HM Inspectorate of **Probation** Arolygiaeth Prawf EM

Risk of Harm Inspection Report

A Stalled Journey

An inquiry into the management of offenders' Risk of Harm to others by London Probation in:

Greenwich & Lewisham;

Hackney & Tower Hamlets;

Merton, Sutton & Wandsworth; and

Brent, Barnet & Enfield.

October 2009

FOREWORD

In March 2009 we embarked on a series of special case inspections in various locations in London, at the request of the Justice Secretary, because of questions arising from the National Offender Management Service review (now published) of the case of Dano Sonnex. We concurred with the view of the Secretary of State that it would be useful to undertake this series of case inspections in order to gauge the general quality of public protection work by London Probation Area in a sample of locations across the capital. Such inspections would provide a more valuable base for planning improvement work than if we were simply to conduct a further review of the original individual case.

These special case inspections were led by the same Inspector who led our general inspection in London in 2008, and they also used a methodology that was consistent with that earlier fuller inspection. (The difference was that the 2009 inspections focused principally on the public protection aspects of each case, while the 2008 inspection also included the important 'Help' and 'Change' elements of work with offenders). Essentially, we reviewed a representative sample of cases, and judged whether the right things were done with the right individuals in the right way at the right time to a sufficiently high level of quality. Accordingly, the percentage 'scores' in our reports provided a measure of how often the various aspects of work with offenders were done to that sufficiently high level of quality. The high level of quality we were looking for is a demanding one but not an impossible one to achieve, and we apply those qualitative judgements consistently across all our case inspections.

We made four visits between April and July 2009, and we examined a total sample of 276 cases from ten London boroughs. The results were somewhat disappointing. We judged that only 54% of the public protection work we examined was of the sufficiently high level of quality we were looking for. This did not compare well with the figure of 63% we found in the 'whole London' sample we examined for the 2008 general inspection, a figure which was itself below the national average of around 69%. We provide details of our analysis in the main body of this report. We have also noted, and recorded in our Overview, the many factors that have made it difficult for London staff to carry out effective practice. These included high numbers of particularly difficult offenders, some high individual caseloads - sometimes exacerbated by staff sickness - and an information technology system that often froze or failed altogether.

Nevertheless, substantial improvement is both necessary and achievable. Plans to improve the quality of London Probation Area's public protection work have been under way for some time, and in our report last year we considered that the service was improving compared with previous inspections and was therefore 'On the Right Road'. But since then progress appears to have stalled, at least for a while, although there has now been a redoubling of management activity from March 2009. Nevertheless, it is only when we conduct a further case inspection in 2010 that we will be able to tell whether this effort is impacting in the desired way on direct work with offenders under supervision. Meanwhile, substantial improvement is now required so that the right level of quality is achieved much more often in the future than it is now.

ANDREW BRIDGES
HM Chief Inspector of Probation

October 2009

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We would like to express our thanks to the London Probation Board, its managers and staff for the considerable assistance received in enabling the inspection to proceed smoothly. Without their help the work could not have been completed successfully.

HM Assistant Chief Inspector:	*Krystyna Findley*
HM Inspectors:	*Sally Lester; Malcolm Bryant; Jude Kelman; Tony Rolley; Andy Smith; Ray Wegrzyn*
Practice Assessors:	*Sarah Ashworth; Stephen Hubbard*
Information team:	*Kevin Ball; Peter Clegg; Oliver Kenton*
Inspection Admin team:	*Zoe Bailey; Catherine Calton; Lynn Carroll; Andy Doyle; Rob Turner*
Publications Team:	*Catherine Calton; Christopher Reeves*

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REASONS FOR UNDERTAKING THE INSPECTION

This report was requested by the Justice Secretary because of the concerns found in the National Offender Management Service's review of the case of Dano Sonnex. We inspected public protection work in London Probation Area by assessing cases in several boroughs that were clustered into four operational and management units - Greenwich & Lewisham, Hackney & Tower Hamlets, Merton, Sutton & Wandsworth and Brent, Barnet & Enfield. The inspection was completed between April and August 2009. A follow up exercise is due to take place in 2010.

An interim report into the work of the first cluster was published in April 2009 because of the understandable public interest in public protection work in the boroughs of Greenwich and Lewisham, where the case of Dano Sonnex had been managed. This final report follows the completion of the inspections in all four clusters.

We used our existing *Risk of Harm* Inspection Module for these case inspections, each of which therefore focuses principally on the assessment and management of offenders' *Risk of Harm to others* in representative samples of cases. We also took account of the evidence from managers responsible for this area of work and made comparisons where possible with the OMI that we conducted across London Probation Area as a whole in 2008.

We were pleased to be asked to assist London Probation Board with their effort to achieve further improvements in public protection work and we look forward to working with managers and staff beyond the end of this inspection in order to help them achieve progress.

OVERVIEW AND SUMMARY

London Probation Area was organised into 12 'clusters' – operational management units covering two or three boroughs, with individual offices managed by senior probation officers. Each cluster was headed by an Assistant Chief Officer, assisted by a business support unit. Within each cluster, teams of probation officers and probation service officers (known generically as offender managers) worked in offender management units, public protection units and substance misuse/ prolific priority offender units. Other staff within the units delivered accredited programmes, unpaid work and work related to the courts. Two Directors of Offender Management were responsible, respectively, for six clusters in the north and six clusters in the south.

The total number of offenders supervised (custody and community) within each cluster was in the region of 3000 at any one time.

The inspection took place over four separate weeks between April and August 2009 in the following clusters:

- Greenwich and Lewisham: w/c 6 April
- Hackney and Tower Hamlets: w/c 5 May
- Merton, Sutton and Wandsworth: w/c 22 June
- Brent, Barnet and Enfield: w/c 27 July

The clusters were chosen to represent inner London and outer London boroughs in both north and south, and covering ten of London's boroughs altogether.
A total of 276 cases were inspected. The sample dates were adjusted for each cluster. The overall sample included offenders:

- Sentenced to Community Orders, including Suspended Sentence Orders, between 1 October 2008 and 31 January 2009
- Released on licence between 1 October 2008 and 31 January 2009
- Sentenced to immediate custody during the period 1 September 2007 and 31 July, who fell within the scope of Phase II of the Offender Management Model – that is, those who were assessed as posing a high or very high *Risk of Harm* or who were Prolific and other Priority Offenders.

After each inspection we produced a report for London Probation Area highlighting strengths and areas for improvement in the cluster. In this overview report, our findings are based on the whole inspection. Our comments do not identify individual clusters, but detailed findings are contained in Appendix 1.

During the inspection, many offender managers reported that they were holding high caseloads, including those based within the public protection units, where it would normally be expected that caseloads are lower to allow for the more intensive work required with these cases. The measurement of workloads within the probation service is not a simple task as, in addition to the number of offenders supervised, some staff undertake other tasks such as court duty, office duty and the preparation of pre-sentence reports. Furthermore, some offenders, such as those in Tiers 3 and 4, require more input than others, particularly when they are being managed in the community. Until recently, the monitoring of individual workloads in London was undertaken largely by senior probation officers, with the workload of different offices in the cluster overseen by Assistant Chief Officers. In May of this year, London Probation Area adopted a workload management tool which was accessible electronically to everyone within the organisation. The Chief Operating Officer and the Directors were able to make regular use of this tool in order to quickly identify 'hotspots' where workloads were increasing unacceptably. They could therefore take swift action to redistribute

resources. A recent example was the recognition that some substance misuse teams in London were better resourced than other teams. As a result, the parameters for referring offenders to these teams had been widened to include more of those for whom alcohol or drugs were identified as an issue in the Offender Assessment System.

