HM Inspectorate of Probation
Arolygiaeth Prawf EM

Risk of Harm Inquiry Report

Turning Good Intentions into Good Practice

An inquiry into developments in the multi-agency management of Risk of Harm in Gwent

March 2008

FOREWORD

When any serious offence, particularly one against a child, is committed by an offender recently under the supervision of criminal justice agencies it is right that questions are asked and answered. One of the most important questions is whether something could have been done to prevent such a terrible offence, or could have made it less likely to happen. In the case of Craig Sweeney, other organisations have rightly addressed this crucial question already. Therefore, the focus of our own inquiry on this occasion has been a different one. We have endeavoured to answer the other important question: whether enough has been done after the event – principally, but not solely, by Gwent Probation Area – to improve the way in which the public is now protected from similar offenders. We have been interested in discovering whether lessons have been learned and progress made as needed. Thus, our focus has been not on one case but on others managed in Gwent on a daily basis, either by probation alone or in partnership with others.

We found that there has undoubtedly been much well-intentioned activity by probation, police and others to improve those processes which had not previously been working to the best effect. There has been a commitment to protect the people of Gwent from those who pose a Risk of Harm. Regrettably, these intentions have not been matched by progress on the ground. Leaders and managers have mistakenly believed that improvements initiated at strategic level had been enacted in practice. We have not found sufficient evidence that good intentions have led to good practice and are not therefore in a position to offer reassurance.

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ACKNOWLEDGEMENTS

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GLOSSARY

ACO	*Assistant Chief Officer* within a probation area.
Approved premises	Formerly known as bail and/or probation hostels, *approved premises* provide controlled accommodation for offenders under the supervision of the Probation Service. *Approved premises* are experienced in dealing with offenders who pose a high *Risk of Harm* to others.
CO	*Chief Officer* of a probation area.
Constructive interventions	As distinct from a *restrictive intervention*. A *constructive intervention* is where the primary purpose is to reduce likelihood of reoffending. In the language of *offender management* this is work to achieve the 'help' and 'change' purposes, as distinct from the 'control' purpose.
CRAMS	*Case Record and Management System*.
Duty to Cooperate agencies	Various organisations providing public services have a *Duty to Cooperate* with the *MAPPA Responsible Authority*. The purpose of this is to ensure that all relevant agencies contribute where possible to the effective assessment and management of offenders under *MAPPA*. Some *Duty to Cooperate agencies* included local housing authorities, education services, children's services and Youth Offending Teams.
Dynamic factors	As distinct from *static factors. Dynamic factors* are the factors in someone's circumstances and behaviour that can change over time.
HMI Constabulary	*Her Majesty's Inspectorate of Constabulary.*
HMI Probation	*Her Majesty's Inspectorate of Probation.*
HRHT	*High Risk of Harm Team* within Gwent Probation Area, within which most of the high and very high *Risk of Serious Harm* cases are held.
IPCC	*Independent Police Complaints Commission.*
IT	*Information technology.*
MAPPA	*Multi-Agency Public Protection Arrangements*: where probation, police, prison and other agencies work together in a given geographical area to manage certain types of offenders.

MAPPA Categories	There are three types of offenders managed under *MAPPA*. These are known as Category 1, 2, and 3. Category 1 offenders are registered sexual offenders. Category 2 offenders are violent offenders sentenced to 12 months or more in custody, as well as other sexual offenders, and offenders subject to Hospital Orders with restrictions. Category 3 offenders are other dangerous offenders who are considered to pose a high or very high *Risk of Harm* and require active multi-agency management.
MAPPA Levels	Each offender managed within *MAPPA* will be managed at a specific level depending on the amount of resources required to manage them effectively. Level 1 cases are those where the risks posed by the offender can be managed solely by the agency responsible for their supervision. Level 2 and 3 cases are managed using *MAPP meetings*, with Level 3 cases being those which are more complex and require close multi-agency cooperation at a senior level, more resources and more frequent formal meetings between the agencies than Level 2 cases.
MAPPA Responsible Authority (RA)	The prison, police and probation services have a duty to act as the *Responsible Authority* for *MAPPA* in each of the 42 *RA* areas in England and Wales. The *RA* is defined by location of the *offender manager* when the offender is serving a sentence, or by the place of residence of the offender when they have completed a sentence but are still under *MAPPA*. The *RA* has a duty to make sure that *MAPPA* are working effectively within the area, and do this via the *MAPPA SMB* which monitors the performance of the area.
MAPPA SMB	*MAPPA Strategic Management Board.*
MAPP meetings	*Multi-Agency Public Protection meetings*: where Level 2 and Level 3 cases managed under *MAPPA* are discussed and managed in a multi-agency way by staff from the relevant agencies.
NHS	*National Health Service.*
NOMS	*National Offender Management Service*: the evolving single Service designed to include responsibility for both HM Prison Service and the *National Probation Service*.
NPS	*National Probation Service.*
OASys	*Offender Assessment System*: the nationally designed and prescribed framework for both the *NPS* and HM Prison Service to assess offenders, implemented in stages from April 2003. It makes use of both *static* and *dynamic factors*.
Offender management	A core principle of *offender management* is that one person takes responsibility for managing an offender through the period of time they are serving their sentence, whether in custody or the community. Offenders are managed differently depending on their *Risk of Harm* and their needs in relation to *constructive* and *restrictive interventions*.
Offender manager	In the language of *offender management*, this is the term for the officer with lead responsibility for managing a specific case 'from end to end'.

