HM Inspectorate of **Probation** Arolygiaeth Prawf EM

Risk of Harm Inspection Report

Getting There Now

A follow-up inquiry into the management of offenders' Risk of Harm to others by London Probation Trust

In:

Croydon; Bexley & Bromley;

Greenwich; Lewisham;

Ealing; Harrow & Hillingdon;

Camden & Islington; Newham

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FOREWORD

In 2009, we carried out a series of special inspections into the public protection work of London Probation, at the request of the then Justice Secretary, due to concerns about the standard of practice that had been identified in a National Offender Management Service review of the management of one specific offender, Dano Sonnex. That series of case inspections, focusing on the work that probation staff do to assess and manage *Risk of Harm to others (RoH)*, took place from April to July 2009 , and we published the resulting report *A Stalled Journey* in October 2009. We found a disappointing quality of practice, and observed that the progress we had noted in previous inspections prior to 2009 had stalled. However, I also noted in my Foreword at the time that there had been a recent "redoubling of management activity" to address public protection concerns, but that it would only be in the planned follow-up case inspection that we would be "able to tell whether this effort is impacting in the desired way on direct work with offenders".

Accordingly, this report now covers the planned follow-up case inspections that took place in July 2010, assessing the quality of public protection practice with a representative sample of individuals under supervision in the community since January 2010, or in custody since June 2009. As in the original report last year, our focus solely on the quality of public protection work with cases means that, unlike in our 'normal' Offender Management Inspections, not only the other aspects of probation practice but also the management arrangements were both outside the scope of this report.

In this year's case inspections we have found a demonstrable improvement in public protection work in London. Overall, 74% of work that we assessed had been carried out satisfactorily, compared with 54% in our 2009 inspections. Much more often than last year, the work we inspected this year has been done well enough and on time, including within MAPPA (Multi-Agency Public Protection Arrangements). As always, there is nevertheless room for further improvement – for example, many assessments and plans still required more precision and detail.

Although we have not made a formal separate assessment of the quality of management and organisational arrangements, we have noted that, by and large, the management, staffing, training and quality assurance improvements that had been planned were being delivered, and were starting to make a difference in practice with the cases we inspected.

These results are very encouraging. The staff and those in leadership positions within London Probation Trust are to be commended on their response to our earlier report. Last year we concluded that their journey towards improving public protection practice had 'stalled'; this year we have found positive evidence that their practice is 'getting there now'.

ANDREW BRIDGES
HM Chief Inspector of Probation

October 2010

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We would like to express our thanks to the Board of London Probation Trust, 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.

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REASONS FOR UNDERTAKING THE INSPECTION

In 2009 we were asked by the then Justice Secretary to inspect the Public Protection work of London Probation because of concerns that had arisen in a scrutiny of the management by London Probation of an offender, Dano Sonnex, who had committed two serious further offences whilst under supervision. Two sets of case inspections were planned, for 2009 and 2010 respectively, partly to cover as much of London as possible, and partly to look at performance over time. In the event, this second set of inspections took on an even greater significance as a follow-up exercise, since our 2009 report was critical of the quality of *ROH* work in London Probation.

We used our Risk of Harm Area Assessment (RoHAA) inspection tool to assess the total sample of 280 cases across 8 Local Delivery Units (LDUs). The tool comprises a subset of the questions used in the OMI 2 programme and focuses principally on the assessment and management of the *ROH to others* in a representative sample of cases. We also received evidence from London Probation Trust and spoke to the Assistant Chief Officers in charge of each LDU. For full details of the inspection methodology see Appendix 3.

OVERVIEW AND SUMMARY

London Probation Trust was organised into 23 Local Delivery Units (LDUs), each headed by an Assistant Chief Officer (ACO), assisted by a business support unit. This arrangement had been introduced since our previous inspection, in December 2009, and replaced the former structure of 12 clusters, each covering two or three boroughs. The new arrangements were designed to provide a larger number of ACOs with a smaller and more manageable span of control in order to manage staffing, operations, partnerships and performance. Individual offices were managed by senior probation officers. Within each LDU, 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 LDUs delivered accredited programmes, unpaid work and work related to the courts. Two Directors of Offender Management were responsible for LDUs in the north and south respectively. The total number of offenders supervised (custody and community) within each LDU varied from 800 in Kingston/Richmond to 2900 in Camden/Islington. The average caseload for an LDU in 2010 was 1,500 compared to an average caseload for a cluster in 2009 of 2800.

The inspection took place over two separate weeks in July 2010 in the following LDUs

Week beginning 5 July:

- Croydon
- Bexley & Bromley
- Greenwich
- Lewisham

Week beginning 26 July:

- Ealing
- Harrow & Hillingdon
- Camden & Islington
- Newham.

We selected the LDUs to achieve a sample of cases that was representative of the work undertaken in London Probation Trust as a whole. However, we chose to look again at practice in Greenwich and Lewisham on the basis that the original concerns arising from the Sonnex case had arisen in Lewisham and that the quality of practice in the 2009 inspection had been of concern.

A total of 280 cases were inspected; 35 in each LDU. The overall sample included offenders

- Sentenced to community orders, including suspended sentence orders, during the period 1-31 January 2010
- Released on licence from prison during the period 1 – 31 January 2010
- Sentenced to immediate custody during the period 1 June- 31 July 2009, who fell within the scope of Phase II or III of the Offender Management Model – that is, those who were assessed as posing a high or very high Risk of Serious Harm or who were Prolific or other Priority Offenders.

The overall finding of the 2010 inspections was that London's public protection practice had considerably improved since the 2009 inspections.

In 2010 the overall score for *RoH* work was 74%, compared to a score in 2009 of 54%. Although we have introduced some minor changes in methodology, these scores can be broadly compared; they show that whereas in the 2009 inspection the *RoH* was being assessed and managed well in just over half of the sample, cases in the 2010 sample have been assessed and managed well nearly three-quarters of the time.