The workload management tool was an important step forward in addressing one of the issues identified in the report into the management of Dano Sonnex.

This is not, however, to underestimate other challenges faced by London Probation Area in managing the workload. We noted particularly that the social environment within which some staff worked was complex and demanding, although not unique. In some of the boroughs we inspected, a high proportion of the sample involved offenders who were using or supplying drugs or had convictions for possession of offensive weapons, including knives and firearms. Some offenders had received lengthy sentences and, if released, were subject to lengthy licences. We recognised the challenge for probation staff to engage, over a lengthy period, with offenders who had little interest in changing their behaviour and who were caught up in criminal sub-cultures.

We had previously commented on high levels of sickness in some areas of London. Where this was the case, other staff in the office reported feeling overwhelmed by the volume of work they were covering. In some offices there was a high turnover of staff and few offender managers had more than about three years of post-qualifying experience. This, in turn, had an impact on the demands made on senior probation officers, who needed to provide additional support and oversight to the less experienced offender managers. Some staff reported that they felt unsupervised and unsupported, although this was variable. Where training and good supervision was available, this was evident in the confidence levels expressed by offender managers.

Several senior probation officers were themselves relatively inexperienced and we were concerned that some unsatisfactory work had been countersigned. Senior managers recognised that there was a need for further work to ensure that middle managers were able to benchmark consistently the quality of practice and to feel confident to take remedial action where this was necessary.

Problems with information technology systems were a common occurrence. These difficulties generally took the form of systems running slowly, or freezing for a short time. During our inspection we experienced ourselves the practical effects of two days when there were significant problems with one of the servers. We were able to catch up with our inspection work, thanks to the flexibility of the offender managers involved. However, it illustrated to us the enormous frustration to staff who were unable to complete their planned work on time.

These problems with information technology were of particular concern in relation to London Probation Area's 'Going Green' initiative. This project referred to the drive to improve London Probation Area's performance on the national Integrated Probation Performance Framework, which uses a system of traffic light indicators to highlight performance levels. The framework is based partly on self-assessment and partly on process measures so, for example, the *timely completion* of Offender Assessment System is currently counted, but not the *quality of its content*. The first stage of London Probation Area's initiative was to ensure that all outstanding assessments had been brought up to date. Recently published performance data indicated that the project had been highly successful , taking the overall rating for both Public Protection and Offender Management from red (Quarter four, 2008-2009) to green (Quarter one, 2009-2010). It was difficult to make exact comparisons between the years on some of the detailed

measures, as a number of these had been changed in the national framework. However, in the key areas of the timeliness of assessments and risk management plans, and the adherence to national standards, there had clearly been substantial improvements in London. This was to the credit of staff and managers, many of whom had worked extremely hard to tackle a backlog of late assessments and reviews. As a result of their efforts, the overall performance of London on the Integrated Probation Performance Framework had moved from red to green.

Despite the demands facing London Probation Area throughout the inspection we were impressed with the commitment and enthusiasm of staff and managers, and with their openness and willingness to engage with the inspection. There was a genuine interest in improving the quality of their work with offenders. We would wish to thank the teams and managers for the positive way in which we were received.

Key findings – Risk of harm assessment and sentence planning:

By necessity a large part of the casework that we assessed was work that had taken place before the 'Going Green' initiative had taken effect. In the work we assessed, there were many worrying shortcomings in the assessment of offenders' *Risk of Harm to others.* In far too many cases the assessment was completed late. In some cases the offender had been managed for weeks, or even months, without an accurate and comprehensive assessment. The success of the 'Going Green' initiative would suggest that this problem had been addressed, but it was too early to see the results in our inspection sample. We were, however, concerned that in some of the cases we saw, the emphasis had been on ensuring that there was a completed Offender Assessment System on the system, rather than on the need to produce a considered assessment that would guide and inform those working with the offender. Senior managers took the view that ensuring that the Offender Assessment System was completed, was only an initial solution and that would then be followed by a focus on improving the quality of the assessment.

There were a number of omissions at the assessment stage which were particularly important. In some cases the *Risk of Harm* screening and analysis overlooked the significance of previous convictions or other relevant behaviour; and offender managers had not taken an investigative approach in seeking out missing information and making appropriate checks with other agencies. Plans for managing offenders' *Risk of Harm* were often not sufficiently comprehensive and issues concerning victims or potential victims were not given enough attention. Some plans did not consider the risks the offender may present whilst in custody; others failed to mention the existence of restrictive interventions – that is, those designed to control or monitor the offender in order to minimise the *Risk of Harm to others.*

In many cases, sentence planning had not been given a high enough priority and did not drive the supervision of the offender, particularly with those who were on licence. There were insufficient links between the *Risk of Harm* analysis and the assessment of problem areas in the offender's life. Sentence planning was not always focused on the issues most connected with offending. Objectives tended to be formulaic and not tailored to individual offenders; as a result, offenders were not adequately engaged in the sentence planning process.

Key findings – Implementation of interventions:

In the cases we inspected there were examples of thoughtful, well delivered work with offenders; this included one-to-one offending behaviour work, attendance on accredited programmes, residence in approved premises and the involvement of specialist agencies to tackle substance misuse or mental health problems. Some of this promising work was let down by inadequate recording, with case files that did little justice to the efforts made by the offender manager and others, and the progress made by the offender. In other cases, however, we were concerned about the lack of active management of the offender.

As with initial assessments, reviews of sentence plans were late – although in the later inspection weeks we found that this had improved substantially. A number of reviews

had simply duplicated the original assessment, with no record of progress and no new objectives.

Reviews of each offender's *Risk of Harm to others* were not always sufficient for the case, and did not draw on all appropriate sources of information. Where a significant change in the offender's circumstances or behaviour should have triggered a review, it was not always completed. In some cases, offender managers were not sufficiently vigilant in identifying and responding to acute factors that may signal an increase in the offender's *Risk of Harm*. Nevertheless, good vigilance was shown where 16 offenders were recalled appropriately to prison when concerns arose about their behaviour.

The frequency of appointments offered to offenders was generally sufficient, and offender managers had worked hard to ensure that offenders complied with the requirements of their supervision. Post-custody licences included a number of appropriate, additional conditions designed to manage the offender's *Risk of Harm.* Where restrictive interventions were in place, they were generally monitored effectively and enforced where appropriate. However, in some cases, we saw insufficient attention to the safety of victims and potential victims, including those who may be at risk whilst the offender is in custody.

Increased video conferencing facilities were helping offender managers to work more closely with prisons and to retain contact with offenders during periods in custody. However, the use of these resources was relatively new and there were still some teething troubles. The development of better communication between probation and prison staff remained important, to ensure that assessments were based on all relevant information from those who had contact with the offender.

RECOMMENDATION

London Probation Area should develop and implement a plan to ensure that, in a higher proportion of cases the overall assessment and management of offenders' *Risk of Harm to others* is of sufficient quality.

NEXT STEPS

This report has been submitted to the Secretary of State and copies provided to the London Probation Board, the London Director of Offender Management and the Chief Executive of the National Offender Management Service. It is available on the website of HM Inspectorate of Probation at:

http://www.justice.gov.uk/inspectorates/hmi-probation

During the forthcoming year, HMI Probation will undertake work to support London Probation Area's plans to improve their public protection practice. A follow-up inspection will be undertaken in 2010.

SCORING

This report includes scores for the practice criteria. In this inspection the number of criteria is smaller than for a full OMI, as only *RoH work* has been inspected. As a summary of the quality of *RoH*, a score is given representing the overall proportion of *RoH* work which we judged to be sufficient across all the relevant criteria.

