	7
Sentence miscalculation	15
Mistaken identity	5
Missed information	14
Drivers of error	
System-level issues with the process, guidance or checks in place	13
Human-level issues or oversight	18
Staffing or resourcing issues	8
Additional contributing factors	
Remand	12
Home Detention Curfew (HDC)	4
Recall	5
Foreign National Offender (FNO)	3
Multiple offences or sentences	11
<p>'Other'</p> <p>Cases where the proforma or documentation noted a point of interest which did not warrant a standalone code. For example, this code was used to note:</p> <ul style="list-style-type: none"> • Home Office involvement (i.e., because of immigration) • Differences between Scottish and English systems cited • Release in error occurring when the prisoner was in the custody of a transport company 	8
<p>'Unknown'</p> <p>Cases where the proforma or documentation did not provide sufficient information to draw definite conclusions on either the type or driver of error</p>	5

Sentence Miscalculation

7. Of the 35 cases reviewed as part of the thematic analysis, 15 involved a sentence miscalculation. These cases reflected a range of contributory factors:
- Some miscalculations arose from individual errors or oversights, such as incorrect data entry.
 - Some errors appeared to be driven by systemic issues, including changes to guidance or the absence of a clear process for notifying prisons of updates made on the Public Protection Unit Database (PPUD⁶⁶).
 - Some proformas referenced staffing and resourcing pressures as contributing factors to sentence miscalculation errors.
 - Some reference remand or the involvement of multiple offences or sentences
 - HDC eligibility and recall were also noted as relevant in some cases.
 - In one case, weekend release was noted as contributing to the sentence miscalculation.

Missed Information

8. Of the 35 cases reviewed, sixteen involved an instance of information being missed – for example, an email not being seen by the recipient, or warrants not being processed or shared with the relevant parties.
9. The sample included instances where information was missed because of human-level issues or oversights (for example, when the information was correctly recorded on internal systems but was missed or misread by an individual) as well as cases where the error appears to have been caused by system-level issues (for example, information not being shared in a timely manner between parties). In one case, the proforma indicated that staffing or resourcing pressures may have contributed to the missed information.
10. Some cases appeared to involve additional contributing factors:
- In 7 of the 16 cases in which missed information led to or contributed to a release in error, remand was also involved;

⁶⁶ A digital system used by the Public Protection Casework Section (PPCS) of the National Offender Management Service (now part of HMPPS) to manage parole and recall cases in the UK.

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- In 5 of the 16 cases, multiple sentences or offences were involved;
- In 2 of the 16 cases, recall was involved; and
- In 2 of the 16 cases, the released individual was a FNO and immigration processes were involved.
- Of the 35 cases reviewed, thematic analysis identified 7 as involving an incorrect outcome being recorded for an offence.
- In many instances, this type of error was associated with human-level issues or oversight – for example, where an error occurred as a result of an outcome given by a judge being misheard by the dock officer or a hearing outcome being recorded incorrectly on the Common Platform.
- Staffing or resourcing pressures were also cited as contributing to incorrect outcomes being recorded in some cases. For example, in one case the proforma described a *'period of exceptionally high operational demand'* in which the *'volume of activity placed significant pressure on processes and affected the accuracy, thoroughness, and consistency of checks being completed'*. As noted previously, the proforma did not provide specific evidence of these staffing pressures.
- Additional contributing factors were identified in some cases: for example, in one case the incorrect outcome recorded related to erroneous eligibility for Home Detention Curfew while in another the incorrect outcome related to the recording of multiple offences.

Incorrect Outcome

11. Of the 35 cases reviewed, thematic analysis identified 7 as involving an incorrect outcome being recorded for an offence.
12. In many instances, this type of error was associated with human-level issues or oversight – for example, where an error occurred as a result of an outcome given by a judge being misheard by the dock officer or a hearing outcome being recorded incorrectly on the Common Platform.
13. Staffing or resourcing pressures were also cited as contributing to incorrect outcomes being recorded in some cases. For example, in one case the proforma described a *'period of exceptionally high operational demand'* in which the

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'volume of activity placed significant pressure on processes and affected the accuracy, thoroughness, and consistency of checks being completed'. As noted previously, the proforma did not provide specific evidence of these staffing pressures.

14. Additional contributing factors were identified in some cases: for example, in one case the incorrect outcome recorded related to erroneous eligibility for Home Detention Curfew while in another the incorrect outcome related to the recording of multiple offences.