During the 2010 inspections, we noted a number of important developments, which appeared to underpin much of the improvement in *RoH* work that we saw. These were largely developments that had already started during the period covered by our 2009 inspections (many under the 'Going for Green' Project), but where they had not yet had a positive impact on cases. One year on, we similarly noted some initiatives in the successor 'Going for Gold' Project, which had been launched in November 2009. Many of these initiatives started during the January-July 2010 period that we were largely inspecting, and so their impact would not necessarily have been evident in the cases we examined. Indeed, two important initiatives had yet to start in the LDUs we visited. Nevertheless, our fieldwork indicated that the 'Going for Gold' Project had been important. Staff were clearly aware of the intent of the Board and senior managers to pursue quality of *RoH* work, in order to tackle the shortcomings in the 2009 inspection, and to consolidate the progress that was already being made in improving basic operational processes under 'Going for Green'.

The LDUs we inspected were to embark on the LEARN (London Enhanced Audit of Risk Network) process, aimed at achieving an organisation wide view of quality, and the Senior Probation Officer skills audit in Sept 2010. This was later than the other LDUs, to reflect the view of the trust that these LDUs should concentrate on preparing for this inspection.

The impact of staff absence on the management of offenders was being managed more effectively than in 2009, and importantly the amount of sickness absence had reduced. ACOs reported that their front line managers had received more guidance and support in dealing with sickness absence. Whereas in January 2009, sickness absence was at an annualised 13.47 days, in January 2010 it was at 11.6. Thereafter (during the latter period in which the cases in this inspection were being supervised) it reduced to an annualised average of 9.7 in the period April-June 2010, compared to 11.7 in the corresponding period in 2009. Although sickness absence rates can vary over time for many different reasons, these were encouraging trends.

The workload management tool (WMT), which had been introduced in May 2009, was being more actively used by the ACOs we interviewed and, as well as having been used to make staffing decisions, showed the majority of staff to be working within the workload capacity levels. This seemed to reflect a relatively stable caseload (there had been a very slight reduction between February 2009 and February 2010), the improvement in sickness absence and the introduction of recently qualified probation officers into teams. Those inspection staff who had previously been on the 2009 inspection team perceived an overall improvement in morale in those staff they interviewed, and fewer instances of staff who felt overwhelmed by their current workload. At the time of our inspection, though, staff were aware of proposed future budget reductions for 2010/2011 and thereafter, and were concerned at the potential impact on them.

Offender managers (and the ACOs) commented very positively on the *RoH* training that they had recently received. In particular, they welcomed the fact that all staff had been trained, or would receive training; that it had been a good blend of theory and practice, and that they had been able to link what was expected to the skills they already had.

Some probation service officers considered that more training on sentence planning was necessary.

During our inspections we experienced at first hand (as we did in 2009) the IT systems running slow or even freezing for a time, which is frustrating and time wasting for offender managers. Even though it is hard to make direct links between experiencing an IT failure and a shortcoming in a particular piece of *RoH* work (for which there are usually other more direct reasons) we acknowledge that frustration and time wasted can make a good piece of work less likely and have a longer term detrimental effect on quality.

In terms of partnerships, ACOs were able to report that there were developing (and in many cases well developed) links with other statutory agencies, and with voluntary bodies. Many of these partnerships had either been reviewed to improve the public protection focus, and/or were being developed to accommodate lower *RoH* offenders and thereby free up resources for higher *RoH* offenders. We noted some positive work on implementing drug rehabilitation requirements, although the arrangements for alcohol treatment requirements seemed less clear.

Inspection staff noted some positive use by offender managers of the Structured Supervision Programme, which had recently been introduced and provided a brief cognitive-behavioural approach for working with offenders who were not suited to a full accredited programme.

Key findings – Assessment and sentence planning:

RoH screenings, full analyses and RMPs were completed and on time in almost all cases, and the large majority of screenings and RoSH classifications accurately reflected *RoH*. In most cases information about the offender's *RoH* had been effectively communicated to others involved in the case, and *RoH* objectives were generally incorporated into the sentence plan for the offender. Restrictive requirements and conditions were proportionate to protecting the public.

However, *RoH* assessments and RMPs were still not of sufficient quality often enough, although there had been progress since 2009. Only one in two *RoH* assessments were completed to a sufficient level of quality (52% compared to the 2009 finding of 46%) and only 37% of RMPs were sufficient (compared to 17% for community orders and 22% for licences in 2009). Often the RMP had not been shared and there had been insufficient management involvement in *RoH* assessment and planning and child Safeguarding issues.

MAPPA processes were properly used in the majority of cases, but there needed to be more connection between the work being done by the offender manager and the content of MAPPA meetings and plans.

Because a significant amount of assessment and planning work scored under this section relates to work done early in the order or licence (in this case largely January and early February 2010), and many offender managers received further *RoH* training after that period, we feel that further improvement in the quality of *RoH* assessments and RMPs is within the capacity of the area.

In summary, despite these criticisms, we still found that 79% of all work inspected, that was associated with assessment and planning to address both *RoH* and Likelihood of Reoffending, was done sufficiently well in 2010, in contrast with the 2009 figure of 49%. Furthermore, we found that a higher percentage of the assessment and planning work was done sufficiently well with some categories of offenders, notably offenders in

the custody sample who were or had been subject to Offender Management Phase II or III (81%), and offenders assessed as high RoSH at the start of sentence, from the custody, licence and community order samples, who were being supervised in the community (84%).

Key findings – Implementation of interventions:

Strengths included the delivery of interventions to address *RoH* in a timely way, levels of contact with offenders, monitoring of offender attendance and choice of unpaid work placement to reflect *RoH*. Most aspects of transfer arrangements appeared sound (although we saw relatively few transfer cases, and one high risk transfer was dealt with inadequately).

