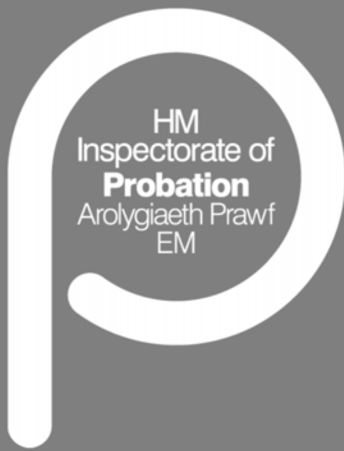

Risk of Harm Inquiry Report

On the Right Road

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

July 2008

FOREWORD

Gary Chester-Nash committed a heinous crime against Jean Bowditch. Our focus in carrying out this inquiry is not retrospective, looking at whether there were failings by the organisations who together managed Gary Chester-Nash. Rather, we have gone back to London – where Chester-Nash was principally supervised in the community – to see whether the lessons of this case have been learned by probation, police and other agencies, and to examine the extent to which improvements have been made subsequently. Our primary interest has been whether similar cases were being managed better than they were before.

We have discovered a mixed picture. There was a problem with the structure and efficacy of Multi-Agency Public Protection Arrangements in London, a uniquely complex and challenging setup. Its Strategic Management Board needed the means to make strategic decisions that would be implemented. It is, of course, important that those identified as the most dangerous offenders receive an intensive and skilled level of management in the community. However, it is also important that *all* offenders, whether labelled as harmful or not, are assessed, monitored, and managed constantly with an intelligent vigilance and a commitment to protect the public from possible harm. In some respects those cases managed under Multi-Agency Public Protection Arrangements are being managed to a higher standard than the bulk of cases; in other key respects the performance remains inadequate. Whilst there were encouraging signs of better practice with the highest Risk of Harm offenders, we were concerned that the base-line level of Risk of Harm practice across the caseload was not of sufficient quality. Nevertheless, we considered that London Probation and its partner agencies were travelling in the right direction in working to improve their Risk of Harm practice.

Andrew Bridges
HM Chief Inspector of Probation

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- Kate White, HM Assistant Chief Inspector
- Ray Wegrzyn, HM Inspector

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GLOSSARY

ACO	*Assistant Chief Officer* within a probation area.
Approved premises	Formerly known as bail and/or probation hostels, *approved premises* provide controlled accommodation for offenders under the supervision of the probation service. *Approved premises* are experienced in dealing with offenders who pose a high *Risk of Harm* to others.
ASBO	*Antisocial Behaviour Order.*
CO	*Chief Officer* of a probation area.
Constructive interventions	As distinct from a *restrictive intervention*. A *constructive intervention* is where the primary purpose is to reduce likelihood of reoffending. In the language of *offender management* this is work to achieve the 'help' and 'change' purposes, as distinct from the 'control' purpose.
CRO	*Community Rehabilitation Order.*
Duty to Cooperate agencies	Various organisations providing public services have a *Duty to Cooperate* with the *MAPPA Responsible Authority*. The purpose of this is to ensure that all relevant agencies contribute where possible to the effective assessment and management of offenders under *MAPPA*. Some *Duty to Cooperate agencies* include local housing authorities, education services, children's services, Jobcentre Plus and Youth Offending Teams.
Dynamic factors	As distinct from *static factors. Dynamic factors* are the factors in someone's circumstances and behaviour that can change over time.
HMI Probation	*Her Majesty's Inspectorate of Probation.*
IT	*Information technology.*
Jigsaw team	Specialist teams within each London borough responsible for information sharing and monitoring those offenders subject to *MAPPA* oversight.
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. For more detail, see the section in the main body of the report.
MAPP meetings	*Multi-Agency Public Protection meetings*: where Level 2 and Level 3 cases managed under *MAPPA* are discussed and managed in a multi-agency way by staff from the relevant agencies.
MAPPP	*Multi-Agency Public Protection Panel.*
NOMS	*National Offender Management Service*: the evolving single service designed to include responsibility for both HM Prison Service and the *National Probation Service*.
NPS	*National Probation Service*.
OASys	*Offender Assessment System*: the nationally designed and prescribed framework for both the *NPS* and HM Prison Service to assess offenders, implemented in stages from April 2003. It makes use of both *static* and *dynamic factors*.
Offender management	A core principle of *offender management* is that one person takes responsibility for managing an offender through the period of time they are serving their sentence, whether in custody or the community. Offenders are managed differently depending on their *Risk of Harm* and their needs in relation to *constructive* and *restrictive interventions*.
Offender manager	In the language of *offender management*, this is the term for the officer with lead responsibility for managing a specific case from 'end to end'.
Offender supervisor	This is the term for staff who fulfil specific roles in working with offenders during their sentence; for example, in the day-to-day management of offenders during the custodial phase of their sentence on behalf of the *offender manager*.
OMI	*Offender Management Inspection.*
OMU	*Offender Management Unit.*
PO	*Probation officer.*
PC	*Probation Circular.*
PC52/2004	The *PC* that gave areas instructions on managing the transfers of cases between them. In particular, it identified cases subject to *MAPPA* needed to be more carefully considered.
PPU	*Public Protection Unit.*
PR	*Public Relations.*

