



HM Inspectorate  
of Probation

HM Inspectorate of Probation



JOINT THEMATIC INSPECTION  
REPORT

*Putting Risk of Harm in  
Context*



An inspection promoting Public  
Protection

Home Office

2006

## Foreword

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This report is being published at a time of heightened public concern and rising expectations about public protection generally. Independent reviews of a small number of recent cases have clearly underscored the importance of effective offender management. While it will never be possible to eliminate risk when an offender is being managed in the community, it is right to expect the work to be done to a consistently high standard.

The police, prison and probation services each have a responsibility to take all reasonable action to protect the public, but no single agency has the capacity to deliver effective public protection on its own. This recognition has led to the development of Multi-Agency Public Protection Arrangements and the designation of the three services as Responsible Authorities. While there is now a much more determined partnership approach to the management of offenders, the challenge of greater collaborative working should not be underestimated. Tackling the complexities of Risk of Harm effectively requires not only coordinated policy, but also coordinated practice.

Against this background, the joint inspection on which this report is based took place in 2005. The aim was to take a snapshot of the progress being made towards more coordinated working by police, prisons and probation staff. While we found that much had been achieved, there were also many areas for improvement. In making sense of our findings therefore, it is important to note that our fieldwork took place at a time of major change. What we are describing can be better understood as the identification of stages on a journey rather than a destination reached.

In our report, we have tried to clarify what we think could be reasonably expected from probation, prisons and the police and their partners in the Multi-Agency Public Protection Arrangements. In essence, this amounts to the identification and assessment of individual offenders, and taking all reasonable action to keep to a minimum their Risk of Harm to the public. We then assessed how far this was being achieved in practice at the time of the inspection.

There can be no doubt that this is difficult and challenging work for organisations that see both the worst of human behaviour and the ability of people to change and develop their potential. In general, our findings reveal many encouraging examples of effective work, but there was a clear need for improvement in about one-third of the case work we looked at last year. The challenge for everyone involved is to do the job well enough often enough, and we hope that this report will make a useful contribution to further progress towards that end.

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## Glossary of abbreviations

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ACO	Assistant Chief Officer (Probation)
ACPO	Association of Chief Police Officers
BCU	Basic Command Unit (Police)
CCTV	Closed Circuit Television
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service
CO	Chief Officer (Probation)
DCI	Detective Chief Inspector (Police)
ESI	Effective Supervision Inspection
GP	General Practitioner
HMP	HM Prison
HMI Probation	HM Inspectorate of Probation
HMPS	HM Prison Service
IDRMM	Inter-Departmental Risk Management Meeting
IRMT	Inter-Departmental Risk Management Team
ISP	Initial Sentence Plan
MAPPA	Multi-Agency Public Protection Arrangements
MAPPP	Multi-Agency Public Protection Panel
MDO	Mentally Disordered Offender
NHS	National Health Service
NOMIS	National Offender Management Information System
NOMS	National Offender Management Service
NPD	National Probation Directorate
NPS	National Probation Service
NSPCC	National Society for the Prevention of Cruelty to Children
OASys/eOASys	Offender Assessment System/electronic Offender Assessment System
OGRS2	Offender Group Reconviction Scale 2
OM	Offender Manager
PC	Probation Circular
PIO	Police Intelligence Officer
PPLRU	Public Protection and Licence Release Unit
PNC	Police National Computer
PSO	Prison Service Order
PSR	Pre-sentence report
RANSNG	Responsible Authority National Steering Group
RM 2000	Risk Matrix 2000
RSO	Registered Sex Offender
SARA	Spousal Awareness Risk Assessment
SFO	Serious Further Offence
SMB	Strategic Management Board
SMART	Specific, Measurable, Achievable, Realistic and Time-bounded
SPO	Senior Probation Officer
SOPO	Sexual Offences Prevention Order
SOTP	Sex Offender Treatment Programme
SPOC	Single point of contact
SSR	Specific sentence report
ViSOR	Violent and Sex Offender Register

\* See **Appendix 1** for detailed explanations of these tools.

## The structure of the inspection and report

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The aim of the inspection was to assess the effectiveness of inter-agency arrangements for the protection of the public. This was done by examining work undertaken by criminal justice agencies to prevent reoffending by offenders subject to MAPPA. The areas covered included an examination of the quality of public protection policies and procedures; the effectiveness of MAPPA; the exchange of information/intelligence at significant points in a sentence; restrictive interventions; evaluating the use of assessment tools and inspecting the quality and linkage of assessment, intervention and outcomes.

Probation and police areas were selected ensuring they had not recently been inspected. The eight areas selected were County Durham, Derbyshire, Hampshire, Kent, Lancashire, the London Borough of Newham, North Wales and Suffolk. There was a mix of urban and rural areas and some had special features. For example, County Durham had a co-located team of police and probation officers; Hampshire invited offenders to their MAPPA meetings.

The case sample lists from each of the eight probation areas determined the selection of prisons. Where there were clusters of offenders in particular prisons, they were included. Nine prisons were inspected: HMPs Wymott, Acklington, Maidstone, Durham, Altcourse, Elmley, Wandsworth, Canterbury and Frankland. The sample consisted of all prison licence cases aged 21 and over, sentenced to 12 months and over, who were assessed as high or very high Risk of Harm or were MAPPA Level 2 or 3 cases.

There were three samples of cases. List A cases were inspected in relation to the three months before and three months after imprisonment, List B cases were inspected in relation to the six months before release and List C cases were inspected in relation to the first six months on licence.

The sample list was sent to the respective police areas via HMI Constabulary, and lists A and B were sent to HMI Prisons. We inspected 184 probation case files, 40 prison files, and the majority of the 80 police files examined were from List C, i.e. post-release. At the time of the inspection, the ViSOR implementation was ongoing and ViSOR records were examined where relevant.

We interviewed 40 offenders, either face-to-face in prison or by phone if supervised on licence in the community. Senior managers from all three agencies were interviewed as well as representatives of Probation Boards, SMBs, frontline staff, and staff in approved premises. The RANSG, the senior management team of the NOMS PPLRU and the Area Manager from HMPS with responsibility for public protection were also interviewed. Finally, we interviewed the head of the lifer review and recall section of the Home Office about how the life sentence system was linked to MAPPA.

Inevitably, an inspection covering the work of three major public services and their partner organisations produced a great deal of detailed material. In order to make this

report as clear and accessible as possible, we start with a list of ten key general recommendations that arise from the report as a whole.

In the main body of the report we draw together the findings relating to assessment, intervention and outcomes, before ending with a chapter on leadership and strategic planning. Although the material did not lend itself to every chapter having exactly the same structure, so far as possible we identify a series of criteria in each, before setting out the strengths and areas for improvement and providing good practice examples. We then summarise the key findings relating to each criterion and give a reminder of the specific priorities for improvement. As appropriate, there is cross-referencing to inspection data contained in the tables in Appendix 2.

Some of the areas for improvement identified in the inspection have relevance to the delivery of police, probation and prison services collectively, but some are relevant to just one or two of these. Wherever possible, and for ease of reference, we have suggested the main target for areas and priorities for improvement by including the abbreviations 'POL', 'PRIS' and 'PROB' alongside.

To summarise, therefore, our findings and recommendations are presented on three levels. The first is the overarching list of strategic recommendations arising from the report as a whole; the second, the priorities for improvement suggested by the findings for each criterion; and the third, the detailed areas for improvement.

## Recommendations

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***The following ten key recommendations summarise the improvements needed and apply to all three services.***

***The prison, probation and police services should ensure that:***

1. good public protection principles take high priority for the police, prisons and probation services and are reflected in clear standards and targets for each agency; recent progress is recognised and built upon by sharing good practice nationally
2. there is a more consistent understanding and use of MAPPA, including common definitions shared by all agencies, better recording of caseloads, streamlined processes, shared targets and co-location of staff where feasible
3. high quality OASys Risk of Harm assessments are completed and used in every case as a key ingredient in effective offender management at all stages of the criminal justice process, and are given a higher profile in prisons
4. thorough sentence planning begins early in sentences and includes outcome-focused objectives, Risk of Harm management issues, and involves prison and probation staff as well as the offender
5. there is effective work during custody to prepare offenders for release, maximising continuity of offender management, demonstrating a commitment to diversity and sustainability and including improved links with approved premises and other accommodation, as well as better arrangements for deportation
6. victim awareness work is given a higher priority, particularly in the prison setting, with greater use of victim impact statements, better recording in custody and the community and greater police involvement in monitoring licence conditions concerning victims
7. information sharing and good recording form the bedrock of effective offender management at all stages of a sentence, including regular reviews of Risk of Harm, improved management of MAPPA and better communication with approved premises staff. Progress is made in the development and use of a common case record format
8. arrangements are made to share good MAPPA practice across England and Wales as a contribution to greater consistency, and regular local multi-agency audits of MAPPA in practice should be carried out in all areas
9. resources are well managed, facilitating adequate staff training on Risk of Harm; information is available on the costs of various interventions, giving greater prominence to value for money; there is a review of the funding arrangements for MAPPA, including the contribution from HMPS
10. the strategic commitment of senior staff in prisons and the police to good public protection practice is encouraged and reinforced, and prison governors should ensure that Risk of Harm assessments are properly managed and that their senior managers are appropriately involved in these.



## 1. ASSESSING OFFENDERS AND SENTENCE PLANNING

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### A. Public and Professional Expectations

The public might very reasonably expect that the police, probation and prison services would work closely together to ensure that information on each offender is shared at all stages of the criminal justice process and that Risk of Harm to others is thereby minimised. In reality, in the past there was a tendency for each of these services to work in a more fragmented way, but the last decade has seen a growing recognition of the importance of good liaison and partnership working if offender management and public protection are to be achieved effectively. This approach was, to a large extent, reflected in organisational changes such as the advent of NOMS, but ultimately required work at regional and local levels to be achieved.

### B. The Inspection Approach

In order to ascertain the overall quality of assessment and planning in 2005, our inspection focused on the following criteria: preparation for a sentence or a release from custody; assessment of Risk of Harm; assessment of likelihood of reoffending; assessment of offender engagement; sentence planning as a whole. After first stating the criterion, we then go on to identify strengths and areas for improvement and to note any good practice examples. We end each criterion with a key finding and summarise priorities for improvement.

#### 1.1 Preparing for sentence or release

***Criterion: Activity in the phase leading up to sentence, release or re-release is timely, purposeful and effective.***

- (a) We covered here the activity immediately before and after reception into custody and later activity around the point of release. The local probation area would normally have prepared a PSR analysing the offence, assessing likelihood of reoffending and Risk of Harm to the public, and proposing sentence. An OASys assessment should have directly influenced the content of the PSR. Sometimes offenders were sentenced to a period of imprisonment without a PSR – e.g. after a guilty verdict at Crown Court trial - and in these cases an OASys would not have been prepared either. Consequently, there were occasions when prisons received neither a PSR nor OASys, leaving them with little information about a new prisoner. Latterly sending OASys to a prison was becoming less of an issue as electronic network connectivity between probation and prisons was achieved.
- (b) There were three levels of management under MAPPA: Level 1 - single agency; Level 2 - local multi-agency; Level 3 - for those offenders who required multi-agency management and additional resources because of their Risk of Harm or media interest.

- (c) From a police perspective, there were logistical issues which impacted on liaison and joint working during the period leading up to release. To assist in addressing these, PIOs were provided by the local force. The role of the PIO varied according to local agreement but, in general, they acted as a SPOC for liaison and the gathering and dissemination of intelligence, and also assisted with the preparation of intelligence packages, where required, for offenders on release. We assessed whether licence conditions were comprehensive and necessary, proportionate to the Risk of Harm and likelihood of reoffending and to the protection of victims.
- (d) The tables in Appendix 2 particularly relevant to this criterion are numbers 1 and 2.

## **Findings**

### **Strengths**

- (i) A number of important documents were being sent by probation staff into prison at the point of sentence. In 75% of our sample of prison files we found a PSR. Other documents sent included psychiatric reports, lists of previous offences, post-sentence interviews and risk of self-harm notifications.
- (ii) Some prisons screened all prisoners for public protection issues during induction, focusing on identifying immediate issues of Risk of Harm. This was separate from work aimed at reducing the Risk of Harm a particular offender posed and which would be incorporated into his or her sentence plan and included such measures as restricting mail or telephone contact and warning staff of the Risk of Harm posed to them, other prisoners, and visitors or other members of the public.
- (iii) In all 90 probation cases where the offender was on licence, a copy of the licence was on the case file. The majority of conditions included in the licence were comprehensive (87%) and not excessive (95%). The conditions were proportionate to the Risk of Harm (88%), likelihood of reoffending (89%) and protection of victim(s) (87%).

### **Areas for improvement**

- (i) CPS packs and victim impact statements were rarely found in prison files.
- (ii) Where a MAPPa meeting had been held, minutes were only sent to the prison if prison representatives had been invited to attend the meeting.
- (iii) We looked at the quality of reports on those in custody prepared by both prison and probation staff, such as those relating to parole, lifers etc. Although these reports were primarily clear and thorough, they did not make sufficient use of OASys and other available assessments.
- (iv) Upon reception, most prisons merely recorded that the prisoner might be a case where public protection measures applied and then waited until a few months before release to contact the home probation area. Not all prisons even routinely screened prisoners who were potentially subject to MAPPa. Some did so only when the offender had been identified as high or very high

Risk of Harm after some time in custody and most focused on those offenders who posed a Risk of Harm to children or a specific individual under the anti-harassment provisions.

- (v) Some prisons were setting their own provisional MAPPA levels. This was worrying practice because it implied that no progress would be made in reducing Risk of Harm throughout the sentence, confused Risk of Harm with the level of resources needed to manage the risk and did not involve other agencies in the decision-making.
- (vi) Direct police involvement with prisons prior to release tended to be limited. Not surprisingly, the level of proactivity in this area was found to depend on the size and composition of the population in a given prison and the consequent level of demand. Also not surprisingly, given that PIOs were employed by a local police force, there was greater proactivity and closer direct liaison when an offender was being released locally. Police were not always advised of releases on temporary licence, which meant that they had no input into these temporary licence conditions.
- (vii) Whilst prison staff potentially had a significant contribution to make to risk management information at the point of release, and were willing to do so, the structures were not yet in place to allow this to happen in a consistent and coordinated manner. It was hoped that the rollout of the ViSOR to the prison and probation services would go a considerable way to addressing this.
- (viii) In a fifth of cases of prisoners just starting their sentence, and just over a third of those prisoners about to be released, we found little evidence of positive, proactive and timely work between prisons, probation and police. When there were examples of the three agencies working well together, too much depended on the prison in which the offender was placed and on the practice of the individual OM.
- (ix) A minority of serving prisoners in the sample had not been allocated an OM. In one area, high Risk of Harm prisoners were not allocated an OM until six months before their release.

***Good Practice Example: Inter-agency liaison***

*HMP Wymott, where public protection arrangements were well established, was consistently referred to as an example of good practice, and in Durham, joint prison visits by police and probation were undertaken three months before release. The PIO attended MAPPA meetings held in the prison, and prison staff were invited to external MAPPA meetings. When a sex offender was released from prison, there was already a management plan in place, and a MAPPP for Level 3 or a risk management meeting for Level 2 would only be held, therefore, if there were other concerns, such as with housing or health, or to ensure that agencies were carrying out necessary actions.*

**Key Finding**

There was a clear need for both prison and probation staff to give more attention to preparing offenders for release, and this task should start at the very beginning of their

prison sentence. This finding fits with the aspirations of the NOMS offender management model, which emphasises continuity of contact between the OM and the offender throughout the prison sentence and the involvement of the OM and offender supervisors (prison staff) in prison with assessment planning and interventions. For probation staff in particular, it will require a sustained focus on the management of a case immediately after the preparation of the PSR.