Offender supervisor	This is the term for staff who fulfil specific roles in working with offenders during their sentence, for example in the day-to-day management of offenders during the custodial phase of their sentence on behalf of the *offender manager*.
OMI	*Offender Management Inspection.*
PO	*Probation officer.*
PC	*Probation Circular.*
PPU	*Public Protection Unit.*
PSO	*Probation service officer.*
Restrictive interventions	As distinct from *constructive interventions*. A *restrictive intervention* is where the primary purpose is to keep to a minimum the offender's *Risk of Harm* to others. In the language of *offender management* this is work to achieve the 'control' purpose, as distinct from the 'help' and 'change' purposes. Example: with a sex offender, a *constructive intervention* might be to put them through an accredited sex offender programme; a *restrictive intervention* (to minimise their *Risk of Harm*) might be to monitor regularly and meticulously their accommodation, their employment and the places they frequent, imposing and enforcing clear restrictions as appropriate to each case. The sex offender programme will hopefully have some impact on the offender's *Risk of Harm* in the long-term, but its primary purpose is to reduce the likelihood of reoffending.
Risk of Harm (RoH)	This is the term generally used by *HMI Probation* to describe probation work to protect the public. *HMI Probation* uses this term instead of *Risk of Serious Harm* in order to ensure that *RoH* issues being assessed and addressed by probation areas are not restricted to the definition given in *OASys*. The intention in doing this is to enable satisfactory clarification of the differences between the likelihood/probability of an event occurring and the impact/severity of the event. The *Risk of Serious Harm* definition only incorporates serious impact, whereas using *RoH* enables attention to be given to those offenders for whom lower impact/severity harmful behaviour is common.
Risk of Harm work	In the language of *offender management*, this is work to achieve the 'control' purpose, with the officer using primarily *restrictive interventions* that keep to a minimum the offender's opportunity to behave in a way that poses *RoH* to others.
RoHAA	*Risk of Harm Area Assessment*: these were being undertaken by *HMI Probation* in those probation areas not due a full *OMI* until after June 2008, in order to provide an assessment of the quality of *RoH* work in every probation area for the *NOMS*. *RoHAAs* provide a *RoH* Thread Score, which describes the overall proportion of *RoH* work which is considered satisfactory in the probation area, equivalent to the *RoH* Thread Score awarded as part of an *OMI*.

Risk of Serious Harm (RoSH)	This is the label used for classifying levels of risk in *OASys*, where offenders are classified as either 'low', 'medium', 'high' or 'very high' *RoSH*, where serious harm is defined as 'an event which is life-threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.' (Chapter 8 of the OASys Manual, July 2006). In this report this term is used solely to refer to this process of *OASys* classification.
SFO	*Serious Further Offence*, committed by an offender under supervision or who has recently completed a period of supervision.
Static factors	As distinct from *dynamic factors*. *Static factors* are elements of someone's history that by definition can subsequently never change (i.e. the age at which they committed their first offence).
ViSOR	*The Violent Offender and Sex Offender Register*.

SUMMARY

This inquiry examined developments in the management of Risk of Harm in Gwent since Craig Sweeney's notorious Serious Further Offence, following his period of supervision on licence ending in December 2005. Our examination revealed a number of findings, both about the work of Gwent Probation Area, and about the quality of multi-agency management of 'high Risk of Harm offenders'.

Offenders managed under Multi-Agency Public Protection Arrangements (MAPPA) should, by their very nature, be receiving a 'premium service'. Robust systems should be in place to ensure that each such offender is managed as effectively as possible to reduce the likelihood of further serious offending. Unless every MAPPA case is managed well, the systems cannot be considered to be truly effective.

There was some evidence of good work within the team in Gwent Probation Area that managed high Risk of Harm cases. However, we were not satisfied by the quality of overall practice that we saw in the assessment and management of Risk of Harm across Gwent. Furthermore, we were not satisfied that the level of knowledge, skills and confidence was high enough across all Gwent probation staff and middle managers in the management of Risk of Harm to others.