Restrictive requirements in community orders were monitored in three out of four cases, and in a similar proportion there was timely victim contact, followed by proper information exchange. Approved premises had been used positively to increase public protection, and in almost all cases where it was necessary enforcement had taken place to deal with *RoH* concerns. We found that MAPPA arrangements had been used effectively in most cases and multi-agency child Safeguarding procedures in all the relevant cases. Relevant probation staff had contributed effectively to most MAPPA cases (an impressive improvement on 2009) although the contribution to child Safeguarding was less positive. Appropriate resources had been allocated throughout the sentence to address *RoH* in the great majority of cases.

Some aspects of practice were of particularly variable quality: initiating breach or recall action where it was appropriate; reviewing risk thoroughly in line with timescales (the level of thorough review was virtually unchanged from 2009), and anticipating, identifying and acting on risk concerns (though this was much improved on 2009).

Other aspects of practice were clearly still areas for future improvement. OASys had not been used to review risk in many cases where we judged there were *RoH* concerns, and sentence planning (and particularly incorporating child Safeguarding concerns into sentence plans) was not well developed. Nor was use of the case log to record work undertaken. Effective monitoring of restrictive requirements in licences, home visiting and effective management involvement in High and Very High RoSH cases and child Safeguarding cases were evident in too few cases. However, we assessed 70% of cases as having been managed with appropriate priority given to victim safety.

In summary, 77% of all work inspected that was associated with implementation of interventions was sufficient; (the corresponding figure for the 2009 inspection, although there are some slight differences in the individual questions we asked, was 55%). The figure for work with offenders in the custody sample who were or had been subject to Offender Management Phase II or III was 81%. The figure for work with offenders assessed as high RoSH at the start of sentence, from the custody, licence and community order samples who were being supervised in the community, was 83%.

Key Findings: Outcomes

We found that in 78% of cases all reasonable action had been taken to manage the offender's *RoH*. Furthermore the contribution of approved premises and multi-agency working in MAPPA had been effective (though less evidently so in child Safeguarding cases).

RECOMMENDATION

We make no further recommendation on this occasion, other than to record that good progress has been made in the last year, and will need to continue. The overall quality of offender management work in London will be inspected in due course as part of the current three year mainstream inspection programme (OMI 2).

NEXT STEPS

This report has been submitted to the Secretary of State and copies provided to the Board of the London Probation Trust, 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

London Probation Trust will be the subject of a normal OMI 2 inspection as part of the three year cycle which started in September 2009. Due to the improvement in *RoH* practice reported here we have no plans to undertake a further special inspection in London.

SCORING

This report includes scores for the practice criteria. In this inspection the number of criteria is smaller than for a full OMI 2, 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. For information, in the two regions inspected so far under the OMI 2 programme, the average score for *Risk of Harm to others* work has been 70%, with scores ranging from 64-81%.

This score indicates the percentage of *Risk of Harm work* that we judged to have met a sufficiently high level of quality.	**74%**
2010 Inspection ROH score for London Probation Trust	

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

The table below provides a set of results, drawn from the same inspection data, of the percentage of work to assess and plan; to implement interventions, and to secure offender compliance and enforce requirements that met a sufficiently high level of quality. Due to the focus on *RoH* these results are not comparable with full OMI 2 scores for other probation trusts.

London Probation Trust – Scores for General Criteria (*RoH* questions only)	
Assessment and planning to address *Risk of Harm to others*	80%
Assessment and planning to address the likelihood of reoffending	71%
Assessment & sentence planning overall	**79%**
Delivering the sentence plan	78%
Delivering restrictive interventions	73%
Implementation of interventions overall	**77%**
Compliance and enforcement	83%

1. ASSESSMENT AND SENTENCE PLANNING

1.2 General Criterion: ASSESSMENT AND PLANNING TO MINIMISE RISK OF HARM TO OTHERS *RoH is comprehensively and accurately assessed. Plans are made to keep to a minimum the individual's RoH.*	**80%**

Strengths:

(a) An OASys RoSH screening was carried out at the start of sentence, release on licence or transfer into the area in 277 (99%) of the 280 cases in the sample. Of these screenings, 93% were completed on time and 84% were accurate. Inaccuracies tended to arise from the failure to recognise the significance of known previous assaults or weapon possession rather than lack of the list of previous convictions *per se*.

(b) A full *RoH* analysis was completed in 98% of the cases where one was required, and was on time in 91%.

(c) Of the cases inspected, 17% had been classified by the offender manager as low RoSH, 63% as medium RoSH, 19% as high RoSH and 1% as very high RoSH. We agreed with the classification in 87% of the cases, assessing that, of the remainder, 22 had been classified at a higher level than appropriate and 14 at a lower level. The *RoH* analysis documentation accurately reflected the risk to children in 87% of cases, to the public in 83%, to known adults in 84%, to staff in 89%, and to prisoners in 73%.

(d) *RoH* issues were effectively communicated by the offender manager to other staff involved in 78% of the cases where this was necessary.

It was pleasing to note that in Lewisham *RoH* issues had been effectively communicated in 96% of cases.

(e) RMPs were required in respect of 228 offenders who had been classified by the area as medium, high or very high RoSH. These were completed in 97% of cases, were timely in 92%, and were completed using the required format in 93%.

(f) Restrictive requirements (e.g. measures such as an electronically monitored curfew, or prohibition on contacting a named person) had been used in 21 community order cases to manage *RoH*. In all cases these were proportionate to *RoH* and the protection of victims. In the 45 post-release licence cases where there were restrictive conditions, we assessed all except one as proportionate to *RoH* issues and all except two as proportionate to the protection of victims.

(g) Of the 78 cases in the sample which met the criteria for referral or notification to MAPPA, 54 were designated as requiring Level 1 management, 22 at Level 2, none at Level 3, and two had incorrectly not been referred or notified. We judged that the initial level of MAPPA management was appropriate in all except three of these 78

cases. Eighteen of the twenty-two cases (82%) that were managed at Level 2 had been referred to MAPPA on time, and proposed actions from MAPPA were communicated to relevant bodies in 82%.