***Priorities for improvement:***

1. Prison and probation staff give more attention to preparing offenders for release and are encouraged to start this task at the very beginning of a prison sentence. (PRIS, PROB)
2. OASys makes a major contribution to every case, especially those involving the assessment and management of high Risk of Harm. (PRIS, PROB)
3. The general arrangements for dealing with cases subject to MAPPAs should be clarified in the planned revision of the Prison Service Public Protection Manual. This revision should include achieving consistent definitions and the screening of prisoners potentially subject to MAPPAs. (PRIS)
4. Information, such as the minutes of previous MAPPAs meetings, is sent to prisons at the start of an offender's sentence and police, probation and prison staff are encouraged to work closely together to reduce the Risk of Harm to others. (PRIS, PROB, POL)
5. Prison sentence plans include internal and external contributions and involve the offender. (PRIS, PROB)
6. There is a need for more consistent resourcing of the PIO role. (POL)

**1.2 Assessment of Risk of Harm**

***Criterion: Risk of Harm is comprehensively and accurately assessed using OASys in each case and additional specialist assessment tools where relevant.***

- (a) The main Risk of Harm tool used by probation areas - and more recently in the prison service - was OASys. Some probation areas were beginning to use SARA for domestic violence perpetrators and others were employing their own psychologist to carry out more specialist assessments. In the majority of probation case files, there was no evidence of other specialist assessment tools being used, apart from RM 2000, which assesses likelihood of sexual reconviction rather than Risk of Harm.
- (b) By April 2004, all probation areas were required to use the electronic version of OASys. This new system also contained a structure for the creation of supervision plans and was introduced in prisons at the same time to assist in the joint assessment of prisoners. OASys included a framework to assess Risk of Harm and ascribed four levels of risk: low, medium, high and very high. The probation national standard required that probation staff should undertake a Risk of Harm 'screening' on every offender at, or soon after, first contact.
- (c) An OASys Risk of Harm screening should have been completed accurately by the OM at the time a PSR was prepared for court and at the point an offender was released from prison in all cases. If this initial screening resulted in a 'concern'-

for example, the nature of the offence or pattern of behaviour - a full Risk of Harm analysis was required. A key element of a good quality full OASys Risk of Harm analysis was the inclusion of assessments drawn from MAPPAs meetings, other agencies' or previous probation assessments (specifically the results and conclusions from RM 2000, post-accredited programme reports, psychological and medical reports) and taking account of victim issues.

- (d) The role of managers in dealing with Risk of Harm was very important. In some instances where the screening document indicated that a full Risk of Harm analysis should have been completed, the OM could put forward exceptional reasons why, in their professional opinion, it was unnecessary. Any such explanation had to be agreed with the SPO who should have countersigned the relevant section of the assessment. Probation areas should have been monitoring such exemptions.
- (e) For all cases other than those assessed as low Risk of Harm, a risk management plan should also have been completed. This plan normally included a specific additional level of management oversight and monitoring of the case.
- (f) For those offenders assessed as presenting a high or very high Risk of Harm, consideration should have been given to referral to the local MAPPAs, and the decision should have been recorded. The purpose of MAPPAs was to ensure that all relevant agencies worked together to assess and manage offenders' Risk of Harm to others.
- (g) The table in Appendix 2 particularly relevant to this criterion is number 3.

## **Findings**

### **Strengths**

- (i) In 91% of probation cases at the start of a prison sentence and 86% of licence cases, the assessment of Risk of Harm was appropriate.
- (ii) In cases where the full Risk of Harm analysis was completed, it was satisfactory in 91% of cases at the start of the licence when the offender was released, but in only 75% of cases where this was completed at the PSR stage.
- (iii) In nearly three-quarters of our sample of probation licence cases, there were references to other assessments and victim issues.

### **Areas for improvement**

- (i) In 39% of cases, a Risk of Harm screening had not been completed at the start of a licence. There were occasionally very lengthy delays in completing OASys after a prisoner's release.
- (ii) The sections relating to likelihood of reconviction in OASys may contribute to the assessment of Risk of Harm, but in some cases these were not completed as they should have been and this linkage was not made.
- (iii) On a few occasions, the reasons given by the OM for not completing a full Risk of Harm analysis were regarded as weak and there was insufficient management consistency in dealing with this issue.

- (iv) In only half of the relevant probation cases had a comprehensive risk management plan been completed on high and very high Risk of Harm offenders within five working days of their release from prison.
- (v) While public protection coordinators and clerks within prisons were very aware of the important role of OASys, governors were less so.
- (vi) In a third of cases of offenders who had recently been sentenced and those on licence, there was insufficient evidence of adequate probation middle or senior management involvement in the assessment of Risk of Harm.
- (vii) In prisons, governors should ensure that Risk of Harm assessments are properly managed.

***Good Practice Example: Management oversight***

*In North Wales Probation Area, middle managers had to countersign OASys within five working days. Back-up arrangements were in place if the SPO was absent. This activity was monitored and any concerns were addressed with individual middle managers.*

**Key Finding**

Practice in 2005 was not sufficiently consistent and the issue was often not receiving the attention it deserved from managers at all levels. A good quality OASys Risk of Harm assessment is a key ingredient in effective offender management at all stages of the criminal justice process. On some occasions, it triggers other specialist assessments, which in turn should be fed back into the OASys assessment itself. A comprehensive risk management plan should be completed on all high and very high Risk of Harm offenders within five working days of their release from prison.

***Priorities for improvement:***

1. The assessment of Risk of Harm is given high priority and a good quality OASys Risk of Harm assessment is widely promoted as a key ingredient in effective offender management at all stages of the criminal justice process. (PRIS, PROB)
2. Probation areas make full use of middle and senior managers in the assessment of Risk of Harm in accordance with probation national standards. (PROB)
3. Although there should be a SPOC in each prison for all public protection/MAPPA cases, at the time of our inspection these arrangements were not yet bedded in. (PRIS)
4. Prison governors should ensure that Risk of Harm assessments are properly managed and that a senior caseworker is nominated to oversee and quality assure OASys assessments for higher risk offenders. (PRIS)
5. Comprehensive risk management plans are completed in a timely fashion. (PROB)



### 1.3 Assessment of likelihood of reoffending

**Criterion: *Likelihood of reoffending is comprehensively and accurately assessed using OASys and RM 2000 as applicable.***

- (a) It is important at the outset to underline the distinction between Risk of Harm under the previous criterion and the likelihood of reoffending dealt with here. Here, we mainly focus on RM 2000, as used by the police and sometimes by probation. We also briefly refer to the quality of the completion of the risk of reconviction element of OASys in probation cases.
- (b) RM 2000 is a nationally agreed assessment tool used by the police and other agencies to assess the likelihood that an offender will carry out further offences. It is an actuarial instrument that uses a number of static factors – such as age, marital status, number of previous court appearances – which are then weighted and scored to arrive at one of four risk levels (very high, high, medium or low). As with all assessment tools, it has limitations. It cannot, for example, be used in relation to female offenders or those under 18 years of age, and has only been validated for use on offenders with sexual convictions. Where a sex offender was also a violent offender, a combined RM 2000 score was calculated to arrive at an overall result.
- (c) Importantly, RM 2000 only assesses likelihood of reconviction, not Risk of Harm, and it is vital that this distinction is understood and recognised by all who use the matrix and any reports based on it. Equally important is the fact that RM 2000 is only one tool in the overall risk assessment process – it does not stand alone. RM 2000 has been incorporated into ViSOR, which automatically defaults to the RM 2000 risk level. It is the ViSOR risk level for any offender that is shown on the PNC. In addition, for RSOs, it is the RM 2000 level of risk that determines the frequency of police visits.
- (d) A sample of 100 police files was inspected. Owing to the small sample size, the use of RM 2000 was explored further during interviews with practitioners and their line managers and this resulted in a number of concerns.
- (e) The table in Appendix 2 particularly relevant to this criterion is number 4.

#### **Strengths**

- (i) There was evidence that RM 2000 was being used by probation and prison staff as well as by the police.
- (ii) Overall risk of reconviction was recorded in 41 of the relevant 54 ViSOR records.
- (iii) There were some examples of good joint working and the use of both OASys and RM 2000 to achieve better overall offender management.
- (iv) In the prison sample, 29% of prisoners just sentenced and 24% about to be released had a completed RM 2000 on file. Where these tools were used in prison, they were generally accurate.

### **Areas for improvement**

- (i) A common theme was inconsistent understanding of RM 2000 and how it should be completed, not just between police areas, but also across individual BCUs.
- (ii) Of the 54 sex offenders in the police sample, an RM 2000 was recorded in 38 cases (approximately 70%) of the total.
- (iii) 29% of RM 2000 assessments were incorrect.
- (iv) The importance of good training was highlighted. There was a general view that to expect officers to carry out risk assessments without training was unacceptable.
- (v) There was a lack of consistency, both in the use of RM 2000 in conjunction with other assessment processes, and how the overall level of risk was recorded on ViSOR.
- (vi) Examples of areas of misunderstanding included a lack of awareness of the need to complete a combined assessment for violent sex offenders; uncertainty about how some crimes, such as internet crime, should be classified; difficulties experienced in transferring ViSOR records for females between police areas.
- (vii) The inspection revealed limited coordination and significant duplication in the use of RM 2000 in some areas, with both police and probation staff completing the assessment on the same case.
- (viii) In the probation sample, the overall quality of the likelihood of reconviction assessment was sufficient in 70% of offenders recently sentenced and 67% of those on licence.
- (ix) The risk of reconviction section of OASys in probation case files was examined. It was found that in a quarter of offenders recently sentenced and a third of licence cases, the likelihood of reconviction assessment had not taken into account other agencies' and previous prison and probation assessments.

#### **Good Practice Example: Successful joint working**

*An example of excellent partnership working was found in Durham, where a joint police/probation unit operated. Here, whilst the police still completed RM 2000, and probation OASys, these were regarded as a guide, and overall decisions about level of likelihood of reoffending were made jointly and involved the manager of the joint unit. There was also clarity and consistency in relation to ViSOR.*

### **Key Finding**

Although some progress has been made, much remained to be done to improve the quality and consistency of assessment of likelihood of reoffending across prisons, police and probation. At the time of the inspection, there was still some confusion between Risk of Harm and likelihood of reoffending, and how different assessment



tools could best be used to complement each other. Good training and partnership working were generally seen as important keys to improved performance.

Since the inspection, the electronic version of OASys has been established in the NPS and will be increasingly used in prisons. RM 2000 has continued in use, but various issues have emerged from this inspection that need to be addressed. There is still no nationally agreed assessment tool for violent offenders and there needs to be a more coordinated and systematic approach to risk assessment generally. A specific national review may be very timely. This could include which risk assessment tool should be used for which category of offender; who should use it and when; whether accreditation is required, and how risk assessment tools can be used together to form an overall assessment of the offender that will contribute effectively to MAPPA.

***Priorities for improvement:***

1. The clear integration of other assessments into OASys. (PRIS, PROB)
2. Improved use of RM 2000, both as a stand-alone assessment and in conjunction with other tools. (POL, PRIS, PROB)
3. Better RM 2000 training provision. (POL, PRIS, PROB)

**1.4 Assessment of offender engagement**

***Criterion: Potential obstacles or challenges to positive engagement are identified and plans made to minimise their possible impact.***

- (a) The public expects that probation, prisons and police know what methods would be most effective with individual offenders to reduce their Risk of Harm and likelihood of reoffending. Evidence that an offender lacks motivation, fails to participate, or does not engage with the opportunities available could be an indicator of increased Risk of Harm. The ability of staff to motivate and engage high Risk of Harm offenders was, therefore, an important ingredient in effective offender management, and also contributed to minimising their Risk of Harm.
- (b) We all learn in different ways. Some people learn about new ideas in an abstract way, others understand ideas only through practical, concrete examples in the real world. To engage effectively with offenders, probation and prison staff, in particular, need to take into account the offender's learning style, motivation and capacity to change at the earliest opportunity.
- (c) Effective engagement also involves being aware of any diversity issues or other individual needs or factors that might act as a block to available interventions that could minimise Risk of Harm. This is not about pampering offenders but about removing obstacles to positive engagement. It means ensuring that they have access to interventions that would have the maximum impact. If, for example, they felt alienated or excluded when attending an accredited programme, it was unlikely to have the desired effect of reducing the Risk of Harm to the public. In the context of this inspection it was, therefore, important to look at the way in which offenders were engaged with as individuals and the extent to which staff took account of learning styles and diversity issues.
- (d) The tables in Appendix 2 particularly relevant to this criterion are numbers 5 and 6.

### **Strengths**

- (i) Both prison and probation staff had some knowledge of learning style and were aware of its significance but generally lacked the tools to assess it.
- (ii) The scores for recording race and ethnicity in our prison samples were consistently high and, for probation cases, improved as the offenders reached their period on licence.
- (iii) The score for identifying and minimising the impact of potentially discriminatory factors was mixed, but had improved by the time the offender was released on licence.
- (iv) In a general sense, interviews with OMs demonstrated that they knew what methods worked to protect the public; however, they did not always make this clear in their records. There was also good awareness of the importance of staff being confident, asking the right questions and communicating effectively.

### **Areas for improvement**

- (i) Staff were not recording how the methods they planned to use matched the learning style of the offender. When offenders were interviewed, two-thirds felt their learning style had not been taken into account.
- (ii) The active assessment of diversity or other issues by prison and probation staff was sometimes poor at the beginning of a prison sentence and required attention.
- (iii) Probation staff had limited 'tool kits' available to them to use with offenders one-to-one, as the emphasis recently had been on the implementation of accredited programmes for groups of offenders.
- (iv) There was very little evidence of prisons tackling obstacles to engagement. In addition, little was done to challenge prisoners who claimed that they were appealing against their sentence/conviction and that they were refusing any accredited programmes on legal advice.
- (v) Even when targets in prison were set, there were delays in assessments for suitability for some accredited programmes, or the programmes were not available.

### **Good Practice Example: Effective offender engagement**

*'Targets for Effective Change' was published by Nottinghamshire Probation Service in 2000. It contained practical exercises that probation staff could use with offenders, one to one. We found that it was extensively used by practitioners in the majority of areas. In County Durham a 'Citizenship' programme had been in use for some years and had recently been re-designed. The programme addressed crime-related needs, assessed using OASys, and covered drugs and alcohol misuse as well as emotional well-being, lifestyle and associations, relationships and next steps. Each module consisted of five to eight 30 minute sessions using a variety of worksheets. During interviews, however, OMs in County Durham felt that the Citizenship programme was not always suitable for use with high Risk of Harm cases.*

### **Key Finding**

Although there was good awareness of the importance of effective offender engagement in 2005, practice was very patchy. There was limited recording of it and little evidence of prisons tackling obstacles to engagement. There was good recording of race and ethnicity in our samples, but taken overall, the quality of offender engagement was judged to be satisfactory in just over half of all the cases.

### **Priorities for improvement:**

1. Explicit consideration, in both custody and community, of offender learning styles and diversity issues. (PRIS, PROB)
2. Active work to reduce obstacles to engagement, especially in prison. (PRIS, PROB)

## **1.5 Sentence planning**

**Criterion: Prison and probation staff plan interventions with a view to addressing criminogenic factors and managing any Risk of Harm. The ISP is designed to describe a coherent plan of work for each offender, while delivering all required elements of the sentence.**

- (a) Sentence planning is central to good offender management. The inspection looked at the extent to which this was happening in 2005 at each stage of the sentence, from the initial probation assessment, through the prison sentence itself and, subsequently, during the period on licence in the community.
- (b) An ISP is part of OASys. It should contain, amongst other things, a list of objectives for the offender to achieve; for example, completing a specific accredited programme. We would expect in our sample of cases that the ISP would be completed by prison staff at the beginning of a prison sentence. For high Risk of Harm offenders, probation staff should then produce a further plan within five working days of an offender's release from prison.
- (c) Ideally, the OM influenced the sentence plan created in the prison, and latterly – under later NOMS offender management arrangements - was expected to take responsibility for its compilation. Any reports on the regime interventions the

offender had experienced in the prison, such as completing an accredited programme, should influence the sentence plan written by the OM at the point the offender is released. The offender management model will facilitate this approach further in the future. However, at the time of the inspection there was little evidence of a connection between the prison and probation sentence planning processes. The use of OASys was taking time to work through the prison system, and in 2005, prisons were tending to concentrate on those who had been sentenced more recently.