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.
Restrictive interventions	As distinct from *constructive interventions*. A *restrictive intervention* is where the primary purpose is to keep to a minimum the offender's *Risk of Harm* to others. In the language of *offender management* this is work to achieve the 'control' purpose, as distinct from the 'help' and 'change' purposes. Example: with a sex offender, a *constructive intervention* might be to put them through an accredited sex offender programme; a *restrictive intervention* (to minimise their *Risk of Harm*) might be to monitor regularly and meticulously their accommodation, their employment and the places they frequent, imposing and enforcing clear restrictions as appropriate to each case. The sex offender programme will hopefully have some impact on the offender's *Risk of Harm* in the long-term, but its primary purpose is to reduce the likelihood of reoffending.
Risk of Harm (RoH)	This will be the term generally used by *HMI Probation* to describe probation work to protect the public. *HMI Probation* uses this term instead of *Risk of Serious Harm* in order to ensure that *RoH* issues being assessed and addressed by probation areas are not restricted to the definition given in *OASys.* The intention in doing this is to enable satisfactory clarification of the differences between the likelihood/probability of an event occurring and the impact/severity of the event. The *Risk of Serious Harm* definition only incorporates serious impact, whereas using *RoH* enables attention to be given to those offenders for whom lower impact/severity harmful behaviour is common.
Risk of Harm work	In the language of *offender management*, work to achieve the 'control' purpose, with the officer using primarily *restrictive interventions* that keep to a minimum the offender's opportunity to behave in a way that poses *RoH* to others.
Risk of Serious Harm (RoSH)	This is the label used for classifying levels of risk in *OASys,* where offenders are classified as either 'low', 'medium', 'high' or 'very high' *RoSH*, where serious harm is defined as 'an event which is life-threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.' (Chapter 8 of the OASys Manual, July 2006). In this report this term is used solely to refer to this process of *OASys* classification.
SFO	*Serious Further Offence*, committed by an offender under supervision or who has recently completed a period of supervision.
SMB	*Strategic Management Board.*

SPO	*Senior probation officer.*
Static factors	As distinct from *dynamic factors*. *Static factors* are elements of someone's history that by definition can subsequently never change (i.e. the age at which they committed their first offence).
ViSOR	*The Violent Offender and Sex Offender Register.*

SUMMARY

In October 2005, Gary Chester-Nash, who had been subject to probation supervision in Cambridgeshire and London and had moved in and out of Essex, was released suddenly from a short prison sentence. He travelled to Cornwall, became involved in a house burglary and murdered Jean Bowditch, who was in the house at work as a cleaner.

This enquiry examined developments in the management of Risk of Harm in London since that offence and more particularly since the completion of the Special Case Review into the London MAPPA management of Gary Chester-Nash in November 2006.

Offenders managed under Multi-Agency Public Protection Arrangements should, by their very nature, be receiving a thorough, consistent and robust service. Good management oversight systems should be in place to ensure that each such offender is supervised as effectively as possible to keep to a minimum their Risk of Harm to others.

London faced unique challenges in managing this across 32 local authority boroughs. The size and scale of the area presented significant difficulties to achieving the same consistent level of activity across the whole piece, and also had implications for the pace at which new practices could be implemented. The Strategic Management Board certainly experienced some of these difficulties.

Nonetheless, we found evidence of some good work with these challenging cases, particularly in assessment and planning and, to a lesser extent, the delivery of interventions designed to reduce the potential Risk of Harm. Staff within the probation Public Protection Units and the police Jigsaw teams, on the whole, enjoyed positive working relationships and seemed to have good skills and knowledge in dealing with offenders who presented a high Risk of Harm to others.

We were concerned that the general level of Risk of Harm work across the breadth of the caseload in London was not yet meeting the required standard sufficiently often. There was, in particular, a need for further development for staff outside the specialist units. However, the work on cases similar to that of Gary Chester-Nash was measurably better in the Public Protection Unit teams, and there were signs that the area was travelling in the right direction.

RECOMMENDATIONS

HMI Probation recommends that:

- the MAPPA Strategic Management Board reviews its composition and structure to ensure that the main Board is attended by those empowered to commit resources and make strategic decisions, and that the sub-group system is enabled to deal with practice and operational matters
- London Probation benchmarks current RoH performance across all staff and devises and delivers further training as appropriate
- given the difficulties experienced at a national level, even with national guidance, and acknowledging the added complexity of geography and population across the 32 boroughs, London Probation reviews the applicability of its local guidance on cross-borough case transfer and then issues appropriate direction and a monitoring system to ensure compliance.

