



## Inspection of Adult Offending Work in Bedfordshire

An inspection led by HMI Probation



### **Foreword**

The inspection of adult offending work in Bedfordshire was undertaken as part of our Inspection of Adult Offending Work programme that started in April 2013 and will cover all areas of England and Wales. Our purpose in undertaking these inspections is to assess whether the sentence of the court is delivered effectively, and whether work with the individual offender protects the public, reduces the likelihood of reoffending, and provides a high quality service to courts and victims.

This inspection is the first of six where we are focusing on the quality of work in cases where the primary offence is one of violence. Work with violent offenders forms a significant proportion of the work of any Probation Trust. Our sample encompasses a range of violent offences and includes domestic violence but not, for these six inspections, sexual offending. In each case inspected, we expect to see an assessment of the factors that have contributed to the behaviour and progress in addressing these factors and thereby reducing the likelihood of reoffending. We also examine the extent to which workers engage positively with individuals, ensuring that they comply with their sentence and are able to respond constructively to the work designed to change their behaviour.

In addition to inspecting cases, we also consider the extent to which the management arrangements have supported those working with offenders through effective leadership and management of staff, appropriate access to resources and constructive partnership with other organisations.

The case sample for this inspection was drawn from those cases managed by Bedfordshire Probation Trust. We found a mixed picture in respect of the work undertaken with adults who have offended. There was good work overall in assisting sentencing, delivering the sentence of the court, and reducing the likelihood of reoffending. Court reports usually contained all relevant information and included clear proposals for community sentences where appropriate. Individuals were seen regularly and work undertaken with them in accordance with their sentence plan.

Although the Trust was working well with other partners on public protection matters at a strategic level, we found gaps in practice in many of the cases we examined. A key area of development centred on the quality of assessments and planning to address the risk of harm posed by some adults who had offended, with more attention paid to the victims in such cases. We expected to see a greater emphasis placed on offender engagement and more management involvement in cases classified as a high risk of harm or where there were child protection issues. More attention also needed to be given to assessing and addressing the contribution of alcohol misuse in violent offending.

We were, nevertheless, impressed by the positive way both managers and staff engaged in the inspection process and were clearly keen to learn from our findings. Our inspection report contains a number of recommendations, addressing our concerns, that are designed to promote the necessary improvements.

Liz Calderbank

**HM Chief Inspector of Probation** 

E. g. alderbank.

August 2013

### **Summary**

Outcomes	The proportion of work judged to have been done well enough
Assisting sentencing	77%
Delivering the sentence of the court	73%
Reducing the likelihood of reoffending	66%
Protecting the public by minimising risk of harm to others	61%
Delivering effective work for victims	61%

### **Outcome 1: Assisting sentencing**

Overall, 77% of the work to assist sentencing was done well enough.

Reports for courts were generally based on sufficient information but some lacked analysis, particularly in relation to likelihood of reoffending and risk of harm to others. In the main, reports contained information about the motivation and capacity of the individual to comply with the proposed sentence but many lacked information about how issues which could affect engagement and compliance with the sentence would be tackled. Almost all reports contained clear and specific proposals for community sentences where this was appropriate, including punitive requirements such as unpaid work (Community Payback) or a curfew. Sentence proposals were broadly followed by the courts. Overall, sentencers were satisfied with the quality of reports. They recognised the skills of probation staff working in courts and appreciated efforts to assist them. Liaison arrangements with the Trust were regarded very positively.

### **Outcome 2: Delivering the sentence of the court**

Overall, 73% of the work to deliver the sentence of the court was done well enough.

Cases were usually allocated to the correct tier of service at the start of a community sentence or release on licence and initial appointments arranged swiftly. In most cases there was a full, timely and individualised induction and people were informed of their rights and responsibilities. However, assessment of individual needs was insufficient in too many cases; this included vulnerability issues and any potential barriers to engagement and successful completion of the sentence. Individuals were not always actively involved in drawing up their sentence plan, and planning did not pay sufficient attention to their strengths and aptitudes or to the methods most likely to be effective with them. More positively, the individual's level of motivation and capacity to change was considered in most cases. Plans usually contained objectives to tackle the factors linked with offending, but objectives to address risk of harm to others or manage child protection issues were missing in some cases. Alcohol misuse was insufficiently addressed in many sentence plans and the contribution of other workers to the plan was not always indicated. Planned levels of contact were generally appropriate to the case.

Interventions were usually delivered in line with the sentence plan and, in the main, took account of any risk of harm to others. In most cases, individuals received sufficient help to improve their integration into the community. Motivational work to encourage engagement was generally done well and, although diversity factors and other individual needs had not been particularly well assessed, they were usually taken into account in the delivery of services. However, some cases needed more work to overcome barriers to engagement. The frequency of contact was usually sufficient to promote positive outcomes and carry out the sentence of the court, and appropriate levels of resource were allocated.

Compliance work was undertaken well in the main, with attendance being monitored and action taken where needed. Professional judgements about absence and other behaviour were almost always appropriate and enforcement proceedings or recall mostly used appropriately. Sentence plan reviews were not sufficient in many cases. They were not done promptly when a requirement or condition had been completed or when there had been significant change, and were not generally used to record progress or reinforce commitment to the sentence. Overall, case records held sufficient information to support the management of the order or licence, but some lacked relevant documents and they did not always sufficiently reflect the work which had been carried out with the individual.

In terms of outcomes, the requirements of the sentence were mostly delivered as intended and action was taken to promote compliance where needed. At the time of the inspection, most individuals had not been cautioned for, charged with, or convicted of a further offence, some nine months into their order or licence. Sentence planning objectives had been achieved fully or in part in most cases.

According to the annual National Offender Management Service survey of offenders' views, individuals were very positive in the main about their experience and there were few suggestions for improvement.

Some offender managers were unclear about how workloads were managed and monitored, and whether this was done in a fair and transparent way. Planned staff absences were generally thought to be managed in an effective way to minimise disruption to offender management. Almost all offender managers held very positive views about the skills of their line managers and the support provided to improve the quality of their work. They received regular, professional supervision, and most of those with individual diversity needs thought that these had been reasonably met by the organisation. The Trust was thought to promote a culture of learning and development. Offender managers expressed positive views overall about training and development opportunities in respect of their current role, but most reported no specific training in practice methods or interventions regarding violent offending. There were mixed views about the availability of formal opportunities to discuss practice with colleagues. Recommendations from our thematic inspections had mostly been taken on board.

### **Outcome: 3 Reducing the likelihood of reoffending**

Overall, 66% of the work to reduce reoffending was done well enough.

The Trust had a strong focus on the provision of interventions, which demonstrated that they reduced reoffending. It continued to invest in accredited programmes which provided structured courses for people who had offended, in order to tackle factors related to offending, such as thinking skill. Accredited programmes also provided interventions in respect of domestic violence (Integrated Domestic Abuse Programme) and other violence (Aggression Replacement Training). The Trust's expertise in running such programmes was recognised, and both the Integrated Domestic Abuse Programme and the locally developed 'Caring Dads' programme were commissioned by other organisations to provide these interventions in the wider community. The Trust had also introduced the modular Citizenship Programme to provide structured activity for most offenders subject to its supervision, to tackle offending-related factors and challenge offending behaviour as part of offender management work.

Partnership work with other agencies, both statutory and from the voluntary and community sector, was good. Partner agencies commented positively on the Trust's contribution to reducing reoffending and community safety generally, particularly in respect of the multi-agency Integrated Offender Management scheme which worked intensively with the most prolific or other priority offenders within the community.

Alcohol misuse was an issue for many individuals whose cases we examined but it was not always taken account of sufficiently at the assessment stage, and interventions were lacking in many cases. Accurate assessment and provision of appropriate services would appear to be a key area for improvement given the extent of alcohol misuse and the known links between alcohol intoxication and violent offending.

Generally, assessments of the likelihood of reoffending were of sufficient quality, taking into account

relevant information from the individual's home and social environment and identifying the factors which contributed to offending. However, people who had offended were not always actively involved in their assessment. In most cases, they were given information about local services that could support their rehabilitation and were referred to these organisations if needed. Assessments were not always reviewed in a timely way or when there had been significant change, so were often not up to date. Reviews were not generally used to celebrate progress in tackling issues related to offending, although most individuals had made at least some progress in addressing significant factors.

Offender managers had positive views about the range of interventions available to them, and resources had been used efficiently in most cases to help individuals achieve the planned outcomes and thus reduce the likelihood of them reoffending. However, there was not always evidence of improved family relationships where this was relevant, or improved integration into the community.

Resources had been used efficiently in most cases to help individuals achieve the planned outcomes and thus reduce the likelihood of them reoffending. However, we noted some gaps in the provision of sufficient interventions for alcohol misuse and for emotional well-being issues, including mental health.

Overall, we found a mixed picture in relation to reducing the likelihood of reoffending. Although there was some good work being undertaken, it was let down, in particular by a failure to involve individuals sufficiently in the initial assessment of offending related factors and in reviews, and by the lack of attention to tackling alcohol misuse.

### **Outcome 4: Protecting the public by minimising risk of harm to others**

Overall, 61% of the work to protect the public by minimising the risk of harm to others was done well enough.

Although there was a positive picture of the Trust's contribution to protecting the public at a strategic level, we found gaps in practice in many of the cases we examined. Risk of Serious Harm screenings and full risk of harm analyses (where needed) were not completed sufficiently well in many cases. In general, planning to manage risk of harm was not done well enough. Our previous inspection of offender management (report published in January 2010) had identified similar issues in respect of the quality of risk of harm assessment and risk management planning, so it was hard to see the impact of quality improvement work undertaken following that inspection. There was some evidence that better quality work was done with individuals classified as posing a high Risk of Serious Harm. Increased attention was needed to improving the quality of assessment, planning and delivery for those in the medium Risk of Serious Harm group. We have made recommendations about improving the quality of assessment of risk of harm to others and about risk management planning.

Offender managers had responded appropriately in most cases where there had been changes in the risk of harm posed to others. When multi-agency work had taken place, for example through Multi-Agency Public Protection Arrangements or child protection proceedings, this had contributed effectively to the management of risk of harm in most cases. However, there were some deficiencies in recording decisions and actions from multi-agency meetings on the offender manager's case file.

Risk of harm assessments were not reviewed sufficiently well in many cases. This included cases where there had been a significant change in the individual's circumstances or risk of harm factors. Actions set out in risk management plans were mostly carried out as required, but the plans themselves were not sufficiently reviewed in over half the cases. Gaps in quality in the initial plan had generally not been redressed in the reviews.

We found limited evidence on case files of management involvement in cases classified as posing a high Risk of Serious Harm or where there child protection issues. Some work was countersigned where there were clear gaps in quality so management scrutiny was not sufficient. Our previous inspection of offender management, referred to above, had identified similar deficiencies and we have made a recommendation about improvement in management oversight in relevant cases. The Trust had already recognised this as an area for improvement and operational managers indicated that they would welcome a focus on what was expected of them.

### **Outcome 5: Delivering effective work for victims**

Overall, 61% of the work to deliver effective services to victims was done well enough.

We saw a mixed picture in relation to victims. Assessment and planning by offender managers lacked a 'Think Victim' approach, and sufficient attention had not always been paid to possible continuing risk of harm to some identifiable victims or potential victims, including children and young people.

Victim contact work was undertaken appropriately overall and the views of the victims who responded to our questionnaire were very positive about the service they had received.

Partner organisations also spoke highly of the Probation Trust's contribution to tackling domestic violence.

Please note – all names referred to in the practice examples have been amended to protect the individual's identity.

### Recommendations

Post-inspection improvement work should focus particularly on ensuring that:

- 1. risk of harm to others is assessed accurately and promptly, and is reviewed as appropriate, taking account of information from other organisations
- 2. planning to manage the risk of harm to others takes full account of the safety of actual and potential victims
- 3. additional attention is given to work to protect children and young people
- 4. effective management oversight is clearly evidenced in the records of all cases involving the protection of children and young people and of those classified as posing a high/very high Risk of Serious Harm to others
- 5. the contribution of alcohol misuse to violent offending is recognised in assessments, objectives to address the issues are included in sentence planning, and appropriate interventions are delivered
- 6. offenders are actively involved in their sentence planning, and timely reviews are used to reinforce objectives and commitment to the sentence, and to support progress.

### **Contents**

Foreword		1
Summary		2
Recommendation	ons	6
Contents		7
Outcome 1: A	Assisting sentencing	9
Outcome 2: D	Delivering the sentence of the court	13
Outcome 3: R	Reducing the likelihood of reoffending	27
Outcome 4: P	Protecting the public by minimising the risk of harm to others	36
Outcome 5: D	Delivering effective work for victims	45
Appendix 1	Contextual information about the area inspected	50
Appendix 2	Contextual information about the inspected case sample	51
Appendix 3	Acknowledgements	54
Appendix 4	Inspection arrangements	55
Appendix 5	Scoring approach	<b>57</b>
Appendix 6	Criteria	59
Appendix 7	Glossary	60
Appendix 8	Role of HMI Probation and Code of Practice	62

### Assisting sentencing

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### **Outcome 1: Assisting sentencing**

### What we expect to see

Pre-sentence reports and work in court are intended to enable sentencers to impose appropriate and effective sentences. We expect to see good quality reports which include an assessment of the offender and, where appropriate, a clear proposal.

### Case assessment score

Overall 77% of work to assist sentencing was done well enough.

### **Key strengths**

- 1. Sentencers were satisfied overall with the quality of reports, and with the skills of the probation staff working in court.
- 2. Liaison arrangements were regarded as effective by sentencers, who felt that they were kept well informed.
- Most court reports were based on sufficient information to aid sentencing and indicated the individual's motivation and capacity to comply with the proposed sentence.
- 4. Almost all reports contained an appropriate proposal for a community sentence, and the sentence imposed broadly followed the proposal.

### **Key areas for improvement**

- 1. Some reports lacked the required risk of harm screening and an assessment of the likelihood of reoffending. Some were descriptive rather than analytical.
- 2. Many reports lacked information about how key issues which would affect compliance would be tackled.