Despite the implementation of new processes to support the arrangements for managing those offenders assessed as high and very high Risk of Harm to others, we were not satisfied that the MAPPA systems were effective. Despite the positive spirit and commitment of the MAPPA Strategic Management Board, the good intentions had not yet led to sufficiently robust practice.

Recommendations

HMI Probation recommends that:

- multi-agency MAPPA training is rolled out to all practitioners involved in work with MAPPA offenders (this was planned to begin in mid-2008)
- improvement is required in the quality of Risk of Harm work by Gwent Probation Area (the Offender Management Inspection scheduled for July 2008 will establish the extent of progress in this area)
- the local Multi-Agency Public Protection meeting minutes template is revised in order that it serves the purpose of enabling accurate and active multi-agency management of Risk of Harm with each case
- effective systems are implemented to manage the cross-area rehousing of MAPPA offenders, with appropriate communication and planning between probation areas and with other agencies to ensure effective Risk of Harm management.

TERMS OF REFERENCE

Following production of a MAPPA Serious Case Review in December 2006, the NOMS PPU requested independent assurance from HMI Probation that improvements had been made in the way cases similar to that of Craig Sweeney were being managed in Gwent Probation Area. It was not part of our remit to pursue the recommendations of other agencies in our inquiry.

The agreed Terms of Reference were as follows:

- to identify the extent to which the required actions were already embedded in the management of MAPPA offenders in Gwent
- to identify any issues arising from the inspection that required further action by the MAPPAs involved or their constituent agencies.

A BRIEF HISTORY OF THE CASE

In July 2004 Craig Sweeney was released on licence from a three year custodial sentence for indecent assault on his six year old step-daughter. He had served almost 15 months of the sentence. He was made subject to the Notification Requirements under Part 2 of the Sexual Offences Act 2003 (placed on the Sex Offender Register), and managed by South Wales Probation Area as a MAPPA Level 2 case in approved premises in Swansea.

Craig Sweeney was recalled to prison in August 2004 for breaching his licence by consuming alcohol and engaging in violence. This behaviour led to his accommodation being withdrawn and he was consequently in breach of three of his licence conditions (to be of good behaviour, not to consume alcohol, and to reside at the approved premises).

He was re-released on licence as a Level 2 MAPPA offender on 1 April 2005, again under the supervision of South Wales Probation Area, to an address in Newport, Gwent, which had been finalised one day prior to his release. This arrangement had not been communicated to Gwent Probation Area until the day before his release and South Wales Probation Area continued to have contact with Craig Sweeney in Newport. A MAPP meeting was held in Gwent on 14 April 2005 to discuss Craig Sweeney's management in the area. His management was officially transferred from South Wales Probation Area on 22 April 2005. Although a further MAPP meeting was scheduled for 19 May 2005, the meeting was later cancelled and not rearranged.

Two significant incidents occurred during Craig Sweeney's second licence period. One was an allegation of violence towards an adult man by Craig Sweeney at his accommodation in July 2005, and the other consisted of Craig Sweeney allegedly making inappropriate comments towards three children and touching one of them on the bottom while he was in Avon & Somerset.

Craig Sweeney's RoH was raised from medium to high in September 2005 when the review of OASys was undertaken.

His licence expired on 31 December 2005 and he abducted and sexually assaulted a three year old girl on 2 January 2006. In June 2006 he was sentenced to life imprisonment for these offences.

ACCOUNT OF PREVIOUS INQUIRIES

This inquiry is being undertaken completely independently of all previous inquiries, details of which are provided here in order to give context to this report:

- *SFO notification and review documentation (undertaken February 2006).*

The SFO review process followed the guidance specified in PC54/2003, which was in operation at the time. The purpose of the SFO review system was to establish what occurred and what could be learned from an examination of the management of the case by the relevant probation area(s), with the aim of improving practice in the management of offenders by probation. Due to Craig Sweeney having been managed by two different probation areas (South Wales and Gwent) since his release on licence in April 2005, the SFO review examined work undertaken by both probation areas and specified which area each of the findings related to in the screening document. Separate full SFO reviews were then undertaken for South Wales and Gwent. An ACO from Dyfed-Powys Probation Area undertook the reviews.

The broad findings from the SFO screening and full analysis process were that the OASys documentation (including the RoH assessment) and some of the contact requirements (e.g. home visiting) were not undertaken in a timely manner. There were also issues in relation to the quality of some key documents (the Risk Management Plan and OASys). Decision-making, in relation to the decision not to recall following the incident in August 2005 in Avon & Somerset, occurred informally and without the structure of MAPPA, and case recording was insufficient. Additionally, MAPPA were not used appropriately, and difficulties in finding appropriate accommodation for Craig Sweeney by South Wales on his release from prison impacted on the way the case was transferred from South Wales to Gwent Probation Area, with Gwent receiving insufficient notice.