Areas for Improvement:

(a) The full *RoH* analysis was of sufficient quality in only 52% of cases (the 2009 result was 46%), although analyses were of a higher quality in Newham (71%) and Camden and Islington (70%). This overall picture reflected our further findings that 38% of *RoH* assessments did not draw sufficiently on all sources of available information, and 32% did not take into account relevant previous behaviour. In none of the five cases where a required full *RoH* analysis was not completed was there a sufficient explanation for non-completion. Conversely, in some cases a *RoH* analysis was completed where not indicated by the screening, and if there was a good reason for doing one it was not clear.

Some *RoH* analyses, triggered by events identified in the screening, did not analyse (or even in some cases mention) these events, or relied only on the offender's recollection of events, without checking with records of other agencies. Other analyses repeated the detail of the most recent offence (in many cases acquisitive offences) and lists of previous convictions, with no link made to *RoH* concerns. In only a few of the licence cases did we find that *RoH* analyses had been updated to reflect the offender's behaviour (whether positive or negative) whilst in custody. In many of the cases where there had been no thorough update, this was due to lack of knowledge by the offender manager of what had happened in custody. We noted some cases where an offender manager's view of the seriousness of a type of offence (e.g. drug supply) had led to an assumption that the offender must therefore pose a risk of serious harm, without sufficient analysis of what harm this particular offender was capable of inflicting directly on others. In most cases offender managers had access to previous convictions (an improvement on the 2009 position), although we noted a reluctance to obtain information from YOTs about offenders who had recently been under their supervision. There were other cases where offender managers could have properly asked for further information from police intelligence, for example, where offender managers suspected an offender might have convictions abroad.

Nevertheless, although there was ample scope for further improvement, we were pleased to note that staff were generally clearer about practice expectations than in our 2009 inspection. Some offender managers were able to use their recent training to identify for themselves what should have been done better, whilst discussing the case with inspection staff.

(b) RMPs were sufficient in only 37% of cases (45% for high RoSH cases in the community), although we found a higher percentage in Ealing, Lewisham and Newham.

RMPs accurately described how the objectives of the sentence plan and other activities would address *RoH* issues and protect actual and

potential victims in 35%. In some cases RMPs which had been originally drawn up to accommodate either a custodial or community sentence were not subsequently updated after sentence to reflect the specific sentence passed. In other cases, either a significant element was missing (e.g. an alcohol intervention where alcohol was a key factor) or actions were stated in such a way that it was unclear exactly who would be doing what and when (e.g. "liaise with relevant agencies") or it was unclear what if any contingency was planned in the event of non compliance. A RMP was completed in some cases classified as low *RoH* where it seemed to serve no purpose; some offender managers stated that they had received a management instruction to undertake a RMP whenever a full analysis had been undertaken. There also appeared to be confusion about the area conventions for amending text during review of RMPs although we were told this was being clarified.

Although further improvement is required, the overall finding that 37% of RMPs were comprehensive suggests some progress had been made compared to the 2009 findings of 17% and 22% for community orders and licences respectively.

(c) The RMP was shared with relevant others involved in the case in 63% of cases (although 86% for high RoSH cases in the community). In some cases offender managers assumed that colleagues would have read it online unprompted but were unclear whether they had done so.

(d) Of 55 high RoSH cases, both in custody and the community, there was effective management involvement in *RoH* assessment and planning in 27 (49%); ineffective management involvement in 22 (40%); and no evidenced management involvement in six (11%). This reflected in part the countersigning, by the manager involved, of insufficient quality *RoH* analyses and RMPs, which should have resulted in the offender manager being asked to improve them. However, we noted some evidence of more management involvement (including asking offender managers to improve assessments and plans, together with the provision of good advice on how to do it) from March 2010 onwards.

(e) In 37 cases involving child protection issues, there was effective management involvement in assessment and planning in 17 (46%); ineffective management involvement in nine (24%); and no management involvement in 11 (30%). Again, this largely reflected the finding that although managers often provided useful advice and guidance in specific instances, the management oversight of many assessments and plans did not pick up inaccuracies and out of date information. We saw some improvements in management attention over the inspection period.

(f) For cases managed at MAPPA Level 2, proposed actions from MAPPA were incorporated in relevant plans in 68% of cases. We noted that some offender managers felt fully part of the MAPPA management of their case and could relate what they did to what other agencies were doing. However, others, particularly those who had not

attended MAPPA meetings, had more difficulty in making the links, which led to a lack of congruence between probation plans and the MAPPA RMP. In one case, MAPPA asked for the RoSH level to be raised to high by the offender manager, but without explaining the rationale, which left the offender manager feeling confused and anxious.

1.3 General Criterion: ASSESSMENT AND PLANNING TO REDUCE THE LIKELIHOOD OF REOFFENDING *The LoR is comprehensively and accurately assessed. Plans address offending related factors to reduce the LoR.*	**71%**

Strength:	(a) Sentence plans included objectives to manage *RoH* in 76% of cases. In Bexley and Bromley the figure was 85%.
Area for Improvement:	(a) Sentence plans included objectives to manage child Safeguarding in only 20 of the 49 cases (41%) where we assessed that this was required. Some offender managers could explain how they saw the planned work contributing to child Safeguarding but they had not made it explicit in the sentence plan or elsewhere in the case record.

2. IMPLEMENTATION OF INTERVENTIONS

2.1 General Criterion: DELIVERING THE SENTENCE PLAN (INCLUDING THE *PUNISH* ELEMENT) *Interventions are delivered in line with the requirements of the sentence and meet prescribed standards.*	**78%**

Strengths:

(a) Interventions to address *RoH* were delivered in a timely manner in 73% of cases. On the whole, we found good links with accredited programmes and a clear system for dealing with drug related issues, but we found that offender managers were less clear about alcohol treatment delivery arrangements.