Mistaken Identity

15. Of the 35 cases reviewed, five cases involved an instance of mistaken identity. In some cases, this related to two prisoners having the same or similar names: in others, the error related to a single prisoner with multiple aliases.

16. Some errors relating to mistaken identity appear to be caused by human-level issues or oversight: for example, in one case the prisoner was misidentified despite all the relevant information seemingly being shared. In other cases, system-level issues with the process, guidance or checks in place may have driven or contributed to the mistaken identity: for example, if known aliases were not included in documentation.

17. In two cases, staffing or resourcing pressures were cited in relation to cases of mistaken identity.

18. In two of the cases where a release in error was attributed to a mistaken identity, the involvement of remand was cited. In one case, the release occurred while the prisoner was in the custody of a transport company. These factors may have contributed to the releases in error.

Annex G – My methodology for determining the gravity of the release in error

In section three of this report, I set out my reasoning for concluding, for each case I reviewed in detail, whether the release in error constituted a more minor administration of justice related error, or a more substantive error with associated risk presented to the public.

To do so I have applied a structured set of tests designed to separate cases with the greatest impact on public safety and the proper application of justice from those with more limited consequences. Although all cases of release in error are a significant concern, it would not be proportionate or operationally productive to treat a case where someone was released, for example, two days early due to a miscount of remand day in the same category as a case where an individual was released several months early or released despite ongoing proceedings. The seriousness and required solutions are not comparable across these scenarios, which is why we have sought to separate them.

To separate these cases, I considered the available data (which was limited in many cases) and noted where:

- **The individual released in error committed further offending whilst Unlawfully At Large (UAL).** In these cases, I determined reoffending during this period constituted a direct and serious harm to the public and therefore automatically classified this as a substantial error.
- **Whether they were released in error from remand, rather being detained.** Individuals released from remand are not subject to the public protection safeguards that normally accompany a planned release from custody. Unlike sentenced prisoners who are released on an incorrect date, they will not by default be managed in the community by probation. This will mean in most cases there will not be a community management plan in place for those released from remand which would ordinarily carry with it licence conditions, such as tagging, exclusion zones and drug testing. As well as this they would not be required to regularly report into probation officers. A release in error in these circumstances results in the individual returning directly into the community without this risk management, and these are by definition cases where a judge has deemed

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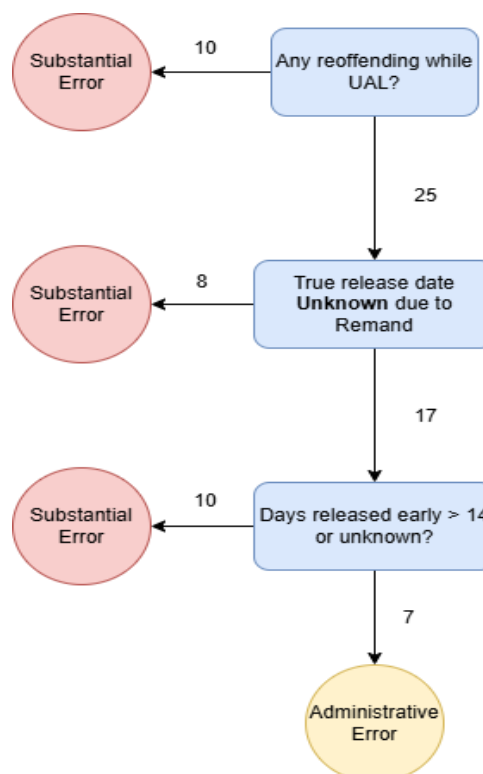
it necessary that the individual is in custody due to their own assessment of risk of various kinds.

- **The scale of the early release to delineate between substantive and administrative cases.** Individuals in this circumstance typically enter probation supervision upon release and therefore are subject to the normal structures of risk management and public protection. Although these individuals typically enter probation supervision upon release, an early release of any more than 14 days raises wider concerns. Losing two or more weeks of the custodial sentence impacts both the fairness of the punishment to the offender and public confidence in the justice system's ability to administer sentences correctly. This threshold therefore marks the point at which the release error becomes more than a minor administrative discrepancy.

To determine the gravity of the release in error I used the decision tree set out below.