The recommendations from the SFO review were in relation to the shortage of accommodation provision for sex offenders being released from prison (identified as a problem not confined to South Wales and Gwent), and the appropriate use of MAPP meetings to make decisions about the management of offenders being supervised as MAPPA cases.

- *IPCC independent investigation into the police response to the report of the abduction of Child A from her home in Rumney on 2 January 2006 (report dated July 2006).*

This document investigated the response of South Wales Police to the serious further offending of Craig Sweeney, following complaints from the child's father about the police action at the time. Several recommendations were made in relation to changing policies and practices of the police in the management of such incidents from the time they were reported by members of the public.

- *A Review of the Management of Craig Sweeney within Gwent MAPPA (report dated November 2006)*

This review was commissioned by Gwent MAPPA SMB and undertaken by a senior member of staff from Dyfed-Powys Police. It focused on the management of Craig Sweeney by the RA within Gwent MAPPA, between the time of his release from prison in April 2005 and his reoffending in January 2006. The review identified lessons which could be learned from the case and aimed to 'improve inter-agency working and enhance the ability of Gwent MAPPA to minimise risk to the public and assist in building public confidence' (page 1).

The recommendations focused on required changes to the local MAPPA processes, engagement with other MAPPA SMBs, and multi-agency training for staff involved in MAPPA. Specific recommendations were also made about police practices in working with registered sex offenders, and about probation practices in recording contacts and decision-making, and in the timely completion of OASys assessments and reviews in line with relevant guidance.

An Action Plan was developed by Gwent MAPPA SMB in order to address each of the recommendations within the review.

GWENT PROBATION AREA RISK OF HARM WORK

MAPPA Level 2 and 3 offenders had a Gwent Probation Area offender manager in charge of the case if they were subject to statutory supervision (for example a community order or a licence). The probation area also managed a wide range of other offenders where RoH issues were present and needed to be addressed. This management of RoH work in Gwent was overseen by an ACO who represented probation at the MAPPA SMB, and also split responsibility for chairing the Level 3 MAPP meetings with the police Detective Chief Inspector.

The ACO line-managed the HRHT manager. The HRHT was semi-specialist, managing the majority of high and very high RoH cases across Gwent Probation Area. Whilst being based in one location, the staff in the HRHT worked in geographical 'zones' across Gwent, enabling them to cover the whole area, and develop and maintain relationships with staff at the probation offices within their 'zones'. Some high RoH cases were managed by staff in other probation offices, and were sometimes co-worked, with members of the HRHT providing advice and support to the offender managers.

OUR APPROACH AND METHODOLOGY

During the week commencing 17 December 2007 HMI Probation visited Gwent to undertake a RoHAA of the quality of RoH work within the area, to provide a benchmark score for NOMS. This was a routine piece of work, identical to that carried out in a number of other probation areas in the ensuing months. A total of 55 cases were analysed. The sample included 20 licence cases and 30 community orders that commenced during June 2007, and 5 custody cases that were sentenced between 1 December 2006 and 31 January 2007. **Findings from the RoHAA were used to inform the current inquiry in as much as they provided a picture of the broad quality of RoH work with a wide range of offenders across Gwent.**

In addition, in parallel with the completion of the RoHAA, the inspectorate also conducted a detailed examination of the case files of the six MAPPA cases held by Gwent Probation Area that were in the RoHAA sample. These were the only Level 2 and 3 MAPPA cases with a probation offender manager that fitted within the sample timings, and therefore provided sufficient work to examine, without being too historical. This additional focus explored the extent to which MAPPA processes had improved in the way offenders similar to Craig Sweeney, with probation offender managers, were being managed within Gwent, almost two years after Sweeney's SFO.

The following interviews were also undertaken with staff and managers from Gwent Probation Area and Gwent Probation Board and members of Gwent MAPPA SMB:

- seven members of staff from the HRHT and the team manager
- the CO and Probation Board representative
- the Chair (the Assistant Chief Constable of Gwent Police) and representatives from the MAPPA SMB (including the Detective Chief Inspector with strategic responsibility for MAPPA in Gwent Police, the MAPPA coordinator, the ACO responsible for MAPPA, the Chief Executive of Monmouthshire Council, the Wales lead for MAPPA within HM Prison Service, and the Medical Director from Gwent NHS Trust)
- the ACO responsible for MAPPA and the MAPPA coordinator.

A telephone meeting was held with the senior manager responsible for MAPPA in South Wales Probation Area to discuss the cross-probation area arrangements for the management of cases.

Initial discussions were held with HMI Constabulary to establish arrangements for involving them in the inquiry, in order to examine in more detail the police practices in relation to MAPPA. However, it was concluded that there was no added value in doing so, given the recently published HMI Constabulary

Inspection Report of Gwent Police (October 2007), which included MAPPA work within its focus.