### **Explanation of findings**

### 1. Assessment and planning to inform sentencing

- 1.1. In our sample there were 28 cases where reports had been prepared for courts, to assist them in passing appropriate sentences. Two of these were oral reports and the remainder were typed reports, half of which were full reports and half were shorter reports that were typically prepared within a shorter timeframe. A written copy of both oral reports was available in the case file. Almost all of the typed reports were clear in meaning and concise, and the sentencers we met confirmed that reports were generally straightforward and understandable.
- 1.2. Over three-quarters of the full and shorter reports were based on sufficient information for the court appearance. However, five lacked the required risk of harm screening and relevant information about the individual's home and social environment, and in four reports the assessment of the likelihood of reoffending was missing.
- 1.3. Just under two-thirds of full and shorter reports were of sufficient quality. An accurate analysis of the likelihood of that person reoffending was missing in some reports, as was the analysis of the

risk of harm posed to others. We noted that these reports described what had happened, without analysing the individual's offending and what had led to it. Some also lacked reference to previous convictions, cautions or other behaviour where this was relevant. There was some evidence that the quality of reports prepared by probation officer (PO) staff was higher than those prepared by probation services officer (PSO) staff. Senior managers recognised that more work was needed to ensure that all relevant PSO staff had the level of skills needed.

- Almost all of the full and shorter reports contained a proposal for a community sentence, where 1.4. this was appropriate. They included clear and specific proposals, which generally followed logically from the main content of the report and were appropriate to the nature of the offending. In most cases they included a proposal for a punitive requirement if appropriate, for example unpaid work (Community Payback) or a curfew. In some instances, though, we judged that the proposal was not proportionate to the seriousness of the offence. For example, we saw two reports where a suspended sentence order (SSO) was proposed, but the court actually made a community order with the same suggested requirements. Managers told us that a proposal for an SSO should only be made after consultation with them, and would only be included in the report if it was thought likely that the court would wish to pass such a sentence. In our view, the proposal was merited in neither case. In some relevant cases the proposal did not include requirements aimed at keeping risk of harm to a minimum. We saw a number of cases where there was a history of domestic violence, but the proposal was solely for an unpaid work requirement. Managers informed us that where the offences were still denied, a supervision requirement would not usually be proposed. This practice meant that the ongoing risk of harm posed to some victims was not addressed.
- 1.5. Most of the full and shorter reports gave an indication of the individual's motivation and capacity to comply with the proposed sentence. Many, however, did not include information about how issues which could hinder the person engaging with their sentence or complying with it (such as travel or carer responsibilities) would be tackled.
- 1.6. In most of the full and shorter reports, the intended outcome of the proposed sentence was clear. Where the outcomes were stated, they took full account of the assessed likelihood of reoffending and the risk of harm posed by the individual. The sentence imposed by the court broadly followed the proposal in all but four cases. The sentencers we met confirmed that proposals in reports were generally realistic and they were satisfied overall with the quality.

### 2. Leadership and management to support sentencing

2.1. We met with four representatives of sentencers and court personnel, including the judge with probation liaison responsibilities. They all spoke very positively about the liaison arrangements with the Trust, describing a mix of individual meetings with probation staff at strategic level, and planned programmes of input to wider groups of sentencers.

### Comments from sentencers:

"We are very happy with our relationship with the Probation Trust."

"If we have any problems they are dealt with quickly and resolved."

2.2. Sentencers were satisfied that they received the information they needed to assist with sentencing. They thought that the probation staff in court had the required skills to undertake assessments and present information. As might be expected, they would have preferred more staff to be available on busy sentencing days but they recognised the pressure on resources. In magistrates' courts magistrates found oral reports particularly useful to aid speedy sentencing, and valued the willingness of staff to "squeeze in" a report, even when capacity was stretched, to enable same-day sentencing where possible.

### **Summary**

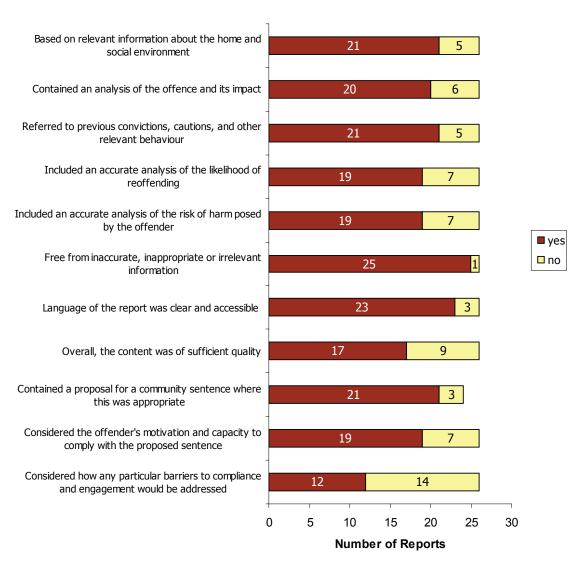
Overall, 77% of the work to assist sentencing was done well enough.

For a summary of our findings, please see page 2

### **Data Summary**

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 50 cases were inspected. However the total answers may not equal this, since some questions may not have been applicable to every case]

### **Pre Sentence Reports**



## Delivering the sentence of the court

### **Outcome 2: Delivering the sentence of the court**

### What we expect to see

Victims, sentencers and the public have the right to expect that the sentence of the court will be delivered as intended, and enforced where necessary. We expect to see work to engage and motivate offenders in order to ensure that they complete their sentences, and that the work undertaken with them is effective in reducing offending and promoting community reintegration.

### Case assessment score

Overall, 73% of work to deliver the sentence of the court was done well enough.

### Key strengths

- 1. Induction into the sentence generally worked well and most people were informed clearly about what they needed to do to complete their sentence successfully.
- 2. In initial sentence planning, attention was generally given to factors likely to assist with rehabilitation such as accommodation and employment. Level of motivation and capacity to change was taken into account in most cases.
- 3. Sentence plan objectives were usually appropriate to the purposes of sentencing and tackled issues linked with the likelihood of reoffending.
- 4. Planned levels of contact were generally appropriate, and the frequency of contact was sufficient to promote positive outcomes and carry out the sentence of the court.
- 5. Interventions were delivered in line with the sentence plan and help was given to improve individuals' social networks and sources of support. In most cases people were encouraged to engage with their sentence and their individual needs taken into account despite not having been particularly well assessed.
- 6. Attendance was monitored and effective action taken if there were missed appointments. Warnings and enforcement proceedings or recall were used appropriately in the main.
- 7. Case records were mostly well kept and the recording of information was clear and timely.
- 8. Sentence requirements were generally carried out as intended and sentence plan objectives were achieved fully or in part in almost all cases. Most people had not been charged with or convicted of a new offence during their sentence.
- 9. People who had offended were largely very positive about their experience of contact with the Probation Trust.
- 10. Offender managers received regular formal supervision and almost all held positive views about their support from line managers. Most had the opportunity to discuss practice issues with colleagues and overall there were positive views about learning and development opportunities.

### **Key areas for improvement**

- 1. At the induction stage, there was not always sufficient assessment of individual needs or issues which might 'get in the way' of successful completion.
- 2. Initial sentence planning was not done sufficiently well in many cases. Individuals were not generally

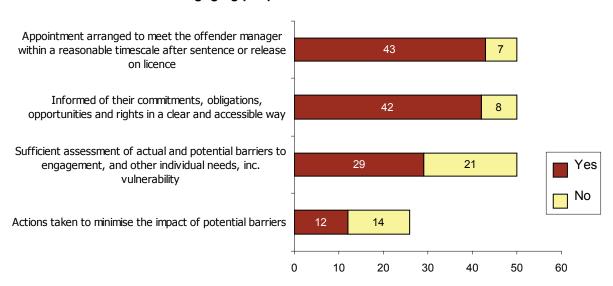
- involved in drawing up their sentence plans and their strengths were not often considered.
- 3. Sentence plan objectives did not always address risk of harm to others, including children and young people. Alcohol issues were often missed.
- 4. Sentence plan reviews were not done sufficiently well in many cases and they often missed the opportunity to encourage individuals in their efforts to desist from offending.
- 5. Case records did not always reflect the work carried out with individuals, and some lacked relevant documents.

### **Explanation of findings**

### 1. Assessment and planning to deliver the sentence

- 1.1. All but five cases in the sample were judged to have been allocated to the correct tier of service at the start of sentence or release on licence or transfer into the area. In a high number of cases, an appointment was arranged for the individual to meet their offender manager soon after sentence.
- 1.2. In most cases, there was evidence that a full, timely, and individualised induction was offered and most people were clearly informed of their commitments, obligations, opportunities and rights in relation to their order or licence in an understandable way. However, it was harder to see that there had been a sufficient assessment of the person's individual needs. This included any vulnerability issues and any potential barriers to that person engaging with their sentence and completing it successfully, such as mental health issues or being homeless. Offender managers could point to many different place in electronic or paper records where they might record such information but it was not 'pulled together' and in our view this initial aspect of engaging people with their sentence was not done sufficiently well in too many cases.

### Engaging people at the start of sentence

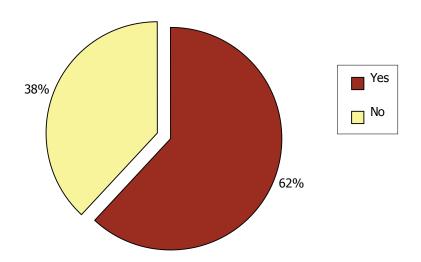


- 1.3. When it comes to sentence planning, we expect to see that individuals are actively and meaningfully involved in their drawing up their plan, but we saw evidence of this in only half the cases. Initial sentence planning was not done sufficiently well in many cases. Although plans were generally completed on time and were informed by the assessment of the individual's likelihood of reoffending, not all drew upon the risk of harm assessment.
- 1.4. In almost three-quarters of relevant cases, there was sufficient assessment of factors likely to assist with rehabilitation. In most cases accommodation issues and education and employment

had been appropriately assessed. However, fewer cases showed evidence that potential sources of support within the family or wider community had been discussed. This is an important issue for rehabilitation as individuals need support from others if they are to change their behaviour. As the health of those who have offended is generally poorer than that of non-offending groups, we also expect that offender managers check at the start of sentence whether the individual is registered with local health services, but in many cases the person's access to primary health services had not been assessed.

1.5. Sentence planning did not always pay sufficient attention to factors which might promote the individual's engagement and compliance with their sentence. For example, their strengths and aptitudes were sufficiently considered in only half of the cases examined, and the methods most likely to be effective in work with them were given sufficient attention in less than half. Where actions were needed to minimise the impact of potential barriers to engagement, these were included in relevant planning documents in less than half the cases. More positively, the individual's level of motivation and capacity to change was considered in most cases.

### Sentence planning paid sufficient attention to factors which may promote compliance



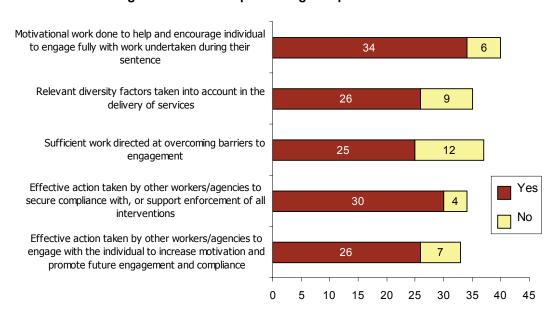
- 1.6. Sentence planning set appropriate objectives in over half of the cases. Plans usually contained objectives which were appropriate to the purposes of sentencing and which tackled the factors linked with the likelihood of reoffending. However, some lacked objectives to address risk of harm to others, and some plans failed to include required actions from multi-agency risk management procedures, for example from Multi-Agency Public Protection Arrangements (MAPPA). In 17 out of 21 cases, there were no objectives to tackle child protection concerns.
- 1.7. The contribution of alcohol misuse to the offence was tackled sufficiently in sentence planning in only 9 out of 19 cases.
- 1.8. We expect to see sentence planning objectives which are clearly and simply worded, set out achievable steps, and are outcome-focused, but just under half of the plans met these criteria. It was clearer in more cases what the individual had to do to achieve the objectives, but that still left over one-third where it was hard to tell what was actually expected.
- 1.9. Planned levels of contact with the individual were generally appropriate to the case and were well recorded. However, there was not always a clear record of the contribution to be made by all

workers in the case to achieving sentence planning objectives, and some cases lacked evidence that relevant parts of the plan had been communicated to other people involved. In over one-third of cases it was unclear when the sentence plan was due to be reviewed. In particular, there was no indication of what changes might prompt an unscheduled review. Where the review period was clear, it was usually appropriate for the case.

### 2. Delivery and review of the sentence plan and maximising offender engagement

- 2.1. Generally, interventions were delivered according to the requirements of the sentence and in line with sentence plan objectives. In most cases, delivery of interventions took account of any risk of harm posed to others by the individual. Most individuals also received sufficient help to improve their social networks and sources of support within the family and community where this was needed. But help was not always provided where needed in relation to education, training and employment (ETE) issues. Senior managers recognised that pathways into ETE provision were not as clear as they should be, and work was planned to harmonise services.
- 2.2. In most cases, motivational work was done with individuals to encourage them to engage fully with their sentence. Although not particularly well assessed, diversity factors and other individual needs were generally taken into account in the delivery of services. However, some individuals did need more work to help them to overcome the barriers they faced in getting through their order or licence, for example lack of settled accommodation, or mental health issues like depression.