This score indicates the percentage of *Risk of Harm work* that we judged to have met a sufficiently high level of quality.	**54%**
2009 Inspection RoH score for London Probation Area	

In addition, the results for individual questions have been included in the main body of the report.

The table below provides a different analysis, drawn from the same inspection data. In terms of the sequence of **'assess, plan, act'** it shows which aspects of the work most require improvement. As we often find in inspections, practitioners were better at saying what the problem is (Assessment) than they were at saying what they were going to do about it (Planning), which is indeed harder. Similarly, the ongoing review of case work was highlighted by this analysis as being done less well.

Risk of Harm London Probation Area – Scores for General Criteria

Assessment of Risk of Harm	53%
Sentence planning	45%
Assessment & sentence planning overall	**49%**
Delivering the sentence plan	49%
Protecting the public by minimising Risk of Harm	42%
Ensuring containment & promoting compliance	77%
Restrictive interventions	76%
Implementation of interventions overall	**55%**

1. ASSESSMENT AND SENTENCE PLANNING

1.2	General Criterion: ASSESSMENT OF RISK OF HARM *RoH is comprehensively and accurately assessed using OASys in each case and additional specialist assessment tools where relevant.*	53%

Strengths:

(a) Of the cases inspected, 27% were classified as low RoSH, 50% as medium RoSH and 20% as high RoSH. No cases were identified as 'very high'. Classifications appeared to us to be correct in 85% of cases from the total sample and in all of the high RoSH cases.

There were only two cases in which there was no clear classification and six in which no OASys assessment was completed. This was a substantial improvement in comparison with the OMI in 2008, where we found that an OASys had not been completed in one-third of cases.

(b) The classification of the RoSH is determined through a screening of previous convictions and other concerns about the individual's behaviour. Where relevant convictions or other factors are identified, the assessor is required to complete a full analysis of the *RoH to others.* At the start of sentence, all offenders should be screened within one working day to determine whether they might be more than low *RoH*. The screening was undertaken in 96% of community and custody cases. 84% of all screening documents were accurate.

(c) The overall classification of the RoSH is determined through a separate analysis of the risk to children, the public, known adults and to staff. Inspection staff judged that the *RoH* analysis accurately reflected the risk to children in 85% of cases, to the public in 70% of cases, to a known adult in 80% of cases and to staff in 89% of cases. Where the offender was in custody, a potential *RoH* to other prisoners was identified and accurately analysed in 12 out of 17 relevant cases (71%). The figures were similar in relation to the high *RoH* sample, with a higher score (83%) where the risk was to the public.

(d) Where an offender was assessed as presenting a high *RoH to others*, this was clearly communicated to all staff involved in the case in 73% of cases.

(e) Sixteen offenders were referred to approved premises as a way of managing their *RoH*. All except one of these referrals we judged to be appropriate and all of these were accepted by the approved premises.

Areas for Improvement:

(a) All offenders who were supervised by the probation service have to be allocated to a tier, which determines the level of resources

allocated to the case. Tier 1 is the lowest level, for an offender requiring one intervention, such as the completion of unpaid work. Tier 4 cases are the most complex, requiring the most active management – generally those presenting the greatest likelihood of reoffending and the highest *RoH*. The majority of offenders in the inspection sample appeared to have been allocated to the correct tier, but in some cases the required document that showed how the decision had been made was not in the case file. There were also some cases where the tier had been changed, sometimes more than once, during the supervision of the offender. This suggested some confusion about tiering processes and inconsistency in how the decision had been reached, and by whom.

(b) Although *RoH* screening documents were completed on the majority of offenders on community orders, 34% of these documents were not completed within the required timescale. Similarly, where offenders were released from custody on licence, *RoH* screening was not completed or reviewed promptly in 36% of cases. However, it is worth noting that high *RoH* licence cases fared better, with 11 of the 12 screening documents being reviewed promptly on release.

While 84% of screening documents were accurate, this left 37 cases where relevant previous convictions or adjudications while in custody had been overlooked. Altogether, in half of the cases in the sample, the offender was being managed *at the start* of their sentence without an accurate screening of their *RoH to others*

(c) Where a screening indicates that the offender might present a medium or higher *RoH to others*, a full analysis should have been completed. The analysis leads to the classification of low, medium, high or very high RoSH to others. The need for a full analysis was indicated in 84% of cases. It was not completed as required in 10% of these and in the majority of cases there was no recorded explanation for this. Inaccurate screening contributed to some of the cases where a full analysis had not been done.

(d) Where the analysis was undertaken, it was completed to a sufficient standard in 46% of all cases. This figure, however, masked a substantial difference between sub-samples; in 65% of high *RoH* cases we judged that the analysis was completed sufficiently for such cases, whereas in only 38% of medium RoH cases were the analyses sufficient.

The significance of previous convictions was missed in some cases and in others previous convictions informed the risk level, but were not taken account of in the risk management plan. Other gaps included insufficient links between problem areas in the offender's life and the *RoH*. In summary, there was uncertainty about the relative weight of static and dynamic factors.

Offender managers in some offices reported difficulties or delays in obtaining Crown Prosecution Service documents. In these cases the assessment was based on incomplete information about the offender's behaviour and previous convictions.

The analysis was completed, unnecessarily, in 19 out of 47 cases where it was not triggered by the screening; these were often of insufficient quality because the content had addressed likelihood of reoffending instead of *RoH*. It appeared that a few staff did not fully understand the function of the *RoH* analysis.

(e) Inspection staff judged that the identified level of *RoH* was incorrect in a total of 40 cases out of 268. In 22 of these cases, we believed that the offender could defensibly have been managed as low *RoH* instead of medium. This, in itself, was not of a great concern to us; of more concern were the nine cases where we found that a medium RoSH classification was an underestimation of the *RoH to others.* Similarly, we judged that nine low *RoH* cases should have been managed as presenting a medium *RoH to others.* These under or overestimations of *RoH* were significant because they may have had an impact on the tiering level and on the consequent allocation of appropriate resources. In a few cases we found a discrepancy between the level of RoSH recorded on OASys and that on Delius, the case recording system used by London Probation.

(f) The *RoH* screening and analysis failed to draw on other relevant sources of information in 39% of cases. This included not making appropriate use of previous probation, prison or Youth Offending Team/ Service assessments. In some cases there was no evidence that appropriate checks had been made with social care services. In some cases Crown Prosecution Service documents were not in the file and it was of concern that they did not appear to have been available to the offender manager. Specialist assessment tools, such as 'SARA' (Spousal Assault Risk Assessment) and 'Risk Matrix 2000', that help assess domestic abusers and sexual offending, were not always completed where required.

(g) Where there were issues concerning a victim or potential victim, the *RoH* assessment covered these sufficiently in 44% of all cases; this included 38% of medium *RoH* cases and 60% of the high *RoH* sample.

(h) The inspection sample included 82 offenders on community orders or suspended sentences, who had been assessed as medium or high *RoH*. These cases all required a plan for managing the *RoH*. This had not been prepared in seven cases. Where plans had been completed, 77% were structured according to the required format, but only 17% were judged by inspection staff to be sufficiently comprehensive for the case. Some included constructive interventions but gave insufficient attention to appropriate restrictive interventions. Some seemed rather formulaic, instead of being an active approach to managing the *RoH* presented by the individual offender. Few included appropriate contingency plans to manage *RoH,* where it was increasing, or if the offender failed to comply with supervision.