- (d) A probation area's relationship with an individual prison inevitably depended, to some extent, on whether the prison had seconded probation staff from the area. This would also involve additional links at senior management level between both services. Another influential factor is, of course, the number of offenders from a particular probation area who served their sentence in a particular prison.
- (e) The management of high Risk of Harm cases usually involves a number of different agencies. As part of the inspection, therefore, we looked at the extent to which the roles and responsibilities of those various workers were recorded on probation case files.
- (f) Another issue we examined was the extent of offenders' involvement in sentence planning as a whole. It was generally agreed by probation staff that offenders should be involved and should be informed about the level of Risk of Harm they posed and that their case may be discussed at MAPPA meetings. However, for a small number of offenders, such information may give them a certain amount of status amongst their peers. Obviously, a decision to share such information has to be made carefully on a case-by-case basis and clearly recorded.
- (g) The extent to which offenders should be invited to be present at MAPPA meetings was also a live issue at the time of the inspection. In Hampshire, offenders attended part of a MAPPA meeting. It was felt by most staff to be generally positive because the offender could be questioned and the process was transparent. However, the subsequent findings of the HMI Probation independent review on the case of Anthony Rice indicated that there were potential pitfalls and distractions in inviting some offenders to MAPPA meetings and involving them too closely with the MAPPA process, despite the laudable aim of transparency and openness. Some national guidance on this issue would bring further clarity.
- (h) The table in Appendix 2 particularly relevant to this criterion is number 7.

### **Strengths**

- (i) In our prison sample of offenders who had been in custody for at least three months, just over half had a prison sentence plan. The majority of those prison sentence plans included an objective to complete an accredited programme.
- (ii) Generally, once an offender had been identified as a MAPPA case, probation and prisons worked closely together to target accredited programmes for the offender to complete.
- (iii) We found that the interventions identified in the ISP in 81% of probation licence cases were likely to reduce or contain the Risk of Harm. Also, in 70% of cases, the interventions mentioned would address offending behaviour and

in 67% would promote community integration.

- (iv) Although our findings for sentence planning were generally insufficient, ironically, in some cases the work actually being done by the OM with the offender was more comprehensive and intensive than the limited planned objective in the ISP. In other words, in some cases OMs were actually doing a good job but they were not using the ISP as a tool to assist them.
- (v) Despite the difficulties identified below, in just over half of the cases where offenders were about to be released, the OM had demonstrated commitment to the offender and played an active part in motivating and supporting them throughout their sentence.

### **Areas for improvement**

- (i) Only a quarter of objectives in the ISPs were outcome-focused.
- (ii) From the prison sample of offenders, six months before their release date, half who had an accredited programme planned had not yet started it, and under a tenth had completed a programme. Our inspection suggested that not enough were getting access to accredited programmes, despite the encouraging national prison service figures that show that 90% of those starting programmes completed them successfully.
- (iii) For offenders just sentenced and about to be released, there was evidence that probation had contributed to prison sentence plans in 32% and 40% of cases respectively, mainly by e-mail or letter and sometimes by attendance at a meeting in the prison.
- (iv) OMs felt that, because they did not undertake regular prison visits to offenders due to financial restrictions, any possible meaningful participation in prison sentence planning was reduced.
- (v) Few Sentence Planning Boards were attended by OMs and often the boards received no input at all from them. Pressure on probation staff in the field and administrative difficulties within prisons were both cited as reasons for this.
- (vi) There was no central prison directory describing what regime interventions were available in each prison. This would have assisted OMs to influence and manage the interventions an offender completed whilst serving their custodial sentence.
- (vii) Earlier engagement with offenders during their sentences and better quality planning and pre-release work were investments that paid off when compared to inadequate release plans that collapsed or unravelled close to the release date.
- (viii) In probation licence cases, just under half of ISPs were not sufficient. Shortcomings included requirements that were not sequenced or timed appropriately; inappropriate contact levels; lack of clarity about who would deliver specific interventions; and timeliness of completion.
- (ix) 57% of ISPs did not cover how any Risk of Harm posed by the offender would be managed and in nearly two-fifths of cases, the ISP did not draw on other sections of OASys or MAPPA, other agencies' assessments and previous plans.

- (x) A review of the internal structure of OASys would have been useful. For example, probation staff expressed concern that in the sentence plan section, the drop-down boxes used to create objectives did not fit with the plans that were needed for the management of high Risk of Harm cases.
- (xi) In only 56% of probation licence cases were the roles and liaison responsibilities of workers in other agencies clearly identified. Contact information was also missing in some cases or was out of date.
- (xii) Partner agencies operating within the prison occasionally arranged interventions for a prisoner that contradicted those planned by probation. Prison and probation staff needed to ensure partner agencies involved with the offender were conversant with the plans made for them.
- (xiii) In only half the probation licence cases was there evidence that the offender had the opportunity to participate in the planning process, and only half of offenders said that they were involved in their sentence plan. Less than a quarter of offenders said that they were involved in any plan reviews.
- (xiv) The personal involvement of offenders in the management of Risk of Harm was very limited. Few had been told the outcome of any Risk of Harm assessment. More than half of offenders interviewed had never heard of MAPPA. Almost all stated that they would have liked to have attended a MAPPA meeting or have been involved in some way.

### **Good Practice Example: Using new technology**

*Good sentence planning requires close partnership working between probation and prison staff in particular, but workload and geographical considerations can sometimes make this difficult to achieve. Although it was not always practical for probation staff in areas such as North Wales to visit offenders in prison due to the distance involved, the area had successfully used a video link for PSR interviews, sentence planning and oral hearings.*

*Other probation areas should consider the potential for using video links to increase contact with the offender and prison staff, and to facilitate the objectives of the offender management model.*

### **Key Finding**

Some progress had been made by 2005 to develop a more coordinated approach to sentence planning, but there was often a significant gap between what was recognised as good practice and what was actually delivered. There was little evidence that probation staff were influencing the planning process in prison, and where accredited programmes were identified as part of a prison plan, they were often not delivered or not completed. There was insufficient attention to Risk of Harm issues generally, and a lack of effective information sharing between prisons, probation, other partner organisations and the offenders themselves.

### **Priorities for improvement:**

1. Early engagement with offenders in custody. (PRIS, PROB)
2. Increased offender involvement in their own sentence plans. (PRIS, PROB)
3. Sentence plans to contain outcome-focused objectives promoting the likelihood that work with offenders will be reliably achieved. (PRIS, PROB)
4. Improved knowledge by OMs of custodial interventions and increased OM involvement in Sentence Planning Boards. (PROB)
5. More joint prison/probation planning prior to release and inclusion of Risk of Harm management issues and responsibilities of respective agencies in licence sentence plans. (PRIS, PROB)



## 2. INTERVENING EFFECTIVELY

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### C. Public and Professional Expectations

The drive to identify offenders who pose a high or very high Risk of Harm to the public and to assess the likelihood of their committing further crimes after release is a direct result of the shared commitment of police, probation and prison services to improved public protection. The public almost certainly expects that resources will be targeted to minimise risk and that the staff of the various criminal justice agencies will work together closely to achieve this end. A widely shared view is that victims' needs should have greater prominence and attention at all stages. In reality, there is a strong policy commitment to all these aims, but as we have seen in the earlier chapters it takes time to move from the fragmented approaches of the past to the more coordinated and effective arrangements demanded by effective offender management.

### D. The Inspection Approach and General Findings

Under the first criterion in this section we looked at the general arrangements in place to protect the public. At the time of the inspection, a number of areas were in the process of implementing the offender management model, and inevitably what was revealed was very much a picture of work in progress. We looked at work in prisons and then examined MAPPA in some detail. We were interested, in particular, to see the way in which the various services shared information and worked together to achieve public protection. As approved premises and accommodation generally play a central part in the resettlement of many prisoners, we examined these in particular. Finally, in this section we looked at the use of intelligence and information, focusing especially on how high Risk of Harm cases were reviewed over time.

The next criterion concerned victims. We wanted to see what progress had been made in giving proper attention to victim issues and to identify where further work was needed.

We then examined some of the practicalities of managing offenders and using information. Finally, we looked at the delivery of interventions themselves, including the extent to which they addressed diversity issues

A great deal is covered in this intervention section so we have adopted a slightly different approach to its structure in relation to the first criterion, 'Protecting the Public'. This has a number of distinct elements within it, and so to aid clarity and avoid excessively long lists, we have dealt with each of them separately. Each of the following, therefore, has its own opening explanatory comments, list of strengths and areas for improvement, and its own set of priorities for improvement:

- Prisons



- MAPPA
- Approved premises
- Accommodation
- Use of risk management information

This first criterion is rounded off by a single key finding paragraph. Subsequent criteria revert to the structure used in the previous section.

## 2.1 Protecting the public

***Criterion: Appropriate and sufficient arrangements are made to protect the public from harm caused by further offending.***

The tables in Appendix 2 particularly relevant to this criterion are numbers 8, 9, 10, 11, 12, and 13.

### Prisons

- (a) The prison service model for Risk of Harm management is set out in its Public Protection Manual. It provides guidance on how prisons should form an IRMT with responsibility for providing regular assessments for prisoners who present the greatest Risk of Harm to the public. It would be expected that all the prison cases sampled would have been case-managed by such a team and that a risk assessment would have been undertaken. The guidance envisages that these teams would use OASys and/or RM 2000.
- (b) The management of risk should be seamless throughout the sentence, with a smooth transition from managing the prisoner safely in a custodial situation to the identification, reduction and management of the Risk of Harm presented in the wider community as release approaches.

### Strengths

- (i) There was evidence of some good work within prisons, but it was not clear in the majority of cases within the file sample what specific work the prison was doing to reduce Risk of Harm.
- (ii) There were two examples of prison areas that had a MAPPA protocol or statement of commitment by HMPS with police and probation Responsible Authorities. These documents covered the prison representation on SMBs and at MAPPA meetings, the role of the IDRMM and information sharing. This was a positive step towards the integration of HMPS with MAPPA, public protection and the implementation of the offender management model.

### Areas for improvement

- (i) In only 28% of those recently sentenced had an IRMT meeting taken place. The position was worse for those approaching release, with only 12% having been considered by an IRMT panel. Paradoxically, this may indicate an

improving position in the sense that as prisons increasingly adopted the IRMT model, prisoners were being picked up early in their sentence.

- (ii) There was a lack of integration between the IDRMMs and the relevant area MAPPAs and a lack of involvement of MAPPAs at significant points in the custodial sentence, particularly relating to decisions about offenders' transfer to open conditions or return to the community, such as parole, release on temporary licence and home detention curfew. More positively, some areas already involved MAPPAs at the point when the Parole Assessment Report was due.
- (iii) Procedures for informing prison staff of the risks posed by individuals considered high Risk of Harm were weak.
- (iv) In general, at the time of the inspection OASys was not being used in prisons to drive the public protection process.
- (v) Police and probation staff recognised the considerable potential for prisons to make a significant contribution to MAPPAs, particularly in terms of risk management information, but this seldom happened in practice.
- (vi) Only 5% of offenders interviewed said that they had been involved in any meeting in the prison that discussed their Risk of Harm and 59% said that they had never heard of any such meeting.

#### **Priorities for improvement:**

1. OASys to have a higher profile in prisons. (PRIS)
2. Use of IRMTs in all relevant cases. (PRIS)
3. Fuller MAPPAs involvement during custodial sentences, and a greater contribution from prisons generally in MAPPAs. (PRIS)
4. Better systems for sharing Risk of Harm information amongst prison staff. (PRIS)

#### **MAPPAs**

- (a) Within the community, the emphasis for both police and probation staff is public protection, and local MAPPAs are the major coordinating bodies for managing the offenders who pose a high or very high Risk of Harm. At the time of the inspection in 2005, achieving agreed definitions about Risk of Harm with other agencies was a major challenge. Since the inspection was conducted, the RANSG Business Plan for 2005/2008 has included ways to improve the consistency of recording and collation of data for MAPPAs, and it will be important that local areas respond positively to that challenge.
- (b) Our sample of probation licence cases included 10% MAPPAs Level 3, 74% Level 2 and 16% Level 1. There were similar percentages for offenders who had started a prison sentence except there were no Level 3 cases. In a small number of cases from both samples, it was either not clear what the MAPPAs level was or the case did not fall within MAPPAs.

## **Strengths**

- (i) The appointment of MAPPA managers and the lead that they had given at local level was an important step towards better risk management. Whilst their role varied, a common feature was the contribution they made to greater consistency between Responsible Authorities. They were in the unique position of having an overview of the workings of other agencies in relation to high Risk of Harm. Our view was that the role was likely to be more effective if there was some form of direct link with the operational side of MAPPA.
- (ii) Whatever the differences in their roles, MAPPA managers had an intimate knowledge of MAPPA and relevant legislation. They acted as a consultant for staff and often chaired Level 2 or 3 meetings. These meetings enabled a wide range of agencies to build up a much fuller picture of the offender than before MAPPA.
- (iii) MAPPA managers generally ensured that the MAPPA process and procedures were followed consistently and were not misused or abused. They acted as a gateway and SPOC for referrals; they ensured OMs did not inappropriately delay making decisions for a MAPPA meeting; they managed thresholds so that cases were managed at the right level, checking minutes of meetings and following up actions; strategically, they provided information and data for the SMB and brought common issues that had arisen at MAPPA meetings to the attention of the SMB; some had a role in the induction and mentoring of lay advisers.
- (iv) Some of the good points we identified from the various MAPPA meeting formats were as follows: having the OASys Risk of Harm assessment table embedded in the minutes; including scores and interpretations of other assessment tools used; a statement of the legal position or status of the offender; clarification about the statutory basis on which they were being discussed at a MAPPA meeting; human rights considerations; and risk management plans that clearly identified the action to be taken, by whom and when.
- (v) From the police file sample, police attendance at MAPPA meetings was found to be excellent, with only one relevant case where there had been no police representation. Preparation was also found to be diligent.
- (vi) In general, attendance of probation OMs at MAPPA meetings was good, with a higher number of meetings attended when the offender was in the community. Some probation officers were involved in the process of inviting other agencies to the meeting. Others gathered information, prepared a report or OASys or both, and were ready to report back about any actions they were allocated at a previous meeting.

## **Areas for improvement**

- (i) The inspection found that different criteria were being applied in different areas in determining the levels at which offenders would be managed. There were also variations in processes and terminology. This was particularly evident at Level 2, where meetings were referred to as MAPPAs, Risk Management Meetings, Risk Assessment Meetings, Multi-Agency Risk Assessment Conferences, MAPPA assessments etc.