TERMS OF REFERENCE

Following the completion of a special case review into the London MAPPA management of Gary Chester-Nash in November 2006, the NOMS PPU requested independent assurance from HMI Probation that improvements had been made in the way cases similar to that of Gary Chester-Nash were being managed in London Probation. It was not part of our remit to pursue the recommendations of, or for, other agencies in this enquiry.

The agreed Terms of Reference were as follows:

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

A BRIEF HISTORY OF THE CASE

Gary Chester-Nash was made subject to a CRO on 2 July 2004. This was one of a series of sentences over a short period of time as a result of a range of offences committed in Cambridgeshire. Over the following 15 months, Gary Chester-Nash moved between Cambridgeshire, the London Borough of Havering, Essex and the London Borough of Newham (where he was resident at Westbourne House approved premises). He was sentenced to short periods of imprisonment on four occasions during this time and was also made subject to two ASBOs; one of which had national restrictions.

Gary Chester-Nash was being managed as a Level 2 MAPPA case. Four days after being made subject to the CRO he was sentenced to four months imprisonment and released with no fixed abode in September 2004. At that point, on his request, his case was transferred from Cambridgeshire to Romford in the London Borough of Havering. The guidance issued by the National Probation Directorate in PC 52/2004, governing the transfer of cases, was not followed by either area. A man whose lifestyle was itinerant and unstructured was subject to a period of supervision which itself suffered from a lack of clarity between two probation areas.

This situation continued as Gary Chester-Nash moved into the Essex area and was made subject to further short periods of imprisonment. In March 2005 he was placed in Westbourne House approved premises, subject to a relatively high level of restriction. He was considered to be compliant, albeit difficult to engage in meaningful work. The main focus of supervision was his lack of permanent accommodation rather than the RoH he presented to others.

Both MAPPA and offender manager ownership were confused as he was resident in one borough but being supervised by an offender manager in another. Once again this was outside the guidance issued for the circumstances. The confusion in the MAPPA ownership of the case was compounded by poor records being kept, which did not clarify the rationale behind some decisions nor contain sound management plans.

Having left the approved premises of his own volition on 8 August 2005, Gary Chester-Nash was arrested and appeared at Horseferry Road magistrates' court and received a sentence of three months and 20 days imprisonment. Again, communication was insufficient and not all of the key parties were aware of the sentence for several weeks. Whilst the prison had correctly calculated a release date of 4 October 2005, Gary Chester-Nash was held beyond this date as a result of a remand order issued in error by Snaresbrook Crown Court on 27 September 2005. In addition to this, the prison service had not been invited to the September or October MAPP meetings and, as a result, following appeals and administrative confusion in the courts, Gary Chester-Nash was released in the early evening of 5 October 2005. He then travelled to Cornwall rather than

returning to London, and within a few days committed a burglary in an occupied house and brutally murdered Jean Bowditch who was working in the house in her capacity as a cleaner.

He was convicted of murder and received a life sentence with a tariff of 30 years.

ACCOUNT OF PREVIOUS INQUIRIES

This inquiry was undertaken independently of all previous inquiries, although the details of them are provided here in order to give context to this report.

- *SFO review*

The purpose of the SFO review system was to establish what occurred and what could be learned from an examination of the management of the case by the relevant probation areas, with the aim of improving practice in the management of offenders by the probation service. The SFO review considered the guidance relating to the transfer of cases specified in PC 52/2004, which was in operation at the time. The issue of case transfer was significant in this case and had always been a complicated matter which needed ongoing attention.

- *A second SFO review*

The initial review by the probation area was considered to be of poor quality as well as reflecting poor work on the case. As a result, London Probation decided to conduct a further analysis of the case in preparation for the SMB commissioned review. Following comments from the NOMS PPU, the area directed the Head of Internal Inspection and Investigations to conduct the new review, which was aimed at addressing the shortcomings identified in the initial one. This was done, and was considered to be of far better quality than the original and to be far more focused on the issues to be learned.

- *Reviews by other bodies*

Internal reviews were also conducted by the Metropolitan Police and the prison service, following their usual procedures and making recommendations for change or improvement as necessary.

- *SMB special case review*

The SMB then commissioned a special case review, which took account of the whole picture and made recommendations for improvement to the MAPPA organisations, although the majority applied directly to the work of the probation area. This report was produced in November 2006, having been fully accepted by the MAPPA SMB. The report made a series of recommendations, the majority of which recognized that there was not a need for new developments, but rather for staff and organisations to adhere to existing policy and best practice guidance.

Nonetheless, because of the details of the case supervision and the concerns raised by the SMB special case review, HMI Probation was asked by the NOMS to undertake an independent inquiry to identify how far this area of work had progressed since the completion of the review process.