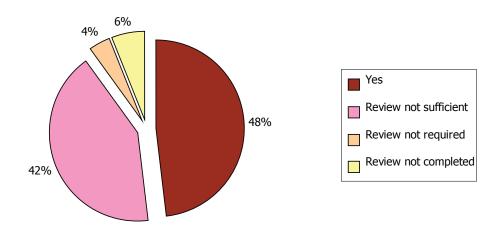
### Increasing motivation and promoting compliance with the sentence



- 2.3. Contact with individuals was generally sufficient to promote positive outcomes. The frequency of appointments or instructions to attend unpaid work facilitated the delivery of the sentence and the achievement of sentence plan objectives in 92% of cases. Contact was sufficient to monitor changes in dynamic risk factors but did not always take full account of the assessed level of risk of harm. There was enough contact with individuals to tackle their likelihood of reoffending in 88% of cases. However, pre-release contact with those in the licence sample was judged to be insufficient to contribute to post-release planning in 6 out of 16 relevant cases.
- 2.4. Overall, sufficient resources were allocated throughout the sentence to address the purpose of the sentence, the likelihood of reoffending, and the risk of harm. In 6 out of 26 cases we thought that more resources should have been applied to tackle the individual's diversity needs, for example referrals to other agencies for support.

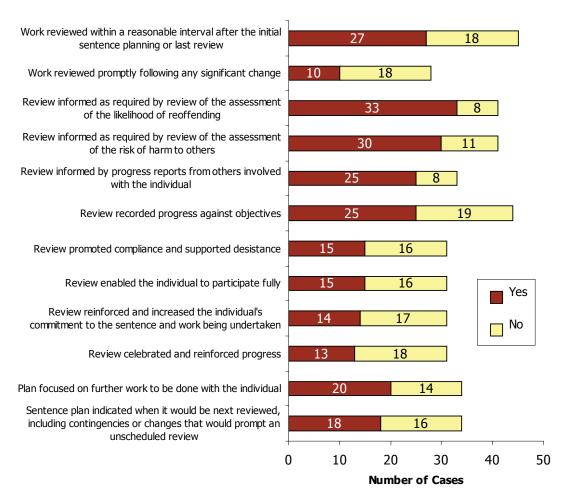
- 2.5. In most cases, the offender manager took a leading role in relation to other workers in managing the sentence. Attendance at appointments for supervision, rehabilitation work or for unpaid work was monitored in all cases, and in all but a few instances a timely and investigative approach was taken where appointments had been missed. Where it was needed, effective action was generally taken by other workers involved in the case to secure compliance. In most cases, other workers also took action to increase motivation and encourage engagement and compliance in the future.
- 2.6. In 38 cases, the individual had not attended when required or there were instances of unacceptable behaviour. Professional judgements by offender managers about the acceptability of absence or other behaviour were appropriate in all but two of those cases, but not all the decisions made were clearly recorded. In all cases bar one, a clear and timely formal warning was given to the individual when needed. Enforcement proceedings or recall were used appropriately in all except four cases. Clear explanations were always given to the individual about why they were being returned to court or recalled, and pro ceedings were started swiftly in the main. For 8 out of 11 cases, sufficient efforts were made to re-engage the individual with their sentence plan and encourage their commitment to continue.

### Sufficient review of the sentence plan



- 2.7. We expect to see sentence plans reviewed within the timescale stated in the initial plan or within a reasonable period. Reviews were done sufficiently well in only half of the cases. Many were not done in a sufficiently timely way, for example not being done when the individual completed one of the requirements or conditions of their order or licence. Just over one-third were reviewed promptly after there had been a significant change in circumstances or factors related to offending. Reviews of the sentence plan were not used sufficiently well enough to record the individual's progress against their objectives, or re-prioritise objectives or allocate additional resources if required. More positively, they were generally informed by a review of the likelihood of reoffending and a review of the risk of harm to others.
- 2.8. In most cases, sentence plan reviews were not being used to celebrate progress and reinforce the individual's commitment to their sentence, and most were not undertaken in a way which enabled the individual to participate fully. These were missed opportunities to encourage individuals in their efforts to complete their sentence and desist from offending. In many cases, reviews did not focus on the further work to be done with the individual. The gaps in quality (noted above in Outcome 2 paragraph 1.3 onwards) regarding the initial sentence planning were not remedied in the reviews. In eight cases, we judged that reallocation to a different level of service was required in light of the review, but this was only undertaken in three.

### Reviewing sentence plans and reinforcing progress



- 2.9. Five cases in the sample had been transferred between different Trusts or other organisations. The two cases transferred out by Bedfordshire Probation Trust had been handled appropriately, with provision of up to date assessments, plans and other relevant documents. However, it was a different picture for cases transferred into the Trust. The likelihood of reoffending assessment and sentence plan was not updated within a reasonable period of time in any of the three cases, although the risk of harm assessment and the risk management plan was updated in one. Offender managers and operational managers told us it was not the practice in the Trust to see transfer as a significant change for the individual that required a review, but we would expect to see one undertaken. Where the individual moved geographical areas as part of the transfer, a new appointment was made with them as soon as possible in both cases, but a home visit was only made in one of them. In one instance which involved a transfer to the Trust from a Youth Offending Team (YOT) it was not absolutely clear who was managing the case at every point in the transfer.
- 2.10. Overall, in most instances, case records (both electronic and paper) held sufficient information to support the management of the order or licence. Relevant information was usually accessible by or communicated to other workers involved in the case. Some SSO cases had been closed (and therefore 'weeded' of most of the content of the paper file) when the single requirement such as unpaid work had been completed. However, the actual SSO remained in force. When we queried the practice of closing and 'weeding' the paper files, senior managers confirmed that the paper file should not be treated as closed until the SSO itself had terminated, but that is clearly not understood in some offices.
- 2.11. Records were generally well organised and the recording of information was clear and timely but some lacked relevant documents. A copy of the order was missing in several cases, which meant

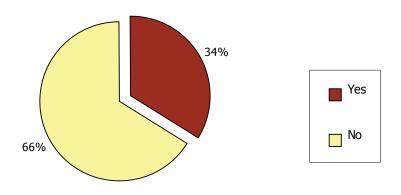
that offender managers sometimes relied on handwritten court result information or the proposal in the pre-sentence report (PSR) for information about the sentence. This was clearly unsatisfactory as the court order is the mandate for supervision or other requirements in an order and should form the basis of any work undertaken. We were told by managers in the Trust that court orders were accessible through Libra, the magistrates' courts' information technology system, to which some of their staff had access. When paper case files were put together for a new sentence, it was expected that the order was printed off and included. We were surprised that, where this had not happened for whatever reason, offender managers did not pursue the matter and obtain a copy.

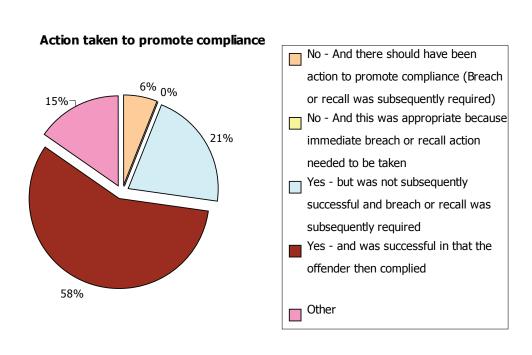
2.12. Case records did not always reflect the work carried out with the individual. From discussion with offender managers it was clear that more thought had gone into the assessment and planning in many cases than was actually evidenced, and the same was true for some of the interventions that had been undertaken.

### 3. Initial outcomes are achieved

3.1. The requirements of the order or licence were delivered as intended in all but seven of the cases in the sample. In one case, a requirement had been missed and we took action to see this remedied. In some other cases, as noted in Outcome 3: Reducing the likelihood of reoffending, paragraph 2.2,

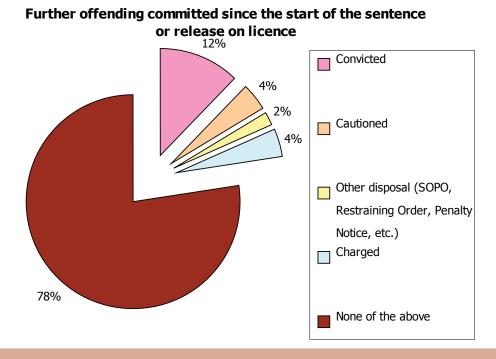
The individual complied with the requirements of the sentence, without the need for the offender manager to take action to promote compliance





accredited programme requirements had not yet been implemented, some nine months into the sentence.

- 3.2. In almost all cases, reporting instructions given to individuals were sufficient for the purpose of carrying out the sentence of the court. In one-third of cases (17), the individual complied with the sentence without the need for additional action by the offender manager. In a further 19, appropriate action was taken to promote compliance and this proved successful. In all but three cases, enforce ment proceedings or recall had been used where required.
- 3.3. Thirty-eight out of the fifty individuals in the case sample had not been cautioned for, charged with, or convicted of a further offence during the period of supervision we inspected.
- 3.4. Sentence planning objectives had been achieved fully or in part in all but eight cases. The delivery of the sentence plan had usually been maintained when there was a change in offender manager.



### This is what people who had offended thought of their experience

The National Offender Management Service (NOMS) conducts an annual survey of the views of people in contact with Probation Trusts. For 2012, Bedfordshire received 288 responses, which were largely positive.

Most had no suggestions for improvement, but the following issues were mentioned by several people:

- Some commented on the need to reduce the waiting time in reception before they were seen for their appointments.
- Some of those who were in employment suggested appointments being made available at more suitable times to fit with their work pattern.
- Others commented on the amount of time they had to spend travelling in order to get to probation offices for their appointments.
- Some people would have preferred to see just one offender manager or other worker during their order or licence, rather than a succession of staff.

### Comments from individuals:

"Whilst being on probation isn't the best situation to be in, it has helped me turn my life around and get to an even better place."

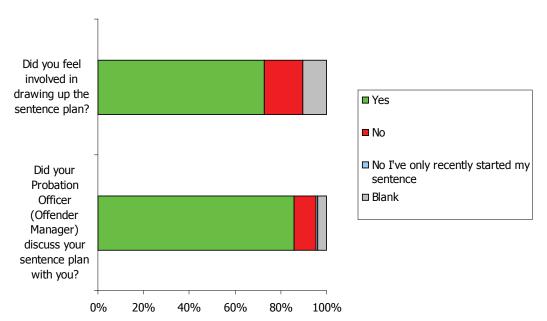
"My probation officer is very supportive and understanding and always helps me to get things off my chest, and understands my point of view."

"I have been treated with respect and as an equal human being. Staff are great, helpful and polite even under the pressure they face from some visitors. Very helpful all round."

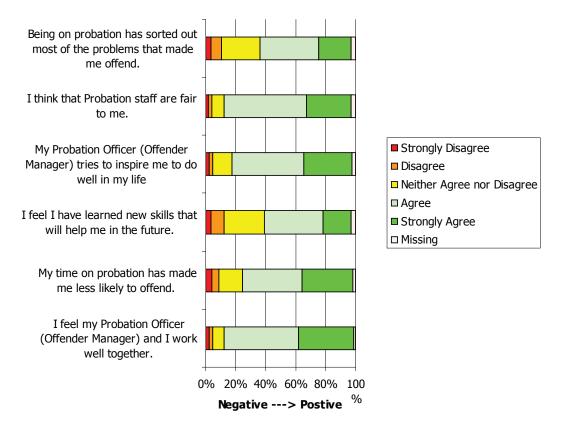
### A less positive comment:

"I'm not entirely sure what the benefit is for me...Probation may be good for some people but not all" and "Probation don't help at all".

### The charts below show some of the responses from the survey

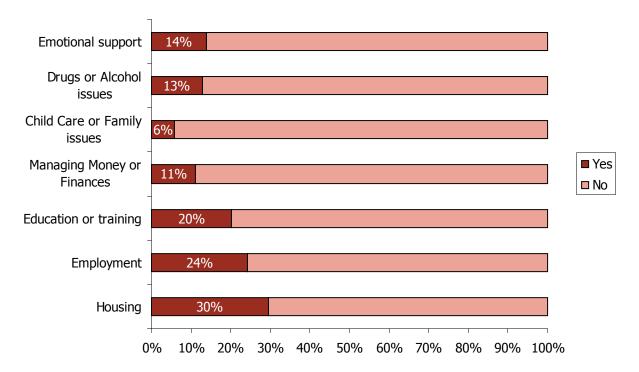


**Section 1 - About Current Order/Sentence** 



**Section 2 - About Experience on Probation** 

### I would like (or would have liked) more help with:



### 4. Leadership and management to deliver the sentence and achieve initial outcomes

- 4.1. We interviewed 32 offender managers d uring the inspection (as part of the inspection of the 50 cases in t he sample) to gain their views about their experience of working for the Trust. We asked about workloads; half thought that these were actively monitored but the remainder thought not or were unsure. Only a third thought that workloads were managed in a fair and transparent way. The issue for many was about transparency being able to see how work for frontline staff was allocated. The Trust did not use the NOMS national workload management tool as this was now outdated and did not address the work of all staff. Workloads and throughput of cases and reports were monitored by strategic managers and allocation undertaken by local operational managers, but the processes were not clear to many offender managers.
- 4.2. With respect to staff absences, most thought that planned absences like leave or long-term sick leave were managed in an effective way to minimise any disruption to continuity of offender management. However, offender managers were less sure about how effectively unplanned absences (like short notice sickness) were handled to ensure that offenders were still seen as planned.
- 4.3. Almost all of the offender managers held very positive views about the skills of their line managers, saying that they had the ability to assess the quality of their work, assist development and support them. All but two thought that their manager was actively involved in helping them improve the quality of their work. Most also thought that routine countersigning of their work and management oversight was an active process.
- 4.4. All those we interviewed reported receiving regular, professional supervision (line management meetings) from their manager, at monthly or six-weekly intervals. Case discussion featured strongly in supervision, as well as feedback about performance, training and development issues and discussion of personal well-being. Just under half reported that their practice had been observed by their manager or another person and they had been given feedback about this, and just under one-third said that they had received mentoring or coaching. Almost all thought that the particular methods used in supervision had promoted improvements in their practice. Of the 16 who indicated that they had particular individual needs, 12 thought that these had been reasonably addressed by the organisation.
- 4.5. In respect of learning and development opportunities, most offender managers either held or were working towards a relevant professional qualification. Most thought that arrangements for ongoing training and development were sufficient to equip them to do their current job but there were slightly less positive views about meeting future development needs. Under half reported receiving any specific training in practice methods or interventions in respect of violent offending. Many felt that they had received sufficient training around diversity factors but several reported less confidence in making initial assessments around learning needs or mental health issues. All those who were interviewed felt confident that they could identify and work with child protection and safeguarding issues, which was interesting given our findings that child protection issues had not always been recognised in the cases we inspected.
- 4.6. Many offender managers spoke positively about formal opportunities to discuss practice issues with colleagues, but 12 thought that there were insufficient opportunities for this. Individual initiatives by some middle managers to support practice development had been welcomed by practitioners. There were mixed views from offender managers about how effectively the learning from serious further offence reviews was shared with them. A significant minority thought that this could be done better. The Trust had experienced few serious further offences over the 12 months prior to the inspection, and senior managers told us that any learning points were included on the shared drive of their information technology system. Overall, almost all the offender managers interviewed thought that the Trust promoted a culture of learning and development, though middle managers were less positive about learning and development opportunities for them.