- (ii) The scope of MAPPA was also found to be expanding to meet the need to establish multi-agency plans for management of individuals falling outside MAPPA criteria. For example, in some areas, domestic abuse perpetrators were managed under MAPPA; in other areas there was a separate process. The same level of variation also occurred with child safeguarding cases.
- (iii) The need for clear shared definitions and understanding was apparent. For example, in some areas, housing organisations viewed risk as risk of non-payment of rent, damage to property or risk to other residents. The worst scenario involved housing departments evicting or accepting tenants with no reference to MAPPA; an indication of the gap between criminal justice and other services.
- (iv) Only two probation areas of eight sent three discrete and clear lists of MAPPA Level 1, 2 and 3 cases. The response to our request for this information was concerning. It indicated that not all Responsible Authorities have complete and accurate data so that at any time they could confidently report on the number of offenders managed at different levels within MAPPA.
- (v) There were also significant variations in the structure and frequency of MAPPA meetings. Most commonly, at Level 2, meetings were held on regular, pre-set days at which time a number of cases would be discussed. As numbers had grown, however, several areas had introduced specific time slots for individual cases so that professionals need only attend for those cases with which they had direct involvement. In some places there was a general lack of clarity about procedures and a growing recognition at all levels of the need to simplify things.
- (vi) The level or rank of attending officers at MAPPA meetings varied between probation and police areas as well as across BCUs in individual police forces. There were examples where the rank of attending police officers was inappropriate, but there were also good examples of lateral involvement by the police, for example, through the attendance of Child Abuse Investigation Unit staff, intelligence officers, domestic violence officers and analysts. There remains a need nationally to ensure that police representation is consistently at the right level and that those who need to be involved are involved.
- (vii) Responsibility for chairing MAPPA meetings also varied and in several areas this role tended to fall to probation staff. In some, however, there were local arrangements whereby police took responsibility for chairing meetings involving sex offenders, with probation chairing meetings involving violent/dangerous offenders. In others, the role of Chair was shared or filled by the MAPPA manager. The need for training for MAPPA Chairs and for dedicated minute-takers was widely noted.
- (viii) The quality of MAPPA meeting minutes and action plans varied and in some cases were inadequate, and slow turnaround times for minutes were a problem in a number of areas. There were variations in the format, content and detail of minutes, and sometimes even a lack of clarity about the MAPPA category and level, Risk of Harm, victim issues and follow-up action from previous meetings. It was also important that information reached the person of the right grade or rank in each organisation to ensure it was noted and relevant action taken. It was important that Risk of Harm and MAPPA

classification were reviewed regularly, with a description recorded of any action that may have been taken as a result.

#### **Good Practice Example: Prison contribution to MAPPA**

*In a prison file at HMP Elmley we found a good example of a prison's contribution to a MAPPA meeting. This was in the form of a report which covered the contact the prisoner had via mail, visits and telephone calls, recent behaviour in custody, who they associated with, attitude to the current offence, mental health concerns and future plans.*

#### **Priorities for improvement:**

1. More consistent understanding and use of MAPPA, including common definitions and processes shared by all agencies. (POL, PRIS, PROB)
2. Clearer recording of MAPPA caseloads by Responsible Authorities. (POL, PRIS, PROB)
3. A streamlining of MAPPA meetings and processes. (POL, PRIS, PROB)
4. Clarity about the involvement of police officers at MAPPA meetings. (POL, PRIS, PROB)
5. Training for MAPPA Chairs and minute-takers. (POL, PRIS, PROB)

#### **Approved Premises**

- (a) Approved premises were one of the main interventions used to protect the public. Nearly half of those offenders about to be released from prison and already released on licence were referred to approved premises and nearly all of those referrals were accepted. It was apparent that there was scope for better integration and recognition of the work of approved premises in the work undertaken by OMs and MAPPA.
- (b) Here again the transition to the offender management model was apparent at the time of our inspection. One implication for approved premises was that instead of an OM based at the approved premises having responsibility for all the resident cases, the OMs based in local probation offices retained responsibility. This change was not popular with some approved premises staff, who had previously dealt with enforcement issues immediately and would now have to refer such matters to the OM elsewhere, but there were also apparent benefits. Taken overall, there were many excellent examples of good working relationships with police and other probation staff.

#### **Strengths**

- (i) Probation areas with approved premises had strategies or policies in place for admission criteria that reflected the focus on high Risk of Harm cases and risk of self-harm or fatality.
- (ii) Communication between staff within approved premises was crucial, particularly when one shift finished and another started. Staff recorded any

significant occurrence that took place hour by hour in the logbook. They ensured that key points were reiterated in the contact logs of individual residents and the police or OM were alerted immediately to any serious concerns.

- (iii) In all seven approved premises visited, each resident would have one member of staff they would see formally, usually once a week. Key working sessions would cover a whole range of issues, including Risk of Harm. If the resident was about to move on, life skills such as shopping, budgets, cooking and cleaning were regularly covered, sometimes with the use of a volunteer.
- (iv) The fact that assistant managers and other approved premises staff were around all the time enabled them to provide pro-social modelling and gave residents every opportunity to share their concerns and discuss issues.
- (v) Staff were generally good at monitoring residents, gathering risk management information and alerting the police promptly. Most approved premises sent a list of their residents to the police on a weekly basis.
- (vi) The police would initially visit RSOs in approved premises when they had been released from prison as part of the sex offender registration process. We found excellent working relationships generally. Police officers were kept up to date by staff or through MAPPA, and almost all approved premises staff praised the police for their quick response in an emergency.
- (vii) Approved premises staff showed great awareness of the importance of employment or constructive activity for offenders and we saw a variety of imaginative arrangements to address these issues and attend accredited programmes which normally took place in probation offices.
- (viii) There was good evidence of a commitment between areas to the management of approved premises. A special quarterly meeting of ACOs in the North East region was working on a protocol for a standardised referral form for approved premises and this meeting was also attended by a representative from County Durham, despite the fact that the area did not have approved premises within its boundary.

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

- (i) It was noted by many managers that if there was not sufficient preparation and planning for a new resident, the placement tended to break down. Approved premises continued to receive referrals for offenders at very short notice, and sometimes residents arrived before a MAPPA meeting had taken place or the police had been informed.
- (ii) The police sometimes expressed concern about particular offenders in approved premises or the number of RSOs being placed there. In one area, the police were particularly unhappy if a high Risk of Harm case from outside the county decided to settle locally. As approved premises are a national resource, it was inevitable that offenders from various areas would be accommodated, and this position was not well enough understood.
- (iii) At the time of the inspection, with the exception of Hampshire, there were no guidance or practice directions about the working relationship that should operate between OMs and approved premises staff. This led to confusion



about such important matters as the frequency of three-way meetings, duplication of contact logs, the contribution of approved premises staff to OASys and who should deliver interventions.

- (iv) Some approved premises staff felt isolated and that OMs did not appreciate their contribution. In only about half the licence cases had approved premises staff been involved in the creation of the sentence plan.
- (v) In two areas, approved premises staff had not received any Risk of Harm assessment and management training. Other staff were concerned that they were working with MDOs without having had any training on mental health issues. Although training for staff who worked shifts presented a challenge, relevant training was important.
- (vi) Staff of approved premises who attended MAPPA meetings did not always accept corporate responsibility for MAPPA decisions relating to the management of offenders, and sometimes colluded with residents' occasional disappointment over those decisions.
- (vii) The national requirement that approved premises achieved a 90% occupancy rate meant that on occasions the target conflicted with careful management of high Risk of Harm cases. For example, if a number of residents were recalled in a short space of time there would then be pressure to fill the beds quickly. Additional pressure could also be placed on the police and other agencies at such times, but public protection should always be paramount in such situations.
- (viii) In a few cases, staff considered that there was not enough purposeful activity for residents in approved premises.
- (ix) The absence of move-on accommodation for residents caused blockages in some approved premises and led to bad feeling between staff, OMs and some housing providers. Staff felt that housing providers did not acknowledge the work they had done with the offender to reduce their Risk of Harm and the large amount of time spent finding move-on accommodation was viewed as wasteful of a specialist and limited resource.

***Good Practice Example: Balancing care for residents and public protection***

*Derbyshire had a system of two-hourly checks on newly arrived residents to ensure that they were settling in without problems. In Lancashire, the monitoring of sex offenders was tiered according to Risk of Harm, from basic monitoring to a high level of restriction that involved the offender remaining in the approved premises or reporting every two hours.*

***Priorities for improvement:***

1. The advanced preparation prior to an offender's arrival at approved premises. (PROB)
2. Approved premises are treated as a national as well as a local resource. (PROB)
3. Greater clarity concerning the work between OMs and approved premises staff in managing offenders and greater cooperation in relation to MAPPA

- decisions. (PROB)
4. Comprehensive training for approved premises staff. (PROB)
  5. Good public protection principles take appropriate priority over occupancy targets. (PROB)
  6. Improved arrangements for the provision of move-on accommodation. (PROB)

### **Accommodation**

- (a) Accommodation generally was a key issue when managing most high Risk of Harm offenders. Supporting People is a government partnership programme that was set up in April 2005 to monitor the quality of existing housing related support services for vulnerable adults and to plan what needed to be done to meet their needs. From the outset, one of the primary groups was offenders. Probation areas were one of three agencies on the local Supporting People Commissioning Body (the other two were the Local Authority and Primary Health Trusts). One crucial feature of any probation offender accommodation strategy would therefore be to achieve successful engagement with the Supporting People programme.

### **Strengths**

- (i) All the offender accommodation strategies received from probation areas made the link with the Supporting People programme and had prioritised the accommodation needs of high Risk of Harm offenders. However, achieving the outcome of actually increasing the number of places available to accommodate such offenders required considerable persistent effort.
- (ii) Those probation areas with a member of staff who had specialist training and knowledge of housing were at a very significant advantage.
- (iii) A few probation areas had used the role of MAPPA to strengthen ties with social landlords, and in Hampshire there were two representatives from the Strategic Housing Officer Group on the SMB.

### **Area for improvement**

- (i) Several areas commented that there had been no increase in offender accommodation since the inception of Supporting People. Some found the scheme difficult to work with and others pointed out that it was hard for probation representatives to influence strategy and planning in the context of general antipathy towards offenders. For smaller probation areas, ensuring probation had an active representative for each local authority sometimes proved difficult.



### **Good Practice Example: Offenders and the Supporting People programme**

Derbyshire Probation Area had achieved successful engagement with the Supporting People programme that was recognised in an Audit Commission inspection in December 2004. Some of the key success factors were ensuring regular and consistent attendance at Supporting People meetings and influencing the local Supporting People five-year plan to include offender needs, particularly for high risk offenders. Other factors included protocols for sharing information with housing providers, and a forum for providers to meet to discuss common issues.

### **Priority for improvement:**

1. Effective probation involvement in Supporting People arrangements and improved provision of accommodation for offenders. (PROB)

### **Using and sharing intelligence and information**

- (a) Past experience of the management of high Risk of Harm offenders has underlined the importance of the effective use of intelligence and information in achieving better public protection. A particular concern has been the need for criminal justice services to share information and work together more effectively, and much progress has been made towards greater cooperation in recent years, not least through the advent of local MAPPA. Where further work is clearly necessary is in relation to the assessment and review of an offender's Risk of Harm at all stages of a sentence, including release on licence.

### **Strengths**

- (i) Seven out of eight areas had a protocol in place between probation and the police, as required under national arrangements for the Supervision, Revocation and Recall of Prisoners Released on Licence.
- (ii) Every probation case file contained a copy of the licence.
- (iii) Out of 90 offenders on licence, 24 had been recalled and in the majority of cases the recall had formed an appropriate part of the Risk of Harm management process.
- (iv) Restrictive interventions (residence, prohibited activity, exclusion and electronic monitoring) were delivered effectively and monitored adequately in 82% of probation licence cases.
- (v) Once the offender was in the community on licence, the amount of information and intelligence contributed by probation staff increased, as did its use of it to manage the offender.
- (vi) Systems to access information out of hours were in place in all areas, typically involving a rota for senior managers and usually a link with approved premises.

### **Areas for improvement**

- (i) While an offender was in prison, there was little evidence that probation staff contributed to the gathering of information and intelligence; however, when they did contribute, in just under three-quarters of cases it was used to manage the prisoner effectively.
- (ii) OMs were not sufficiently proactive with prison staff in asking for prisoners' correspondence, social visits and telephone calls to be monitored, and prisons were not always sufficiently responsive to such requests.
- (iii) In only one probation area was there specific guidance to staff about the management of intelligence and information. In other areas, the guidance was more general about information sharing and confidentiality under MAPPA. Practitioners were sometimes unsure about whether they could, for example, photocopy a contact log and give it to the police or quote the number of police domestic violence call-outs in a PSR.
- (iv) Although the police usually received notification of licence conditions from the PIO, OM or the MAPPA meeting, such notification was not always timely, especially when it related to release on temporary licence.
- (v) The home probation area had contributed to only half of those cases where Risk of Harm had been reviewed in prison.
- (vi) We found cases where there had been a significant change that might have impacted on the offender's Risk of Harm, but in only 50% of prison files for those approaching release had Risk of Harm been reviewed swiftly in response.
- (vii) High and very high Risk of Harm cases should be reviewed a minimum of every 16 weeks and following any significant incident. Our results for probation licence cases were disappointing. Sentence plan reviews were generally poor and lacked detail. In only 31% of cases had Risk of Harm been reviewed regularly and in just over a quarter of cases where there had been a significant incident or change.
- (viii) Staff in all three agencies were not alert enough to acute risk factors, for example, increased use of drugs or alcohol, non-compliance, low mood, which may indicate an increase in the offender's Risk of Harm and which should trigger a review.
- (ix) The overall quality of arrangements to protect the public from harm improved slightly when offenders were supervised on licence in the community; however, approximately a quarter to a third of cases were insufficient or poor across the three probation samples.
- (x) There was a consensus among senior managers that arrangements for monitoring the completion of Risk of Harm reviews should be improved.

### **Priorities for improvement:**

1. Prison staff to be more proactive in sharing offender information relevant to Risk of Harm and OMs to involve prison staff more in the appropriate monitoring of prisoner activity.
2. Prison staff to be more proactive in sharing offender information relevant to

- Risk of Harm, and OMs to involve prison staff more in the appropriate monitoring of prisoner activity. (PRIS)
3. Clear guidance about inter-agency information sharing at frontline level. (POL, PRIS, PROB)
  4. Swifter notification of licence conditions to police. (POL, PRIS, PROB)
  5. More consistent routine reviewing of Risk of Harm and rapid response to possible changes in its nature or level. (POL, PRIS, PROB)

**Good Practice Example: Making information available to approved premises**

*In Kent Probation Area, for MAPPA Level 3 cases, there was a recall pack at approved premises which contained a copy of the licence, MAPPA minutes, previous convictions and a trigger plan or contingency plan that could be immediately activated if necessary.*

**Key Finding**

In examining the delivery of interventions that manage high Risk of Harm and protect the public effectively, our inspection revealed a very patchy picture, with some examples of good practice as well as some shortcomings. The advent of MAPPA represented a huge step forward from past practice, but even here we found many areas of inconsistency. A general theme was the need for more proactive offender management, involving better communication between all the services, and regular reviews of cases. Taken overall, we found that the quality of arrangements to protect the public from harm were insufficient in as many as a quarter to a third of cases.

**2.2 The victim perspective**

**Criterion: Consistent attention is given to issues concerning victims.**

- (a) A growing concern for victims has been the theme of many criminal justice developments in recent years. The NPS has a statutory duty to offer contact to victims of certain serious violent or sexual offences for which the perpetrator was imprisoned. A PC issued in January 2005 (PC05/2005) provided an agreed memorandum of understanding between police and the NPS concerning victims, when an investigation of serious crimes involving offenders under probation supervision had commenced. The purpose of the circular was to ensure that there was coordination and understanding between police, family liaison officers and probation victim contact officers when they worked in their distinct roles with the same victim or victim's family. A follow-up circular in June 2005 (PC42/2005) extended the earlier one to include victims of MDOs. Most areas were in the process of implementing these circulars when the inspection took place. At that time, only one area out of the eight had experienced the protocol being used in practice but it appeared to have worked well.
- (b) The majority of offenders in the inspection sample who were subject to a prison licence had committed a serious sexual or violent offence, and the victims of these offenders therefore attracted statutory contact from probation. Over a third

of victims lived outside the probation area where the offender was being supervised. This was often because offenders were placed in approved premises so that they lived away from their victims.

- (c) The tables in Appendix 2 particularly relevant to this criterion are numbers 14 and 15.