As well as scrutinising the Serious Case Review document and associated Overview Report, Action Plan and attached documents, we examined the following records and documents:

- Gwent Probation Area case files
- records from MAPP meetings held in Gwent and South Wales
- minutes from MAPPA SMB meetings held in Gwent since January 2007
- Gwent MAPPA SMB Business Plan 2007/2008 and Strategic Vision 2006-2009
- independent investigation by the IPCC (Redacted Report – July 2006)
- SFO notification and review documentation completed by the ACO from Dyfed-Powys Probation Area in relation to the management by Gwent and South Wales Probation Areas of the case
- Gwent local MAPPA procedures (revised as part of the Action Plan and agreed by the MAPPA SMB in January 2007)
- HMI Constabulary Inspection Report of Gwent Police (October 2007).

FINDINGS

Knowledge, skills and confidence of Gwent probation staff and managers

- The movement of the HRHT into one office with their manager had facilitated good communication systems within the team in relation to offender management. This reorganisation had occurred in response to the review of the management of Craig Sweeney. Staff discussed individual cases of concern in group meetings and shared strategies for the effective management of such offenders. This semi-specialist model of managing most high RoH cases within the HRHT provided a concentration of expertise in RoH work within the team. Discussions with some offender managers outside of the HRHT revealed that the knowledge and skills in working with high RoH offenders was not spread adequately across the whole area.
- Despite RoH training having been provided to PSOs between 2006 and 2007, some PSO offender managers holding medium RoH cases expressed a lack of confidence and knowledge in RoH assessment and management.
- Our inspection data showed that the skills and competence of middle managers were variable. There were examples of OASys documents having been countersigned even where the quality was far below the level required. Accurate OASys documents were core to effective RoH work, and therefore some middle managers were missing opportunities to influence and improve the quality of practice. However, there was also good evidence of the HRHT manager rolling back OASys for amendments to be made by practitioners prior to countersigning.
- The CO had no means of confirming whether team managers had adequately disseminated learning from SFOs to their teams, or that performance had altered in relation to specific issues raised by SFOs. There was recognition of the need to get the feedback loop right in terms of being satisfied that dissemination of the learning from SFOs actually led to changes amongst practitioners and middle managers as required.
- Probation offender managers had not received MAPPA training, with the exception of staff in the HRHT who had been briefed by their line manager. This lack of training contributed to limited knowledge and confidence amongst offender managers, and evident confusion about the criteria for MAPPA and its correct application. Decisions to refer cases to MAPP meetings were being made by some offender managers on the basis of the level of RoH posed by the offender, rather than being based on the MAPPA categories. Some cases were therefore not being identified appropriately as MAPPA cases despite this being mandatory by virtue of their offending/sentences.

Conclusion

Despite some evidence of positive practice within the HRHT, we were not satisfied by findings across the probation area as a whole, in terms of the knowledge, skills and confidence of staff and managers in the assessment and management of RoH.

Quality of practice

Timeliness:

- The timeliness of the completion of OASys documentation at the start of sentence or at release from custody was generally good. This was important because there needed to be a clear picture of RoH issues from the earliest possible opportunity. The assessment was completed on time in 86% of those cases with an OASys RoH screening completed. Reviews of RoH were undertaken promptly in most cases. It was local practice within the HRHT for high RoH cases to be reviewed every 16 weeks even when national standards at the time did not require it.
- Home visits were used effectively to monitor child safeguarding concerns in 83% of relevant cases. In high and very high RoH cases, home visits were either carried out within ten working days of sentence or release, or carried out appropriately at a later stage. Repeated home visits were undertaken as necessary to keep RoH to a minimum in all except one case.

Quality of assessments:

- There had been no initial RoH screening completed in 13% of cases in the RoHAA sample, despite one being required in every case. This occurred in some cases where oral reports had been presented to the court, and was a significant omission. Sentencing decisions as well as management decisions in those cases had been made without relevant information about harm-related behaviour. The RoH screening was not accurate in 35% of cases in the RoHAA sample for which the screening was undertaken. This was mostly because information about previous convictions and other relevant risk-related behaviour had been missed. Accuracy of the initial screening had substantial consequences for effective management of RoH and also management of cases within MAPPA, where it was vital that all relevant information about previous risk-related behaviour was used to inform management of the case.
- Full RoH analyses were not undertaken in approximately one-quarter of cases requiring them, and no acceptable reasons were recorded for their absence in almost all of those cases. Offender managers had not therefore adequately considered the harm-related behaviour of all offenders, and how this needed to be addressed and/or managed during the order or licence period, in order to reduce the offenders' RoH to others. Where full RoH analyses were done, there were many that were lacking in detail and not completed to a sufficient standard, including two of the six MAPPA

cases. This could have had implications for the quality of the management of the cases as well as the resulting RoH classifications, with missed information leading to a lack of appreciation of the full range of risk-related issues present in the case, or a RoH classification that did not accurately reflect the RoH of the offender.