MULTI-AGENCY PUBLIC PROTECTION ARRANGEMENTS

The MAPPA provide a framework for the consistent management of RoH presented by offenders. The detailed guidance in PC 54/2004 clarifies how MAPPA should work, and the offenders to whom attention should be given. This can be briefly summarised as follows.

Categories:

There are three categories of offender considered under MAPPA:

- registered sex offenders. (Those offenders eligible for registration under the Sex Offender Act 1997 – and subsequent relevant legislation)
- violent and other sex offenders. (This category is often summarised as violent offenders who receive a sentence of imprisonment of 12 months or more. The legislation is more complex than that and includes those detained under hospital and guardianship orders and those who have committed specific offences against children. A detailed definition can be found in Appendix 1 of the MAPPA guidance)
- other offenders. This category comprises other offenders, not in either Category 1 or 2 but who are considered by the RA to pose a RoSH to the public. Identification of Category 3 offenders is different from Category 1 and 2 offenders in that it is determined by the judgment of the RA rather than automatically by the sentence or other disposal imposed by the court. The judgment is exercised in respect of two considerations. First, it must establish that the person has a conviction that indicates that they are capable of causing serious harm to the public. Secondly, the RA must reasonably consider that the offender may cause serious harm to the public.

Levels:

The MAPPA framework identifies three separate but connected levels at which risk is assessed and managed. These levels are not a reflection of the actual level of RoH; rather, they are a framework for its management:

Level 1: ordinary risk management
Level 2: local inter-agency risk management
Level 3: MAPPP.

Level 1 is the level used in cases in which the risks posed by an offender can be managed by one agency without actively or significantly involving other agencies.

Level 2 should be used where the active involvement of more than one agency is required, but where either the level of risk or the complexity of managing the risk is not so great as to require referral to Level 3, the MAPPP.

Level 3 - the MAPPP is responsible for the management of the 'critical few'. Details of 'the critical few' can be found in the MAPPA guidance. Although they will nearly all be cases assessed as high or very high RoH, there may be some that are not – such as cases where, because of likely media scrutiny and/or public interest, there is a need to ensure that public confidence in the criminal justice system is sustained.

Structure:

The prison, police and probation services have a duty to act as the RA for MAPPA in each of the 42 RA areas in England and Wales. The RA is defined by location of the offender manager when the offender is serving a sentence, or by the place of residence of the offender when they have completed a sentence but are still under MAPPA. The RA has a duty to make sure that MAPPA are working effectively within the area. This is a key role of the SMB which, amongst other duties, monitors the performance of the area.

The SMB should include senior managers from the agencies. In addition, there should be two lay advisors, to bring a public perspective to the Board's strategic function.

Various organisations providing public services have a Duty to Cooperate with the MAPPA RA. The purpose of this is to ensure that all relevant agencies contribute where possible to the effective assessment and management of offenders under MAPPA. Some Duty to Cooperate agencies include local housing authorities, education services, children's services, Jobcentre Plus and Youth Offending Teams.

ViSOR:

This is a secure database of MAPPA offenders that can be accessed by the police, probation and prison services, enabling the sharing of risk assessment and risk management information on individual violent and sex offenders in a timely way. It had not been implemented at the time of the SFO, but became available in all areas in April 2008.

LONDON PROBATION RISK OF HARM WORK

London faced a uniquely complex challenge in terms of both structure and the nature of the highly mobile population in some boroughs, in terms of ensuring that MAPPA worked well.

London Probation covered 32 local authority boroughs. Within each borough there was a probation service OMU and a PPU. The Metropolitan Police had also all established a Jigsaw team within each borough, whose role was to manage any MAPPA registered offenders in partnership with staff from other involved agencies.

Once a case within a borough was identified as being high RoH to others, it was allocated to a qualified member of probation staff within the PPU, who then completed a formal assessment and, in consultation with their line manager, made decisions about referral to MAPPA and other key decisions relevant to the RoH assessment.

Level 2 MAPP meetings were chaired by either the SPO or the local Jigsaw team sergeant or inspector. There was evidence of a high level of contact and positive working relationships between the probation PPU staff and Jigsaw teams about those offenders that were known to both agencies. Level 3 MAPPPs were chaired by more senior staff such as the probation ACO or the police equivalent. The area had developed a single document set for use within all boroughs to record the detail and the decisions of meetings and to act as a running record of the case whilst registered to MAPPA. This approach was being promoted nationally by the NOMS.

APPROACH AND METHODOLOGY

During the week beginning 3 March 2008 HMI Probation conducted an OMI across London Probation. This is one of our inspectorate's main programmes of inspection, and London was being inspected as part of the normal schedule of work. This inspection programme involved the receipt of evidence in advance, which provided evidence for many of the management criteria. Some 280 cases were inspected during the course of the week, which included an interview with the offender manager for each case. A series of interviews and surveys with management, Board members, staff, partners, offenders and victims were also held.