### **Strengths**

- (i) All probation areas had a policy on victims and victim contact work, but the majority needed updating to take account of recent developments and the recommendations from HMI Probation's 2003 thematic inspection report 'Valuing the Victim', an inspection into national victim contact arrangements.
- (ii) Victim contact units or other victim contact arrangements in probation areas were working well and provided a relatively consistent service to victims.
- (iii) In 87% of probation files on offenders just sentenced, victims were offered the opportunity to provide views on the conditions to be applied to the licence of an offender. 75% of victims were informed of any relevant conditions regarding an offender's release and 70% of victims were informed of the release date in a timely fashion.
- (iv) In most areas, Victim Contact Officers attended MAPPA meetings or submitted a report, although victim issues were not a standard agenda item on MAPPA meetings in all areas. We found that in three-quarters of cases, MAPPA meetings and risk management plans had sufficiently taken into account victim issues.
- (v) There were a number of examples where the victim's account of the offence influenced the assessment and management of Risk of Harm of the offender.
- (vi) In some cases, practical support was given to victims through, for example, licence conditions with exclusion areas in domestic abuse cases, and the police fitting alarms in the home of victims.
- (vii) There were generally good links between police family support officers and the victim contact unit, and these should be formalised in all police and probation areas.
- (viii) In probation cases, the work completed by victim contact staff was generally of a good standard, but there was a lack of recorded victim awareness work taking place with offenders.

### **Areas for improvement**

- (i) Prison files indicated a lack of victim focus that, in some cases, may have also been a failure to record work undertaken.
- (ii) Probation staff were not being sufficiently proactive in promoting victim awareness work with prisons. Probation had provided information about relevant victim issues to prisons in just over half the cases of offenders about to be released. Very few OMs had contacted the prison concerning the delivery of victim awareness work.
- (iii) In only 19% of cases had an accredited programme of victim awareness taken place in prison, and none of the prisons we visited had any comprehensive

process for preventing offenders contacting adult victims.

- (iv) We found very few victim impact statements, normally prepared by the police before the offender is sentenced, on probation case files and only two on prison files. Information from victim impact statements can assist probation and prison staff when undertaking victim awareness work with offenders. NB prisons often could not access CPS documentation, including victim statements, which was routinely made available to probation at the point of sentence.
- (v) Several OMs admitted that they did not always record the victim awareness work they had done with an offender, which may explain why evidence of such work was found in only 30% of probation licence cases. It is not claimed that raising victim awareness would effectively impact on reoffending rates with all offenders. However, attempts to carry out such work can help staff to make a fully-rounded assessment of an offender's Risk of Harm to future potential victims.
- (vi) There was no evidence that the police were monitoring conditions on licences relating to the victim.
- (vii) In general, there was more evidence recorded on probation case files than police files that action had been taken to prioritise and ensure victim safety.

***Good Practice Examples: Making use of the victim perspective***

*In one case, an offender was convicted of indecent assault but it was clear from the account of the victim that the offence was close to attempted rape. This information was fed into the Risk of Harm assessment and affected the way the case was managed.*

*In another case, involving domestic violence, the victim's account of a common assault in the context of a history of abuse was very important in influencing the work done with the offender.*

**Key Finding**

There was encouraging evidence that victim issues: victim contact, victim safety and victim awareness, are much more regularly addressed than they used to be. We found some good examples of concern for victims and information from them being used effectively in managing offenders. There were, however, too many cases where the victim dimension had not received attention, and this seemed particularly prevalent while offenders were serving prison sentences. Where victim considerations had influenced the specific requirements of licences, for example, through offender exclusion areas, there was concern that these were not being monitored.

**Priorities for improvement:**

1. An increased consideration about the potential value of victim awareness work in the prison setting and concerning its recording both in custody and community. (PRIS, PROB)

2. Greater use to be made of victim impact statements in both raising awareness and refining Risk of Harm assessments. (PROB)
3. Involvement of the police in monitoring licence conditions concerning victim contact. (POL)

### 2.3 Managing offenders and using information

***Criterion: Contact with the offender and enforcement is consistent, planned, well managed and implemented, and properly recorded.***

- (a) Effective intervention requires that the delivery of supervision is implemented in accordance with the requirements of the licence or other civil order and that each case is dealt with consistently and receives good management oversight. To give a proper account of these aims in action, good record keeping is fundamental, and in some cases the way in which information is shared and used by different agencies is the key to prompt and appropriate action to minimise Risk of Harm.
- (b) On a few well publicised occasions in the past, it has been difficulties relating to this last point that have been criticised when things have gone seriously wrong, and it is important that services learn from these cases. We were therefore pleased to see that at the time of our inspection in 2005, the London Probation Area provided its staff with comprehensive guidance on record-keeping. At the beginning of the London document, there was a quote from the Victoria Climbié Inquiry which merits repetition in this report, 'The case file is the single most important tool available to staff and their managers when making decisions as to how best to safeguard others. It should be clear and accessible. Reference to the file should be made at every stage of a case and before any significant decision is made.'
- (c) Another issue that has received a good deal of attention recently is deportation. We found that in 2005, the link between deportation and the consistent management of high Risk of Harm cases was an issue in the London and Kent Probation Areas in particular.
- (d) The tables in Appendix 2 particularly relevant to this criterion are numbers 16, 17 and 18.

#### ***Strengths***

- (i) In nearly all probation licence cases, the frequency of appointments complied with national standards, facilitated the requirements of the licence and met any Risk of Harm considerations. The OM had monitored attendance sufficiently and, where necessary, had taken action to ensure compliance.
- (ii) In 95% of cases, judgements about acceptability of absences was consistent and appropriate. In 86% of relevant cases, breach action had taken place within the required timescale.
- (iii) The overall quality of probation licence cases in relation to enforcement, compliance and engagement was sufficient in 87%; 4% were excellent.
- (iv) Senior probation managers were clear about their role and task in public protection in relation to staff, partner agencies and offenders.



- (v) Public protection was a high priority, competing with other priorities within probation areas. Senior managers also acknowledged the stress this area of work produced, and tried to support and motivate staff by emphasising the collective responsibility for the management of public protection cases.
- (vi) There were examples of newly qualified probation officers being paired with experienced staff to enable them to manage public protection cases appropriately.
- (vii) Probation middle managers made a crucial and impressive contribution to ensuring that the public were protected by managing and supporting OMs who worked directly with high Risk of Harm offenders. SPOs in all probation areas would countersign OASys for these cases and provide regular supervision for staff.
- (viii) Probation staff were generally very clear about their role, and the probation licence sample of cases painted a picture of probation staff successfully implementing the conditions in licences, and in the majority of cases demonstrating commitment to the offender, motivating and supporting as appropriate.
- (ix) The probation contact log was a key document recording the organisation's interaction with the offender, providing an audit trail of accountability, and contributing to decisions and judgements about assessment and interventions with the offender.

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

- (i) At any one time in all three agencies there could be up to nine files on one offender or prisoner, and the quality of these files varied considerably. If standards for file structure and content had been set, these were not always adhered to, and when there were a number of volumes on one individual there was a risk that important information from earlier files would be lost. The lack of a standard file format contributed significantly to deficits in clear recording.
- (ii) The fact that prison files were not kept in one place, and there was no consistency across the prisons we visited, was noted. Poor records in prison meant that there were gaps in continuity in case management between the various disciplines working in the prison. When NOMIS is fully operational it should make a huge difference by providing a single case file that is readily accessible from multiple locations.
- (iii) It was noted that where probation middle managers regularly reviewed high Risk of Harm cases under local arrangements, there was a tendency for staff to focus less on completing and reviewing OASys properly. Similarly, the managers themselves were not giving sufficient time to quality assure OASys, and were instead concentrating on their own local review system. This was an important finding, given the central contribution that OASys can make to the management of Risk of Harm.
- (iv) It should be possible for an SPO to inspect a file for the NPD, review it under a local arrangement, discuss the case in supervision and quality assure the OASys. Just under two-thirds of sentence plans were not reviewed every 16

weeks, and where they had been reviewed only a third of these were of a sufficient standard. There was, however, some encouraging evidence that at the time of the field work in 2005, SPOs were about to start quality assuring OASys as per the national OASys Quality Management Plan (PC48/2005).

- (v) The link between the prison service, police and immigration service needed to be strengthened. In one case, a Nigerian serving a six-year sentence for two offences of rape was recommended for deportation, but it was unclear what was going to happen on his release. In another case, an offender was detained by immigration on his release from prison but probation staff were not informed and were expecting him to report to them.
- (vi) Correspondence on probation files between OMs and the immigration service revealed a lack of clarity from immigration about the status of some offenders. Immigration officials appeared to be overwhelmed by their workload, and for probation staff this raised questions about whether to prepare an offender for resettlement in this country when they may be deported on release.
- (vii) At the time of the inspection, ViSOR implementation was ongoing, and transfer of information to ViSOR was at various stages of completion. Only one force was able to provide information routinely on the status of home visits.
- (viii) There was generally considerable scope for improvement in the quality and consistency of offender management, particularly leading up to the release of the offender from prison.

**Good Practice Example: Frequency of contact and Risk of Harm**

*In Derbyshire Probation Area, it was good to see frequency of contact clearly linked to Risk of Harm. Offenders often questioned why contact had either increased or not decreased. OMs explained the rationale behind their decision-making to offenders. Offenders were involved in an inclusive way, encouraging them to take some responsibility for managing their own Risk of Harm. In one case, despite a member of staff being threatened and abused by an offender, the offender was successfully made to report weekly, which was achieved through the persistence and consistency of several staff involved.*

**Key Finding**

Our inspection revealed a generally excellent performance by probation staff in requiring and achieving good levels of compliance from offenders on licence. Where breach action was taken, this was almost always appropriate and there was a good level of supervision and support from probation managers.

The picture during a prison sentence and at the time of release was less encouraging. Case records were often not maintained consistently, and the need to improve communication between services was apparent. This was especially true in 2005 in cases where deportation was an issue and where the immigration service needed to be more proactive and communicative to ensure proper public protection.



### **Priorities for improvement:**

1. Improved record keeping, particularly by the prison service. (POL, PRIS, PROB)
2. Better quality assurance of OASys. (PRIS, PROB)
3. Arrangements regarding deportation need to be better coordinated. (PRIS, PROB)

## **2.4 Delivering appropriate interventions**

**Criterion: *Interventions are delivered to meet diverse needs, achieve identified objectives and to fulfil the requirements of the sentence or civil order.***

- (a) Whilst the first priority of criminal justice agencies is to ensure that appropriate demands are made on offenders to ensure that they comply with the conditions and requirements of their sentences, successful intervention requires more than this. To achieve maximum impact and effectiveness with offenders, objectives should be identified and interventions should be delivered in the correct order or sequence, taking proper account of diversity issues.
- (b) The challenges are many and varied. Probation senior managers were very aware of the diversity issues that frontline staff had to manage and gave some interesting examples. These included the NPS's response to the impact, on black staff, of offenders who were members of extreme right-wing organisations, or how they dealt with the relatively high number of black offenders who were sectioned under the Mental Health Act. In North Wales, the issues relating to Welsh language and culture were a predominant focus for effectively engaging with offenders.
- (c) The tables in Appendix 2 particularly relevant to this criterion are numbers 19 and 20.

### **Strengths**

- (i) Staff in approved premises were good at monitoring offenders and they wanted to intervene more constructively in addition to their key working sessions.
- (ii) There were several good examples of motivational work with offenders who were attending accredited programmes while on licence.
- (iii) Almost two-thirds of offenders who were interviewed considered that their contact with prison or probation staff had increased their motivation to change, although not enough offenders experienced the interventions that were available.
- (iv) Much good work was being done by probation staff to preserve appropriate community links when offenders were in prison, but probation staff could increase their role in this area of work and prison staff could potentially do more.
- (v) There was evidence of some solid work completed six months before an offender's release by OMs, characterised by regular prison visits, victim work, MAPPA meetings and correspondence as well as useful work completed by

prison staff.

- (vi) One diversity issue that was noted in several probation areas was the management of older sex offenders, sometimes over 70 years of age, who needed special housing provision.
- (vii) There was generally good use of a standard form in probation areas to monitor offenders' race and ethnicity, but it was noted that it was important that the offenders themselves completed the form because it was based on their perspective.
- (viii) In three-quarters of the probation licence sample, arrangements for interventions had taken into account race equality and diversity issues. In the majority of probation and prison cases where disability, literacy and/or dyslexia were issues, these issues had also been addressed specifically.
- (ix) Although the overall quality of interventions to meet diversity needs was insufficient at the start of a prison sentence, there was evidence of a significant improvement when they were released on licence.

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

- (i) OMs' knowledge of restrictive or constructive interventions that were available in local approved premises varied considerably. Restrictive interventions such as curfews, CCTV and hostel rules about drug and alcohol misuse were generally known. There was, however, less awareness of constructive interventions, such as those relating to drugs and alcohol, mental health, social and life skills and any access to local colleges and employment services.
- (ii) In some cases, there was little clear evidence that objectives had been progressed or that structured work was taking place. In only 61% of probation licence cases, and 41% of prison cases about to be released, did constructive interventions challenge the offender to accept responsibility for the offence and its consequences.
- (iii) In only 56% of probation cases and 35% of prison cases was there evidence of appropriate sequencing of interventions according to Risk of Harm and likelihood of reoffending. In some cases, offenders appeared to hijack the agenda by raising health or personal social issues, such as access to their children or homelessness. Whilst these issues were important and should be addressed, there was concern that they should not undermine work on reducing reoffending and minimising Risk of Harm.
- (iv) Both during and after a prison sentence, there was scope for more offenders to have completed an accredited programme. In our sample of those prisoners recently sentenced, more than half had no interventions planned, and nearing release only 13% had completed a planned intervention. From 90 offenders on licence, only 21 were either currently on an accredited programme or had completed one.
- (v) Not enough work on community reintegration was taking place before the offender's release on licence. Where relevant, this should have been happening in conjunction with a MAPPA meeting.

- (vi) We found considerable variation in the use by courts of SOPOs. This ranged from orders being made in almost every sex offender case in some areas, to the view that if the police wanted a SOPO later, when the offender was on licence, they should make a special application to the court at that point. We considered that the widely different practices around the country necessitated some national guidance on this matter.
- (vii) Despite progress, the files we examined showed that there was still a need for greater attention to diversity issues. For example, from probation files, staff were not using some health and other considerations that were identified by OASys. In only a minority of cases was there evidence that the OM had passed on any diversity issues to the prison.

***Good Practice Examples: Integrating prison, police and probation work***

*In Hampshire, the MAPPA Protocol Prison Document described the role and contribution of HMPS generally as well as individual prisons. It was a thorough document, particularly the pro-forma for information exchange and was an example of good integration of prison processes.*

*In Kent, police were invited to prison reviews of the SOTP, and SOTP tutors from a prison would attend MAPPA meetings.*

*In County Durham, police and probation officers undertook a visit to see an offender in prison as soon as possible after the offender had been recalled. The purpose of the visit was to explain why recall had happened and to engage the offender constructively in looking ahead. Where this did not happen in other places, offenders were often unclear about why they had been recalled and were sometimes angry and intent on being uncooperative in the future.*

**Key Finding**

Taken overall, the quality of interventions to meet the requirements of the sentence in both prisons and probation required considerable improvement. We found many examples of good practice, but in general there was a lack of well planned and delivered interventions that addressed Risk of Harm issues in particular. There was considerable scope for more offenders to benefit from accredited programmes at all stages.

There had been identifiable progress in relation to diversity issues, especially in probation practice post-release, but there were still areas that needed attention. There was some evidence that MAPPA were already having a positive effect but there remained a great deal of local variation, for example in the use of SOPOs.