- In 14% of those cases in the RoHAA sample for which there was a clear RoH classification, we did not agree with the classifications given. In many cases this was because the documented classification was lower than we felt it should have been (i.e. with cases being managed as low RoH when they warranted management at medium RoH). Incorrectly classifying cases as low RoH instead of medium RoH meant that no Risk Management Plan was completed despite there being relevant risk issues that required assessment and management.
- Overall, the quality of the RoH assessment was sufficient in only three of the six MAPPA cases examined. Additionally, MAPPA was judged to have been used effectively in just two of the six cases.
- Reviews of OASys were undertaken appropriately in those MAPPA cases that required them. However, reviews were not undertaken following a 'significant event' in 43% of relevant cases in the RoHAA sample. By this, we mean any change in an offender's life that could make it easier (or harder) for them to offend, or an offender disclosing new information that provided new evidence for the offender manager about their offending, for example. Offender managers were not always appropriately identifying and managing the dynamic RoH issues, and could therefore have missed triggers for increased likelihood of reoffending and raised RoH to others, evident in the offenders' behaviour or attitude. Additionally, offender managers were not always good at recognising the impact of positive changes in dynamic risk factors which reduced RoH to others and the likelihood of reoffending.
- Although structured according to the required format, in 80% of cases (including three of the six MAPPA cases) the Risk Management Plans did not describe clearly enough how the risks would be managed. They were lacking in detail, and not written in an active enough way, which led to the plans not always being at the forefront of the management of medium, high and very high RoH offenders. The plans appeared to be documents that were updated as required but not used actively with each offender.

Accuracy of recording:

- Within the NPS, computerised case records were held for all offenders. Staff were required to document their contacts with offenders - or other relevant information obtained from other sources - in the form of a log. There was no national system for case recording in the Probation Service, so staff were not normally able to electronically access the case records for another probation area. However, a system existed between Gwent and South Wales Probation Areas which enabled a degree of shared access for those cases held in approved premises in South Wales and managed by Gwent. Staff expressed confusion about the processes of cross-area case

recording. Given that the majority of Level 2 and 3 MAPPA cases were likely to have been located within an approved premises in another area for a period of time during their management by probation, it was of concern that such confusion existed. There was no protocol in place to clarify procedures, and staff confirmed that on occasions entries had been made by individuals using other people's names in order to attempt to solve the problems of shared access to IT.

- Whilst we saw some very good examples of thorough recording in CRAMS, not every case demonstrated this clearly or in enough detail. Whilst offender managers were often able to verbalise the risk management work undertaken, this was not always sufficiently evidenced in the case record. A dip-sampling exercise had been undertaken by the probation area to quality check the content of CRAMS entries, although the outcome of this had not been written up formally.
- Information about all Category 1 MAPPA offenders was entered onto ViSOR. However, we found three additional cases within the Gwent RoHAA sample that should have been identified as either Category 2 or Category 3 MAPPA offenders, but there was no information within the probation case files that indicated that they had been.

Restrictive interventions:

- Ways of managing and reducing RoH were often not given sufficient priority on sentence plans. Only approximately half of relevant cases gave appropriate consideration to restrictive conditions/requirements on the sentence plans, and included clear explanation of how the RoH posed by the offender would be managed.
- Risk seemed to be predominantly managed by external means using restrictive interventions within both MAPPA and general offender management arrangements. Whilst restrictive interventions were necessary, this approach alone was not sufficient. Extra licence conditions were used routinely as a means of controlling offenders' movements, sometimes without a good balance of constructive interventions to enable them to address their offending behaviour. In most cases with additional licence conditions, discussions with offender managers revealed that they were not sufficiently clear about the ways in which the offenders' adherence to the conditions would be monitored, and which agency or agencies would be responsible for doing so.
- The procedure for ensuring that recall action was taken in all those cases requiring it was not sufficiently robust. The approach called for the use of ad hoc MAPP meetings to make the decision. However, this placed the responsibility for initiating the process with the offender manager, leaving the potential for vulnerability in cases where offender managers did not believe that cases warranted recall consideration, or were not confident in doing so. Team managers were responsible for ensuring that the procedures were adhered to. This, therefore, relied on the team managers being fully aware of all developments in every case in order to monitor this effectively, and this was felt to be impractical. A routine process for

consideration of recall issues as a standard agenda item at each MAPP meeting could have been a useful approach. It would have helped to ensure that recall was discussed regularly and multi-agency information shared, in order to enable probation to make appropriate decisions in relation to recall.