Of the total sample of 280 cases (the main sample) there were 38 that were MAPPA Level 2 registered (the MAPPA sub-sample). All Level 1 MAPPA cases were excluded from this sample to enable proper comparison. The statistical report from the 38 Level 2 MAPPA cases was used to inform this inquiry as they represented the same type of MAPPA offender as Gary Chester-Nash. These cases were taken from across the area and assessed by a range of inspectors and practice assessors, thus ensuring that they were being judged in line with the cases in the main sample.

In addition to the case evidence there were a series of meetings with the following groups:

- the Head of Internal Inspection and Investigations and SFO review group Board members from London Probation
- middle managers from PPUs
- the Director of Operations, Head of Internal Inspection and Investigations, Divisional ACO, project manager for VISOR and PR officer
- the MAPPA SMB: Chair (Director of Operations, London Probation); Head of Internal Inspection and Investigations, London Probation; lay advisor; YJB performance manager; detective inspector and detective sergeant, central Jigsaw team, Metropolitan Police; area lead for offender management, HM Prison Service; external relations manager, Jobcentre Plus.

Comments were invited from the COs of Cambridgeshire and Essex Probation Areas as their areas were referred to in the SMB's special case review. However, given that the inquiry's focus was on developments in the work in London, this was a courtesy invitation rather than a specific request for involvement. Responses were received from both areas.

As well as scrutinising the SFO reviews and the serious case review reports and action plans, we also examined the following records and documents:

- the London SMB Business Plan 2007/2008

- the Terms of Reference for, and the minutes from, the December 2007 MAPPA SMB meeting
- the report of the SFO sub-group to the probation area Board (January 2008)
- the report of the internal inspection of RoH management in London Probation (December 2007)
- The Joint Regional Quality Assurance Audit of OASys assessments for London Probation and HM Prison Service (January 2008).

FINDINGS

1. Strategic Management Board

The MAPPA SMB comprised the main Board and three sub-groups. The main Board was chaired by the probation service Director of Operations with responsibility for public protection. Of the three sub-groups, the performance and review group was chaired by the Head of Internal Inspection and Investigations in London Probation. There was also a training and a communications sub-group.

The SMB was responsible for 32 boroughs, each one conducting MAPPA work. As mentioned above, the probation service had a PPU in each borough. The police had a Jigsaw team in each borough, which was supported by the central Jigsaw team. However, whilst probation service resources were very centrally determined, the Metropolitan Police allocated responsibility for the provision and deployment of staff in each borough to the local borough commander. Within their competing priorities they were required to provide a Jigsaw team, but the make-up and priority given to each one varied according to the local situation. This arrangement made it difficult for the SMB to take a decision which it was confident was able to be implemented equitably across each of the borough structures.

The main Board was reasonably well represented across the statutory and the Duty to Cooperate agencies such as Jobcentre Plus and health who, along with the lay advisors, brought a community perspective to the table. However, some agencies, notably the Metropolitan Police, were represented by officers who brought tremendous operational expertise to the group but were not able to make resource decisions on behalf of their organisation. This limited the ability of the Board to function as a true strategic group, as proposals had to be discussed separately within the Metropolitan Police and then brought back to the Board along with any new issues raised outside the meeting by this process. It was likely that this had contributed to slowing up some of the developments that the Board had been trying to achieve, such as the provision of consistent administration to all the MAPPPs. The issue of attendance had been addressed by the Chair, and whilst there had been some improvement in both range of organisations and level of representation, there was still a need for further development in order that the Board could conduct the proper business in the right way.

Recognising that there was still much to do, the SMB had begun discussions with the Chief Executive of the LCJB. He had agreed to look into the changes necessary and to develop a business case with the SMB. This had recently been completed and received by the SMB, which was now in the process of establishing a partnership with the LCJB to help drive through the changes needed to improve the operation and oversight of MAPPA across London.

This Board faced many challenges that were unique to London. Not least of these was the size and complexity of the area and the engagement with 32 different boroughs, which in itself had a number of barriers to easy communication. A good example of one of these difficulties was the situation of pan-London borough agreements. In order to achieve an agreement for a specific housing department formal activity in each local MAPPA, the SMB needed to negotiate with each borough's housing department and have agreement from all of them. If any of the boroughs did not agree, then there could be no formal agreement with the remainder. Whilst one can see where such an agreement may have come from, it was clearly unhelpful to a local borough MAPPA, which may have had a willing housing department but were constrained by another, unwilling borough, to have only an informal arrangement in place.

Whilst it was clear that there were very good working relationships between the police and the probation service at all levels, probation operational managers described the overall MAPPA structure as needing to be more robust and commented that it was inconsistent. For the most part this seemed to be a result of the ongoing separation of the two organisations at practice level. Within three of the 32 boroughs, there were shared premises, although not a joint team. As yet, there was not shared access to either organisation’s IT and information system and there were clear reservations at investing in the costs of such developments when many of the buildings were in relatively poor condition and could be vacated in the short to medium term. This situation was unlikely to be helped, at least initially, by the implementation of ViSOR, a computerised system for recording information about violent and sexual offenders which was in use in all probation areas from April 2008. Our concerns about the limited practitioner access to this important system will be explored in our routine inspection work.