***Priorities for improvement:***

1. More knowledge needed by OMs of the interventions available at approved premises. (PROB)
2. A higher prominence given to offending behaviour work, with appropriate sequencing of interventions. (PROB)

3. National guidance on SOPOs. (POL, PROB)
4. Greater attention to diversity issues. (POL, PRIS, PROB)

### 3. MEASURING RESULTS

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#### E. Public and Professional Expectations

A major theme of this report has been the need to put the findings from the inspection into a broader context. Whilst the public has every right to expect that criminal justice agencies do their respective jobs properly, most people also understand that when dealing with many conflicting demands it is not easy to get things right every time. The need for the proper review and evaluation of what has been achieved is obvious. Not only is this part of public accountability but it also helps to inform the ongoing development of professional practice.

Knowing whether a case has been successfully managed should not be based on anecdote or impressions. The advent of clear national standards and performance targets has provided the police, prison and probation services with a number of objective measures against which outcomes may be assessed. The extent to which managers use these systematically still varies, but there is little doubt that a greater shared commitment to effective offender management is emerging strongly when compared with past practice.

#### F. The Inspection Approach

In order to assess the results achieved, we looked first at the extent to which interventions were delivered with the desired outcomes. We then went on to examine how far the progress achieved was sustainable and how far data were used well to review and evaluate the work done. Finally, we attempted to measure how far interventions demonstrated good value for money.

#### 3.1 Interventions are delivered with the desired outcomes

**Criterion: *Planned objectives are achieved.***

- (a) Senior managers in probation had difficulty describing how they measured the success of their service's work with public protection cases. In general, they sought to satisfy themselves that the organisation had done everything it could to manage the case. More specifically, some referred to one of the performance targets at that time. This required that at least 90% of initial supervision plans, risk management plans and assessments of Risk of Harm should be completed for high Risk of Harm cases within five working days of commencement of the order or licence.

- (b) From a prison perspective, compliance with PSO 4745 'Multi-agency public protection arrangements' was seen as a measure of the successful implementation of public protection processes.
- (c) Measuring the completion of a licence without serious further offending was clearly a key indicator. This demonstrated that Risk of Harm had been managed in the community, but it was, of course, also necessary to count the cases where SFOs did occur. The effectiveness of MAPPA in managing high or very high Risk of Harm cases was also examined, including the extent to which cases were successfully managed to a lower MAPPA level, and the use of appropriate recall to prison as a public protection measure.
- (d) Perhaps understandably, OMs measured success by a variety of factors. They were primarily concerned that offenders did not reoffend, or reoffended less seriously, but they also paid attention to other issues. For example they saw positive progress where offenders achieved a period of stability in their lives, completed an accredited programme and maintained contact with agencies once their licences had expired. One strong indicator of success was evidence that offenders had developed some insight into their own behaviour and could explain and apply what they had learned to avoid risky situations.
- (e) The tables in Appendix 2 particularly relevant to this criterion are numbers 21 and 22.

### **Strengths**

- (i) In nearly all probation licence cases, offending behaviour had been contained.
- (ii) In more than 80% of all cases, there was evidence that the restrictive interventions applied were working.
- (iii) In those probation licence cases where domestic abuse was a factor, there were many examples of good joint working between probation and the police to protect the victim.
- (iv) The active use of the Child Protection Register indicated general awareness of the importance of child protection measures.
- (v) In 17% of our sample of prisoners nearing release, there was an improvement in the OASys likelihood of reconviction score and in 37% of probation licence cases. This result suggests that the likelihood of reconviction reduced for a larger number of offenders when they were in the community after release.

### **Areas for improvement**

- (i) In over half the cases, planned objectives had not been achieved, but this figure was slightly better for offenders on licence.
- (ii) Very few offenders demonstrated victim awareness: under a quarter of probation licence cases and just 15% of those offenders about to be released.
- (iii) In only 51% of probation licence cases had OASys been reviewed and re-scored. Of those OASys that had been done, just under a quarter were re-scored after four months rather than 16 weeks and were therefore late.
- (iv) In only about a third of both prison and probation cases was there any

evidence that learning skills had been applied. Improvements in attitude recorded in the prison and probation samples were 41% and 28% respectively.

***Good Practice Example: Achieving objectives together***

*In County Durham, OMs in the Public Protection Unit indicated that the combined expertise of probation and police officers working together contributed to their success. Among the contributory factors were testing each other's professional judgements, regular attendance at MAPPA meetings and continued joint visits to sex offenders when probation involvement had formally ceased.*

**Key Finding**

Planned interventions were generally effective in containing offending behaviour. There were also many good examples of joint working, especially between probation and police. These included domestic abuse and child protection cases. Where OASys was used, it tended to indicate some progress by offenders, but increased victim awareness was poor and planned objectives were only achieved in under half the cases examined. Once again, there was evidence to suggest that OASys was not used as regularly and effectively as it should have been.

***Priorities for improvement:***

1. The regular and consistent use of OASys as the main tool for measuring the extent to which planned objectives have been achieved at all stages of an offender's sentence. (PRIS, PROB)
2. The issue of victim awareness is given a higher priority in work with offenders. (PRIS, PROB)

**3.2 Sustainability of progress**

***Criterion: Results are capable of being sustained between different phases of a sentence and beyond the end of supervision.***

- (a) We looked at the extent to which work had been done to sustain positive results as the offenders progressed through their sentences and on licence. This included the continuity of staff supervising the case as well as the overall quality of work directed towards this aim.
- (b) The tables in Appendix 2 particularly relevant to this criterion are numbers 23 and 24.

***Strengths***

- (i) In 70% of probation licence cases, the overall quality of work undertaken to achieve sustainable progress was assessed as sufficient or excellent.
- (ii) Generally, there was more evidence of work on sustaining the progress the offender had made in the probation sample than in the prison one. Examples



included ensuring that the offender was aware of community organisations that would continue to help with issues related to their offending, such as drug or alcohol misuse, accommodation etc.

### **Areas for improvement**

- (i) Perhaps not surprisingly, the number of OMs and prison/personal officers experienced by offenders increased the further they went through prison and their licences. It is a matter of concern, however, that in spite of the drive to more consistent offender management, almost half the cases had had more than four supervisors before they were released, and the level of involvement of personal officers in prison was very patchy.
- (ii) The overall quality of work undertaken to achieve sustainable progress dipped for those offenders about to be released from prison.
- (iii) We noted significant turnover of staff in some probation areas, either through retirement, long-term sickness, a large number of prison secondments, or staff moving to adjoining areas that paid more. The movement of staff had been disruptive and some areas had struggled to replace experienced probation staff with staff able to supervise high Risk of Harm offenders.

### **Key Finding**

The extent to which work with offenders was sustained varied significantly. During the prison sentence there was little evidence of this issue being addressed, but the position improved considerably when the offender was on licence. The number of supervisors in any one case was a matter that required further work in order to maximise the impact of good offender management.

### **Priorities for improvement:**

1. The sustainability of work with offenders is promoted as an important practice issue at all stages of a prison sentence. (PRIS, PROB)
2. To ensure that developments in offender management have the greatest chance of success, efforts are made to minimise the number of supervisors in each case, and policies to support this aim are developed as soon as possible. (PRIS, PROB)

## **3.3 Review and evaluation**

**Criterion: *Outcomes of interventions are assessed and reviewed using available data.***

- (a) An important ingredient in the development of practice is the use of available data to review past experience and learn from it. We looked at the extent to which managers and MAPPA were making use of such information on a regular basis.

### **Strengths**

- (i) Two areas had used the recent work by Hazel Kemshall et al (2005

'Strengthening MAPPA' Home Office Development and Practice Report 45) to inform their MAPPA policy and procedures.

- (ii) There were several good examples of MAPPA giving a lead in the use of data, including a Level 3 multi-agency audit that identified some of the issues that have been noted in this report. Case files were examined from police, probation, approved premises, the local public protection unit and, where appropriate, prisons. It was an exercise that should be replicated by other SMBs in England and Wales.
- (iii) MAPPA initiatives provided important opportunities for managers in different services to gain experience and familiarity with other agency files, recording issues and the interaction of processes across organisations and how they impacted on frontline services and staff.
- (iv) Areas that employed their own psychologists, or had other psychological resources, were undertaking limited research into the effectiveness of the interventions they delivered.

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

- (i) The extent to which SMBs monitored their local MAPPA varied considerably between areas. At the time of our fieldwork, not all areas had business plans, but since the inspection there had been a national lead on SMB business plans.
- (ii) There was an acknowledgement that some SMBs needed to do more to obtain performance information and use ViSOR, deliver joint training in a more systematic way and begin to engage with Level 1 MAPPA cases.
- (iii) There was a general issue about the attendance and involvement of mental health professionals in MAPPA. In one area, the large number of MDO cases was congesting Level 2 meetings, and a decision was needed about whether there should be separate MDO panels. We found that in areas where formal involvement of mental health staff with MAPPA had been established - either a named CPN or forensic psychiatrist - there was clearly an improvement in understanding of the mental health assessment process and access to services
- (iv) No probation area could give any examples of using local, national or international research that had informed policy and practice in public protection. Most agreed that they did not use research as much as they might.

### **Good Practice Examples: MAPPA using data to develop practice**

*In Lancashire, the Chairs of MAPPA meetings completed a MAPPA SMB Data Collection Form. This covered the offender, supervision, management and meeting details and any relevant information or concerns. From these data the SMB received regular reports about meeting activity, including, for example, the percentage of meetings chaired by police or probation, the attendance of other agencies and referrals to MAPPA by division and agency. Lancashire also undertook a small research project involving the MAPPA Coordinator, Mental Health Services and a trainee forensic psychologist. This investigated the effectiveness of MAPPA meetings in assisting the management of identified mentally ill offenders in the community.*

*In Hampshire, bi-annual MAPPA SMB case reviews were completed as a matter of policy. The case review involved a panel assessing a small number of MAPPA Level 2 and 3 files and interviewing key practitioners. The panel consisted of representatives from the Responsible Authorities, a lay advisor and two SMB members. The purpose of the review was to ensure the quality and effectiveness of the MAPPA process so that the SMB could be satisfied that consistent and acceptable standards were in place across the area. The panel gave verbal feedback to the practitioners on the day; general learning points were shared with other agencies and a summary of findings was submitted to the SMB.*

### **Key Finding**

We discovered many excellent examples of SMBs using data very effectively to monitor, review and develop their local MAPPA. The good practice now needs to be shared across England and Wales so that areas can learn from the experience of others and achieve greater consistency in service delivery.

### **Priorities for improvement:**

1. Arrangements are made to share good MAPPA practice across England and Wales as a contribution to greater consistency in the delivery of services. (POL, PRIS, PROB)
2. Regular local multi-agency audits of MAPPA in practice are encouraged in all areas. (POL, PRIS, PROB)

### 3.4 Value for money

**Criterion: *Interventions demonstrate good value for money.***

- (a) The most effective and efficient use of resources are important issues for the police, probation and prison services. We noted, however, that many senior managers saw the extent to which resources were being used efficiently in practice, to protect the public, as a difficult question.
- (b) The offender management model was seen generally as an opportunity to direct resources according to the Risk of Harm of the offender, and there was widespread acknowledgement that greater use should be made of OASys to achieve this. The need for more consistency within MAPPA, both in meetings and in ensuring cases were managed at the right level, were also viewed as important contributors to value for money.
- (c) The tables in Appendix 2 particularly relevant to this criterion are numbers 25 and 26.

#### ***Strengths***

- (i) In over 90% of probation cases, after release the resources allocated were judged to be consistent with the offender's Risk of Harm and likelihood of reoffending, and in 68% of those cases the resources were being used effectively to achieve planned outcomes.
- (ii) Tasking and coordinating within police forces appeared to be working well in relation to prioritising and allocating resources for individual cases.

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

- (i) Some Probation Boards expressed the view that it was difficult to gain assurance that resources were being used efficiently to protect the public when there were hardly any discrete data about the cost of various interventions.
- (ii) The funding of MAPPA was a contentious issue. In every area we visited, agencies remarked that MAPPA had never received any specific funding from central government.
- (iii) The absence of a financial contribution to MAPPA from HMPS was sometimes a distraction and an embarrassment for their representatives. We considered that this should not become an obstacle to the developing relationship between prisons, probation and police. The amount of money involved would be relatively small compared to the added value of prisons continuing to be fully involved as a Responsible Authority.
- (iv) In the small prison sample, we found that interventions in the earlier part of sentences represented sufficient value for money in nearly a third of cases, but in less than a fifth for those nearing release.

## **Key Finding**

There was good general evidence to show that probation and police resources were being used in ways that were consistent with offenders' Risk of Harm and likelihood of reoffending, but there was less evidence of this in the prison sample. At senior management and Probation Board level, the absence of cost information relating to various interventions was noted, and the absence of specific national funding for MAPPA was an issue.

### ***Priorities for improvement:***

1. Information on the costs of various interventions is made available. (PRIS, PROB)
2. The funding arrangements for MAPPA are reviewed, including the contribution from HMPS. (POL, PRIS, PROB)
3. The issue of value for money in the management of Risk of Harm should be given more prominence by the police, probation and prisons. (POL, PRIS, PROB)

## 4. LEADERSHIP AND STRATEGIC MANAGEMENT

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### G. Public and Professional Expectations

It will be clear from this report that the development of a partnership approach to improved public protection has had very substantial implications for the way in which services are delivered at local level. Although the public might for a long time have expected a joined-up approach by the various criminal justice services and their partner organisations, the reality in the past was far from this ideal.

What has been occurring in recent years has, in effect, been a major change in culture and this in turn has led to some fundamental changes in the way that services are led and structured. Concurrent with these structural changes, the importance of good strategic leadership at national, regional and local levels has been recognised. To put this section of our report in context, we now set out a brief description of some of the key elements in the structure in 2004.

#### The Responsible Authorities National Steering Group

The inaugural meeting of the RANSG took place in June 2004 and further meetings have taken place at least quarterly. The purpose of the RANSG was to set the direction and broad shape of MAPPA by advising on the preparation and publication of further statutory guidance and the MAPPA annual reports. It also took a lead in devising a communication strategy, including national and regional conferences, and providing a forum for Duty To Cooperate Agencies and others to resolve any difficulties and review the effectiveness of MAPPA.

The membership of the RANSG included the ACPO lead on Child Protection and Sex Offenders, HMPS's Head of Sentence Management Group and the Head of the PPLRU as national representatives of the three Responsible Authorities. The relevant HM Inspectorates and Home Office policy leads and the PPLRU development lead also attended, and others were co-opted including the national leads of the Duty To Cooperate Agencies. The PPLRU provided the administrative support.

There were 42 Responsible Authorities in England and Wales with a duty to deliver local MAPPA, and these reported to the Secretary of State. Although RANSG provided national strategic oversight, it had no power to tell any local Responsible Authority what to do and it did not issue policy or strategy. Any guidance or instructions would be issued, once approved within each organisation, via their normal channels of communication.

## **Public Protection and Licence Release Unit**

The PPLRU was established primarily to contribute to one of the five statutory aims of the NPS, HMPS and NOMS, namely to protect the public. The unit had a wide range of tasks, which included policy guidance on new legislation and the development and implementation of MAPPA, configuring the approved premises estate for the management of public protection cases, coordinating critical public protection cases under PC19/2004 and the SFO process under PC 08/2006.

Further PPLRU responsibilities included developing the use of enhanced supervision accommodation as part of the management of the highest Risk of Harm cases, responsibility for NPS strategies for domestic abuse, victims, children, mental health and sex offenders.

The unit also had an overarching remit to analyse local performance data from probation areas related to public protection. They determined the framework and finalisation of area MAPPA annual reports and supported the appointment and training of lay advisers. A comparatively recent development had been the inclusion of the work of licence release and forming direct links with HMPS and the Parole Board.

The head of the unit reported to the Director of the NPS and the Director of NOMS HQ who in turn are accountable to the Home Secretary.