(b) The frequency of contact arranged with the offender met or exceeded the national standard in 90% of cases, facilitated the requirements of the sentence in 89%, and took full account of the assessed *RoH* in 90%. We saw a number of cases where the offender manager had commendably maintained contact above the minimum level required due to the offender's behaviour and/or unresolved concerns about the individual's *RoH*.

(c) We judged that appropriate resources had been allocated throughout the sentence to address *RoH* in 87% of cases.

(d) The offender manager coordinated the input of all workers concerned with the offender in 78% of cases, and monitored fully the offender's attendance at interventions in 89% of cases. In 81% of cases where it was necessary, effective action had been taken to secure the offender's compliance with interventions.

(e) Judgements about acceptability of offender absence or other behaviour were appropriate (91%), consistent (91%) and clearly recorded (92%).

(f) Of the 44 cases involving unpaid work, 36 (86%) of placements took account of the offender's *RoH*.

(g) *RoH* assessments were reviewed thoroughly in line with required timescales in 73% of cases. This was virtually unchanged from the 72% recorded in our 2009 inspection.

(h) There were 25 cases involving transfer, whether between areas or between offices in London. The transferring office provided up to date assessments and sentence plans in line with national requirements in 24 cases (96%). Nineteen cases required an up to date RMP and this was provided in 17 (89%). An appointment was arranged for the offender within five days of transfer in three-quarters of the cases. A home visit took place within ten days in six of the eight cases where required due to the offender's high *RoH* status.

Areas for Improvement:	(a) Interventions were sequenced according to *RoH* in 67% of cases. Offender managers did not on the whole use OASys or Delius to explain why some interventions were used at one stage, and other interventions at another. (b) We judged that in 101 of the cases in the sample there had been incidents or behaviour that necessitated a *RoH* review. A review using OASys was undertaken in 44% of these cases. The corresponding finding for High RoSH cases was a disappointing three out of ten cases. (c) In the quarter of *RoH* assessments that were not reviewed thoroughly in line with required timescales, many contained un-amended (or largely un-amended) information from previous assessments. Disappointingly, only 14 of 21 high RoSH cases in the community were reviewed both thoroughly and in line with required timescales. (d) Reviews of *RoH* were used to inform sentence plan reviews in 57% of cases and to prioritise objectives appropriately in 56%. In part this was because the review did not reflect changes in the offender's circumstances and in other cases information in OASys which could have led to a change in approach (e.g. in the delivery of an alcohol intervention) was not used. (e) The offender was able to participate in the sentence plan review process in 64% of cases. Although greater emphasis was being given to timeliness of reviews we found some sentence plan reviews had been written without discussion with the offender. This meant that some plans which framed objectives as "I will" were unseen by the offender to whom they related. (f) In one of the three cases involving transfer of a high RoSH offender, the RMP was not updated within 5 days of transfer. (g) Breach or recall action was taken in 46 of the 65 cases (71%) on all occasions where we assessed that such action was appropriate; it was instigated in line with relevant timescales in 78%, and resolved in line with relevant timescales in 73%.

2.2 General Criterion: DELIVERING RESTRICTIVE INTERVENTIONS (THE *CONTROL* ELEMENT OF THE SENTENCE PLAN) *All reasonable action is taken to keep to a minimum the individual's RoH.*	**73%**

Strengths	(a) MAPPA had been used effectively in 17 of 20 cases (85%). This compares favourably to a 2009 figure of 37%. Decisions taken within MAPPA were clearly recorded (85%); followed through and acted upon (95%); and reviewed appropriately (78%). Relevant probation staff had contributed effectively to MAPPA in 80% of cases and the input by other agencies was effective in 84%. Levels of knowledge about MAPPA were good, and the recent establishment in most LDUs of dedicated MAPPA administrators had been well received.

(b) We judged that all of the 17 cases which had involved the use of multi-agency child Safeguarding procedures had done so effectively. Decisions taken within multi-agency child Safeguarding procedures were clearly recorded in 14(82%); acted upon in all 17 (100%); and reviewed appropriately in 14 (82%).

(c) Restrictive requirements in community orders were monitored fully in 16 of the 21 (76%) relevant cases. There was evidence that the trust had taken steps to improve the communication between electronic monitoring staff and offender managers.

(d) Statutory victim contact was required in 69 cases. Contact was offered in 56 (81%) and within the required timescale in 49 (72%). In 18 of the 22 cases (82%) where victim contact was taken up there was regular and accurate information exchange between the offender manager, VLO and prison staff. Victims were offered an opportunity to provide views on proposed licence conditions (90%); to see relevant parts of any report (77%); and informed of any relevant events during the offender's sentence and their conditions of release (94%). We saw one case where the offender manager, VLO and prison staff had worked very well to deal with a situation where a victim was himself remanded into custody and there were concerns that uncoordinated decisions about prison allocation of the offender and/or victim could lead to an increase in *RoH*.

(e) In all five cases where the offender was resident in approved premises for a significant period, we judged this had been used effectively to manage the offender's *RoH*.

(f) Where enforcement action (through the courts or via direct recall to prison) was required due to concerns about *RoH* it was instigated in 22 of the 24 cases (92%). In 19 cases (79%) it was prompt. Clear explanations were given to the offender about the reasons for enforcement in just over three-quarters of the cases.

Areas for Improvement:

(a) Potential and actual changes in *RoH* factors were anticipated in 72% of cases, and identified in 71% of cases, although only acted on in 69%. In both Ealing and Lewisham these took place in a greater proportion of cases. The picture for high RoSH cases in the community was more mixed; changes were anticipated, identified and acted upon in 75%, 79% and 62% respectively.

(b) Offender managers and other relevant staff contributed effectively to multi-agency child Safeguarding procedures in 36 of the 53 (68%) cases where we considered that a contribution was required.