Risk management plans in the 12 high *RoH* community cases were particularly disappointing. Although most were structured according to the required format, only one-quarter (three out of 12) were

sufficiently comprehensive for the cases and only 42% (five out of 12) were completed within five working days.

(i) A risk management plan had not been prepared in 14% of the licence cases where it was required (11 of 76 relevant cases). Ten of these were cases had been assessed as medium *RoH*; in the other case there was no clear classification of RoSH. Where plans had been completed, 72% followed the required format, but only 22% were sufficiently comprehensive and only 16% were completed prior to release.

In relation to the high *RoH* licence cases, we judged 58% of risk management plans were sufficient for the case (seven out of 12 cases). It was of concern that only three out of 12 were completed prior to release.

(j) In the overall sample 71 offenders were being managed within the MAPPA: 30 were managed at Level 1 and 17 at Level 2. The inspection sample did not contain any cases being managed at Level 3. A further 24 cases were being managed within the MAPPA but the level was not clearly recorded. This indicated a lack of clarity in referral procedures and documentation, and was of particular concern in relation to high *RoH* cases, of which 13 had no clearly identified MAPPA level. In a few cases there was no evidence of referral to MAPPA, although this appeared to be necessary.

(k) We inspected the cases of 38 offenders who had been sentenced to custody. In two cases no OASys had been completed; four offenders were assessed as medium *RoH*; and the remainder were all classified as high RoSH. During the period in custody, people who may be at *RoH* from these offenders include prison staff, other prisoners, visitors or previous and potential victims in the community. The completed assessment should therefore include a plan to manage these risks during the custodial period. This was completed within the appropriate timescale in 44% of cases and was judged to be sufficiently comprehensive in 17% of cases. Offender managers tended to overlook the *RoH* present during the custodial sentence, focusing instead on planning for release.

(l) Where an offender, on a community order or a licence, was assessed as high *RoH* there was sufficient evidence of appropriate management involvement in 55% of cases (16 out of 29 cases). We saw examples of inadequate assessments countersigned by middle managers, including cases where there were gaps in information. Where child Safeguarding issues were identified, there was sufficient management involvement in only 25% of cases (ten out of 40); this included four out of ten high *RoH* cases where there were Safeguarding issues.

(m) Overall we were concerned about the quality of the assessment of *RoH*. A significant factor was the late completion of OASys, including the *RoH* assessment. Some were weeks, or even months late and had been prepared shortly before the inspection, in

response to London's 'Going Green' initiative[1]. The inspection samples pre-dated this project, so it was too early for the impact to be seen in the timeliness of initial assessments.

Although we found that all of the offenders in the high *RoH* sample had been appropriately classified, we found that there were deficiencies in aspects of the assessment in many cases.

In the OMI undertaken in 2008 we raised concerns about the quality of the assessment and management of offenders classified as presenting a medium RoSH to others. This remained an area of concern in this inspection.

1.5	**General Criterion: SENTENCE PLANNING** ***The offender manager plans interventions in custody and the community with a view to addressing criminogenic factors and managing any RoH to others. The initial sentence plan or unpaid work assessment is designed to describe a structured and coherent plan of work for each offender.***	**45%**

Areas for Improvement:

(a) Sentence planning had not generally been given a high enough priority. It had given a clear shape to supervision in 31% of the total inspection sample; focused on achievable change in 40%, set relevant goals in 35%; and reflected the sentencing purpose in 61% of cases. In 28% of cases, sentence planning met none of the above criteria.

We saw examples where the sentence plan had been 'pulled through' electronically from a previous plan and had not been updated to reflect changes in circumstances or progress achieved. Many sentence plans tended to use formulaic objectives. Some sentence plans were too limited in scope and did not include objectives to address the most significant offence related problem areas. Where offenders had completed a self-assessment, identifying problem areas linked to offending, there was scope for these to be used more actively to inform the sentence plan.

Community cases, however, tended to fare better than licence cases. For example, 39% of plans in community cases gave a clear shape to supervision; 50% focused on achievable change; set relevant goals in 42%; and in 68% reflected the sentencing purpose. The comparable figures for licence cases were 28%, 35%, 28% and 59%.

In these respects, there was little difference between the quality of sentence plans in high *RoH* cases and those in the total sample.

[1] Our inspection methodology focuses on work done over time with individual offenders; therefore cases need to have run for a sufficient period for us to be able to see the different phases of assessment and planning, delivery of interventions and initial outcomes. Hence we inspected cases that were around six months old.

[redacted]

(b) The roles and liaison responsibilities of all workers involved with the offender were clearly defined in 31% of sentence plans where this needed to be done.

(c) Restrictive conditions or requirements designed rightly to minimise the offender's *RoH to others* had been considered during sentence planning in 48% of relevant cases in the overall sample and in 61% of high *RoH* cases.

(d) Where the assessment of the offender identified a potential *RoH,* there were appropriate references to the risk management plan in 51% of sentence plans on community and custody cases. In relevant cases, interventions designed to reduce or contain the *RoH* were included in 65% of initial sentence plans on all cases.

(e) In 23 cases in the community and custody samples, there was no sentence plan. This included 12 high *RoH* cases. There was no sentence plan in five licence cases.

2. IMPLEMENTATION OF INTERVENTIONS

2.1 General Criterion: DELIVERING THE SENTENCE PLAN *The offender manager facilitates the structured delivery of all relevant elements of the sentence.*	49%

Strengths:

(a) Custody reports (parole or pre-release reports; sentence planning documents or reports for Home Detention Curfew; or Release on Temporary Licence) were prepared in eight cases. All were clear and thorough and contributed to decision-making processes within the required timescales. Six incorporated accurate *RoH* assessments.

(b) Despite our comments to the contrary about the majority of cases, in a minority we did see evidence of good engagement with offenders and work that was clearly focused on factors connected with offending. There were examples of partnership agencies being used effectively to address problems with substance misuse, mental health, accommodation and employment, training and education. In many cases, offender managers were undertaking thoughtful and focused one-to-one work with offenders. Accredited programmes, such as those for sex offenders or for domestic abuse perpetrators, also provided structured interventions designed to change the behaviour of offenders and to protect the public.

Some offender managers noted the challenge of working in a meaningful way with an offender throughout a lengthy order or licence. Where materials were available to provide a structure for individual work focused on offending behaviour, these were valued by practitioners. Examples included Targets for Effective Change and a structured supervision programme that was in use in one cluster. Newly qualified POs reported that they had found the training as Think First tutors useful in providing them with a 'toolkit' of exercises that they could adapt to use in one-to-one sessions with offenders.

(c) Similarly, although sentence plan reviews were not good enough in too many cases, there were notable examples of offender managers who clearly worked hard to engage the offender in the process of planning and review. In these cases, the offender manager had taken care to tailor the wording of the objectives to the individual offender and had made effective use of the review 'comments' box to record progress, or otherwise.

(d) Video links had been developed between probation offices and prisons in London. This was a welcome development that was expected to provide an efficient way for offender managers to retain contact with offenders and offender supervisors in prison.

Areas for Improvement:

(a) The video links with some prisons were still in their infancy. We were told that some planned appointments could not go ahead because of technical problems and delays in prisoners being produced for the session with the offender manager. As a result, the offender manager sometimes had to prepare an assessment on the basis of a very brief interview.

(b) The work undertaken with an offender should be delivered in an appropriate sequence, prioritising interventions that have the most impact on reducing the *RoH* and the likelihood of reoffending. In some cases preparatory work needs to be undertaken to ensure that an offender is able to engage with the planned interventions. There was evidence of appropriate sequencing in 40% of all cases and 33% of cases in the high *RoH* sample.