Conclusion

We were not satisfied by the quality of the assessment and management of RoH within Gwent Probation Area, and specifically in the MAPPA cases examined.

Strategic management of MAPPA

- Resources were made available from police and probation budgets to employ a MAPPA coordinator within Gwent, and the post was filled in January 2007. The post-holder was enthusiastic and committed to developing and improving MAPPA systems and contributed to all three sub-groups of the MAPPA SMB (training, accommodation and audit).
- The addition of a prison representative at the SMB meetings, in accordance with national developments, had enabled effective links to be built with prisons, and had increased the contribution of HM Prison Service to MAPPA.
- Training for chairs of MAPP meetings had taken place in 2007, and multi-agency MAPPA training for practitioners was being developed. This was due to be rolled out by mid-2008, to assist agencies in understanding each others' roles in MAPPA. Health and police staff were exploring ways to evaluate the effectiveness of the training to see what the impact was on those who attended.
- Gwent Police had undertaken a review of its procedures in relation to all MAPPA Category 1 sexual offenders in Gwent between May and August 2007, which had led to a number of police division-specific recommendations being made, and action being taken across the organisation. It had also undertaken a service improvement review of the whole of public protection in the police. As a result of the review, plans were underway to centralise the process of strategic and operational management of public protection matters.
- Despite a requirement being in place from April 2006, the SMB did not have robust procedures for monitoring and reviewing, and measuring success. It recognised the need to improve management information and arrangements for monitoring the contributions of Duty to Cooperate agencies.
- There were no procedures in place for SMB members to satisfy themselves that Category 2 and 3 MAPPA cases were always being identified appropriately, and not being missed. Whilst it was recognised that procedures for the systematic identification of Category 3 MAPPA cases would have been difficult, it was possible for Category 2 MAPPA cases.

- Three MAPPA cases from South Wales had been placed into accommodation in Gwent without South Wales having communicated appropriately with Gwent, or used the required transfer procedures between August and December 2007. In all cases, a housing provider in South Wales had been involved, and had used their informal relationships with other agencies to secure accommodation in other areas without using the formal MAPPA structures. An All Wales Accommodation Strategy had recently been agreed, which aimed to address the issue of cross-area transfer and placement of offenders.
- The attendance of the accommodation representative at the MAPPA SMB was irregular. However, SMB members were positive about the contributions made by the representative outside of the meetings.
- Minutes from MAPPA SMB meetings did not fully reflect the discussions held. This could have made it difficult for members unable to attend to establish a clear picture of the content of the meetings, as well as making it hard to evidence what had been discussed and achieved within the forum. For example, although the Business Plan indicated that the Communication Strategy was due to have been updated in July 2007, at the time of the inquiry this had not yet happened. It was the consensus amongst the MAPPA SMB members with whom we spoke that an agreement must have been reached to extend this timescale, although this had not been documented in any MAPPA SMB minutes.
- The local MAPPA policy had been revised following feedback from the MAPPA Serious Case Review published in November 2006. There were no arrangements specified in the local policy for ensuring that MAPP meetings took place just before the licences of high risk sexual offenders expired. This was instead captured by the requirement that any changes in the way offenders were managed should prompt a MAPP meeting. This left the decision to individuals to request such a meeting depending on the timing of licence expiry as compared with the timing of the review meetings. Such subjectivity was therefore open to error.
- Informal processes for information-sharing appeared to be used regularly, with formal systems not yet embedded fully into practice. For example, the Action Plan completed by Gwent MAPPA SMB in response to the MAPPA Serious Case Review indicated that a formal route for information to be passed from practitioners to the MAPPA SMB had been established, via the addition of a box for comments on the MAPP meeting minutes. However, this box was not on the template for meeting minutes that was in use at the time of this inquiry.

Conclusion

Despite the positive spirit and commitment of the MAPPA SMB, the good intentions had not yet led to sufficiently robust practice.