In Newham all six cases involved an effective contribution.

(c) Monitoring of restrictive requirements in post-release licences was insufficient in 14 of the 44 (32%) relevant cases. In some licences with prohibited contact requirements (where there had been victim contact, and information was in the record), insufficient attention had been given to how the requirement could be monitored.

(d) Appropriate priority was given to victim safety in 70% of the cases (and 82% of high RoSH cases in the community) where this was a relevant factor. In the other cases there was either insufficient knowledge of the victim or potential victim (or all reasonable action had not been taken to obtain the information), the identity of the known adult at risk was unclear, or the plan to protect a known person at risk lacked clarity.

(e) An initial and purposeful home visit was carried out in 14 of the 21 (67%) high or very high RoSH cases, in 31% of the cases where there were child Safeguarding concerns and in 39% of other cases where it would have been appropriate to undertake such a visit. Where further home visits were necessary to help manage *RoH* they were repeated in 11 of 18 cases (61%), and where necessary to deal with other issues of concern in three of five cases (60%). However, further visits did take place in all four child Safeguarding cases where an initial visit had taken place and it was necessary to undertake further visits. In general, offender managers viewed home visiting as a necessity to meet national standards in cases classified as high or very high RoSH, rather than as a tool to be used, selectively and appropriately, to manage *RoH*.

(f) In 8 of 12 (67%) cases where the offender had been subject to breach action, the offender manager had made efforts to re-engage the offender with his or her sentence plan.

(g) There had been effective structured management involvement in 31 (57%) of high and very high RoSH cases, and management involvement, but not effective, in a further 16 (30%). The figure for Greenwich was four out of five.

The corresponding figures for the 59 cases with child Safeguarding concerns were 32 (54%) and 8 (14%) respectively. All seven cases in Newham had received effective, structured, management involvement.

3. OUTCOMES

3.2 General Criterion: **MINIMISING RISK OF HARM TO OTHERS (THE CONTROL OBJECTIVE)**
All reasonable action has been taken to keep to a minimum the individual's RoH.

Our inspections include findings about initial outcomes, as set out in this section. In principle, this is the key section that specifies what supervision is achieving, but in practice this is by necessity just a snapshot of what has been achieved in only the first 6-9 months of supervision, and for which the evidence is sometimes only provisional.

Overall, our inspection findings provide the 'best available' means of measuring, for example, how often offenders' *Risk of Harm to others* is being kept to a minimum. It is never possible to eliminate completely Risk of Harm to the public, and a catastrophic event can happen anywhere at any time – nevertheless a 'high' *RoH* score in one inspected location indicates that it is less likely to happen there than in a location where there has been a 'low' *RoH* inspection score. In particular, a high *RoH* score indicates that usually practitioners are 'doing all they reasonably can' to minimise such risks to the public, in our judgement, even though there can never be a guarantee of success in every single case.

Main Finding:

- We assessed that in 78% of cases all reasonable action had been taken to keep to a minimum the offender's *RoH*.

Other Findings:

- In all five relevant cases the degree of restriction in approved premises had contributed to the management of *RoH*. We noted the high level of offender compliance achieved in these cases overall.
- Multi-agency work had effectively contributed to managing *RoH* in 12 of 17 (71%) cases that had been actively managed through MAPPA.
- Multi-agency work had contributed effectively to managing *RoH* in 30 of 46 (65%) cases where there were child Safeguarding concerns.

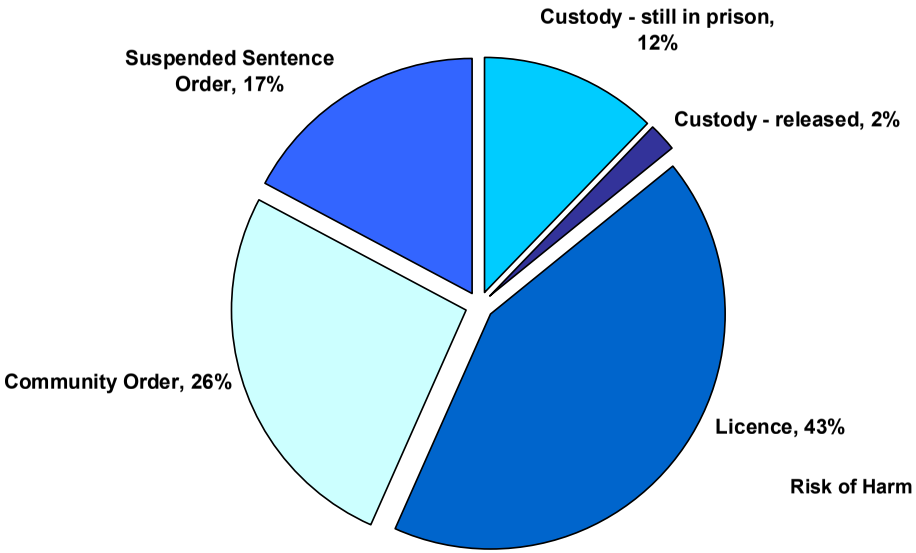
APPENDIX 1
Table – Selected Key Findings