## **Serious Further Offences and serious case reviews**

At the time of the inspection, the SFO process was operating under a national probation circular PC54/2003 'Notification, Screening and Review Systems for Serious Further Offences committed by Supervised Offenders'. At the first stage, probation areas would notify the PPLRU if any offender under supervision committed a SFO. At stage two, a senior manager completed a screening document that confirmed whether the area was required to complete a full review.

## **H. The Inspection Approach**

We looked first at the way that the national, regional and local arrangements for managing Risk of Harm were working in practice. This involved meeting a number of representatives from the various organisations and looking at minutes of meetings etc. Our focus was mainly on leadership and planning. One detailed part of the inspection also involved a limited validation exercise, comparing the answers given in SFO stage two screening documents and stage three full reviews with the information in the case file of the offender.



## 4.1 Leadership and planning

**Criterion: *Public protection is a corporate responsibility. The Responsible Authorities, individually and jointly, lead in the implementation of national guidance through the production of local protocols and procedures that are regularly monitored and reviewed.***

- (a) As indicated in the introduction to this section, the national and local public protection arrangements in England and Wales had undergone significant change at the time of our inspection fieldwork in 2005. We wanted to assess both the leadership that was being given by the local Responsible Authorities and the way in which service delivery was being jointly planned between the various agencies.

### **Strengths**

- (i) The achievements of RANSNG have included the development of ViSOR, increased cooperation in the last two years between all those involved in MAPPA, the MAPPA Guidance, a contribution to the appointment of lay advisers, and more recently the development of a training manual for Risk of Harm.
- (ii) PPLRU aimed to increase public confidence in the work of NOMS by promoting the consistent assessment and management of Risk of Harm across the 42 probation areas. The Risk of Harm Improvement Strategy that was launched in September 2005 was being used by the unit to improve practice.
- (iii) In high profile public protection cases, there was close contact between the probation area, the PPLRU and relevant Ministers. The unit also supported probation areas dealing with various local campaigns and helped them to engage effectively with communities.
- (iv) There were positive comments from probation areas about the support and advice the PPLRU had given in individual cases and in helping to organise regional events.
- (v) There was evidence of some good regional work, mainly involving probation senior managers who met to discuss public protection, approved premises, SFOs and victims. There were also MAPPA managers' meetings. The potential duplication of regional meetings concerned with public protection, approved premises and victims was also noted, however, as some members of each of the meetings were the same.
- (vi) In June 2005, each probation area had to complete a return detailing how they had progressed improvement objectives in their business plans related to public protection and answering various detailed questions regarding the management of high Risk of Harm offenders. Most replies from areas were full and generally positive, confirming that they had done what they were supposed to do, but some were minimal.
- (vii) The recent minutes of meetings of the eight SMBs illustrated that they were usually well attended and there was evidence of purposeful activity, discussing an appropriate range of issues, and in some cases MAPPA

performance data.

- (viii) A particular role of SMBs was to facilitate the integration of HMPS with MAPPA. One issue that arose was that often offenders were not imprisoned within the area the SMB covered. However, in several areas, through the action of prison service managers, prisoners were moved to a prison closer to their home area and had appropriate assistance with the management of Risk of Harm and the transition from custody to the community.
- (ix) Generally, Probation Boards were satisfied that MAPPA and the SMB were working well, based on information from the designated ACO and the MAPPA annual report. However, in our view the linkage was not always sufficient, particularly bearing in mind that the Probation Board was the designated Responsible Authority in the legislation rather than the SMB. It was noted, for example, that it was difficult for the London Probation Board of 12 members to impact on the 32 MAPPAs that operated within London. They had nonetheless given leadership and support to senior managers, and the CO had made public protection one of three major priorities for the area.
- (x) Most Probation Board members interviewed were aware of the importance of OASys and Risk of Harm work and of their role in ensuring that the allocation of resources was linked to Risk of Harm. In most areas, there was a strong commitment from Boards to maintaining an organisational focus on public protection and ensuring that national strategic priorities were implemented at a local level.
- (xi) Policies and procedures for public protection were in place in all the probation areas. Some had just been revised and others were in need of revision. They were sometimes very long and contained numerous appendices, reproducing legislation, PCs and other guidance. Although comprehensive, having involved a significant amount of work, they were often too complex for staff on the frontline to use as a tool in their day-to-day work.
- (xii) All areas had information sharing and liaison arrangements for exchanging information in individual cases, and according to staff these were generally working well. In some areas, the need for better strategic links with Children's Services and the health community was apparent.
- (xiii) There was impressive evidence of some probation areas carrying out reviews of their public protection work as part of an improvement plan arising from earlier HMI Probation ESIs.
- (xiv) In general, the local SFO procedure seemed to be working well. All probation areas had systems in place for the identification of SFOs and action for staff. Most Probation Boards and SMBs received summaries of SFOs, outlining concerns and lessons learned. From a total sample of 90 licence cases, we discovered just one case that should have been notified to the PPLRU under the SFO process, where this had not happened.
- (xv) A number of probation areas we visited were employing psychologists. Although not within the scope of this inspection, the role and potential contribution of psychologists to the assessment and management of high Risk of Harm offenders in the community was important and worth exploring.

### **Areas for improvement**

- (i) MAPPA had been introduced without a specific budget and the RANSG acknowledged there were inconsistent resources allocated to MAPPA across the 42 Responsible Authorities. This situation was often the subject of critical comment.
- (ii) The RANSG depended on the commitment and cooperation of its membership and saw MAPPA as still in its infancy. By far the majority of staff in the PPLRU were from probation, and it was suggested that a multi-disciplinary national body would be more likely to give an effective national lead.
- (iii) Public protection was not in every agency's business plan. There were no shared targets for public protection at the time of the inspection, and no police or probation area had joint performance indicators for this important work.
- (iv) The PPLRU was satisfied with the development of the RANSG, but it was thought that the links between police and prisons at a national and strategic level could be improved. There were, however, some good examples of joint submissions to Ministers and joint work on OASys.
- (v) Whilst there was evidence of partnership working in some places such as the North West, the absence of regular regional meetings of the three Responsible Authorities in many areas was apparent. There was scope for much more multi-agency regional work concerning public protection.
- (vi) We found little evidence of strategic involvement by senior management in prisons. None of the senior management teams at prisons we visited had sought or discussed data related to public protection, other than sentence planning. The prison service nationally has set processes in the Public Protection Manual that would achieve good standards but the faltering implementation of OASys has impacted severely on prisons' ability to deliver.
- (vii) In police areas, operational responsibility for public protection, including resourcing, was devolved locally to BCU Commanders. In practice, there was a tendency for this then to be delegated to local Crime Managers (DCIs) who carried a wide range of responsibilities for all crime matters in the local area. As a result, there was a general lack of understanding of the MAPPA process amongst officers above the rank of DCI and little direct involvement, except where individual cases were brought to their attention.
- (viii) An examination of eight probation area business plans illustrated the different emphasis individual areas placed on public protection. Although there was a standard template for these business plans issued from the NPD, the number of local improvement objectives varied from one to six, with consequences for the resources allocated. We considered that public protection required a consistent commitment across all 42 probation areas, including sufficient feedback to the centre when requested.
- (ix) One of the recommendations in the sex offender thematic inspection was concerned with defining and strengthening the role of the SMB. There was still a vacuum in terms of accountability and governance but little support for the SMB becoming a sub-group of the LCJB.

- (x) The SMBs we visited raised many issues, including the view that central government departments were still not joined up sufficiently. A nationally agreed database for MAPPA data and the adoption of best practice for MAPPA minutes would be welcomed by some. Others thought that national protocols should be enforced and fully implemented by areas to ensure consistency, that other agencies should be more involved, and that greater training for frontline staff was needed.
- (xi) The special challenges that faced the London Probation Area with 32 boroughs operating individual MAPPA was noted, and in other areas engaging effectively with the Health Service required understanding and attention. There could be a number of health trusts and GPs running, in effect, independent businesses with numerous community staff working to them.
- (xii) Most areas were confident about their Level 3 MAPPA meetings but another challenge was ensuring there were enough resources to enable processes and procedures to operate effectively for Level 2 meetings.
- (xiii) There was some concern that the remit of the lay advisor was poorly thought out, rather limited, and that it lacked national consistency.
- (xiv) It seemed like considerable duplication for each of the 42 probation areas to create individual public protection policies and procedures, but there was also a need for a document that reflected local arrangements. There was a strong argument for a national template covering public protection policies and procedures that was produced and updated centrally, but which allowed for local implementation with some variation.
- (xv) Despite national guidance to probation areas regarding domestic abuse cases, we found major differences in arrangements between and within areas.
- (xvi) One objective in the RANSO Business Plan for 2005/2008 was a review of current legislative arrangements for serious case reviews and the development of guidance for those offenders who commit SFOs and who were managed by MAPPA. The need for this was very apparent.
- (xvii) Arrangements for sharing good practice in probation areas were patchy. Although some OMs specifically referred to co-working cases, the sharing of good practice was mostly informal.
- (xviii) The potential use of different staff in public protection work was important. In probation, there was reason to believe that psychologists could make a big contribution, but many issues such as their conditions of service, career structure and accountability needed attention. There was a risk that without such matters being addressed, psychologists employed by probation areas would leave, which would be a great loss. Similarly, police analysts have traditionally worked on volume crimes such as burglary and vehicle crime, but further exploration of their potential role and use in public protection work should be undertaken.
- (xix) One of the objectives of the inspection was to examine how the lifer sentence planning system fitted with MAPPA. At the time of our fieldwork there was no reference to MAPPA in the Lifer Manual, but work was currently underway to update the post-release sections of the manual and the PPLRU was developing a probation service working guide.

### **Good Practice Examples: Innovations in leadership and management**

*In Kent Probation Area, the Board had formed a Public Protection Panel. The panel consisted of five Board members and relevant senior managers. The panel had developed knowledge of the work of public protection and MAPPAs, reviewing related objectives and targets from the area business plan and had provided written reports to a full Probation Board meeting on public protection topics. Board members had occasionally attended MAPPAs meetings to find out what happened, and represented the Board at stakeholder events to spread agency awareness of MAPPAs.*

*Also in Kent, two police analysts were attached to the Public Protection Unit to assist with MAPPAs cases. They provided a valuable service, undertaking laborious and detailed work converting huge amounts of information and intelligence from a number of different sources into diagrams and charts that could easily be used to gain a picture of an offender which would contribute to their risk assessment and management.*

*In the North West region, there was a pilot project that provided a community-based intensive intervention programme for personality disordered offenders released from prison. This was a partnership between Merseyside NHS Trust, the NW Secure Commissioning Team, and the NW Prisons Service and probation areas. The funding was secured by NOMS Health Care Partnership to support the work of MAPPAs.*

### **Key Finding**

The national leadership provided in relation to public protection has generally been appreciated at regional and local levels and has led to some excellent developments in effective partnership working. Every area inspected had arrangements in place for information sharing and liaison, and the role of SMBs in relation to local MAPPAs was still developing.

While some progress has been made, however, the theme of inconsistent and patchy arrangements identified in earlier parts of this report continued in relation to leadership and strategic management. We found very little senior management involvement in prisons generally, and in police areas the impression was that BCU Commanders were divorced from the issue of public protection unless individual cases were brought to their attention. Probation, generally, had more involvement at senior and Board levels, but here the case for more consistency between areas and less duplication of effort was strong.

### **Priorities for improvement:**

1. The progress in recent years is recognised and built upon by sharing good practice nationally. (POL, PRIS, PROB)
2. The resources allocated to MAPPAs are reviewed. (POL, PRIS, PROB)
3. The strategic commitment of senior staff, in prisons and the police, to good public protection practice is encouraged and reinforced. (POL, PRIS)
4. A national template for public protection policies and procedures is developed for probation areas, allowing for some variation in local

implementation. (PROB)

5. Local police and probation areas develop shared targets for public protection and joint performance indicators. (POL, PROB)

## 4.2 Human resource management

**Criterion: *Human resource management achieves a good match between staff profile and service delivery requirements.***

- (a) The many changes experienced by the police, probation and prison services in recent years have had many implications for the effective management of the major resource of these services. In order to get a sense of the progress made in relation to public protection and human resource management, we looked at staff deployment, supervision, workload, training and the use of partnerships.

### **Strengths**

- (i) We found a number of different models of co-location of police, probation, and staff from other agencies, and these arrangements generally seemed to work well. Co-location of staff required a clear understanding and agreement about a variety of working arrangements and relationships between staff.
- (ii) In County Durham, the joint management by probation and police of the Public Protection Unit and the pairing system of OMs and police officers were definite strengths, but the remit was limited to RSOs rather than all public protection or MAPPA cases.
- (iii) Apart from police and probation staff working together in the same premises, other professionals had been seconded to co-located teams including police analysts, forensic psychologists, CPNs, and prison staff.
- (iv) The majority of probation areas inspected had staff supervision policies in place, but more specific references to discussing high Risk of Harm cases would have been helpful.
- (v) Staff supervision notes in probation varied in quality, but in Derbyshire and Suffolk in particular, general management support and oversight of cases was good, with SPOs reading case files on a regular basis.
- (vi) All police areas provided training in the use of RM 2000 and ViSOR, and the majority also provided role specific training on sex offenders. Officers who worked alongside probation staff commented on the benefits of undertaking joint visits and the learning to be gained from probation colleagues.
- (vii) Training for probation middle managers varied, but generally had included MAPPA awareness issues and use of OASys.
- (viii) Access to specialist staff was sometimes achieved through contracts with service providers, for example, for substance misuse in approved premises. In Derbyshire, the NSPCC delivered the community sex offender programme, which was an arrangement that was working well. In Lancashire, the NSPCC was contracted to provide interventions for sex offenders who were not suitable for the community sex offender programme, either due to learning difficulties or language.



- (ix) There was evidence that operational issues with Duty To Cooperate Agencies were being addressed.

### **Areas for improvement**

- (i) Workload measurement tools in probation generally were not responsive enough to accommodate the more intense nature of working with high Risk of Harm cases, leaving some OMs feeling that they could not adequately supervise these cases. In some probation areas, however, the workload models weighted high Risk of Harm cases.
- (ii) For the police, workload and resourcing became a key issue during the inspection. All eight police forces visited had dedicated staff for the management of RSOs. In seven, these officers also had responsibility for the management of other sex offenders and violent/dangerous offenders.
- (iii) In more than half the police areas, staffing levels were historic. As a result, the variation in the number of offenders in all categories managed by individual dedicated officers was found to be considerable, from 40 to 200. There was consistent and growing concern amongst practitioners over capacity, not only in terms of increasing offender numbers, but the demand for greater proactivity in offender monitoring and management.
- (iv) ViSOR implementation was ongoing at the time of the inspection and responsibility for back record conversion and data-cleansing from paper records and local databases had added to the workload of dedicated staff.
- (v) There were many variations in the way in which police areas were managing workload issues. In two areas, for example, reviews had resulted in changes to staffing levels and structure. In two other areas, home visits to low and medium Risk of Harm RSOs were undertaken by other personnel, such as Community Beat Managers, to allow the dedicated officers to focus on higher Risk of Harm offenders. (This had, however, led to concerns about training of non-specialist personnel). In others, the response was short-term and limited to the provision of additional staff on a temporary basis during the ViSOR implementation period.
- (vi) Although there was recognition by senior managers of the pressures faced by dedicated staff, at a practical level senior managers tended to focus on the 'critical few' – those presenting the greatest potential risk and requiring the greatest resources to manage.
- (vii) The main issues identified by dedicated officers in relation to training were timeliness and quality. As already highlighted, the inspection found examples of officers undertaking RM 2000 risk assessments without having completed the relevant training.
- (viii) There was no specific training on public protection work for SPOs. SPOs had not received any dedicated training about supervising staff who managed high Risk of Harm cases and sometimes very little about supervisory skills. Their role was important, however, and included involvement in public protection cases, identifying appropriate MAPPAs, supervising staff and chairing Level 2 MAPPAs meetings.
- (ix) A general training course covering risk assessment and management of high



Risk of Harm cases was not evident in most probation areas. It was hoped that this gap in training provision would be addressed when the Risk of Harm training package commissioned by NOMS, and developed by Hazel Kemshall and others, was rolled out in the summer of 2006.