Of the 14 recommendations in the special case review, seven were specific to the work of the probation service, and seven were applicable to one or more of the MAPPA agencies. It was pleasing to hear that work had been undertaken on all 14 recommendations. Many had been completed whilst there was still some activity outstanding on a small number of them. For example, recommendation nine referred to consistency by Chairs of MAPP meetings. Training had been planned and was due to be delivered during 2008 and certainly the PPU SPOs were very keen to have it. This would be of significant value in terms of developing consistent practice by Chairs of the MAPP meetings and the recording of outcomes. However, the SMB reported a high turnover of Chairs, particularly on the police side, and unless the training was maintained and its implementation monitored, its benefits would soon slip away.

Similarly, the SMB was aiming to achieve consistency in the administration of the MAPP meetings. At the time of this inquiry, administrative support was provided according to the resources available. This might have included a police constable on light duties, a police civilian worker or a probation service administrative officer. The process of recruiting dedicated MAPPA administrative resources was in hand but had taken a considerable time to sort out. Again, they would have to work in a way that included putting information onto ViSOR through a highly restricted system.

Conclusion

The MAPPA SMB had a complex area to manage and had been reviewing its structure and performance. It needed to continue to seek sufficient strategic representatives from all agencies so that it could make decisions which would be implemented.

2. London Probation – improvement action

London Probation had taken significant steps to bring about improvement in the work undertaken with all high RoH offenders, including those subject to MAPPA oversight. The key development was the establishment of an Inspections and Investigations Unit with specific responsibility for performance improvement in relation to public protection issues. This small unit had only recently been established but had already begun to produce useful information on SFOs across the area, which could in turn be used by local managers to help develop the work of practitioners.

The area had run a mandatory training event for all staff on dealing with these difficult cases, had tracked all who had attended, and was targeting newcomers and those who missed their local events for whatever reason. An important element of this training - and one which had proved difficult to implement - was the follow-up to establish whether or not the training had improved practice on an individual basis. This would have required some sort of systematic benchmarking exercise before and after the training event was delivered. There was a system for SPOs to check two cases in each supervision session and it would have been possible for senior management to link that process with the training in an attempt to make a direct connection, rather than an indirect one, between what had been a significant training investment and day-to-day practice with these challenging high RoH and MAPPA cases.

The Probation Board had established an SFO Scrutiny Group to review all the Stage Four SFO reviews conducted by the area. The SFO review process started if an offender under supervision was charged with a listed offence. A Stage Four (full review) should have provided an enhanced level of scrutiny for those cases where an area’s risk assessment, risk management or offender management procedures could have been improved. This served three key purposes: firstly, it enabled the Board to know about and contribute to one of the most potentially high-profile areas of the organisation's work. Secondly, it allowed the reviewing officer to hear questions from a lay perspective. Thirdly, it provided a further vehicle for promoting change and improvement in relation to RoH work. From meetings with the members of the SFO Scrutiny Group, it was clear that their focus was on the quality of the reviews and they had identified a number of themes that were both reported to the main Board and fed back into the management structure. The method by which lessons learned were shared

across all staff was being further developed, towards a consistent and manageable model.

A key issue identified in the case review was the failure to adhere to the guidance on transfer of cases issued centrally in PC 52/2004 (Updated by PC 25/2007). London Probation had supplemented this guide with its own internal procedures so that the requirements to transfer a case to the office local to the offender's home address now applied if an offender moved from one borough to the next. Whilst this gave consistency in approach at a strategic level, operational managers, whilst supporting the principle of clarity of responsibility, highlighted some difficulties in applying this as rigorously as directed by the area. This occurred in a number of boroughs, particularly where there was a large transient population who frequently moved accommodation across a borough boundary but still remained near to their former probation office. Offender managers, knowing that these individuals were quite likely to move again in a short period of time, were sometimes loath to transfer them to a new office, which may well have been the correct one for their new address but was further away and harder for them to access, when the chances were high that they would move back to the original borough within weeks. This conflict between policy and operational reality was just one example of some of the difficulties in achieving consistency in such a large and complex area. In the sub-sample, there were two cases involved in transfer between areas and one of these was managed correctly.

One of the aspects of practice that was of concern in the SFO review document was the role of the staff of the approved premises when Gary Chester-Nash left of his own volition. Although this put him in breach of his conditions, staff at the hostel did not feel party to the overall supervision process and so simply recorded the fact that he had left and did not alert the offender manager directly of the need to instigate appropriate proceedings.