	ALL LONDON		Bexley & Bromley		Camden Islington		Croydon		Ealing		Greenwich		Harrow & Hillingdon		Lewisham		Newham	
	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	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard
Was this the correct classification?	277	87%	35	86%	34	97%	35	86%	34	82%	35	83%	35	77%	34	88%	35	97%
Was an OASys RoSH screening:																		
Completed?	280	99%	35	100%	35	100%	35	94%	35	97%	35	100%	35	100%	35	100%	35	100%
Completed on time?	280	93%	35	83%	35	91%	35	83%	35	91%	35	100%	35	100%	35	97%	35	100%
Accurate?	280	84%	35	91%	35	89%	35	86%	35	80%	35	80%	35	74%	35	89%	35	86%
Was a full RoSH analysis:																		
Completed?	246	98%	33	100%	33	100%	29	93%	33	91%	31	100%	30	100%	29	100%	28	100%
Completed on time?	246	91%	33	88%	33	88%	29	79%	33	85%	31	100%	30	100%	29	90%	28	100%
Of sufficient quality?	244	52%	32	50%	33	70%	29	62%	33	58%	30	27%	30	23%	29	55%	28	71%
Did the RoSH analysis accurately reflect risk of harm to:																		
children?	245	87%	32	88%	33	94%	29	83%	32	88%	31	74%	30	80%	30	100%	28	93%
the general public?	245	83%	32	78%	33	91%	29	86%	32	72%	31	74%	30	77%	30	87%	28	100%
known adults?	245	84%	32	94%	33	85%	29	86%	32	84%	31	90%	30	63%	30	87%	28	86%
staff?	244	89%	31	87%	33	91%	29	86%	32	94%	31	81%	30	87%	30	93%	28	96%
prisoners?	33	73%	4	50%	4	100%	5	60%	5	100%	3	100%	3	33%	5	80%	4	50%
Were RoH issues effectively communicated to all staff involved in the case?	212	78%	29	69%	28	68%	23	70%	27	89%	26	81%	28	68%	25	96%	26	88%
Did the RoH assessment draw sufficiently on all available sources of information?	247	62%	33	58%	33	70%	29	79%	33	64%	31	48%	30	40%	30	83%	28	50%
Was previous relevant behaviour considered and taken into account?	221	68%	30	57%	31	77%	27	85%	27	59%	28	61%	27	37%	27	89%	24	83%
Was the risk management plan:																		
completed?	228	97%	27	100%	30	97%	27	89%	30	90%	31	100%	28	100%	30	100%	25	100%
completed on time?	229	92%	27	85%	30	90%	27	78%	30	90%	31	100%	28	100%	30	93%	26	96%
completed using required format?	228	93%	27	100%	30	83%	27	89%	30	90%	31	97%	28	96%	29	97%	26	96%
Was the RMP shared with all relevant others involved in the case?	226	63%	27	52%	29	55%	26	54%	29	72%	31	77%	29	41%	30	77%	25	76%
Was the initial level of MAPPA management appropriate?	76	96%	12	83%	9	100%	6	100%	10	100%	9	100%	10	100%	10	90%	10	100%
Did the sentence plan:																		
include objectives to manage RoH?	273	76%	34	85%	35	66%	35	77%	35	69%	34	71%	35	83%	35	80%	30	80%
include objectives to manage child safeguarding?	49	41%	9	44%	9	11%	2	0%	5	100%	8	25%	7	29%	1	0%	8	75%

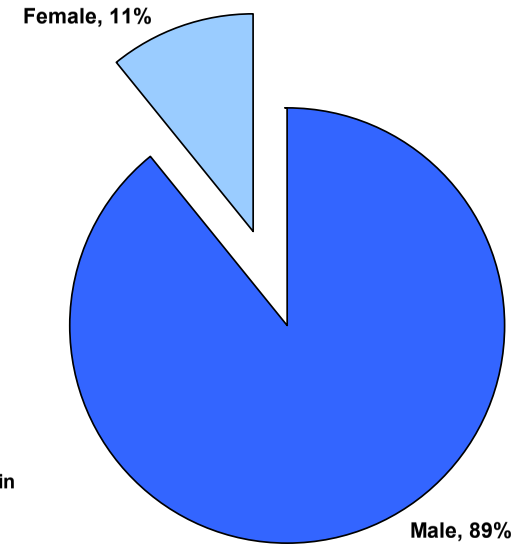
	ALL LONDON		Bexley & Bromley		Camden Islington		Croydon		Ealing		Greenwich		Harrow & Hillingdon		Lewisham		Newham	
	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard	Denominator	% meeting the inspection standard
Were interventions delivered in a timely manner according to RoH?	279	73%	35	71%	35	89%	35	63%	35	54%	34	68%	35	69%	35	80%	35	91%
Does the frequency of contact arranged:																		
meet or exceed the national standard?	278	90%	35	86%	35	100%	35	80%	34	91%	34	85%	35	97%	35	83%	35	97%
facilitate the requirements of the sentence?	278	89%	35	80%	35	91%	35	86%	34	94%	34	85%	35	91%	35	89%	35	97%
take full account of the assessed level of RoH?	278	90%	35	94%	35	89%	35	86%	34	97%	34	85%	35	91%	35	89%	35	91%
Were appropriate resources allocated throughout the sentence to address RoH?	279	87%	35	89%	35	89%	35	74%	35	83%	34	94%	35	83%	35	94%	35	91%
Does the Offender Manager co-ordinate the input of all workers in the case?	221	78%	30	70%	30	67%	22	77%	31	74%	28	82%	29	83%	24	88%	27	89%
Does the Offender Manager monitor offender attendance across all interventions?	277	89%	35	83%	35	86%	35	86%	35	89%	34	85%	35	89%	35	100%	33	94%
Where necessary has effective action been taken to secure compliance with all interventions?	124	81%	17	76%	16	69%	10	80%	17	88%	20	85%	16	75%	11	91%	17	88%
Were judgements about acceptability of absence and other offender behaviour:																		
appropriate?	267	91%	31	90%	33	79%	34	97%	31	84%	33	91%	35	94%	35	94%	35	94%
consistent?	266	91%	31	94%	33	76%	34	94%	31	84%	33	91%	35	94%	34	100%	35	97%
clearly recorded?	264	92%	31	90%	33	82%	34	91%	29	90%	33	91%	34	94%	35	97%	35	97%
Was the RoH assessment reviewed thoroughly																		
in line with required timescales?	276	73%	35	60%	34	76%	34	85%	35	89%	34	44%	35	69%	35	69%	34	91%
following a significant change?	101	44%	19	37%	12	50%	11	18%	9	22%	18	44%	14	57%	9	56%	9	67%
In this case were reviews of the RoH used to:																		
Inform sentence plan reviews?	277	57%	35	60%	34	29%	34	59%	35	74%	34	44%	35	60%	35	57%	35	71%
Prioritise objectives appropriately?	277	56%	35	57%	34	29%	34	41%	35	66%	34	44%	35	60%	35	63%	35	83%
Was the offender able to participate in the sentence plan review process?	275	64%	34	62%	35	54%	34	56%	35	71%	34	41%	34	50%	35	80%	34	94%
In order to protect the public were potential and actual changes in RoH factors:																		
anticipated?	134	72%	20	65%	21	67%	25	64%	14	86%	23	74%	10	70%	12	83%	9	78%
identified swiftly?	100	71%	15	67%	17	59%	12	58%	11	82%	15	73%	10	70%	8	88%	12	83%
acted on appropriately?	98	69%	15	47%	15	80%	12	50%	11	82%	15	73%	10	70%	7	86%	13	77%
Were the MAPPA used effectively in this case?	20	85%	5	80%	2	100%	2	100%	2	100%	1	0%	1	100%	5	80%	2	100%
Was appropriate priority accorded to victim safety by the offender manager and other workers?	162	70%	25	68%	15	67%	21	67%	24	83%	18	78%	27	56%	14	79%	18	72%
Has all reasonable action been taken to keep to a minimum RoH?	279	78%	35	66%	35	71%	35	77%	35	83%	35	83%	34	79%	35	80%	35	89%