I have also included in Annex H a compendium of all cases I reviewed, and listed results of the qualitative analysis (i.e., the found 'type' of error), as well as my conclusion on whether they constituted a substantive or administrative error.

Error Gravity Decision Tree



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Annex H: Compendium of cases analysed

Case number	Location	Main Offence (see proforma for more detail)	'True release date' (where known)	Date of release	Date returned to custody (where applicable)	Offences committed whilst released in error	Days UAL	Days Released Early	Gravity of error (administration of justice error vs more substantive error)
2	HMP Peterborough	Breach criminal behaviour order	2025-11-24	2025-11-04	2025-11-19		15	20	Substantial
4	HMP Ranby	Burglary dwelling and theft - no violence	2025-05-23	2025-01-29	2025-11-14	Burglary other than dwelling - theft	289	114	Substantial
5	HMP Foston Hall	Section 18 - grievous bodily harm with intent	2025-10-27	2025-10-24	2025-11-18		25	3	Administrative
6	HMP Wealstun	Burglary other than dwelling with intent to steal	2024-05-17	2024-04-11	2025-11-11	Possess an offensive weapon in a public place	579	36	Substantial
7	HMP Leicester	Affray	2025-09-17	2025-09-15	2025-09-23		8	2	Administrative
8	HMP Bristol	Section 18 - wounding with intent	2027-08-21	2025-11-27	2025-11-28		1	632	Substantial
10	HMP Kirkham	Possess with intent to supply a controlled drug of Class A - Heroin	2026-02-03	2024-09-10	2025-12-22		468	511	Substantial
11	HMP Humber	Possess with intent to supply a controlled drug of Class A - Cocaine	2025-07-27	2025-01-29	Still UAL - warrant amended to not required		See note in true release date	179	Substantial

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					to return to custody				
13	HMP ISIS	Assault a person thereby occasioning them actual bodily harm	2025-05-02	2024-12-05	2025-05-28	Possess a firearm with intent to endanger life / enable an other to do so	174	148	Substantial
14	HMP Coldingley	Possess knife blade / sharp pointed article in a public place - Criminal Justice Act 1988	2025-12-04	2025-11-26	2025-12-01		5	8	Administrative
15	HMP Humber	Possess with intent to supply a controlled drug of Class B - Cannabis	2025-09-09	2025-08-26	2025-12-22		118	14	Administrative
16	HMP Winchester	Assault a person thereby occasioning them actual bodily harm	2025-12-25	2025-11-07	2025-12-04		27	48	Substantial
18	HMP Altcourse	Assault a person thereby occasioning them actual bodily harm	2025-05-07	2025-05-01	2025-05-12		11	6	Administrative
19	HMP Nottingham	Wound / inflict grievous bodily harm without intent	2025-09-14	2025-09-11	2025-09-20		9	3	Administrative
20	HMP Oakwood	False imprisonment	2022-08-30	2022-07-19	2022-11-03	Threaten a person with a blade / sharply pointed article in a public place	107	42	Substantial

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21	HMP Leeds	Intentional strangulation	2024-07-07	2024-04-17	2024-04-23		6	81	Substantial
22	HMP Liverpool	Burglary dwelling - with intent to steal	2025-05-03	2025-02-27	2025-03-04		5	65	Substantial
23	HMP Wealstun	Burglary other than dwelling - theft	2025-05-29	2025-05-28	2025-06-23	Theft from a shop	26	1	Substantial
35	HMP Featherstone	Affray	2026-01-08	2024-09-10	2024-09-18	Harassment - breach of a restraining order on conviction	8	485	Substantial
40	HMP Belmarsh	Theft of motor vehicle	2025-06-01	2025-01-02	2025-05-05	Theft from a shop	123	150	Substantial
41	HMP Brixton	Burglary other than dwelling - theft	2024-09-20	2024-09-20	2024-08-28	Burglary other than dwelling - theft	13	36	Substantial
42	HMP Pentonville	Assault a person thereby occasioning them actual bodily harm	2025-07-22	2025-07-22	2025-08-29		38	0	Administrative
1	Maidstone Crown Court	Theft - other - including theft by finding	Remand	2025-11-03	2025-11-18		15	Unknown	Substantial
9	Highbury Corner MC	ABH	Remand	2025-09-26	2025-12-10		75	Unknown	Substantial
12	Bexley Heath Magistrates Court	Common assault	Court - no sentence calc	2025-03-19	2025-11-29	Common assault	255	Unknown	Substantial
17	Released from HMP Peterborough	Send communication threatening death or serious harm	Remand	2025-10-30	2025-12-09		40	Unknown	Substantial