As a direct result of that, the area had worked with hostel staff to develop a greater clarity of their role within the overall offender management model and had given them both the authority and responsibility to be actively involved in issues of enforcement and compliance so that speedier and more dynamic action was taken when such circumstances arose again.

Conclusion

London Probation evidenced that it had taken a series of appropriate steps to implement the recommendations of the SFO and SMB review reports. However, it was harder to demonstrate the impact of those actions on the general quality of offender management practice, although work was in hand to move towards this.

3. Practice issues

What follows are some detailed descriptions of the quality of practice as seen in the cases we inspected**.** Within the main case sample for the OMI, a sub-sample of 38 MAPPA Level 2 cases was identified. These cases were used as the nearest comparator to the Chester-Nash case, and are used here to give an account of practice with this type of case at the time of the inquiry.

Assessment and sentence planning

- Of the 38 cases, 35 had been subject to imprisonment, although only seven were currently serving the custodial part of the sentence at the time of the inspection. 29 of them had committed sexual or violent offences and 38% of the cases had a history of domestic violence. 49% of the cases included child safeguarding concerns, in the majority of which the offender themselves presented the main RoH to the child. 30 of the cases had been classified as high RoSH. Inspectors considered that the remaining eight *should* have been so classified. All but one of the cases were supervised by a qualified PO. This served to indicate the range of issues and the potential complexity of these cases, the majority of which (if not all) would have been managed within one of the PPUs, involving liaison with the local police Jigsaw team in one of the 32 boroughs.
- Seven pre-sentence reports pertaining to this sample were assessed. In every case where the court had indicated the seriousness level, this had been taken into account by the report writer. All of the reports were completed in a timely manner, based on the appropriate assessments, and in the correct format. In only one of the reports did inspectors consider that there had not been sufficient information about the victim. In six of the seven reports, (85%) inspectors considered that overall, the quality of preparation for sentence was at least sufficient. This compared with 70% of those in the main sample, albeit one of much greater numbers.
- In a third of the MAPPA cases, the overall view of the RoH assessment was that it was insufficient. Victim issues were fully considered in slightly more than two-thirds of this sub-sample, and in a similar proportion, risk management plans were structured correctly and were also assessed as being comprehensive. However, the follow-through from planning to implementation was not as consistent as required, with evidence of victim awareness work being undertaken with the offender in only 46% of cases, a similar proportion to that of the main sample for the full inspection.
- Of even more concern, however, was the finding from the main inspection sample relating to the quality of RoH analyses. There were 155 cases where the RoH screening indicated that there should have been a full analysis. 138 of these were completed, of which we judged only 73 to be of sufficient standard. This suggested that there were a sizeable number of cases in the area where the RoH assessment was not carried out properly and therefore cases were at risk of having insufficient plans to monitor and support them.

- Within the MAPPA sub-sample, referrals to approved premises were made appropriately and on the whole accepted. Other assessments were taken account of and informed the RoH decisions. Although there was room for further improvement, in 80% of the cases there was clear evidence of effective middle or higher management involvement in the case. This was not the finding in the general sample, where this figure was only 62%.
- With regard to sentence planning, there was evidence of knowledge and competence on the part of the offender manager in the majority of MAPPA cases. Restrictive conditions had been appropriately considered and interventions identified were on the whole likely to reduce or at least contain the RoH. In two-thirds of the cases there was evidence that the offender had actively participated in the planning process, which would suggest they were more likely to engage from the start. Clear steps had been taken to ensure that offenders understood their responsibilities, and the penalties should they fail to cooperate. Of 28 custody cases that had been released on licence, ten of the 11 that were recalled were judged to have been managed appropriately and correctly.
- Sentence planning for those MAPPA cases serving custodial sentences was less thorough and this was acknowledged as an area that required improvement.
- Overall, in comparison with the main sample, the assessment and sentence planning for these high RoH MAPPA cases in the sub-sample was substantially better, with a score of 78% of the work being at least satisfactory compared to 63% for the main sample.
- It seemed reasonably clear that the majority of staff within the PPUs understood the principles and practices of RoH assessment and sentence planning and were able to make quite fine judgements within that work. This is not to suggest that there was not scope for improvement and better attention to detail, but in comparison with the main case sample, this sub-sample evidenced better work.

Conclusion

There was a clear difference in the ability and knowledge of the specialist PPU staff in terms of dealing with assessment and sentence planning compared to those in OMUs. The performance for RoH assessment and planning in OMUs needed considerable improvement.

Implementation of interventions

- Compared with the main sample, there was a measurable positive difference in this section amongst the 38 MAPPA cases in the sub-sample,

albeit to a lesser degree than in the assessment and planning section. (64% of work sufficient, compared with 58% in the main sample.)