- 4.7. Representatives we met from partner agencies confirmed that there were protocols in place to enable the sharing of information between themselves and the Trust, for example between youth offending services and the Trust. However, senior managers told us that there were some issues in relation to provision of information by ETE providers about the progress of those referred by offender managers.
- 4.8. As noted in Outcome 3: Reducing Reoffending, paragraph 4.1, the Trust was keen to ensure that work undertaken with individuals was based on evidence of 'what works' in reducing reoffending. It also took account of national reviews of specific topics. For example, strategic leaders spoke of *The Corston Report* in respect of offending by women, being influential in developing local provision to meet their specific needs.
- 4.9. We also checked to what extent the Trust had taken into account recommendations from our thematic inspections. In respect of the inspection of work with women who have offended¹, the Trust was well on course with this. Women-only provision was available for unpaid work and offending behaviour programmes. In the Luton local delivery unit (LDU) where there was a women's centre run by Stepping Stones, a community sector agency, offender managers met women under supervision there, so that the women could access the other services on offer, such as individual counselling and group work programmes to meet different needs. In the other LDU (Bedford/ Central Bedfordshire) a women's centre was under development, and in the meantime the approved premises for women was used as a base for meetings with offender managers and a variety of other services. The Stepping Stones manager confirmed that referral criteria were clear and channels of communication generally worked well. For the current business year, 2013-2014, there had been more focus from the Trust on what the outcomes were for women who attended the centre, so that everyone could be clear what the tangible benefits were.
- 4.10. As regards the recommendations from our thematic inspection on transition between youth offending services and services for adults who have offended<sup>2</sup>, the picture was more mixed. Local YOT Managers confirmed that protocols were in place to guide staff in both youth offending and probation staff in managing that transition. Several cases in our sample had been transferred from youth offending services as the young person turned 18. Information had clearly been supplied by the YOT and there was evidence of case transfer meetings, but it was not always clear how much that useful information had been taken account of by offender managers in efforts to engage the young person and ensure that the interventions needed (or required by the sentence) were actually delivered.
- 4.11. Recommendations from the thematic inspection about MAPPA are covered in Outcome 4: Protecting the public by minimising risk of harm to others.

### **Summary**

Overall, 73% of the work to deliver the sentence of the court was done well enough.

We have recommended that post-inspection improvement work focuses on ensuring that:

• offenders are actively involved in their sentence planning, and timely reviews are used to reinforce objectives and commitment to the sentence, and to support progress.

For a summary of our findings, please see page 2

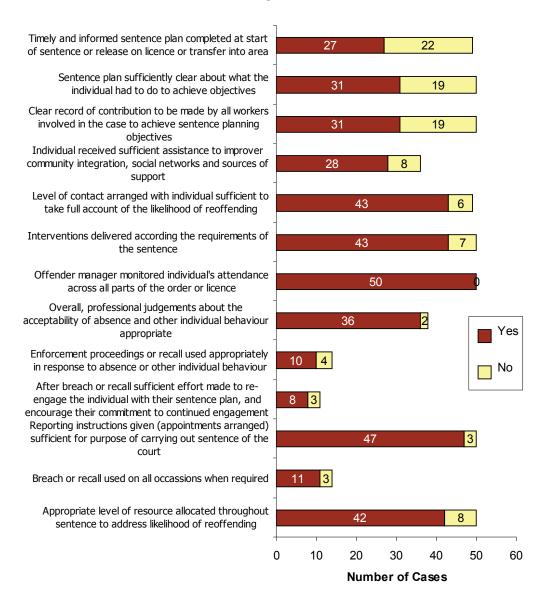
<sup>1</sup> HMI Probation, Thematic Inspection Report: *Equal but different?: An inspection of the use of alternatives to custody for women offenders,* October 2011.

<sup>2</sup> HMI Probation, *Transitions: An inspection of the transitions arrangements from youth to adult services in the criminal justice system,* October 2012.

### **Data Summary**

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 50 cases were inspected. However the total answers may not equal this, since some questions may not have been applicable to every case]

### **Delivering the Sentence**



# Reducing the likelihood of reoffending

3

### Outcome 3: Reducing the likelihood of reoffending

### What we expect to see

A number of factors may contribute to the likelihood of an offender committing further crime. We expect to see an accurate assessment of these factors at the start of sentence and evidence that effective, targeted work has reduced the likelihood of reoffending.

### Case assessment score

Overall, 66% of work to reduce the likelihood of reoffending was done well enough.

### **Key strengths**

- 1. The Trust had a strong focus on providing interventions which had shown that they contributed to reducing reoffending. The Citizenship Programme, undertaken with most individuals in the first months of their sentence, provided a good structured approach to tackling offending-related factors and rehabilitation generally. Accredited programmes made a strong contribution to tackling factors related to offending, such as thinking skills or domestic violence. One accredited programme Aggression Replacement Training (ART) specifically targeted anger management. The Trust was also commissioned by other organisations to run some intervention programmes in the wider community, including its 'Caring Dads' programme.
- 2. A range of interventions were provided to tackle patterns of offending locally, many in partnership with local organisations. These included programmes covering domestic and other violence.
- 3. Assessments of the likelihood of reoffending were generally sufficient, taking into account relevant information from the individual's home and social environment and identifying the factors which contributed to offending.
- 4. Most individuals were informed of local services which could support them in their rehabilitation, and were referred if this was needed.
- 5. Two-thirds of individuals under supervision had made either good progress or some progress in tackling the most significant factors associated with their likelihood of reoffending.
- 6. Resources had generally been used efficiently to achieve the planned outcomes with the individual.

### **Key areas for improvement**

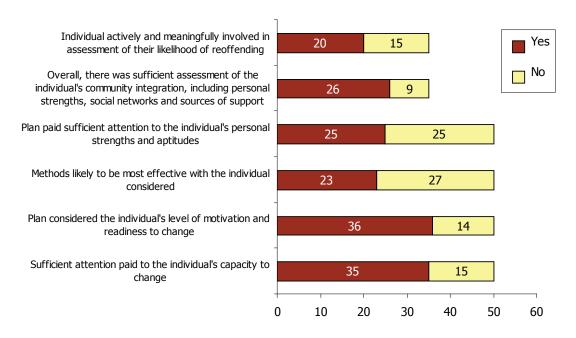
- 1. Individuals were not always actively and meaningfully involved in assessment of their likelihood of reoffending.
- 2. In many cases, alcohol misuse was a factor which made the individual more likely to reoffend, but it was not always taken account of sufficiently in assessments, and interventions to address the problems were lacking in two-thirds of relevant cases.
- 3. Interventions to tackle alcohol misuse and emotional well-being (including mental health issues) were lacking in a significant number of cases.
- 4. Assessments of the likelihood of reoffending were not always reviewed in a timely way, or reviewed when there had been significant change. Reviews were not generally used to celebrate progress or acknowledge the changes individuals had made in their lives.

### **Explanation of findings**

### 1. Assessment to reduce the likelihood of reoffending

- 1.1. An assessment of the factors which may contribute to the likelihood of further offending was required in all cases in the sample, except where the only requirement in a community order or SSO was for unpaid work. In four cases, no such assessment was completed. In the other cases, all but five assessments of the likelihood of reoffending were judged to be sufficient. Generally, they drew fully on all available sources of information and took previous relevant behaviour into account. In almost all cases they included relevant information from the individual's home and social environment and identified the factors which related to that person's offending, for example lack of stable accommodation, or drug or alcohol misuse. However, just over half were completed in a timely manner.
- 1.2. We expect that individuals are actively and meaningfully involved in the assessment of what factors are related to their offending and what will help them to desist from reoffending. Evidence of this was lacking in a significant number of cases. From discussion with offender managers it was clear that some did actively involve offenders in their assessment but did not always record this effectively.

### Involving people in assessing the likelihood of them reoffending

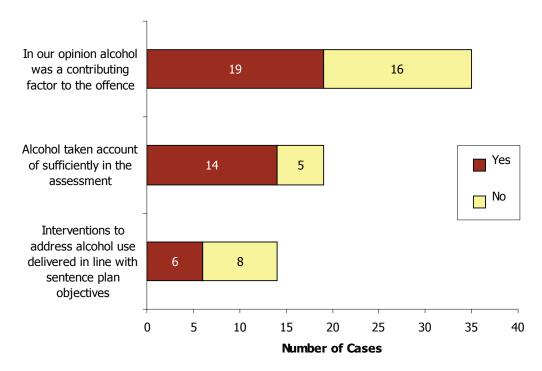


- 1.3. In view of the links between alcohol intoxication and violent offending, we were particularly interested in this inspection to see what role alcohol use played in the main offence and to what extent this was recognised in the likelihood of reoffending assessment. In 30 out of the 50 cases, we judged that alcohol misuse was a factor which made the individual more likely to reoffend. In 19 of these cases, alcohol was judged to be a contributing factor in the current offence, but was not taken into account sufficiently in the assessment in five cases. If offending-related factors are not recognised in the assessment then it is unlikely that the right interventions will be provided.
- 1.4. Over the 50 cases, there were a variety of factors that were related to the likelihood of reoffending. As well as alcohol misuse, issues around thinking and behaviour, attitudes to offending, and lifestyle and associates featured in many cases. Problems with relationships and emotional well-being (including mental health and behavioural issues) were also present in just under half of the cases. This meant that individuals whose sentences or licences were being managed by the Trust faced many challenges in desisting from offending.

### 2. Delivery of interventions to reduce the likelihood of reoffending

- 2.1. Constructive interventions encouraged and challenged the individual to take responsibility for their actions and decisions related to offending in a high number of cases (81%). The Trust had introduced the Citizenship Programme for most offenders under supervision. This meant that for the first months of their order or licence they took part in a structured programme of activity focused on tackling offending-related factors and their rehabilitation generally. Most of the relevant cases contained good evidence of this programme being undertaken and almost three-quarters of relevant cases showed that work with the individual kept a focus on the changes they needed to make to their behaviour.
- 2.2. Twenty cases in the sample additionally included the planned delivery of an accredited programme longer, structured programmes tackling specific issues such as domestic violence. The programmes included ART, which focused on managing emotions including anger, the Integrated Domestic Abuse programme (IDAP), and the Thinking Skills Programme (TSP). In 14 of these cases, the delivery of the programme was consistent with the sentence plan; it had either been completed by the time of our inspection or there were plans to deliver it at an appropriate time in the future. However, in two cases the programme was delivered later than planned and in four cases it had not yet been delivered (but should have been) some nine months into the order or licence. There were a variety of reasons for this, including accommodation changes for the individual.
- 2.3. There were two approved premises in the Bedfordshire area, providing controlled accommodation for offenders under supervision. Four cases in the sample involved people who had been resident in approved premises, and constructive interventions had been provided for three of these through meetings with their keyworker.
- 2.4. In three cases, the individual's sentence contained a specified activity requirement for example in relation to tackling alcohol use. In only one of these did delivery of the specified activity make the intended contribution to the planned work with the person who had offended.





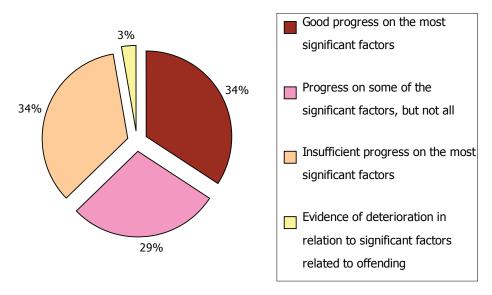
2.5. In respect of alcohol misuse issues, interventions to address this were delivered in line with the sentence plan in only 6 out of 14 cases. So, out of the original 19 where alcohol use was identified as contributing to the current offence, just under one-third actually received an appropriate service.

- 2.6. Individuals were generally well prepared for the interventions delivered throughout their community order or licence, for example accredited programmes include work that needs to be done by the offender manager with the individual before they start the group work element of the programme. In three-quarters of cases the offender manager then regularly reviewed with the individual the work they had done in other parts of their order or licence. In some cases we noted excellent communication from ART programme tutors in relation to individuals' participation and issues which had emerged during the group sessions.
- 2.7. To support and sustain their desistance from offending, over three-quarters of individuals were informed of relevant local services which could assist them. Most were then referred to these services if relevant.
- 2.8. We expect to see the likelihood of reoffending assessment reviewed thoroughly when required. In just under two-thirds of cases we judged that there had been a sufficient review. While changes in relevant factors were taken into account in most cases, not all were reviewed within a reasonable interval after the initial assessment. The Trust expected that a review was undertaken after the individual had completed the compulsory modules in the Citizenship Programme, before they moved on to 'Next Steps' provision, but this was not being done regularly. Middle managers acknowledged that there was 'some drift'. There seemed to be a standard approach to reviewing cases after six months, regardless of the needs of the case or if a requirement or condition in the order or licence had been completed earlier than six months. NOMS standards required that reviews were undertaken where there had been significant change, for example completion of a requirement of the sentence, or changes in the individual's circumstances which might affect classification of risk of harm to others. We saw several cases where reviews had not been done when a requirement, such as unpaid work, had been completed. Also, out of 26 cases where there had been significant change, only nine had been reviewed promptly following this. This meant that assessments of likelihood of reoffending were not as up to date as they needed to be. Undertaking reviews of risk of harm and likelihood of reoffending following a significant event featured in the learning points for the Trust following a serious further offence (SFO) review in 2012-2013.