(c) The sentence plan was not used in an active way often enough; work with the offender flowed coherently from it in 42% of cases. The objectives and milestones gave a clear direction to the sentence in 20% of the inspection sample. There was evidence that the continuing ownership of the offender was sought in 31% of cases.

Some of the work with offenders was let down by inadequate recording. Offender managers could describe the work they were doing, but their case records did little justice to the content of the sessions with the offender. In these circumstances we gave practitioners the benefit of the doubt, where it was reasonable to do so, even when, from the records alone, it was difficult to find evidence of the approach taken to the work, or of the progress that was being made by some offenders.

(d) Sentence plans were reviewed within the required timescale in 61% of all cases and in 55% of high *RoH* cases. There was some evidence to suggest that the timeliness of reviews was improving during the four month period of the inspection. In the last cluster inspected, sentence plans had been reviewed within the required timescale in 74% of cases. This may have been the result of the attention given by London Probation Area to the achievement of assessment and review targets as part of the 'Going Green' initiative. However, the improved timeliness was not matched by an improvement in quality. Many reviews simply replicated the initial plan; in those weaker reviews there was little comment on progress and objectives were not amended to reflect changes. Where there were other plans (for example, Safeguarding children plans, care plans, MAPPA action plans), these were incorporated into the review in 39% of cases (33 out of 85 cases).

(e) Thirteen cases in the sample had been transferred between probation areas. As high *RoH* offenders, three required the risk management plan to be reviewed and updated by London Probation Area, as the receiving area, within five working days of contact with the offender. This had been completed appropriately in two of the three cases.

The inspection did not separately identify cases that had been

transferred between London boroughs or clusters. However, there was some evidence that the management of these offenders was more problematic, with examples of cases being overlooked, missing paperwork and gaps in liaison between courts, offices and other agencies. In some cases, the supervision of offenders had been inadequate during the transitional period. London Probation Area managers were aware of these issues and they were being addressed.

2.2	General Criterion: PROTECTING THE PUBLIC BY MINIMISING RISK OF HARM ***All reasonable actions have been taken to protect the public by keeping to a minimum the offender's RoH to others.***	**42%**

Strengths:

(a) Following release from custody, 16 offenders had been recalled because of concerns about their *RoH to others*. In every case we judged that recall action was the right thing to have been done. This was particularly pleasing to note, as eight of these offenders had been classified as medium *RoH* and one as low *RoH*. This suggested that the offender managers in these cases had been vigilant and responsive when possible changes in the *RoH* had been observed.

(b) The offender's *RoH* had been reviewed as required within four months of the start of a community order or suspended sentence or release on licence in 72% of cases. Subsequent reviews were appropriately undertaken in 77% of relevant cases. These figures reflect an aggregate from the whole inspection which took place over a three month period. The timeliness of the reviews of the *RoH* improved from 49% (initial reviews) and 67% (subsequent reviews) in the first cluster, to 86% and 92% in the final cluster, which was inspected three months later than the first.

In the high *RoH* community and licence cases, changes in the offender's circumstances had appropriately triggered a review in eight out of nine relevant cases.

Some of the best risk management work by offender managers was characterised by a healthy suspicion, an investigative approach and tenacity in following up areas of concern.

(c) Domestic abuse was a feature in 22% of cases in the sample. The availability of places for offenders on the Integrated Domestic Abuse Programme was variable, as was access to Integrated Domestic Abuse Programme training for offender managers. We saw some good use of trained staff delivering individual work to offenders, with women's safety workers appropriately involved with the partner. Other offender managers had wanted to undertake the training in order to increase their confidence in managing domestic abuse, but had not been able to obtain a place on the course.

Areas for Improvement:

(a) In the overall sample, there had been insufficient response to significant changes in the offender's circumstances. Where a review of the *RoH* should have been completed, this had been undertaken in only 38% of relevant cases. We saw examples where further offences or changes in domestic circumstances had failed to trigger a review of the *RoH*.

(b) In the custody sample, the offender's *RoH* had been reviewed no later than 12 months after sentence in 55% of cases. Significant changes had triggered reviews in two out of seven relevant cases. The *RoH* had been reviewed in preparation for release in six out of 11 cases.

(c) Reviews of the offender's *RoH* should incorporate ongoing planning to address risk to children, the public, known adults and staff. This had been completed to a sufficient standard in 49% of cases, where the risk was to children; 48%, where the risk was to the public; 45%, where it was to known adults; and 42% where staff may be at risk. The *RoH* to other prisoners was considered in only one out of seven relevant cases.

We found a few cases where there was some misunderstanding of the definition of 'known adult'. This could easily have been clarified, but unfortunately the OASys manual appeared to be underused.

Ongoing planning was slightly better in the high *RoH* sample, with 55% addressing risks to children; 64%, risks to the public; 59%, to known adults; and 54% where the perceived risk was to staff.

(d) Where an offender is in custody, the offender manager should ensure that prison staff are aware of the assessed level of *RoH*. There should also be appropriate communication with regard to MAPPA meetings and release proposals. In 35% of the custody cases, offender managers and offender supervisors had engaged appropriately with the internal risk management processes. Some offender supervisors (in prisons) expressed frustration at the frequent changes of probation staff and the difficulty in tracking down the appropriate offender manager. These changes had a negative impact on the continuity and consistency of the assessment and management of each offender.

The behaviour of a prisoner is potentially a significant source of information for the overall assessment of an offender's *RoH*. For example, their adjudications record, or their behaviour towards other prisoners, visitors, or male and female staff, could provide relevant information. On the other hand, there is a danger that compliant behaviour within prison may be mistaken for a reduction in the offender's *RoH to others.* However, information about prison behaviour had rarely been received, or sought, by the offender manager.

Furthermore, offender managers were not always well informed about prison sentence plans and in a number of cases there were no copies of these in the case file. This was a missed opportunity to

capitalise on work undertaken in the prison. Targets set in the prison were not transferred into the community sentence planning documents, and post-programme reports were inadequately used to inform ongoing work on release.

However, there was some evidence during the period of the inspection that offender managers had started to contact prison staff in relation to offenders who were within scope of the Offender Management Model. This had been welcomed by custodial offender supervisors and in some cases had triggered required work with the offender, including appropriately prompting additional interventions before an offender moved to open conditions.

(e) Seventy-one cases in the inspection sample were being managed through the MAPPA. In 41% of cases, offender managers and other staff had contributed effectively to the MAPPA. In 37% the MAPPA had been used well to manage the risks posed by the offender; this figure varied from 32% of the medium *RoH* cases to 41% of the high *RoH* sample. Gaps in multi-agency management included late referral into the MAPPA and insufficient contact with social care services and police community safety units. In one area we saw examples of poor communication between the police and probation where staff had not recognised the importance of collaborative working to deal with significant developments in a case. We found instances where offender managers were unaware of further charges and where there were delays in obtaining information needed in order to process an application for recall.

(f) Although recall action was an appropriate part of the risk management process in all relevant cases, there were five cases where the recall was not implemented properly.

We also found a number of cases where offender managers had not been sufficiently vigilant in anticipating changes in an offender's *RoH*, identifying acute factors and acting appropriately. In relation to the medium *RoH* sample, changes were anticipated in six out of 26 cases; when these changes occurred, they were identified swiftly and acted upon in half of the cases.

Perhaps not surprisingly, we found a more proactive and responsive approach with high *RoH* cases, where changes were anticipated in eight out of ten cases. In seven out of 11 cases, changes were identified and acted upon. This still showed room for improvement.