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24	HMP Rochester	Threats to kill	Remand	2025-06-03	2026-01-05		216	Unknown	Substantial
25	HMP Humber	Theft from a shop	Remand	2025-03-14	2025-03-20		6	Unknown	Substantial
29	HMP Durham	Racially / religiously aggravated intentional harassment / alarm / distress - words / writing	Not Available	2025-05-12	2025-07-21		70	Unknown	Substantial
30	HMP Nottingham	Assault a person thereby occasioning them actual bodily harm	Remand	2025-07-21	2025-07-25		4	Unknown	Substantial
33	PECS north	Not known	Remand	2025-05-09	NSP		No return date	Unknown	Substantial
34	HMP Bronzefield	ILLEGAL IMMIGRANT/DETAINEE	Removal Order - no release date	2024-03-27	Immigration bail		No return date	Unknown	Substantial
36	HMP ISIS	Conspiracy to supply controlled drug - Class B - Other	Not Available	2022-05-13	2023-07-02		415	Unknown	Substantial
38	HMP Norwich	ILLEGAL IMMIGRANT/DETAINEE	Remand	2023-09-15	2023-10-12		27	Unknown	Substantial
39	HMP Berwyn	Assault by beating	Remand	2023-06-22	2024-02-07	Theft from a shop	230	Unknown	Substantial

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Annex I: An example of a Proforma used to report Release in Error

01. Prison where the incident occurred.
02. Type of incident (highlight).
03. Date(s) of incident.
04. Details of incident. (Please include as much detail as possible covering time of discovery, method of discovery, person who discovered abscond/ROTL failure, immediate follow up action taken – eg police notified, contingencies activated etc)
05. If the incident was a release in error or unlawful detention, was it an SDS40 sentence? (Please provide details as to if it was part of tranche 1 or 2 releases and if CRDS was used as part of the calculation).
06. Name and prison number(s) of individual(s) involved.
07. Date(s) of birth.
08. Details of current offence(s).
09. Current sentence length(s). (include tariff if relevant)
10. Recall information. (if applicable) Date recalled and recall offences
11. Release date(s).
12. Date each prisoner arrived at current establishment and from where.
13. Custodial movement history of each prisoner.
14. Custodial behaviour of each prisoner to include adjudications, IEP reviews in the last 6 months. Any recent pertinent intelligence.
15. Any previous abscond history for each prisoner.
16. Any previous instances of ROTL including ROTL failures for each prisoner.

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17. Details of each prisoner's previous convictions.

18. Has an investigation/review been locally commissioned and by who.

19. Has any immediate initial learning been identified? If yes, provide details.

20. What is the local view on the root cause of this incident? i.e. why did it happen?

21. Will enhanced management checks be applied until the investigation reports – give details of what is being applied.

22. When is the next update from the Police.

23. Number of Absconds/TRF/RIE/UD over the last 12 months and date of the last incident.

24. Date of incident being reported onto IRS

25. Local IRS report reference number

26. This form completed by:
Contact information (email & phone)

27. Confirm that a copy of this document has been shared with the PGD Office and that the investigation/review report will be shared with the Deputy Director.

Annex J: Release in Error - Root Cause Analysis 2021 – Recommendations

Primary recommendations

- Standardise the format of all Custody files
- All sentence calculation checks should be blind checks in a process overseen by the Hub Manager
- Consider moving the 14 day check to earlier in the sentence (90 days or 3 months before release)
- Dispense with the second sentence calculation check altogether to save resource
- The standard of investigations should be raised, with an imperative for Prison Group Directors to satisfy themselves that a sufficient level of enquiry has taken place following a release in error and that learning is shared

Further and future enquiries

- PECS should review the 3 most recent releases in error when the local investigations have been concluded
- The value of using Root Cause Analysis as a method of quickly identifying systemic failings should be reinforced by establishing the capability through OSAG to respond promptly in the future when required

Training and Resourcing recommendations:

- Establish and publish a baseline for sentence calculation competence
- Governors should ensure that all Caseworkers have received Introduction to Sentence Calculations training
- Governors should ensure that all OMU Hub Managers, Heads of Offender Management Services and a sufficient number of Caseworkers have received Advanced Sentence Calculations training
- Learning & Development Group should complete analysis and ensure there is a sufficient supply of sentence calculation training to meet projected demand
- Learning & Development Group should complete an evaluation of the effectiveness of that sentence calculation training which has been delivered remotely during the pandemic

Structure of OMUs:

- Encourage the revision of Offender Management Units staffing models to show the potential offered by Band 4

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- The organisation should satisfy itself that the job descriptions of Band 4 Caseworkers specify responsibilities relating to checking sentence calculations
- Change the default position to encourage Governors to consider the Head of Offender Management Services and Head of Business Administration as non-operational roles
- Promote the value of dedicated personnel/teams in Receptions and Offender Management Units. Discourage the use of Agency staff in the latter

Policy development and communication

- Ensure future changes to the sentence calculations and discharge frameworks pass through the management line and not just through the Senior Leaders Bulletin. Consider using Prison Group Officers to confirm receipt
- Begin work with the Ministry of Justice to seek to rationalise the length of existing policy and strengthen it

Work with other Agencies

- Enter into dialogue with HMCTS to discuss changing the appearance of warrants to ensure they are consistent in their format and denote remand warrants

Prison operations

- Out of hours immediate releases should not be signed up off by Duty Governors unless they have sufficient knowledge that enables them to do perform the role
- There should be clear escalation routes for staff to follow in the event of a potential error being detected
- No calculations should be conducted without first accessing any back records that may exist
- Require the printing and immediate filing of all electronic licences
- Embrace and promote the use of checklists circulated w/c 24 May 2021; Consider enhancing this offer with a Licences checklist
- Promote the use of peer audit

The organisation

- Don't put too much stock in quickly and affordably finding a digital solution

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Annex K: Government Internal Audit Agency Recommendations

Recommendations
1.1 HMCTS and HMPPS should work together to engage with senior judiciary to share the difficulties being experienced and seek buy-in to the pursuit of solutions to difficulties emerging where sentences are not accurately captured. (High Priority)
1.2 HMCTS and HMPPS should work together (including with their respective digital providers) to seek digital solutions to provide validation and reduce downstream processing. (High Priority)
1.3 HMCTS should review arrangements for the manual sharing of orders and warrants during technical outages or other circumstances that necessitate their use to ensure a prominent and suitably accessible record of changes made is available to all users of Common Platform. (High Priority)
1.4 HMPPS should consider an organised programme of recalculation of historic sentences supported by Calculate Release Date Service (CRDS). (Low Priority)
1.5 HMCTS and HMPPS should investigate what solutions might be available to enhance communication and resolution of urgent operational queries outside of normal working hours. (Medium Priority)
1.6 HMCTS should consider the provision of limited access to LIBRA for nominated staff in Offender management Units (OMUs). (Medium Priority)
2.1 HMCTS and HMPPS should work together to identify and allocate SPOCS in all courts and establishments and direct all post court communications from establishments direct to courts. (Medium Priority)
2.2 HMCTS and HMPPS should work together to consider how day to day operations can be more effectively coordinated (Medium Priority)
2.3 HMCTS and HMPPS should work together to encourage a programme of 'go see' visits and knowledge sharing. (Medium Priority)
2.4 HMCTS and HMPPS should work together to review and refresh the SLAs (Low Priority)
2.5 HMCTS and HMPPS should work together to encourage the introduction of regular local operational stakeholder meetings (Low Priority)
3.1 HMCTS and HMPPS should review the Terms of Reference for the Criminal Custodies Improvement Board (CCIB) to assess whether they are sufficiently broad in scope to enable it to address the issues it has identified to date. (Medium Priority)
3.2 HMCTS and HMPPS should work together to develop the profile of the Criminal Custodies Improvement Board (CCIB) and its ability to capture, coordinate and learn from local initiatives and intelligence gathered. (Medium Priority)
4.1 HMCTS and HMPPS should work together to develop Management Information sources that can provide insight on operational effectiveness as part of the Criminal Custodies Improvement Board (CCIB) activity. (Medium Priority)
4.2 HMCTS and HMPPS should work together to reconcile release in error and unlawful detention records (HMPPS) with detention related failure records (HMCTS) and improve reporting if discrepancies are confirmed. (High Priority)