### 3. Likelihood of reoffending is reduced

- 3.1. Some of the factors identified as contributing to the individual offending had been tackled by the time of our inspection, some nine months into the sentence. While sufficient interventions had been provided in most cases where there accommodation problems, there were significant gaps in relation to other issues such as alcohol misuse and emotional well-being. So it was not surprising that we saw limited progress in some cases.
- 3.2. If planned work with the individual has been completed, we would expect to see improvements in factors associated with the likelihood of reoffending. Just over one-third were judged to have made good progress on the most significant factors, and just under one-third had made some progress. In just over one-third of the cases we thought that there had been insufficient progress in respect of the most significant factors for that individual.
- 3.3. Offender managers were not always making a sufficient record when progress had taken place. In discussion with them, it seemed that many did not think of using reviews to celebrate the individual's achievements or changes they had made in their lives. This is an important aspect of encouraging people in their efforts to desist from offending, but it had not been evidenced well in many of the cases we saw.
- 3.4. Resources had been used efficiently to help the individual achieve the planned outcomes in most cases, but it was a mixed picture in terms of improved integration into the community. Just over half the cases contained evidence of improved family relationships or other community links, where this was relevant, and some cases lacked attention to ensuring that positive outcomes were sustainable beyond the end of the sentence.

### Overall progress made in relation to factors identified as making the individual more likely to reoffend



### 4. Leadership and management to reduce the likelihood of reoffending

4.1. The Trust had a strong focus on providing interventions which had been shown to reduce reoffending. It continued to invest in nationally accredited programmes although their length meant that they were costly in terms of staff resources, and the decision to purchase the Citizenship Programme from another probation Trust was also based on evidence of its effectiveness. The same principle drove investment in provision by voluntary and community sector agencies, for example the women's centre provided by Stepping Stones in one part of the Bedfordshire area, and the befriending scheme provided by a voluntary agency, the Community Resettlement Support Project

### Working in partnership with local agencies:

The Community Resettlement Support Project (CRSP) is a small agency from the voluntary and community sector in Bedfordshire. Initially undertaking befriending work with prisoners in HM Prison Bedford, its evaluated success in this work led to the Trust part-funding a post from April 2012 so that CRSP could undertake this work in the community with people who had offended. Referrals come from a variety of sources including probation staff - many are through the Integrated Offender Management (IOM) scheme and some from Approved Premises. Befriending is undertaken by a small group of volunteers, and the arrangements with people who have offended are carefully set up so that everyone is clear what the befriending involves. The volunteer role is an informal one, described to us by the acting project manager as "helping people make sense of what is happening around them, particularly on release after a long sentence in custody". Volunteers help to "fill the gaps", pointing people in the direction of other services they might need in the community and helping them make contact with those services where needed. The project has had a number of successful outcomes, where people have been supported through difficult early days after release. The Trust was described as a good partner for the project, being supportive at many levels and willing to work alongside the project staff and volunteers.

(CRSP).

4.2. Partner organisations commented positively on the contribution of the Trust to reducing reoffending

and community safety generally, particularly through the IOM scheme run in partnership with the police and other agencies. This Bedfordshire-wide scheme works intensively with the most prolific and other priority offenders (PPOs) identified through Community Safety Partnerships, and has had significant success in reducing reoffending rates locally. Several partner agencies expressed concern to us that the Government's 'Transforming Rehabilitation' policy (which will reduce considerably the current work undertaken by Probation Trusts) would adversely affect the current partnerships which worked well.

- 4.3. Data from our case sample indicated that alcohol misuse was a key feature for many people under supervision by the Trust. One of the Citizenship Programme modules addressed alcohol issues; this was an optional module which could be provided if there was an assessed need. It appeared that offender managers may not always recognise the need to tackle alcohol issues, or include interventions in sentence plans where these had been identified. Appropriate services were then not always being provided. Given the links between alcohol intoxication and violent offending, any gap in assessment or provision of interventions is a matter of concern.
- 4.4. The recently commissioned service providing alcohol treatment requirements (ATRs) and alcohol specified activity requirements (ASARs) in one part of the Trust's area was not yet fully operational. Both sentencers and offender managers raised with us their concerns about this. This was not a partnership contract managed by the Trust it was a contract between the local authority and health providers, to which the Trust was a party. The Trust's senior managers recognised that there were issues with the quality of provision and were tackling these with the provider and through the local authority as commissioner. The provision of appropriate services was clearly a key issue, given the extent of alcohol misuse problems identified in the case sample.
- 4.5. A small group of full-time staff (supplemented by part-time input and sessional staff working at weekends) ran the accredited programmes ART, TSP, and IDAP. The full-time tutors we met were clearly very experienced staff who were very committed to the work they did and who were keen to provide effective interventions. With regard to the suite of programmes delivered, the tutors were looking forward to the planned replacement of the ART programme (which had been running nationally for many years) with the more up to date programme to address violent offending. They were not involved in running the women-only provision or delivery of the Citizenship Programme or 'Caring Dads', although had expressed interest in doing so. Communication to the team from offender managers varied; some were described as having a good knowledge of programmes work but others failed to pass on relevant information about individual need or deal with practical issues like travel for those attending a programme.
- 4.6. The Trust was also commissioned by other agencies to run IDAP for people in the wider community who were not subject to its supervision but who were otherwise suitable for the programme. It had also designed and developed the 'Caring Dads' programme which was commissioned by the Children's Trust locally as a parenting skills programme that addressed the impact of domestic violence on children and young people. A complementary programme for women who were mothers was under development. Wider provision of IDAP and the development of the 'Caring Dads' programme were good examples of the Trust's expertise in providing interventions being recognised by partner agencies and commissioned by those agencies to meet local need.
- 4.7. The Drink Impaired Drivers group, which had been provided by a local voluntary agency, had been decommissioned by the Trust on the grounds of increasing costs. So provision to address alcohol-related offending relied on the optional Citizenship Programme module, referred to in paragraph 4.4, and the ATR and ASAR services referred to in paragraph 4.5. Given the number of individuals under supervision whose offending is related to alcohol use, the provision now available seemed inadequate.
- 4.8. During the inspection we interviewed 32 offender managers who, between them, were responsible for the 50 cases in the sample. Almost all had positive views about the range of interventions

available to them to enable the delivery of planned work. With regards to partnership work with other organisations, we heard from offender managers of good links with MAPPA, and with police, particularly in respect of domestic violence issues. Approved premises were also praised for their handling of referrals and for their good communication links with offender managers. JobCentre Plus staff were based in the probation offices and this was viewed as very helpful, as individuals under supervision were able to 'sign-on' for employment benefits and access learndirect services at the same time as keeping their appointments with offender managers. However, there were mixed experiences with children's social care services. Some offender managers reported good communication and joint management of cases, but others painted the opposite picture. There were also mixed views about access to mainstream mental health services for people who had offended, and about communication with community mental health teams. Several offender managers told us of difficulties in getting support for those under supervision unless there was a referral from a general practitioner, and lengthy waiting periods before referrals were actioned. Other offender managers spoke to us about their more positive experiences, which included swift response to referrals in respect of women residents in approved premises.

### Summary

Overall, 66% of work to reduce the likelihood of reoffending was done well enough.

We have recommended that post-inspection improvement work focuses on ensuring that:

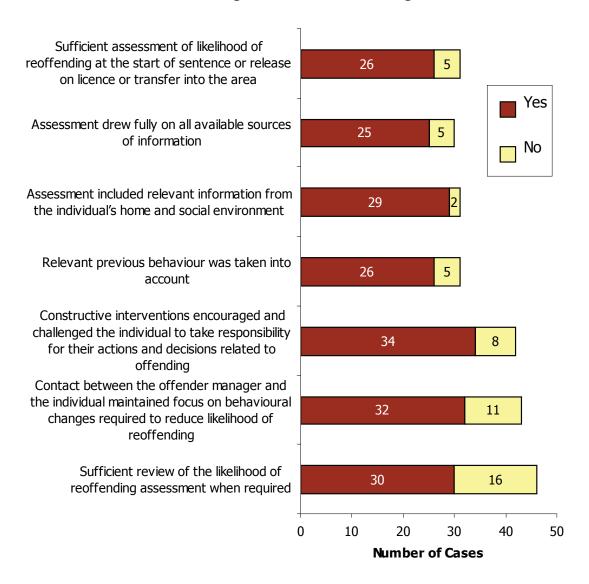
• the contribution of alcohol misuse to violent offending is recognised in assessments, objectives to address the issues are included in sentence planning, and appropriate interventions are delivered.

For a summary of our findings, please see page 2

### **Data Summary**

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 50 cases were inspected. However the total answers may not equal this, since some questions may not have been applicable to every case]

### **Reducing Likelihood of Reoffending**



# Protecting the public by minimising the risk of harm to others

4

# Outcome 4: Protecting the public by minimising the risk of harm to others

# What we expect to see

Some offenders present a risk of harm to other people. In all cases we expect to see the level of this risk properly assessed and, where necessary, plans made to manage and minimise risk to other people. All reasonable action should be taken to protect the public and ensure the safety of victims<sup>1</sup>.

#### Case assessment score

Overall 61% of work to ensure the protection of the public was done well enough.

# **Key strengths**

- 1. The Trust made a strong contribution at a strategic level to multi-agency work to protect the public. Contribution by probation staff to MAPPA and multi-agency risk assessment conferences (MARAC) was regarded as effective, as was involvement with Local Safeguarding Children Boards.
- 2. The Risk of Serious Harm (RoSH) classification was correct in almost all cases; in other words the case was accurately identified as posing a low, medium, high or very high RoSH to others.
- 3. In most cases, key risk of harm information had been passed between all relevant staff and other agencies involved in the case.
- 4. Almost all of the cases which met the criteria for MAPPA had been correctly identified, and appropriate referrals were done in a timely way in all instances where case management was needed at higher levels within MAPPA. Decisions taken within MAPPA were generally clearly recorded.
- 5. In most cases where there had been changes in risk of harm factors, offender managers had responded appropriately. Restrictive requirements or conditions were monitored fully in most cases and approved premises were used effectively to manage risk of harm to others.

## Key areas for improvement

- 1. In work with individuals subject to supervision or other involvement with the Trust, the RoSH screening was not completed sufficiently well in too many cases. Previous relevant behaviour and other information was not always taken into account.
- 2. Where a full risk of harm analysis was required, this was done well enough in under half of the cases. Account was not always taken of relevant information and there was insufficient analysis of the offending in many cases. Risks to children and young people were not always recognised in cases where there had been domestic abuse or other violent offending. Information was not always sought from other agencies such as children's social care services where this was needed.
- 3. Few risk management plans were of sufficient quality. Gaps included failing to address risk of harm to specific victims and not tackling factors identified in the full risk of harm analysis. Possible changes in risk of harm factors were not anticipated and plans did not always set out the actions needed.
- 4. Actions agreed at MAPPA meetings were not always included in other planning documents on the

Our judgements about work to protect actual and potential victims are incorporated into the overall score for Protecting the Public as well as contributing to the score for Delivering Effective Work for Victims. In this report, the detailed findings are discussed under Outcome 5: Delivering Effective work for Victims.

- offender manager's file and it was not always evident from the file that decisions were followed through and acted upon or reviewed appropriately. In respect of recording, it was a similar picture where multiagency child protection procedures had been used.
- 5. Risk of harm assessments and risk management plans were not sufficiently well reviewed in too many cases. These included cases where there had been significant change in circumstances or risk of harm factors.
- 6. There was limited evidence of effective management scrutiny in cases classified as posing a high RoSH or where there were child protection issues.

# **Explanation of findings**

# 1. Assessment and planning to minimise risk of harm to others

- 1.1. The initial RoSH screening was not completed sufficiently well in over one-third of cases. Two screenings were missing and 15 were not timely. In 14 cases the screening was inaccurate for example it failed to note that the current offence or previous behaviour involved abuse against partners or other family members, or that the individual had been assessed as posing a high or very high risk of harm to others on a previous occasion.
- 1.2. In all but three cases in the sample, we judged that the RoSH classification was correct. In one of those three, no classification had been recorded. So in almost all cases, the individual had been accurately assessed as posing a low, medium, high or very high RoSH.
- 1.3. Having an accurate assessment at an early stage of the order or licence is important as it enables all staff to understand what level of risk of harm is present and what factors might increase or lower that risk. Where a full risk of harm analysis was required, it was completed sufficiently well in under half of the cases. Some assessments were not completed as quickly as they needed to be. Some did not make reference to all of the available information, and previous relevant behaviour was not always taken into account. It was not always clear exactly who was likely to be harmed and in what circumstances, as there was insufficient analysis (as opposed to description) of the offending and other behaviour. There were similar findings about gaps in the quality of the full risk of harm analysis in our inspection of offender management in Bedfordshire published in January 2010. We have made a recommendation about improving the assessment of risk of harm to others.
- 1.4. In the 20 cases where restrictive requirements (such as a curfew, electronic monitoring or restraining orders) were in place, their use was judged to be appropriate in almost all instances. They were generally proportionate to the risk of harm and the likelihood of reoffending, and minimised the risk of harm to actual or potential victims. In all but three cases, the curfew was seen as providing a significant punishment, and in all but two it protected the public from risk of harm or further offending by the individual.
- 1.5. Risk management plans are required in cases where the RoSH classification is medium or higher. Forty-seven cases in the sample needed such a plan and this was completed in all but three. Only nine of the completed risk management plans were of sufficient quality. Gaps included failing to address the risk of harm to specific victims and not tackling the factors identified in the risk of harm analysis. Few anticipated possible changes in risk of harm factors or included specific planning for contingencies such as losing employment or accommodation or increased consumption of alcohol. Most failed to describe how the objectives in the sentence plan or other activities would protect actual or potential victims. Plans did not always set out all the action needed in the case, for example being unclear about who should do what and when or how information would be shared. There was limited evidence that individuals were actively involved in plans to manage their own risk of harm. More positively, there was evidence in most cases that key risk of harm information was passed between all relevant staff and other agencies involved.