- In nearly three-quarters of the MAPPA sub-sample, there was evidence of appropriate interventions being identified, aimed at reducing RoH. This compared very favourably with the 63% identified in the main sample.
- In similar proportions of cases - 75% from the sub-sample and 63% from the main - it was clear that work in the community was building on activity undertaken during the custodial phase of the sentence.
- It was pleasing to note that in over 75% of cases in the sub-sample of MAPPA cases, there was evidence of offender managers communicating well with other workers involved in the case and demonstrating commitment to their work with individual offenders. This compared with 68% of cases from the main sample.
- More work needed to be done specifically in motivating and supporting the offender throughout the sentence for both samples and in putting in place opportunities to prepare offenders thoroughly for interventions, as well as to reinforce new skills following the delivery of the intervention. Although this had occurred in less than 66% of the MAPPA cases and an even lower proportion of the main sample, this was a very important step in supervision and merited greater attention. Evidence suggested such practices made it more likely that the learning from interventions would be taken on as normal behaviours.
- RoH assessments were reviewed in a timely way in over 80% of the MAPPA cases. However, less than two-thirds of relevant cases were reviewed following a significant change in circumstances (e.g. moving in with a new partner, getting or losing a job) and this needed to be improved. The quality of reviews of the RoH assessment for those in custody, albeit based on a very small sample, was lower still, and the area needed to ensure that this group of offenders received a consistent service. In the main sample, these reviews were happening on time in only 55% of cases.
- In 30 of the 38 cases in the sub-sample, inspectors considered that offender managers and other staff had contributed effectively to the MAPPA and that they had been used effectively.
- In 80% of these cases, offender managers demonstrated good evidence of anticipating potential changes in RoH. This featured in only 42% of cases from the main sample.
- There was a need for improved emphasis on home visiting, particularly in cases where there were concerns about children's safeguarding issues, as in 33% of the relevant cases from the MAPPA sub-sample, there was no evidence of home visits being used to monitor the child’s safety. However, this was considerably better than the 78% of such cases in the main sample.
- In 71% of the MAPPA sub-sample, we were of the view that all reasonable actions had been taken to protect the public from harm, compared with 54% from the main sample.

- Victim awareness work and interventions to assist an offender to understand the impact of their behaviour on victims needed to be made more consistent. In just over half of the MAPPA cases was the overall quality of work in relation to victims considered to be sufficient, and this applied both in the custodial phase and during periods of licence or other community supervision. This was the same as the main sample. On a more positive note, the vast majority of victims contacted in the MAPPA sub-sample were given the opportunity to express a view on licence conditions and asked to be informed of release conditions once they were finalised. However, the few relevant cases from the main sample showed a very low rate of victim take-up of similar opportunities.
- In 83% of MAPPA cases, offender managers showed evidence of taking effective action to secure compliance, and this included implementing breach proceedings within the proper timescale. In the main sample, performance on this activity was 66%.
- The case records were well organised and contained clear and timely information, which in almost three-quarters of MAPPA cases was considered to be sufficient. The comparable figure from the main sample was only 50%.
- Overall, containing these MAPPA Level 2 offenders and promoting their compliance with their period of supervision was judged to be significantly better than for the whole case sample (82% compared with 66%). However, when comparing the full range of activities under the implementation of interventions section, the difference between the two was somewhat smaller, 64% for the MAPPA sub-sample as opposed to 58% in the main sample.

Conclusion

Whilst the implementation of interventions was relatively better in the PPUs, the performance level evidenced was generally low across both samples.

Achievement of initial outcomes

- A clear and positive outcome of the work undertaken with this group was that 30 of the 38 MAPPA cases in the sub-sample (79%), had neither been cautioned nor convicted of an offence since being sentenced to the current period of supervision. This was even better for the main sample at 84%.
- In the 74% of cases in the sub-sample where the OASys assessment was rescored (which should have been in every case), 32% of them showed an improvement over the initial assessment. The main sample figures for the same points were 49% and 41% respectively.

- In the majority of the MAPPA cases, there was no evidence of any actual change in behaviour or attitude, but this should not be taken to imply that the work had no impact, given the range of issues and complexity of many of these cases. In 53% of them, there was evidence that the planned objectives had been achieved efficiently. In over 80%, there were indicators that the offender was now aware of the community organisations that could help address their criminogenic needs once the period of supervision had finished. The figures from the main sample were a little lower on each of these points.
- Overall, there was sufficient evidence to support the view that the work of the offender managers and their line managers in the London borough PPUs had improved. Whilst there was not room for complacency, they demonstrated good skills in assessment and planning and showed some of the key skills required within the implementation of interventions work. These needed to continue to improve and a better focus on outcomes throughout the process of supervision would enhance the work still further. Active engagement with the offenders during the custodial phase, which was then appropriately followed-up after release, would be another important development in keeping good control and oversight of RoH issues.

Conclusion

A better focus on intended outcomes from the start was required. Performance within PPUs and OMUs was very similar and both required improvement.

APPENDIX

The Role of the Inspectorate

Statement of Purpose

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

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

Code of Practice

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

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

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

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