The operation of MAPPA

- A new MAPPA referral system had been established since this SFO. Probation staff felt that it was an improvement on the previous arrangements. However, the system did not guard against cases being missed from MAPPA.
- It was not always clear from the offender files whether cases had been referred to a MAPP meeting for consideration of the appropriate level of MAPPA management or not.
- Staff reported sometimes waiting a number of months for referred cases to be scheduled for a MAPP meeting. Whilst it was possible that this was a historical position, it was not possible to check average waiting times between date of referral and initial MAPP meeting as this information was not recorded on the database.
- There had been gaps in the provision of administrative support to MAPPA for a considerable time. This had led to the MAPPA coordinator undertaking administrative work, which detracted from his main role.
- At the time of the inquiry there were further plans in place to address consistency issues amongst staff who chaired Level 2 MAPP meetings. Chairs of the meetings were being brought together for a joint event, following on from the multi-agency training for Chairs of MAPP meetings which had already taken place. The MAPPA coordinator was working to address the issues which had been identified in relation to consistency of the way meetings were chaired, and the level of understanding of MAPPA and RoH management amongst the Chairs.
- A template had been introduced for recording the minutes of MAPP meetings. However, despite recognising that the template represented an improvement from the previous system, offender managers reported ongoing dissatisfaction with the template in practice. The quality of minutes in the cases we looked at was inconsistent, and some probation staff reported that information recorded did not always adequately reflect the discussions and issues raised at the meetings. Two of the MAPPA cases examined did not have the most recent minutes located in the offender's record, meaning that they were unavailable to the offender managers. Additionally, as many cases were managed under MAPPA for many months the minutes became unwieldy, serving as a log for previous as well as current discussions. The information recorded on the front sheets of the minutes was also not routinely updated after initial completion at the first meeting. This detracted from the function of the minutes as a document to record active risk management, and made them appear to be more of a historical record.
- The MAPPA coordinator was aware of some of the issues with the template and had been understandably waiting for a national template to be introduced rather than making further amendments to the local one. However, absence of a confirmed publication date for the national template meant that the problems with the local one required attention.

- Feeding through of the Risk Management Plan from OASys into the MAPP minutes provided an opportunity to dovetail the two processes together effectively. In practice, the probation Risk Management Plan was normally imported from OASys and adopted as the MAPP 'Risk Discussion and Management Plan' without amendments. This was then viewed by other agencies as 'the probation bit', without the required multi-agency contributions to make it truly effective.
- MAPPA cases were identified when they reached six months before their date of release from prison. Although this met the requirements of the national guidance, there would have been distinct advantages for the area in formally determining the RA at an earlier point. It would have ensured more accurate prediction of the numbers of future MAPPA cases and enabled longer-term planning for the management of such cases.
- Offender managers based other than in the HRHT were often very unclear about MAPP processes. This caused confusion when they occasionally managed MAPPA cases.
- A number of cross-area issues were present in relation to MAPPA, which complicated the management of those cases held by Gwent Probation Area but residing temporarily within approved premises within South Wales Probation Area. Offender managers reported that MAPP meetings were sometimes held in both Gwent and South Wales in relation to the same cases. Additionally, staff had not always been given sufficient notice of MAPP meetings held in the other areas, which meant that they were unable to attend. Minutes from MAPP meetings held about Gwent cases residing in approved premises within South Wales were not always sent through to the offender managers in Gwent. Level 2 MAPP meetings for Gwent cases living in Swansea approved premises were held in Gwent, and invitations were extended to Swansea staff for the MAPP meetings, but approved premises staff from Swansea were not always able to travel to attend the meetings. This meant that the day to day management of Level 2 MAPP offenders living in the approved premises in Swansea was not being effectively coordinated through MAPPA. There was an urgent need to clarify and formalise the procedures for the management of Gwent MAPPA cases living in approved premises in other areas (for which Gwent remained the RA).
- We were encouraged to hear that plans were in place to enable staff in South Wales to contribute to MAPP meetings in Gwent via the introduction of a video-conferencing system within the approved premises in the next financial year.

Conclusion

We were not satisfied that the MAPPA systems were effective, although many new MAPPA processes had been implemented since the SFO.

APPENDIX

The Role of the Inspectorate

Statement of Purpose

HMI Probation is an independent Inspectorate, funded by the Ministry of Justice and reporting directly to the Secretary of State. Our purpose is to:

- report to the Secretary of State on the effectiveness of work with individual offenders, children and young people aimed at reducing reoffending and protecting the public, whoever undertakes this work under the auspices of the National Offender Management Service or the Youth Justice Board
- report on the effectiveness of the arrangements for this work, working with other Inspectorates as necessary
- contribute to improved performance by the organisations whose work we inspect
- contribute to sound policy and effective service delivery, especially in public protection, by providing advice and disseminating good practice, based on inspection findings, to Ministers, officials, managers and practitioners
- actively promote race equality and wider diversity issues, especially in the organisations whose work we inspect
- contribute to the overall effectiveness of the criminal justice system, particularly through joint work with other inspectorates.

Code of Practice

HMI Probation aims to achieve its purpose and to meet the Government's principles for inspection in the public sector by:

- working in an honest, professional, fair and polite way
- reporting and publishing inspection findings and recommendations for improvement in good time and to a good standard
- promoting race equality and wider attention to diversity in all aspects of our work, including within our own employment practices and organisational processes
- for the organisations whose work we are inspecting, keeping to a minimum the amount of extra work arising as a result of the inspection process.

The Inspectorate is a public body. Anyone who wishes to comment on an inspection, a report or any other matter falling within its remit should write to:

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