1.6. From discussion with offender managers, many saw the risk management plan as a 'form to fill in' rather than a key element of protecting the public. Managers confirmed that there was no specific guidance to staff about how to undertake risk management planning, apart from that contained in the OASys on-screen manual. We noted that similar issues with the quality of risk management planning were found in our previous inspection of offender management in Bedfordshire, published in January 2010. Following that inspection, improvement work had been undertaken through training for offender managers using NOMS materials and through use by operational managers of the national quality assurance process for OASys. However, senior managers accepted that good planning to manage risk of harm to others was clearly not yet embedded throughout the organisation. Given our findings, further improvement work should take a high priority and we have made a recommendation about the need for this.

# Yes Plan not sufficient Plan not completed

Sufficient initial plan in place to manage risk of harm

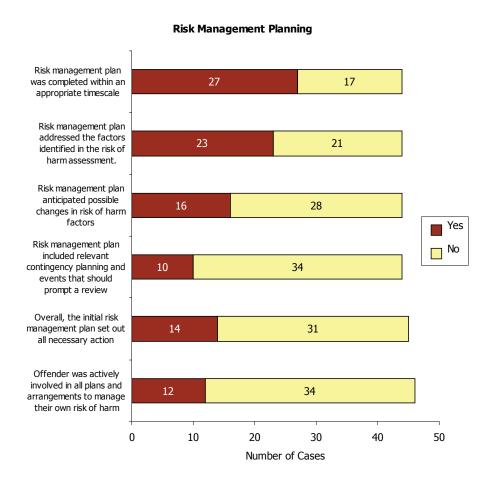
# Case illustration

Stephen had served a long prison sentence for a very serious offence of violence. He was released on licence to approved premises so that his behaviour could be monitored closely, including through regular drug testing. As well as tackling the drug use, Stephen's offender manager worked with him about his alcohol use as his offending was linked to this. Her case recording gave a very clear indication of what was covered in each meeting with him and what work still needed to be done.

Despite making some progress, Stephen was recalled to prison for breaching his licence conditions through poor behaviour and testing positive for drug use. His offender manager visited him quickly to explain the reasons for the recall and to try to re-engage him with his sentence plan. Stephen accepted that he needed to improve his behaviour and learn to manage himself more appropriately, and at the time of the inspection his offender manager was trying to keep him motivated, learn from his mistakes, and try again when re-released.

Desisting from offending is not straightforward and there can be setbacks as well as progress. The offender manager's role in 'sticking with' the individual is crucial in keeping the person motivated to 'make a better go of things' next time. This case was managed really well from prior to initial release until now. Assessment, planning and reviews were excellent and there was a good level of contact with Stephen. The quality of case recording was also first rate.

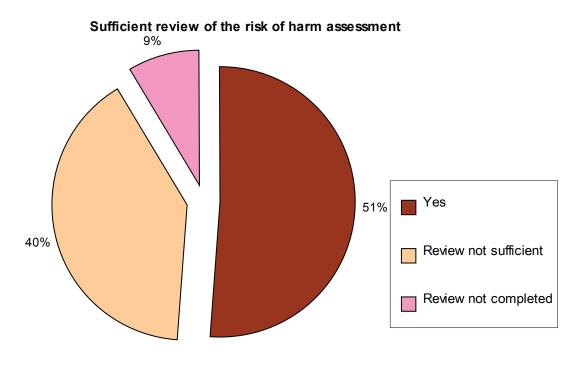
1.7. Fourteen cases met the criteria for MAPPA and in all but two of these this was identified accurately. In all of the cases that were identified, the initial level of MAPPA management was appropriate. Where cases needed management at higher levels within MAPPA, appropriate referrals were done in a timely way. However, in four out of the five cases managed at Level 2, there was no evidence that actions agreed by MAPPA had been included in all relevant planning documents, for example risk management plans. In two out of the five, those actions had not been communicated to all relevant bodies.



# 2. Delivery of interventions to minimise risk of harm to others

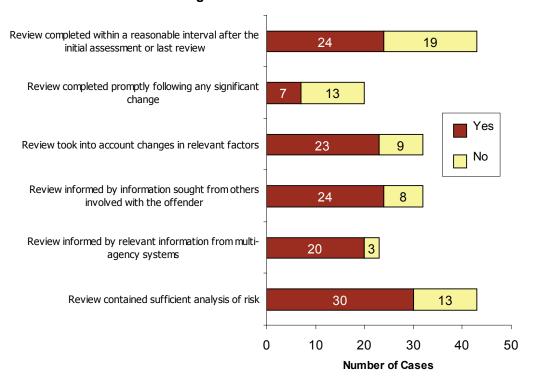
- 2.1. In most of the cases where there had been changes in the risk of harm posed to others, there was an appropriate response by the offender manager. Changes were generally identified swiftly and acted upon, and other agencies notified where needed. However, this did leave three cases where changes should have been spotted more speedily and other agencies informed about an increased risk of harm.
- 2.2. Where there were restrictive requirements or conditions in community orders or licences, they were monitored fully in most cases. For the four residents in approved premises, the requirement to reside there and other restrictions on their behaviour were used effectively to manage risk of harm to others.
- 2.3. In cases classified as posing a high RoSH to others or where there were child protection concerns, we expect to see an initial home visit carried out. This was not done in 13 out of 20 cases where we thought that it should have been. In our view, home visits should have been repeated in 12 cases, but they were only done in four.
- 2.4. There were six cases in the sample where enforcement proceedings or recall to custody were needed in response to an increase in the risk of harm posed by the individual. This was done appropriately in four instances and sufficient efforts were made to re-engage the individual with their sentence plan.

2.5. MAPPA management worked effectively overall for four out of the five cases at Level 2. Decisions taken within MAPPA were generally clearly recorded. However, in three of the cases there was no evidence in the offender manager's case file that decisions taken were followed through and acted upon or reviewed appropriately. Regarding ViSOR (the information system managed by the police to share information in some cases where there has been sexual or serious violent offending), we came across a general lack of knowledge by offender managers of its usefulness. Some were not aware that its use extended to particular cases where there was violent offending, as well as being used for those who had offended sexually. Accessing the information held on ViSOR was not a routine part of offender managers' work in relevant cases, and we were told by operational middle managers that not all had ready access to it.



- 2.6. Multi-agency child protection procedures were used effectively in five out of nine relevant cases. In the remaining four cases decisions had not been recorded clearly, or communicated, followed through and acted upon, or reviewed appropriately. This was similar to what we found in some MAPPA cases, noted in paragraph 2.5 above.
- 2.7. Risk of harm issues change over time for many individuals and we expect to find that the assessment is reviewed to reflect this. In just over half of the relevant cases (24 out of 43) the review was sufficient. In 13 out of 20 cases there had been no review promptly after a significant change in circumstances or risk of harm factors.

# Reviewing the risk of harm assessment



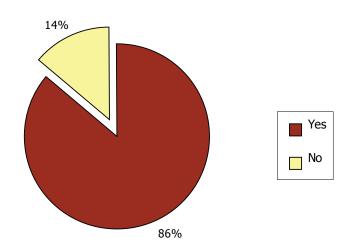
- 2.8. Actions set out in risk management plans were mostly carried out as required. The plans themselves, however, were not sufficiently well reviewed in over half of the cases. In too many instances they were not dynamic in other words they were not actively used to manage the identified RoSH and were not updated promptly following any significant change in circumstances or risk of harm factors. There was no improvement in the quality of the plans when they were reviewed; the gaps were similar to those identified in the initial risk management plan.
- 2.9. Where cases are assessed as posing a high or very high RoSH to others, or where there are child protection concerns, we expect to see structured management involvement in the case. We found little evidence of this in the relevant cases in the sample and some work had been countersigned by a manager when there were clear gaps in quality, for example in risk management planning. Operational managers told us that their practice varied in recording their discussions with offender managers or the advice given. Some would countersign the OASys even if it was inadequate (in order to meet performance standards in respect of timeliness) as they planned to discuss the issues in supervision meetings with the offender manager and then expect an early review of the assessment. However, any actions agreed might not necessarily be recorded in the notes from supervision meetings, and, as already found, reviews were not generally undertaken quickly. Thus, it was difficult to see from case records that managers were providing sufficient scrutiny or support, which was a matter of concern. The Trust had already recognised this as a key area for improvement, and operational managers said they would welcome a focus on what needs recording, when, where and by whom. We have made a recommendation about evidencing effective management oversight in case records.

#### 3. Risk of harm is minimised

3.1. We saw a number of domestic violence cases where the only requirement of the community order or SSO was for unpaid work. As there was no supervision requirement to the order, some offender managers seemed unsure what was expected of them and so failed to liaise with other agencies regarding domestic violence issues and potential risks to children and young people. Senior

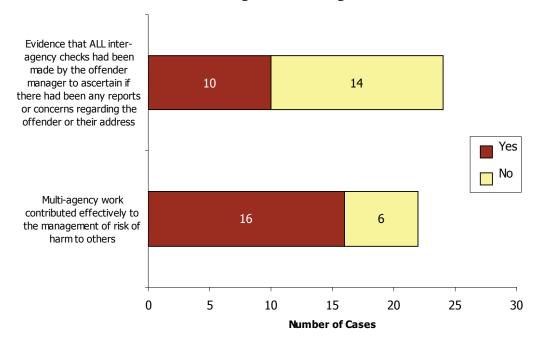
managers confirmed that they would expect this to be done in such cases, where the offender manager was acting as 'responsible officer' for the order, and that there was guidance in the risk of harm policy and in notes about working with domestic violence. Our findings indicate that a reminder to staff would be beneficial if risk of harm is to be kept to a minimum.

All reasonable action was taken to keep to a minimum the offender's risk of harm to others



3.2. Where multi-agency work had taken place, it had contributed effectively to the management of risk of harm in most cases. However, we were concerned to find that in 14 out of 24 relevant cases, there was no evidence that all inter-agency checks had been made to see if there had been any reports or concerns regarding the individual or addresses they were connected with. For ten cases, checks had not been made with police regarding domestic violence callouts, and in nine no check had been made with children's social care services. More positively, where the checks had been done and there was new information, the offender manager took appropriate action in all four cases.





3.3. For cases managed through MAPPA at Levels 2 and 3, we expect to see that plans are in place to minimise the risk of harm presented by the individual in the longer term when no longer subject to MAPPA management. (This was a recommendation in the Joint Criminal Justice Inspectorates' thematic inspection *Putting the pieces together: an inspection of Multi-Agency Public Protection Arrangements*, November 2011.) There was no evidence of this in the three cases where it would have been relevant. Other recommendations had been addressed, although as noted at paragraph 2.5 above, MAPPA meeting decisions and risk management plans were not always reflected adequately in the offender manager's case file.

# 4. Leadership and management to minimise risk of harm to others

- 4.1. Partnership organisations commented positively on the contribution made by the Trust, both at operational and strategic level, to multi-agency work which protected the public. It had strong links with the Community Safety Partnerships in all three local authorities within its area and the Chief Executive Officer of the Trust was the chair of one of these. There were information sharing protocols in place with community safety partners and probation staff were described as sharing appropriate information readily. The Trust had also forged links with the Police and Crime Commissioner's office for Bedfordshire.
- 4.2. The Trust was seen by partnership agencies as working effectively through MAPPA, regarding offenders who posed higher risks of harm to others, and through MARAC, in respect of protecting victims of domestic abuse. The MAPPA coordinator was seconded from the Trust and provided support and advice for probation staff and others where needed. Partner agencies also commented on the Trust's effective contribution to the Local Safeguarding Children Boards. A suggestion for improvement from one partnership organisation was that the Trust could provide more information about the challenges it faced in working with particular service user groups, and what it could offer in terms of addressing radicalisation issues and hate crime. Another suggestion was that the Trust could take a higher profile in MARACs, including chairing MARAC meetings a role currently undertaken by police and local authority representatives.
- 4.3. Overall, over a range of indicators, there was some evidence that work to protect the public and deliver effective work to victims was of a higher quality in cases classified as posing a high RoSH than in medium RoSH cases. This may reflect the Trust's priorities in allocating resources, but given the higher proportion of cases in the medium RoSH category, increased attention needs to be given to improving the quality of assessment, planning and delivery for this group. Failure to do this could pose an organisational risk to the Trust.

#### Summary

Overall, 61% of work to ensure the protection of the public was done well enough.

We have recommended that post-inspection improvement work focuses on ensuring that:

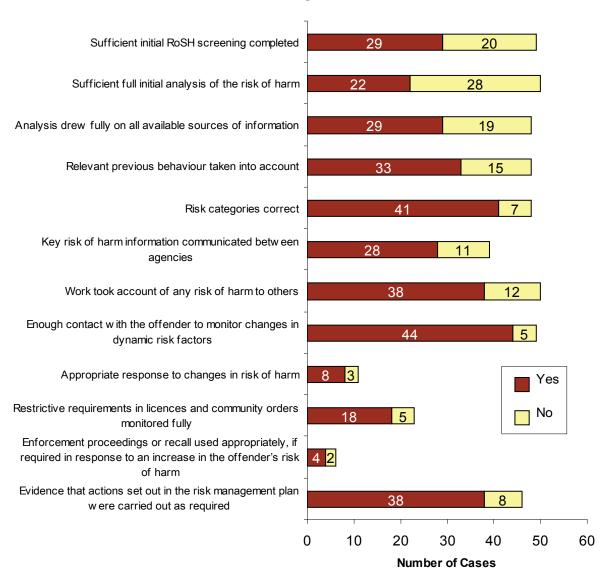
- risk of harm to others is assessed accurately and promptly, and is reviewed as appropriate, taking account of information from other organisations
- planning to manage the risk of harm to others takes full account of the safety of actual and potential victims.
- Additional attention is given to work to protect children.
- Effective management oversight is clearly evidenced in the records of all cases involving the protection of children and of those classified as posing a high/very high risk of serious harm to others.