(g) National Standards for the Management of Offenders (2007) require a home visit to be carried out following a community sentence or release from custody in cases where offenders are assessed as high *RoH*. This was completed appropriately in only five of the 20 relevant cases in the inspection sample. Although a home visit is not formally required in medium *RoH* cases, there are occasions when it would be appropriate to undertake a visit in order to gain further information to contribute to a fuller assessment of the offender's *RoH*. We found little evidence that home visits were used in this way and some assessments therefore lacked a perspective on relationships within the home or family. For example, there were

	Safeguarding concerns in 40 cases; in only three of these cases were home visits employed effectively to monitor the concerns.

2.3	**General Criterion: VICTIMS** ***Consistent attention is given to issues concerning victims.***	**29%**

Areas for Improvement:	
	(a) Where there is direct or potential victim, restrictive or prohibitive conditions may be included as a condition of a licence or order. Appropriate attention was given by the offender manager and other workers to the safety of a victim or potential victim in 40% of relevant cases in the total sample. This included 33% of medium *RoH* cases and 54% of the high *RoH* sample. In certain cases, offender supervisors will have a role in promoting victim safety from a custodial setting by, for example, monitoring telephone calls and working to prevent harassment from prison. There was evidence that this took place in 18% of relevant cases (five out of 28 cases).
	(b) It was not always clear from case records whether the offender manager had liaised appropriately with the VLU. Some anticipated that the VLU would pick up the case from court records, but had not always checked with the unit. They tended to rely on the unit to notify them of relevant issues concerning the victim.

2.4	**General Criterion: ENSURING CONTAINMENT AND PROMOTING COMPLIANCE (Punish)** ***Contact with the offender and enforcement of the sentence is planned and implemented to meet the requirements of national standards and to encourage engagement with the sentence process.***	**77%**

Strengths:	
	(a) The frequency of appointments offered to offenders conformed to the national standards in 83% of cases. In 76% the appointments were sufficient to facilitate the requirements of the sentence. In 73% of cases, the level of contact offered was appropriate to the offender's assessed level of *RoH*. We saw some examples where contact levels had appropriately been increased in response to issues of risk or vulnerability.
	(b) In 94% of cases, satisfactory arrangements were in place to restrict the offender's liberty during this custodial sentence. In most cases this criterion is met by adequate containment by the prison. We also saw examples of good work by offender managers who had actively and appropriately contributed to decisions that an offender should not move to open conditions without further intervention and evidence of progress.

Areas for Improvement:	
	(a) Where the offender had failed to comply with the requirements of the order or licence, appropriate and timely breach action had been

taken in 74% of cases. In 61% of these cases, the breach had been resolved within the required timescale.

(b) We saw cases where the offender manager had not had access to prosecution papers and others where the court order had not been received promptly, particularly from courts outside the area. Managers were aware of the problem and had been trying to resolve it, to ensure that it did not hinder breach action.

In a few additional cases, a copy of the licence was missing from the file, which raised the question of how the offender manager could be certain that all conditions were being appropriately implemented.

(c) Many offender managers rightly tried hard to reengage offenders who had missed an appointment in order to avoid unnecessary breach action. However, sometimes we saw insufficient evidence to justify an acceptable reason for a failed appointment. There were examples of offender managers giving the offender the benefit of the doubt because of administrative errors or oversights within the probation office.

2.6	**General Criterion: RESTRICTIVE INTERVENTIONS (Control)** ***Interventions are delivered to identified ends and to meet the requirements of the sentence: control.***	**76%**

Strengths:

(a) In cases where restrictive interventions were in force (for example, exclusion zone, curfew, restricted activity, residence requirements), these were monitored effectively in 67% of the inspection sample. In 65% (13 out of 20) of relevant cases, approved premises were being used effectively as a restrictive intervention.

(b) Post-custody licences include six standard conditions. Additional specific conditions were added in 65 cases. In the majority, we judged the conditions to be necessary and proportionate to the offender's *RoH* and the likelihood of reoffending.

Areas for Improvement:

(a) Although we assessed additional licence conditions to be sufficiently comprehensive in 85% of cases, this still left ten cases where a further condition should have been considered, including those where a specific condition was required to enhance the protection of victims. Better liaison with the offender and the offender supervisor during the custodial part of the sentence may have improved the preparation for release in these cases.

(b) Overall, there were 50 cases where we considered further action was required to keep to a minimum the offender's *RoH to others,* including seven out of the 26 cases in the high *RoH* sample. In some cases inadequate recording of actions taken left the management of the case vulnerable to criticism.

APPENDIX 1

This table presents some of the key findings disaggregated into clusters. Not all of the inspection criteria are represented here. The majority of those where the denominator for the whole inspection sample is less than 45 have been omitted. The detail relating to these criteria can be found in the body of the report.
Reports on the findings about individual clusters have been presented to London Probation Area managers.

We inspected a total of 276 cases. Eight had no OASys or no clear *RoH* classification. These cases are therefore omitted from some of the analysis and reduced the total denominator to 268.

	LONDON		GREENWICH & LEWISHAM		HACKNEY & TOWER HAMLETS		WANDSWORTH		BRENT, BARNET & ENFIELD	
	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard
1.2 Assessment of Risk of Harm										
RoH classification appeared correct.	268	85%	67	91%	65	91%	69	80%	67	79%
OASys RoH screening was completed.	157	96%	39	95%	39	97%	40	98%	39	95%
The RoH screening was completed at the start of sentence.	151	66%	37	57%	38	66%	39	59%	37	81%
OASys RoH screening was completed or reviewed on release from custody	118	64%	28	54%	30	70%	30	53%	30	77%
The screening appeared to be accurate	225	84%	52	77%	59	90%	55	82%	59	85%
The full RoH analysis was completed to a sufficient standard	216	46%	48	44%	56	64%	56	39%	56	36%
The analysis accurately reflected RoH:										
· to children	126	85%	20	70%	16	94%	50	88%	40	85%
· to the public	188	70%	36	64%	47	74%	55	75%	50	66%
· to known adults	147	80%	27	78%	29	76%	49	82%	42	83%
· to staff	114	89%	12	83%	17	88%	49	90%	36	92%
A high RoSH classification was communicated to all staff involved in the case	55	73%	12	75%	16	75%	12	75%	15	67%
The OASys risk of harm screening and analysis drew on other assessments?	162	61%	37	65%	35	74%	50	60%	40	48%
The risk of harm assessment covered victim issues thoroughly?	200	44%	47	45%	44	64%	59	41%	50	28%
Community cases: The risk management plan was:										
· Comprehensive	82	17%	19	11%	22	27%	22	18%	19	11%
· Structured according to the required format	82	77%	19	74%	22	82%	22	82%	19	68%
· No risk management plan completed	7 cases		3 cases		1 case		1 case		2 cases	
On release from custody: The risk management plan was:										
· Comprehensive	76	22%	17	35%	18	22%	20	20%	21	14%
· Structured according to the required format	76	72%	17	59%	18	83%	20	75%	21	71%
· Completed prior to release	76	16%	17	12%	18	17%	20	30%	21	5%
· No risk management plan was completed	11 cases		6 cases		0 cases		3 cases		2 cases	
1.5 Sentence Planning										
The roles and responsibilities of all workers were clearly defined in sentence planning documents	259	31%	63	16%	61	48%	68	43%	67	16%
During sentence planning, appropriate consideration was given, where relevant, to restrictive conditions/requirements, designed to minimise risk of harm to others.	115	48%	25	40%	21	38%	34	53%	35	54%
Sentence planning:										
· Gave appropriate focus to supervision	276	31%	68	31%	69	36%	70	30%	69	28%
· Focused on achievable change	276	40%	68	41%	69	42%	70	47%	69	29%
· Reflected the sentencing purpose	276	61%	68	49%	69	61%	70	66%	69	67%
· Set relevant goals for the offender	276	35%	68	37%	69	41%	70	31%	69	30%
· None of the above	276	28%	68	38%	69	26%	70	23%	69	26%