- (x) Prison staff who used OASys had to be trained in their part of the process before they could access the system. This covered assessors, supervisors, managers and clerks. However, there was no specified training for prison public protection coordinators or clerks, although some was planned and training was being designed by the Prison Service Training College at Newbold Revel.
- (xi) There were very few services provided by partnerships for high Risk of Harm offenders.
- (xii) At the time of our inspection, there were concerns raised about contestability and the implications for responsibility for public protection under NOMS.

**Good Practice Example: Training for OMs**

*The Derbyshire Area Staff Development and Training Plan for 2005/2006 was aligned to the priority areas of work identified in the business plan, which placed protecting the public as the first priority. Risk of Harm training was ongoing, with a number of related training events taking place, such as child protection, sex offender work, domestic abuse and lifers.*

**Key Finding**

Much progress had been made towards effective joint working, and we discovered some excellent examples of the co-location of police, probation and staff from other agencies. These arrangements seemed to be working well, but they were the exception rather than the rule. Although some good public protection training had taken place, the need for much more training was obvious. The very wide variations in workload were also a concern. The importance of good workload management in this area of work was very apparent, if the public were to be properly protected and staff supported as they do a difficult job.

**Priorities for improvement:**

1. The co-location of police, probation and staff from other agencies is encouraged wherever logistically feasible. (POL, PROB)
2. Greater consistency in workload measurement and staff deployment is achieved in police and probation areas in particular. (POL, PROB)
3. Our contact with the police in this inspection suggested that a national review of public protection across all police services in England and Wales could be timely and helpful. This might cover a wide range of issues in more depth than was possible during this inspection. (POL)
4. More consistent training courses for staff in managing high Risk of Harm cases are provided for police, prisons and probation staff nationally, regionally and locally. (POL, PRIS, PROB)

## Appendix 1: Assessment tools

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**\*The Offender Assessment System (OASys)** is a comprehensive risk/needs offender assessment tool developed by the prison and probation service. It has five main components:

1. Risk of reconviction and offender related details. This includes case identification, offending information, offence analysis, assessment of factors linked to offending, health and other considerations such as accommodation, education, employment and employability.
2. Risk of serious harm, risk to individuals and other risks. This includes a screening section, full analysis, risk management plan and harm summary section. OASys describes four levels of Risk of Harm. It currently employs the following descriptors:
  - Low – no significant, current indicators of Risk of Harm
  - Medium – there are identifiable indicators of Risk of Harm. The offender has the potential to cause harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse
  - High – there are identifiable indicators of serious Risk of Harm. The potential event could happen at any time and the impact of the event would be serious
  - Very high – there is an imminent risk of serious harm. The potential event is more likely than not to happen imminently and the impact would be serious. A risk of serious harm was defined as ‘a risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological can be expected to be difficult or impossible’.
3. The OASys summary sheet, which draws together the above information and includes a scoring schedule.
4. Supervision and sentence planning. This includes an outline plan for PSRs only, an initial plan and a review plan including transfer and termination.
5. Offender self-assessment. A questionnaire which gives the offender an opportunity to record their views.

There is also a confidential section for information that must not be disclosed to the offender and a form to use to obtain information from other parties.

**\*Risk Matrix 2000** is a specialist actuarial assessment based on static factors to predict the likelihood of sex offender reconviction. It is mainly used by the police. Risk Matrix score categories have been given labels - low, medium, high and very high for the practical purpose of dividing convicted sexual

offenders into groups that represent the likelihood of reconviction. OASys should trigger the use of RM 2000. Where there is a disparity between OASys (OGRS2 and the total score for sections 1 – 12) and RM 2000 regarding the likelihood of reconviction, RM 2000 takes precedence. OASys can be used to provide additional guidance to other behaviours related to offending and specific factors which could affect the imminence associated with Risk of Harm. (Sources: OASys – Additional Operational Guidance – Version 1 May 2003 NPD, Scoring Guide for Matrix 2000.4, April 2003 Version, David Thornton, Ph.D.)

## Appendix 2: Public protection report tables

**Table 1 The quality of reports written on those in custody**

	LIST A Offenders recently sentenced to imprisonment		LIST B Offenders before release from prison	
	Prison	Probation	Prison	Probation
Were reports prepared in relation to this sentence?	9%	13%	47%	43%
Were they clear and thorough?	75%	75%	100%	92%
Produced within the required timescale?	75%	100%	88%	92%
Incorporated OASys and other assessments into Risk of Harm assessment?	75%	75%	18%	79%
Contributed to the decision-making process?	50%	100%	67%	91%

**Table 2 Overall quality of preparation for sentence or release**

	LIST A Offenders recently sentenced to imprisonment		LIST B Offenders before release from prison	
	Prison	Probation	Prison	Probation
Excellent	0%	5%	0%	11%
Sufficient	32%	61%	28%	49%
Insufficient	45%	32%	67%	32%
Poor	23%	2%	6%	8%

**Table 3 The overall quality of Risk of Harm assessments**

	LIST A Offenders recently sentenced to imprisonment		LIST B Offenders before release from prison		LIST C Offenders on licence in the community
	Prison	Probation	Prison	Probation	Probation
Excellent	0%	0%	0%	0%	1%
Sufficient	45%	66%	47%	68%	66%
Insufficient	27%	12%	41%	25%	20%
Poor	27%	22%	12%	8%	13%

**Table 4 Sources of risk assessment recorded on ViSOR**

RM 2000 for violence	6
RM 2000 for sex offending	17
Information from previous paper file	4
Overall risk assessment	12
Level 3 MAPPP	1
Unknown	1

**Table 5 A summary of the results of prison and probation assessment of offender engagement**

	LIST A Offenders recently sentenced to imprisonment		LIST B Offenders before release from prison		LIST C Offenders on licence in the community
	Prison	Probation	Prison	Probation	Probation
Have probation and prison staff given full attention to methods likely to be most effective when working with this offender?	38%	61%	53%	53%	68%
Has the offender's learning style and capacity to change been taken into account at the earliest opportunity?	52%	49%	65%	55%	69%
Has a clear race and ethnic monitoring classification been recorded?	91%	85%	94%	77%	91%
Have diversity issues and any other individual needs been actively assessed?	36%	33%	72%	40%	68%
Any potentially discriminatory or disadvantaging factors been identified?	23%	7%	28%	26%	40%
If yes, have plans been put in place to minimise their impact?	67%	25%	50%	17%	80%

**Table 6 Overall quality of the offender engagement assessment**

	LIST A Offenders recently sentenced to imprisonment		LIST B Offenders before release from prison		LIST C Offenders on licence in the community
	Prison	Probation	Prison	Probation	Probation
Excellent	0%	5%	0%	2%	2%
Sufficient	48%	44%	56%	48%	64%
Insufficient	33%	46%	39%	40%	29%
Poor	19%	5%	6%	9%	4%

**Table 7 Overall quality of the sentence planning**

	LIST A Offenders recently sentenced to imprisonment		LIST B Offenders before release from prison		LIST C Offenders on licence in the community
	Prison	Probation	Prison	Probation	Probation
Excellent	0%	0%	Not assessed	0%	0%
Sufficient	59%	22%		30%	41%
Insufficient	18%	68%		60%	47%
Poor	24%	10%		9%	12%

**Table 8 From 55 cases where both police and probation files on the same offenders were inspected**

Where the case has been within MAPPAs, what is the highest level at which it has been managed?	Agreement between police and probation files Either Level 2 or 3 – 10 Not clear – 4 NA - 1	Disagreement between police and probation case files.  Probation file either Level 1, 2 or 3 police file not clear – 31	Probation file Level 2, Police file Level 1 – 6  Probation file Level 1, Police file Level 2 – 1 Probation file not clear of NA, Police file Level 2 – 2

**Table 9 Prison and probation involvement in MAPPA and recording MAPPA and Risk of Harm**

	LIST A Offenders recently sentenced to imprisonment		LIST B Offenders before release from prison		LIST C Offenders on licence in the community
	Prison	Probation	Prison	Probation	Probation
Has the probation OM or prison staff submitted a report or attended MAPPA meetings and made a contribution?	23%	67%	38%	79%	87%
Was the Risk of Harm and MAPPA classification recorded clearly on the case file?	50%	75%	29%	61%	78%
Were any changes in Risk of Harm and MAPPA classification described and dated?	20%	67%	29%	50%	31%

**Table 10 From 55 cases where both police and probation files on the same offenders were inspected**

Has the offender spent more than six weeks in approved premises?	In 44 cases there was agreement (either yes or no)	Probation Yes, Police Not Known – 3 Probation No, Police Not Known - 5	There was 1 case where police and probation files were not clear and 1 case where the probation file was No and the police file was Yes
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**Table 11 From 55 cases where both police and probation files on the same offenders were inspected**

Is there a copy of the licence on the case file?	Probation No 0 Yes 55	Police No 31 Yes 24
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**Table 12 Prison and probation staff contribution to intelligence and information gathering**

	LIST A Offenders recently sentenced to imprisonment		LIST B Offenders before release from prison		LIST C Offenders on licence in the community
	Prison	Probation	Prison	Probation	Probation
Have probation/prison staff contributed to intelligence and information gathering by recording appropriately on the third party or confidential section of the case file and/or informing the prison/probation or police?	23%	20%	24%	34%	69%
If yes, had the intelligence and information been used to manage the prisoner or offender effectively?	27%	70%	57%	67%	85%

**Table 13 Overall quality of arrangements to protect the public from harm**

	LIST A Offenders recently sentenced to imprisonment		LIST B Offenders before release from prison		LIST C Offenders on licence in the community
	Prison	Probation	Prison	Probation	Probation
Excellent	0%	0%	6%	2%	1%
Sufficient	32%	61%	38%	58%	76%
Insufficient	59%	32%	56%	35%	21%
Poor	9%	7%	0%	6%	2%

**Table 14 From 55 cases where both police and probation files on the same offender were inspected**

Where there is a direct victim/potential victim and/or restrictive or prohibitive conditions on the licence or civil order, action has been taken by the police and the probation area to prioritise/ ensure victim safety?	There was agreement in 26 cases either yes, no or NA.	The majority of disagreements were probation files Yes and police files No – 21, with a further 8 cases with several variations of results.
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**Table 15 Overall quality of victim work**

	LIST A Offenders recently sentenced to imprisonment		LIST B Offenders before release from prison		LIST C Offenders on licence in the community
	Prison	Probation	Prison	Probation	Probation
Excellent	0%	3%	6%	2%	1%
Sufficient	14%	78%	25%	49%	64%
Insufficient	73%	15%	44%	43%	30%
Poor	14%	5%	25%	6%	4%

**Table 16 Quality of prison and probation records**

	LIST A Offenders recently sentenced to imprisonment		LIST B Offenders before release from prison		LIST C Offenders on licence in the community
	Prison	Probation	Prison	Probation	Probation
Are case records well organised?	45%	83%	72%	66%	69%
Do they contain all the relevant information?	Not assessed	Not assessed	44%	53%	60%
Is the recording of information:					
Clear?	72%	93%	88%	79%	90%
Timely?	72%	65%	76%	75%	76%
Sufficient?	17%	100%	67%	45%	71%

**Table 17 Suggested structures of a contact log entry**

List 1	
The five 'As'	
ATTENDANCE	Was it a planned appointment?
APPLICATION	What work was undertaken?
ASSESSMENT	What was achieved?
ACTION	What action followed the above?
APPOINTMENT	When is it?
List 2	
Work undertaken	
Change in circumstance	
Action taken or to be taken	
Explanation for failed appointments	
Contact with other agencies	
List 3	
Keep it succinct and simple!	
Appointments and instructions given	
Attendance, key events and developments	
Decisions made and reasons for those decisions	
Progress of interventions from sentence plan e.g. objective 1, 2, 3	

**Table 18 Overall quality of consistency and continuity of offender management**

	LIST A Offenders recently sentenced to imprisonment		LIST B Offenders before release from prison		LIST C Offenders on licence in the community
	Prison	Probation	Prison	Probation	Probation
Excellent	0%	0%	0%	2%	0%
Sufficient	18%	68%	24%	56%	72%
Insufficient	64%	30%	59%	33%	27%
Poor	18%	3%	18%	10%	1%

**Table 19 Overall quality of interventions delivered to meet the requirements of the sentence**

	LIST A Offenders recently sentenced to imprisonment		LIST B Offenders before release from prison		LIST C Offenders on licence in the community
	Prison	Probation	Prison	Probation	Probation
Excellent	0%	Not assessed	0%	2%	1%
Sufficient	27%		33%	55%	64%
Insufficient	59%		50%	40%	30%
Poor	14%		17%	4%	4%

**Table 20 Overall quality of interventions to meet diverse needs**

	LIST A Offenders recently sentenced to imprisonment		LIST B Offenders before release from prison		LIST C Offenders on licence in the community
	Prison	Probation	Prison	Probation	Probation
Excellent	0%	2%	0%	0%	0%
Sufficient	59%	17%	72%	51%	81%
Insufficient	41%	80%	28%	47%	18%
Poor	0%	0%	0%	2%	1%

**Table 21 Offenders charged, cautioned, convicted or adjudicated**

	LIST A Offenders recently sentenced to imprisonment	LIST B Offenders before release from prison	LIST C Offenders on licence in the community
Has the offender been:	Prison	Prison	Probation
Charged with an offence?	5%	8%	7%
Cautioned for an offence?	0%	8%	19%
Convicted of an offence?	22%	41%	9%
Dealt with at an adjudication while in custody?	25%	31%	21%

**Table 22 To what extent have planned objectives been achieved to date?**

	LIST A Offenders recently sentenced to imprisonment		LIST B Offenders before release from prison		LIST C Offenders on licence in the community
	Prison	Probation	Prison	Probation	Probation
Excellent	0%	Not assessed	8%	0%	1%
Sufficient	36%		38%	47%	52%
Insufficient	36%		8%	45%	38%
Poor	27%		46%	8%	9%

**Table 23 How many probation OMs and prison/personal officers have supervised this case?**

	LIST A Offenders recently sentenced to imprisonment		LIST B Offenders before release from prison		LIST C Offenders on licence in the community
	Prison	Probation	Prison	Probation	Probation
1	36%	34%	8%	31%	17%
2	36%	63%	38%	40%	41%
3	14%	2%	8%	23%	33%
4+	14%	0%	46%	6%	9%

**Table 24 Overall quality of work undertaken to achieve sustainable progress**

	LIST A Offenders recently sentenced to imprisonment		LIST B Offenders before release from prison		LIST C Offenders on licence in the community
	Prison	Probation	Prison	Probation	Probation
Excellent	0%	2%	0%	2%	1%
Sufficient	27%	71%	15%	53%	69%
Insufficient	55%	24%	69%	43%	26%
Poor	18%	2%	15%	2%	4%

**Table 25 Resource allocation**

Are the resources allocated consistent with the offender's:	LIST A Offenders recently sentenced to imprisonment		LIST B Offenders before release from prison		LIST C Offenders on licence in the community
	Prison	Probation	Prison	Probation	Probation
Risk of Harm	32%	66%	38%	79%	92%
Likelihood of reoffending	27%	73%	38%	79%	91%

**Table 26 The extent to which the interventions in this case represent good value for money**

	LIST A Offenders recently sentenced to imprisonment		LIST B Offenders before release from prison		LIST C Offenders on licence in the community
	Prison	Probation	Prison	Probation	Probation
Excellent	0%	0%	0%	0%	1%
Sufficient	29%	61%	17%	64%	75%
Insufficient	43%	37%	58%	30%	24%
Poor	29%	2%	25%	6%	0%