For a summary of our findings, please see page 2

# **Data Summary**

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 50 cases were inspected. However the total answers may not equal this, since some questions may not have been applicable to every case]

# **Protecting the Public**



# Delivering effective work for victims

5

# **Outcome 5: Delivering effective work for victims**

## What we expect to see

The safety of actual and potential victims should be given a high priority. We expect to see this given attention in work with individual offenders. Where statutory victim contact work is required, we expect to see this undertaken so that victims are kept appropriately informed.

#### Case assessment score

Overall, 61% of work to deliver effective services for victims was done well enough.

# **Key strengths**

- 1. Overall, victim contact work was undertaken appropriately, and the victims who responded to our questionnaire about their experience had positive views about the work undertaken with them.
- 2. Partner organisations spoke highly of the Probation Trust's contribution to tackling domestic violence.

# **Key area for improvement**

1. In assessment and planning, and delivery of interventions, offender managers and others did not always give sufficient priority to the safety of victims and potential victims. There appeared to be a lack of a 'Think Victim' approach to assessing and managing risk of harm.

## **Explanation of findings**

## 1. Assessment and planning to minimise risk of harm to victims

- 1.1. In their assessment and planning, we expect to see offender managers and others giving appropriate attention to risk of harm to actual and potential victims. As already noted in Outcome 4: Protecting the public, section 1, the quality of this work was insufficient in too many cases. To ensure an assessment is sufficiently thorough, information may need to be sought from other agencies. In just over half of the relevant cases (22) this was not done. Information from children's social care services was not sought on a routine basis at the start of any new order of licence, so it was not always known if there were children and young people living in the same household or if those children and young people were already known to children's social care services. Given this, it was not surprising that in just over one-third of cases we judged that attention to the safeguarding of children and young people had been insufficient. There were no protocols in place regarding routine checks with children's social care services; managers told us that it was left to an offender manager's judgement as to whether such checks were needed in a particular case. Our findings would suggest that this was not always happening where it needed to. We have made a recommendation about additional attention needed to work to protect children and young people.
- 1.2. Risk management plans did not always focus on the risk of harm posed to specific victims. Most plans failed to describe how the objectives in the sentence plan or other activities would protect actual or potential victims. In general, there appeared to be a lack of a 'Think Victim' approach to planning to manage risk of harm to them and it was difficult to tell how the victim or potential victim was made safer by the planning. Senior managers recognised that 'there was work to do' with offender managers in raising their awareness and understanding of the perspective of victims. We have made a recommendation about improvement in risk management planning.

# 2. Delivery of interventions to minimise risk of harm to victims

2.1. In ongoing work with offenders, offender managers and others need to give appropriate priority to the safety of current and potential victims. This was done sufficiently well in only 24 out of 44 relevant cases. Offender managers were not always giving enough thought to any continuing risk of harm posed by the offender or taking into account the likely impact of the offender's behaviour on the victim. For example, in cases where a victim contact worker was involved there was not always evidence of active communication between the offender manager and the victim contact worker. In several instances, offender managers were not aware if victim contact was continuing or whether the victim had specific concerns. If there are deficiencies in assessment and planning, then it is not surprising that these are reflected in the work done later in the case.

#### 3. Risk of harm to victims is minimised

3.1. In just over one-third of relevant cases (14 out of 41) we judged that the risk of harm to actual or potential identifiable victims had not been managed effectively. In particular, the safety of children and young people had not been promoted in 11 cases where this was needed. As noted elsewhere in this report, risks to children and young people had not always been identified in cases where there was domestic abuse or other violent offending.

# 4. Victim contact and restorative justice

- 4.1. Probation Trusts have responsibility for running victim contact schemes. The scheme provides victims of some crimes with information about the key points in an offender's custodial sentence, and gives victims the chance to say what conditions they think should be included in the offender's licence once that person is released. There were 12 licence cases in our sample where victim contact work was required. In eight of these we found evidence of an offer of a face to face meeting with the victim contact worker, and six of these were made within eight weeks of the offender being sentenced to custody. Six victims took up the offer of contact and the quality of the work undertaken with them was sufficient in all but one case. This related to lack of evidence of regular and accurate information exchange between the offender manager and the victim contact worker or between the offender manager and prison staff. One victim was not given the opportunity to give their views on proposed licence conditions or informed of relevant conditions of the offender's release.
- 4.2. Nine victims of crime, who were in touch with the victim contact scheme, responded to our questionnaire:

#### Case Illustration:

Andy was subject to a community order following an offence of domestic violence against his partner, who was in the early stages of pregnancy at the time of the assault. The offender manager identified the child protection issues and noted those concerns within the assessment of risk of harm to others and in the risk management plan. She followed up her concerns and referred the case to children's social care services, with the result that the unborn child was made the subject of a child protection plan and the family were provided with support from other agencies. Multi-agency work was clearly recorded throughout the offender manager's case records, and the risk management plan showed what was happening to protect the unborn child.

This was effective work by the offender manager to ensure that the child was protected, whilst the offender manager was able to concentrate on ensuring that Andy completed his community order to reduce the likelihood of reoffending.

• All confirmed that the initial letter about the scheme was easy to understand and made it clear that they had a choice about whether to become involved.

- In all cases they said that their individual circumstances and needs had been taken into account, and they thought that victim contact staff had a full understanding of the impact of the offence on them.
- All but one of the victims said that they were kept informed about key points in the offender's sentence, and in all the cases where the offender was being considered for release they

had the chance to say what conditions they thought should be included in the licence.

In the five cases where the offender had been released, the victims confirmed that extra licence conditions had been added to keep them safer.

## Comments from victims:

Two victims of crime who responded to our questionnaire about their experience of the victim contact scheme said "Just the help when you need it, thanks" and "Thank you for all your help, keep up the good work".

- The four people who had reported concerns about the offender were satisfied with the response from the Probation Trust.
- Seven thought that the work of the victim contact scheme had made them feel safer; the other two felt it had made no particular difference.
- Seven were completely satisfied with the service provided, while the remaining two people were partly satisfied.
- 4.3. With regard to restorative justice, this was offered to the victim in two cases in the sample. One took up the offer but there was no evidence of the type of intervention which took place or of the outcome.

# 5. Leadership and management to deliver effective work for victims

- 5.1. Bedfordshire's victim contact staff were co-located with the MAPPA unit and managed by the MAPPA coordinator. A short while before this inspection, the Trust had completed an in-depth review of its victim contact scheme, looking at the challenges faced and the resources required. As a result, it was planning to clarify what work it required from victim contact staff, and to increase the front-line staffing.
- 5.2. Partner organisations spoke highly of the contribution made by the Trust to tackling domestic violence, for example through support at strategic and operational level for local MARAC meetings which worked to assess and manage risk of harm to partners and family members. As noted elsewhere in this report, the Trust also provided IDAP to domestic abuse perpetrators who were not subject to its supervision, and also ran the 'Caring Dads' programme in the wider community.
- 5.3. The use of restorative justice interventions by the Probation Trust was at an early stage. At the time of the inspection it was being offered in the multi-agency IOM scheme which worked with the most prolific or other priority offenders across Bedfordshire. So far, take-up by victims had been relatively low.

# Summary

Overall, 61% of work to deliver effective services to victims was done well enough.

We have recommended that post-inspection improvement work focuses on ensuring that:

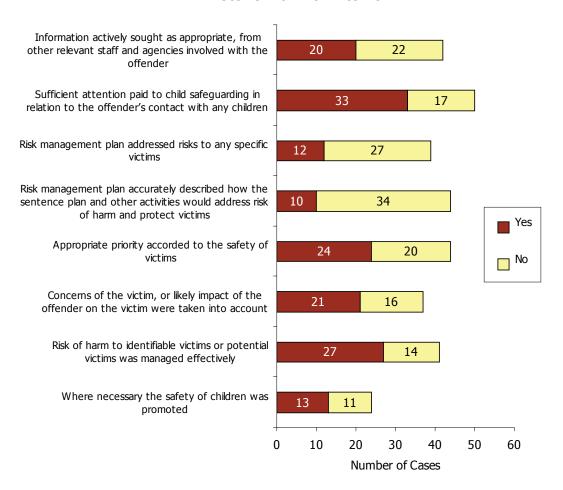
planning to manage the risk of harm to others takes full account of the safety of actual and potential victims.

For a summary of our findings, please see page 2

## **Data Summary**

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 50 cases were inspected. However the total answers may not equal this, since some questions may not have been applicable to every case]

#### **Effective Work for Victims**



# Appendices

# **Contextual information about the area inspected**

# Bedfordshire demographic data

Local Authority	Unemployment <sup>1</sup>	Population <sup>2</sup>	Black and minority ethnic population <sup>3</sup>
Bedford Unitary Authority	7.6%	157,000	19.5%
Central Bedfordshire Unitary Authority	6.3%	254,400	6.2%
Luton Unitary Authority	10.4%	203,200	45.4%
England and Wales	8.0%	56,075,900	14.1%

<sup>&</sup>lt;sup>1</sup> Office for National Statistics Local Labour Market Indicators - Oct to Sept 2012

# Crime Survey for England and Wales, 2011/2012

Offences per 1000	Bedfordshire	England and Wales
Violence against the person offences	13	14

## **Probation Caseload Data**

Analytical Services, MoJ, October 2012

Bedfordshire	Supervised in community and Pre-release	National average
Total caseload	2,551	n/a
% white	65.4%	77.1%
% black and minority ethnic	31.5%	19.7%
% male	90.2%	89.9%
% female	9.8%	10.1%

<sup>&</sup>lt;sup>2</sup> Office for National Statistics 2011 Census

<sup>&</sup>lt;sup>3</sup> Office for National Statistics 2011 Census

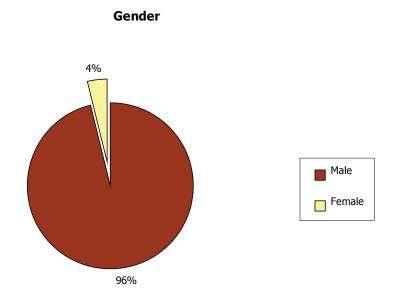
# Contextual information about the inspected case sample

In the first fieldwork week we look at a representative sample of between 50 and 90 (depending on the size of the area) individual cases, which have been supervised for around nine months. These are community orders, suspended sentence orders and post-custody licences.

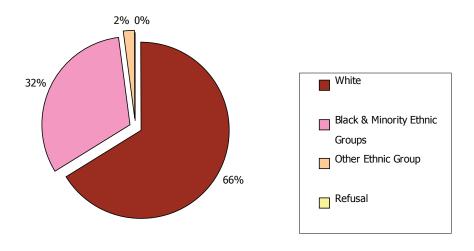
During the year 2013-2014 this sample is drawn from cases managed by a Probation Trust. The sampling methodology will be adapted in future to incorporate work managed by other providers.

Between April and September 2013, the focus of the inspections is work with those who have committed violent offences.

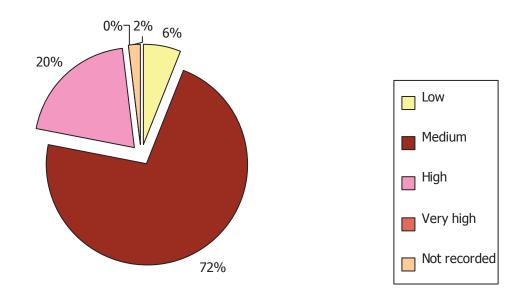
In Bedfordshire we inspected a total of 50 cases.



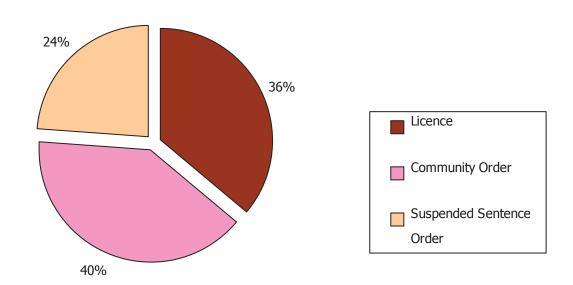
# **Race and Ethnicity**



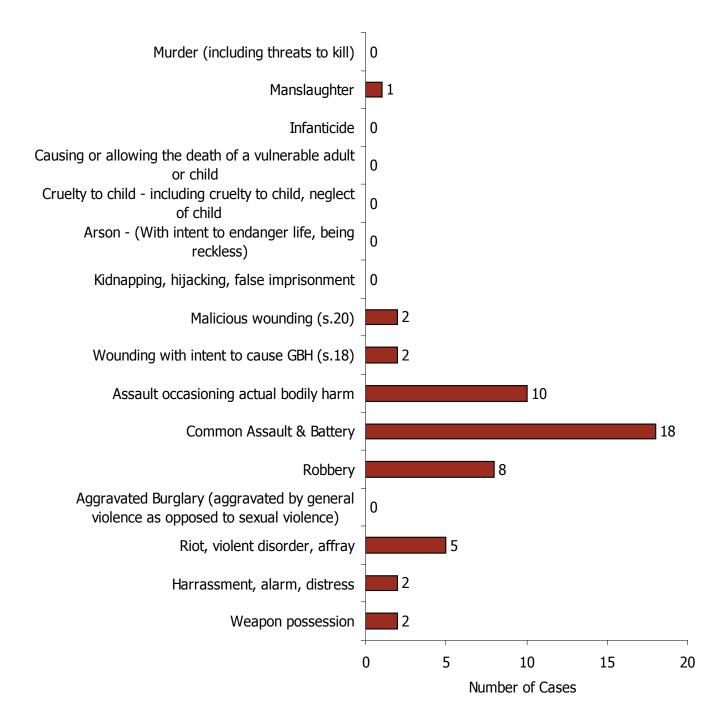
# OASys RoSH classification as recorded at the start of sentence or release on licence or transfer into this area



**Type of Case** 



# **Principal Offence**



# **Acknowledgements**

We would like to thank all the staff from Bedfordshire Probation Trust, members of the management team and partner organisations for their assistance in ensuring the smooth running of the inspection. We are particularly grateful to the staff who were trained as Local Assessors and worked as members of the inspection team.