	LONDON		GREENWICH & LEWISHAM		HACKNEY & TOWER HAMLETS		WANDSWORTH		BRENT, BARNET & ENFIELD	
	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard
2.1 Delivering the sentence plan										
There was appropriate sequencing of interventions according to risk of harm and likelihood of reoffending	251	40%	56	38%	61	52%	67	37%	67	34%
Sentence plans were reviewed in accordance with the required timescales	271	61%	67	42%	69	71%	67	58%	68	74%
In relation to the sentence plan:										
· Work with the offender flowed from it coherently	253	42%	61	43%	60	47%	68	46%	65	32%
· Objectives and milestones gave a clear direction to the sentence	253	20%	61	23%	60	25%	68	15%	65	17%
· Continuing ownership of the offender was sought	253	78%	61	21%	60	48%	68	24%	65	31%
Reviews integrated other plans as appropriate	85	39%	26	46%	11	64%	17	24%	31	32%
2.2 Protecting the public by minimising Risk of Harm										
Community and licence cases: The risk of harm was reviewed:										
· No later than four months from the start of sentence	230	72%	55	49%	58	79%	60	72%	57	86%
· At least every four months thereafter	48	77%	15	67%	10	70%	11	82%	12	92%
· Following a significant change	73	38%	12	17%	15	67%	33	30%	13	46%
There was ongoing planning to address the RoH to:										
· Children	65	49%	16	38%	11	55%	23	48%	15	60%
· Public	182	48%	39	38%	52	54%	52	50%	39	49%
· Known adults	87	45%	22	50%	22	55%	25	32%	18	44%
· Staff	33	42%	5	20%	9	56%	39	33%	7	57%
The MAPPA were used effectively	67	37%	19	47%	15	27%	16	56%	19	21%
In order to protect the public, changes in the RoH/ acute factors were:										
· Anticipated where feasible	47	34%	7	14%	10	60%	20	30%	10	30%
· Identified swiftly	57	49%	8	25%	12	67%	27	52%	10	40%
· Acted upon appropriately	57	44%	7	14%	14	79%	26	42%	10	20%
2.3 Victims										
Where there was a direct victim/potential victim, restrictive/prohibitive condition on the licence or order, or children's safeguarding concerns, appropriate priority had been accorded to victim safety by the offender manager and other workers	134	40%	34	41%	27	37%	36	36%	37	43%
2.4 Ensuring Containment and Promoting Compliance										
The frequency of appointments:										
· Conformed to national standards	241	83%	59	85%	59	76%	62	84%	62	87%
· Facilitated the requirements of the sentence	241	76%	59	69%	59	71%	62	77%	62	85%
· Met any RoH considerations	241	73%	59	63%	59	69%	62	74%	62	82%
· None of the above	28	12%	59	12%	59	17%	62	10%	62	8%

	LONDON		GREENWICH & LEWISHAM		HACKNEY & TOWER HAMLETS		WANDSWORTH		BRENT, BARNET & ENFIELD	
	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard
Where required, breach was:										
· instigated within the required timescale	69	74%	14	79%	16	75%	26	69%	13	77%
· Resolved within the required timescale	66	61%	13	46%	15	60%	25	68%	13	62%
2.6 Restrictive interventions										
Restrictive interventions were monitored fully	93	67%	20	65%	19	84%	25	64%	29	59%
Every reasonable action was taken to minimise RoH	132	62%	30	50%	39	74%	35	63%	28	57%
Additional licence requirements were:										
· Comprehensive	65	85%	13	85%	16	69%	19	84%	18	94%
· Necessary	65	92%	13	85%	16	94%	19	95%	18	89%
· Proportionate to RoH	65	94%	13	85%	16	94%	19	95%	18	94%
· Proportionate to LoR	65	89%	13	85%	16	94%	19	95%	18	78%
· Proportionate to protection of victims	65	82%	13	62%	16	75%	19	89%	18	89%
· None of the above	65	2%	13	8%	16	0%	19	0%	18	0%

APPENDIX 2

Chart 1 Case Sample: Clusters

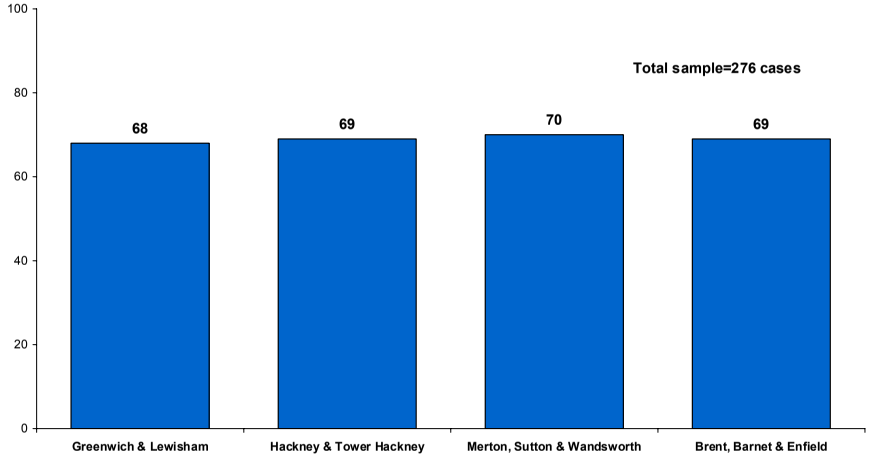

Chart 2 Case Sample: Tier

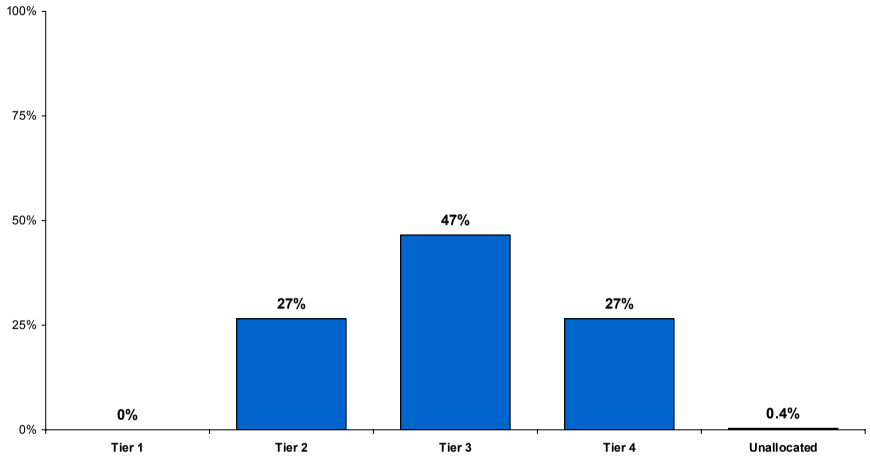

Chart 3 Case Sample:
OASys RoSH classification as recorded by London Probation

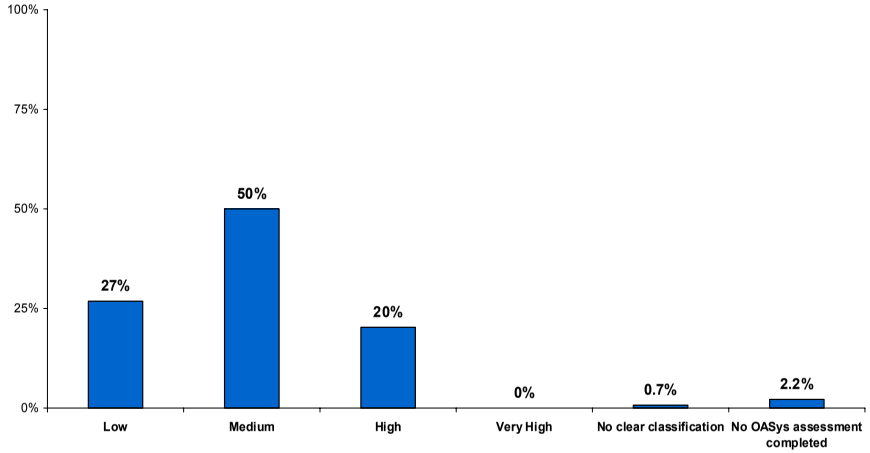

Chart 4 Case Sample: Sample diversity

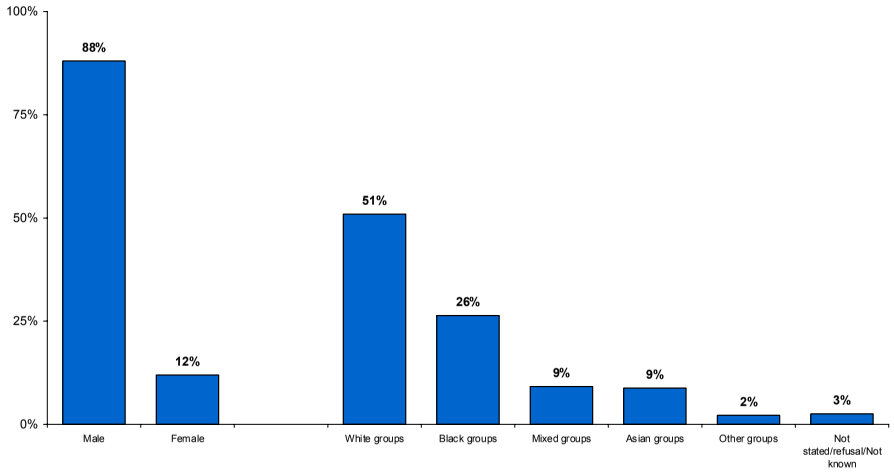

Chart 5 Case Sample: Offence Types

London Risk of Harm Area Assessments: Offence	London	Greenwich & Lewisham	Hackney & Tower Hackney	Merton, Sutton & Wandsworth	Brent, Barnet & Enfield
Violence against the person	**26%**	29%	26%	25%	25%
Fraud and forgery	**5%**	3%	3%	6%	7%
Sexual offences	**6%**	7%	4%	6%	6%
Criminal damage (excluding arson)	**1%**	1%	1%	0%	3%
Burglary	**8%**	7%	7%	16%	3%
Arson	**3%**	3%	0%	6%	1%
Robbery	**6%**	9%	3%	3%	10%
Drug offences	**18%**	16%	33%	12%	12%
Theft and handling stolen goods	**12%**	12%	12%	14%	12%
Motoring inc: Drive whilst disqualified	**1%**	1%	0%	0%	3%
Motoring inc: Drive with excess alcohol	**3%**	1%	1%	3%	6%
Other	**10%**	9%	9%	10%	12%

APPENDIX 3
Inspection methodology and publication arrangements

Methodology

- Each individual inspection took place over one week. The area was asked to identify a sample of approximately 50 - 70 offenders who have been managed by a probation offender manager for approximately six months. We then ensured that there was a minimum number of the following types of cases: high/ very high *RoH*; PPOs; approved premises residents; statutory victim contact; black and minority ethnic offenders. The cases were drawn from community orders, licences, and those in custody.
- The four separate inspections took place in operational 'clusters' and we interviewed a senior operational manager who was responsible for the *RoH* work in each cluster.
- We interviewed Senior Managers.

Publication arrangements

- Summary verbal feedback was given to the area at the end of each inspection week.
- A draft of this report was sent to the area for comment before finalising publication. A copy is sent to the secretary of State, NOMS HQ and is placed on our website.

APPENDIX 4
Role of HMI Probation

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
- promote actively 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:

HM Chief Inspector of Probation
2nd Floor, Ashley House
2 Monck Street
London SW1P 2BQ

GLOSSARY

CO	*Chief Officer* of a probation area.
Dynamic factors	As distinct from *static factors. Dynamic factors* are the factors in someone's circumstances and behaviour that can change over time.
FDR	Fast Delivery Report: short format Pre-sentence report, as distinct from an SDR (Standard Delivery Report)
HMI Probation	*Her Majesty's Inspectorate of Probation.*
IPPF	*Integrated Probation Performance Framework*
Interventions	*Work with an offender which is designed to change their offending behaviour and to support public protection.* 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. 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.
IT	*Information technology.*
LCJB	*Local Criminal Justice Board*. This is a group made up of the *COs* of the five criminal justice agencies (police, probation, courts, prisons and the Crown Prosecution Service) in each of the 42 criminal justice areas.
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. The National Guidance for *MAPPA* was contained within *Probation Circular* 54/2004.
MAPP meetings	*Multi-Agency Public Protection meetings*: The most challenging offenders, and those presenting the highest risk of harm to the public are managed in a multi-agency way by staff from the relevant agencies. Level 2 meetings are generally local risk management meetings; Level 3 meetings (the MAPP Panel) are attended by senior staff from the agencies within the area.
MAPPP	*Multi-Agency Public Protection Panel.*
National Standards	*Standards issued by NOMS which govern the management of offenders. They include the minimum requirements for contact with offenders and for the completion of key management tasks by offender managers and offender supervisors.*
NOMS	*National Offender Management Service*: the single service responsible for both HM Prison Service and *Probation Areas and Trusts.*
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 a single offender manager

	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*. Individual intervention programmes are designed and supported by the offender management team, which is made up of the offender manager, offender supervisor, key workers and case administrators.
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.*
OMU	*Offender Management Unit.*
PO	*Probation officer.*
PSO	*Probation Service Officer.*
PSR	*Pre-sentence report. Includes both SDR and FDR.*
PPU	*Public Protection Unit.*
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.
'RoH work' or 'Risk of Harm work'	This is the term generally used by *HMI Probation* to describe work to protect the public. In the language of *offender management*, this is the work done to achieve the 'control' purpose, with the offender manager/supervisor using primarily *restrictive interventions* that keep to a minimum the offender's opportunity to behave in a way that is a *Risk of Harm to others*. *HMI Probation* uses the abbreviation *'RoH'* to mean specifically *RoH* <u>*to others*</u>. We use it instead of RoSH 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 help to clarify the distinction between the *probability* of an event occurring and the *impact/severity* of the event. The RoSH definition only incorporates 'serious' impact, whereas using *'RoH'* enables the necessary attention to be given to those offenders for whom lower *impact/ severity* harmful behaviour is *probable*.
RoSH (Risk of Serious Harm)	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.
Safeguarding	The ability to demonstrate that all reasonable action has been taken to keep to a minimum the risk of a child or young person coming to harm.
SDR	Standard Delivery Report – a 'full' Pre-sentence report, as distinct from a FDR (Fast Delivery Report)
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).
VLU	Victim Liaison Unit