APPENDIX 2
Case Sample – Background Information

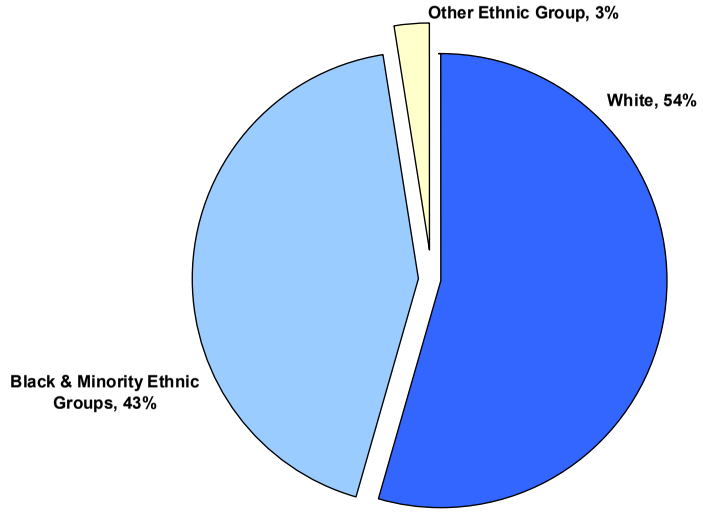
Risk of Harm Area Assessment London: Case types



Risk of Harm Area Assessment London: Gender



Risk of Harm Area Assessment London: Race and ethnic origin



APPENDIX 3
Inspection methodology and publication arrangements

Methodology

- Eight LDUs were inspected in July 2010, four in one week and four in another. The area was asked to identify a sample of offenders from a stipulated time period who had 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 and subject to Offender Management Phases II or III.
- 280 cases were inspected, 35 from each LDU, using the *Risk of Harm* Area Assessment Tool. This tool comprises a sub-set of questions concerned with *RoH* drawn directly from the tool used in the Offender Management Inspection (OMI) 2 programme. The tool we used in 2009 drew directly from the previous OMI programme, and a new OMI programme started in September 2009. Consequently there are some differences in 2010 in wording, choice of questions, and how the questions are grouped into sections. Overall, however, in comparing 2009 and 2010, the majority of individual questions are capable of comparison, as is the headline score for *RoH*.
- We received evidence from London Probation Trust, and interviewed each of the LDU ACOs at the conclusion of the fieldwork, about public protection work and the improvement initiatives that had been planned.
- At the end of each of the two weeks we provided oral feedback for senior managers in London. In this overview report, our findings are based on the whole inspection, although where we have found that a LDU appears to have dealt with an aspect of practice particularly well, we have drawn attention to it so that staff elsewhere in the area may be able to learn from it. A summary of findings by LDU is included in Appendix 1.

Publication arrangements

- 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.

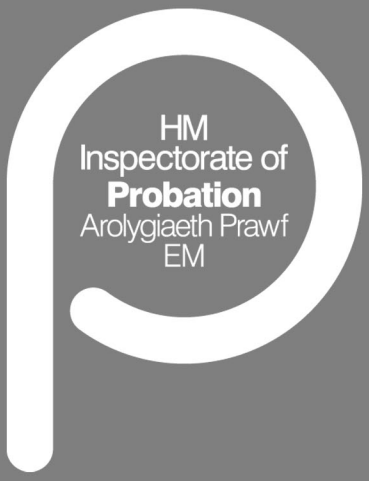
The Inspectorate is a public body. Anyone who wishes to comment on an inspection, a report or any other matter falling within its remit should write to:

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

APPENDIX 5
Glossary

ACO	*Assistant Chief Officer*
HMI Probation	*Her Majesty's Inspectorate of Probation.*
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.*
LDU	*Local Delivery Unit*
MAPPA	*Multi-Agency Public Protection Arrangements:* Probation, police, prison and other agencies working together locally to manage offenders who are of a higher *Risk of Harm to others*
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.
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 Prisons and *Probation 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.
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 *RoH* and what *constructive* and *restrictive interventions* are required. Individual intervention programmes are designed and supported by the wider .offender management team or network., which can be 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'.
RMP	Risk management plan.
'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* *to others*. 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.
VLO	*Victim liaison officer*: responsible for delivering services to victims in accordance with the trust's statutory responsibilities



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