Lead Inspector	Joy Neary, HMI Probation
Deputy Lead Inspector	Tony Rolley, HMI Probation
Inspection Team	Caroline Nicklin, HMI Probation
	Helen Rinaldi, HMI Probation
	Steve Woodgate, HMI Probation
	Claire Dempster, Local Assessor
	Gabriel Judge, Local Assessor
	Kyela Puech, Local Assessor
Observers	Greg Maguire, HMI Probation
	Beverley Reid, HMI Probation
HMI Probation Support Services	Pippa Bennett, Inspection Support Manager
	Stephen Hunt, Inspection Support Officer
	Oliver Kenton, Assistant Research Officer
	Alex Pentecost, Publications Manager
	Christopher Reeves, Proof Reader
Assistant Chief Inspector	Sally Lester, HMI Probation

# **Inspection arrangements**

Full details of arrangements for the Inspection of Adult Offending Work are available from the HMI Probation website at the following address:

http://www.justice.gov.uk/about/hmi-probation/inspection-programmes-adult/inspection-of-adult-offendingwork

# **Inspection focus**

During the year 2013-2014, the Inspection of Adult Offending Work focuses on the work of Probation Trusts, supported by local partnership arrangements. This will change in due course, when work with offenders is managed and delivered by other organisations. The inspection framework has been designed to be adapted to accommodate these changes.

This inspection focuses on the quality of practice through inspecting a sample of cases managed by the organisation. In each case we follow the 'offender's journey' - that is, we firstly examine the quality of the *assessment* of the factors that need to be addressed to prevent offending; secondly the quality of *work* that is done with the offender to change their behaviour; and thirdly the evidence of outcomes – that is, whether the work has been well targeted, effective, and supports desistance. The inspection of these cases contributes to our overall judgements about the quality of work to:

- assist sentencing
- deliver the sentence of the court
- reduce the likelihood of reoffending
- protect the public
- deliver effective work for victims.

The type of cases inspected will change every six months. We are currently selecting cases where the index offence is one of violence (but not including sexual offending, as this has been the subject of a thematic inspection). After each group of inspections, we will publish an aggregate report, in which we will use data from case inspection to highlight good practice and identify areas for improvement.

The case sample comprises offenders who are subject to a community order or post-custody licence.

# Methodology

Each inspection is announced ten weeks before the first fieldwork week. The primary focus is the quality of work undertaken with adults who have offended, and statutory victim contact work in relevant cases. The work is assessed by a team of inspection staff and trained Local Assessors. Practitioners working with the case are interviewed in-depth and asked to explain their thinking and to identify supporting evidence in the record. They are also asked about the extent to which elements of leadership and management support the quality of their work.

Although our main focus is the quality of practice, we will also comment on leadership and management in our reports *where this provides an explanation or context for the findings about practice.* Prior to or during this first week, we receive copies of relevant local documents that inform our understanding of the organisation's structure and priorities. Inspection teams follow up lines of enquiry triggered by case inspections, this may involve meeting local managers, talking with practitioners or administration staff, or general observation of office practice.

Formal meetings with managers, sentencers and service providers are held two weeks after the case inspection. Preliminary analysis of the data from the case inspections allows us to explore, in greater detail, the themes that are emerging. We also consider specific local characteristics and needs; the ways in which gaps in provision are identified and filled; and work that has been done to improve the quality of service delivery. In particular, issues relating to leadership, management and partnership are explored to help us understand their contribution, or otherwise, to the quality of the work delivered.

The views of victims are obtained through a questionnaire, and sentencers are interviewed about the quality of court based work. The views of offenders are obtained through a survey conducted annually by NOMS.

At the end of the second fieldwork week, we present our findings to local strategic managers.

# **Publication arrangements**

A draft report is sent to the Probation Trust for comment three weeks after the inspection, with publication approximately six weeks later. In addition the published copy goes to the relevant Ministers, other inspectorates, the Ministry of Justice Policy Group, NOMS and Police and Crime Commissioners. Copies are made available to the press and placed on our website. Reports on inspections undertaken in Wales are published in both Welsh and English.

# **Scoring approach**

This describes the methodology for assigning scores to each of the sections of the report.

In each case inspection staff examine how well the work was done across the case, following the criteria below:

#### 1. ASSESSMENT AND PLANNING

- 1.1 Assessment and planning to inform sentencing
- 2.1 Assessment and planning to deliver the sentence
- 3.1 Assessment to reduce the likelihood of reoffending
- 4.1 Assessment and planning to minimise risk of harm to others
- 5.1 Assessment and planning to minimise risk of harm to victims

#### 2. DELIVERY AND REVIEW

- 2.2 Delivery and review of the sentence plan and maximising offender engagement
- 3.2 Delivery of interventions to reduce the likelihood of reoffending
- 4.2 Delivery of interventions to minimise risk of harm to others
- 5.2 Delivery of interventions to minimise risk of harm to victims

#### 3. CASE OUTCOMES

- 2.3 Initial outcomes are achieved
- 3.3 Likelihood of reoffending is reduced
- 4.3 Risk of harm to others is minimised
- 5.3 Risk of harm to victims is minimised

#### 4. LEADERSHIP AND MANAGEMENT

We look for evidence that leadership and management support the work with individual cases. This evidence is obtained through interviews with staff and managers from probation trusts and other organisations, and from sentencers.

- 1.4 Leadership and management to support sentencing
- 2.4 Leadership and management to deliver the sentence and achieve initial outcomes
- 3.4 Leadership and management to reduce the likelihood of reoffending
- 4.4 Leadership and management to minimise risk of harm to others
- 5.4 Leadership and management to deliver effective work for victims

# 5. VICTIM WORK

5.5 Victim contact and restorative justice.

Each scoring question in the inspection tool contributes to a score for the relevant section in the report. This approach enables us to say how often each aspect of the work was done well enough. Each section of the report focuses on a key outcome.

The score is based on the proportion of work judged sufficient ('above the line') across all the cases we inspected.

The **score for each of sections 1 - 5** is then calculated as the average of the scores for the component general criteria.

The **ASSISTING SENTENCING score** is calculated as an average, over all the relevant questions in the case assessment tool, of the proportion of work judged 'above the line'.

The **DELIVERING THE SENTENCE OF THE COURT score** is calculated as an average, over all the relevant questions in the case assessment tool, of the proportion of work judged 'above the line'.

The **REDUCING THE LIKELIHOOD OF REOFFENDING score** is calculated as an average, over all the relevant questions in the case assessment tool, of the proportion of work judged 'above the line'.

The **PROTECTING THE PUBLIC score** is calculated as an average, over all the relevant questions in the case assessment tool, of the proportion of work judged 'above the line'.

The **DELIVERING EFFECTIVE WORK FOR VICTIMS** score is calculated as an average, over all the relevant questions in the case assessment tool, of the proportion of work judged 'above the line'. Some of the questions in this section also contribute to the Protecting the Public score.

# **Development of the inspection criteria**

We are grateful to the service users we met through Revolving Doors for their input on 'what an experience of supervision should be like'. Their thoughtful comments contributed to our detailed inspection criteria, and helped to shape our inspection guidance and set benchmarks for the quality of practice we define as sufficient.

# Criteria

CRITERIA for the INSPECTION of ADULT OFFENDING WORK

		PRO	PROCESS								
Ŧ Ö Ö	Headline CRITERIA OUTCOMES	<b>+</b>	ASSESSMENT AND PLANNING	7	DELIVERY AND REVIEW	м	CASE OUTCOMES	4	LEADERSHIP AND MANAGEMENT	ю	VICTIM WORK
Ŧ	ASSISTING SENTENCING	1.1	Assessment and planning to inform sentencing					1.4	Leadership and management to support sentencing		
2	DELIVERING THE SENTENCE OF THE COURT	2.1	Assessment and planning to deliver the sentence	2.2	Delivery and review of the sentence plan and maximising offender engagement	2.3	Initial outcomes are achieved	2.4	Leadership and management to deliver the sentence and achieve initial outcomes		
m	REDUCING THE LIKELIHOOD OF REOFFENDING	3.1	Assessment to reduce the likelihood of reoffending	3.2	Delivery of interventions to reduce the likelihood of reoffending	3.3	Likelihood of reoffending is reduced	3.4	Leadership and management to reduce the likelihood of reoffending		
4	PROTECTING THE PUBLIC by minimising the risk of harm to others	4.1	Assessment and planning to minimise risk of harm to others	4.2	Delivery of interventions to minimise risk of harm to others	4.3	Risk of harm to others is minimised	4.4	Leadership and management to minimise risk of harm to others		
2	DELIVERING EFFECTIVE WORK FOR VICTIMS	5.1	Assessment and planning to minimise risk of harm to victims	5.2	Delivery of interventions to minimise risk of harm to victims	5.3	Risk of harm to victims is minimised	5.4	Leadership and management to deliver effective work for victims	5.5	Victim contact and restorative justice

The aspects of adult offending work that were covered in this inspection are defined in the inspection criteria, which are available at

http://www.justice.gov.uk/downloads/about/hmiprob/iaow-criteria.pdf

# **Glossary**

Structured courses for offenders which are designed to identify and reduce the Accredited programme

factors related to their offending behaviour. Following evaluation, the design of the

programmes has been accredited by a panel of experts

Approved premises provide controlled accommodation for offenders under Approved premises

supervision

ART Aggression Replacement Training: an accredited programme

**ASAR** Alcohol Specified Activity Requirement

ATR Alcohol Treatment Requirement

Child protection Work to ensure that that all reasonable action has been taken to keep to a

minimum the risk of a child or young person coming to harm

The process by which people stop offending and build a new, crime-free identity Desistance

**ETE** Education, training and employment: work to improve an individual's learning, and

to increase their employment prospects

**HMI Probation** Her Majesty's Inspectorate of Probation

**IDAP** Integrated Domestic Abuse Programme – an accredited programme

Interventions; constructive and restrictive

interventions

A constructive intervention is where the primary purpose is to reduce likelihood of

reoffending.

A restrictive intervention is where the primary purpose is to keep to a minimum

the individual's risk of harm to others.

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.

NB: Both types of intervention are important

IOM **Integrated Offender Management** 

**LDU** Local delivery unit: an operation unit comprising of a probation office or offices.

LDUs are generally coterminous with police basic command units and local

authority structures

**MARAC** Multi-agency risk assessment conference: part of a coordinated community

> response to domestic abuse, incorporating representatives from statutory, community and voluntary agencies working with victims/survivors, children and

the alleged perpetrator

MAPPA Multi-Agency Public Protection Arrangements: where probation, police, prison and

other agencies work together locally to manage offenders who pose a higher risk

of harm to others

**NOMS** National Offender Management Service: the single agency responsible for both

**Prisons and Probation Trusts** 

OASys/ eOASys Offender Assessment System/electronic Offender Assessment System: the

> nationally designed and prescribed framework for both Probation and Prisons to assess offenders, implemented in stages from April 2003. It makes use of both

static and dynamic factors

Offender management A core principle of offender management is that a single offender manager takes responsibility for managing an offender through the period of time they are serving their sentence, whether in custody or the community. Offenders are managed differently depending on their risk of harm to others 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'

OMI 2

Offender Management Inspection 2: HMI Probation's inspection programme which

ran from 2009 to 2012

PO

Probation officer: this is the term for a 'qualified' offender manager who has undertaken a higher education based course for two years. The name of the qualification and content of the training varies depending on when it was undertaken. They manage offenders posing the highest risk of harm to the public

and other more complex cases

PPO

Prolific and other priority offender

PSO

Probation services officer: this is the term for an offender manager who was originally recruited with no qualification. From 2010 they may access locally determined training to 'qualify' as a PSO or to build on this to qualify as a Probation Officer. They may manage all but the most complex cases or those posing the highest risk of harm to the public depending on their level of training

and experience

**PSR** 

Pre-sentence report: this refers to any report prepared for a court, whether

delivered orally or in a written format

Risk of harm work

This is the term generally used by HMI Probation to describe work to protect the public, primarily using restrictive interventions, to keep to a minimum the individual's opportunity to behave in a way that is a risk of harm to others

RoSH

Risk of Serious Harm: a term used in OASys. All cases are classified as presenting a low/ medium/ high/ very high Risk of Serious Harm to others. HMI Probation uses this term when referring to the classification system, but uses the broader term risk of harm when referring to the analysis which has to take place in order to determine the classification level. This helps to clarify the distinction between the probability of an event occurring and the impact/severity of the event. The term Risk of Serious Harm only incorporates 'serious' impact, whereas using 'Risk of Harm' enables the necessary attention to be given to those offenders for whom lower impact/severity harmful behaviour is probable

Safeguarding

The ability to demonstrate that a child or young person's well-being has been 'safeguarded'. This includes – but can be broader than – child protection

**SFO** 

Serious Further Offence: when an offender is charged with an offence classified as an SFO (serious sexual or violent offences), the Probation Trust conducts an

investigation and review of the management of the case

Suspended sentence order

TSP Thinking Skills Programme: an accredited programme

YOS/YOT/YJS Youth Offending Service

Youth Offending Service/Youth Offending Team/Youth Justice Service: these are common titles for the bodies commonly referred to as YOTs

62

# **Role of HMI Probation and Code of Practice**

Information on the role of HMI Probation and Code of Practice can be found on our website:

www.justice.gsi.gov.uk/about/hmi-probation

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

HM Chief Inspector of Probation 6th Floor, Trafford House Chester Road Manchester M32 0RS



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HM Inspectorate of Probation, 6th Floor, Trafford House, Chester Road, Stretford, Manchester M32 0RS

ISBN:

