HM Inspectorate of Probation
Arolygiaeth Prawf EM

Inspection of Adult Offending Work
Arolygiad o Waith Troseddu Oedolion

Inspection of Adult Offending Work in **Merseyside**

An inspection led by HMI Probation

independent inspection of adult offending work

September 2013

Foreword

The inspection of adult offending work in Merseyside 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 second 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 Merseyside Probation Trust, from three of the six local delivery units covered by the Trust (Knowsley, Liverpool North and Sefton). We found a good standard of work undertaken with adults who had offended. Overall, work to deliver the sentence of the court was effective. Individuals were seen regularly and work undertaken with them in accordance with their sentence plan. The delivery of interventions to minimise risk of harm to victims generally gave priority to victim safety, and victim contact work was undertaken appropriately.

Court reports included clear proposals, and recommended community sentences where appropriate. A range of interventions was delivered to reduce the likelihood of reoffending, supported by effective work with other organisations at a strategic level. The Trust was working well with partners in public protection work, and had been actively addressing the recommendations from our last inspection to improve the quality of risk of harm work in individual cases. However, there was room for further improvement in the quality of risk of harm assessment and planning and management scrutiny.

We were 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

September 2013

Summary

Outcomes	The proportion of work judged to have been done well enough
Assisting sentencing	**79%**
Delivering the sentence of the court	**83%**
Reducing the likelihood of reoffending	**75%**
Protecting the public by minimising risk of harm to others	**76%**
Delivering effective work for victims	**87%**

Outcome 1: Assisting sentencing

Overall, 79% of work to assist sentencing was done well enough.

Most court reports were based on sufficient information for the court appearance. However, nearly one-third lacked a sufficient risk of harm screening and/or assessment. There were gaps in the quality of some reports that typically contained a description rather than an analysis of the offending.

Most court reports contained a clear and appropriate proposal for a community sentence, and the sentence imposed by the court broadly followed the proposal. Most reports were appropriate to the nature of the offending and indicated the individual's motivation and capacity to comply with the proposed sentence. However, many lacked information about how any particular barriers to compliance and engagement would be addressed.

Sentencers were satisfied overall with the quality of reports, and with the quality and enthusiasm of probation staff working in court, whom they regarded highly. Strategic relationships with sentencers were generally good, but inadequate probation accommodation in court buildings prevented the Trust from meeting the desire of sentencers for more pre-sentence reports to be completed on the day.

Outcome 2: Delivering the sentence of the court

Overall, 83% 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 sentence or release on licence or transfer into the area, and an initial appointment arranged quickly. Most were offered a full, timely and individualised induction and informed of their rights and responsibilities. This included sufficient assessment of individual needs and the potential barriers to that person engaging with their sentence and completing it successfully.

The quality of initial sentence plans was generally sufficient, but in some cases planning should have been more timely and better informed. In a number of cases no initial sentence plan had been produced. In most cases assessment and sentence planning had sufficient regard to factors likely to assist with rehabilitation, but could have paid more attention to promoting the individual's engagement and compliance with their sentence, such as their level of motivation and capacity to change and the methods most likely to be effective in work with them.

Sentence plan objectives were usually appropriate to the purposes of sentencing and tackled issues linked with the likelihood of reoffending, risk of harm to others, and alcohol issues. However, in many relevant cases there were no objectives to manage Child Protection concerns, or to address required actions from multi-agency risk management procedures.

Planned levels of contact with the individual were generally appropriate to the case and were recorded, but in many cases it was not clear when the sentence plan would be reviewed. The timescale for reviewing progress against objectives was often unclear, with no indication of what changes might prompt an unscheduled review. Where the review period was clear, it was usually appropriate for the case.

Interventions were generally delivered according to the requirements of the sentence and in line with sentence plan objectives. Most individuals received sufficient help to improve their social networks and sources of support within the family and community where this was needed, and motivational work was done to encourage them to engage fully, and any diversity factors were taken into account. Sufficient work was done to help individuals overcome any barriers they faced in getting through their order or licence.

In nearly all cases the offender manager took a leading role in managing the sentence and monitoring attendance. In nearly all cases a timely and investigative approach was taken where appointments had been missed and, where it was needed, effective action was generally taken. Professional judgements by offender managers, about the acceptability of absence or other behaviour, were appropriate and clearly recorded.

Sentence plan reviews were not sufficiently timely in many cases. Many had not been reviewed in line with the timescale stated in the initial plan or following any significant change, and some had not been reviewed at all. In many cases sentence plan reviews were not being used to increase the individual's commitment to their sentence, and were not undertaken in a way which enabled full participation.

Case records were well kept and were usually accessible by, or communicated to, other workers involved in the case. However, they did not always fully reflect the work carried out with individuals.

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, and the majority had complied with the sentence without the need for additional action by the offender manager.

Results from the annual National Offender Management Service survey of offenders' views indicated service users were generally positive about their experience being on supervision.

Offender managers received regular formal supervision and almost all held positive views about the quality and support of line managers. Most had opportunities to discuss practice issues with colleagues and many were involved in professional development activities. Nearly all thought the Trust promoted a culture of learning and development.

Outcome 3: Reducing the likelihood of reoffending

Overall, 75% of the work to reduce reoffending was done well enough.

The assessment of the factors which may contribute to the likelihood of further offending was generally sufficient and timely. Assessments took into account previous relevant behaviour and relevant information from the individual's home and social environment, and identified the factors which related to that person's offending. However, individuals were not always actively and meaningfully involved in the assessment.

In many cases, alcohol misuse was a factor which made the individual more likely to reoffend, and it was nearly always taken into account sufficiently in assessments. However, while there were interventions available to address the problem they were not delivered in one-quarter of relevant cases.

The provision of group and other structured interventions was well resourced by the Trust. A range was provided to tackle local patterns of offending, many in partnership with other organisations. These included programmes covering domestic and other violence, and addressing alcohol and drug misuse and mental health issues.

In most cases constructive interventions encouraged and challenged the individual to take responsibility for their actions and decisions related to offending, and work with the individual kept a focus on the

changes they needed to make to their behaviour. Individuals were well prepared for interventions delivered throughout their community order or licence. In most cases the offender manager maintained regular contact with the individual during their attendance on programmes, and regularly reviewed with them the work they had done in other parts of their order or licence. Most individuals were informed of local services which could support them in their rehabilitation, and were referred if this was needed.

There was generally a sufficient record of the progress made by the offender. More than two-thirds of individuals under supervision had made either good or some progress in tackling the most significant factors associated with their likelihood of reoffending.

Offender managers had positive views about the range of interventions available to them, and resources had generally been used efficiently to achieve the planned outcomes with the individual. However, only two-thirds of cases showed improved integration into the community or improved family relationships.

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

Overall, 76% of the work to protect the public by minimising the risk of harm to others was done well enough.

The Trust made a strong contribution at a strategic level to multi-agency work to protect the public, and was well regarded by the partner organisations with which it worked. We saw effective use of Multi-Agency Public Protection Arrangements in the cases we inspected, supported by a strong strategic approach in this area of work.

Almost all cases which met the criteria for Multi-Agency Public Protection Arrangements had been correctly identified, and appropriate referrals were done in a timely way where case management was needed at higher levels within Multi-Agency Public Protection Arrangements. Decisions taken within Multi-Agency Public Protection Arrangements were generally clearly recorded, followed through and acted upon. However, in some cases the use of multi-agency child protection procedures was less effective and decisions were not clearly recorded or communicated, or followed through, acted upon and reviewed.

There was effective partnership working in relation to Integrated Offender Management cases, although improvement was needed in work with multi-agency risk assessment conference. The Trust had strong strategic relationships with Children's Services but at operational level the quality of joint work was variable.

The Trust had been actively addressing the recommendations from out last inspection to improve the quality of risk of harm work in individual cases. While the quality of this work overall was now good, there was room for further improvement in certain aspects. The risk of serious harm classification (low, medium, high or very high risk of serious harm to others) was correct in most cases, but an initial risk of serious harm screening was missing or not completed sufficiently well in too many cases. Full details of the current offence and relevant previous behaviour were not always taken into account. Some failed to note that the current offence or previous behaviour involved abuse against partners or other family members. Where an initial full risk of harm analysis was required, this was either not done or not done well enough in more than one-third of cases. Account was not always taken of relevant previous behaviour. Some cases needed to draw more fully on all available sources of information, such as full details of current and previous offences, and information from Children's Services. There was insufficient analysis of the offending in some cases.

Risk management plans were either not completed or of insufficient quality in more than one-third of cases. Most addressed factors identified in the risk of harm analysis, but many did not anticipate possible changes in risk of harm factors or set out all the necessary actions needed, and details of events that should prompt a review. More than one-third of risk management plans did not accurately describe how the objectives of the sentence plan and other activities would address risk of harm issues and protect actual and potential victims. Many plans were not clear about who would do what and when. However, in most cases key risk of harm information had been passed between all relevant staff and other agencies involved.

In over one-third of cases where there had been changes in risk of harm factors, offender managers had not responded appropriately. Changes had not been identified swiftly or acted on by all relevant staff and other agencies notified where needed. Restrictive requirements or conditions were monitored fully in most cases. Approved Premises played an important role in public protection, and were used effectively to manage risk of harm to others. Home visits were not always carried out where needed.

Risk of harm assessments and risk management plans were not reviewed in a timely way or promptly after a significant change in circumstances or risk of harm factors in a third of cases. A quarter of assessment reviews contained insufficient analysis of risk. Actions set out in risk management plans were generally carried out as required.

There was insufficient evidence of effective management scrutiny in nearly half of the cases classified as posing a high risk of serious harm or where there were child protection issues. Some work had been countersigned managers when there were gaps in quality, and oversight arrangements had failed to identify and remedy cases where risk of harm assessments or plans had not been done or not reviewed where required.

Outcome 5: Delivering effective work for victims

Overall, 87% of the work to deliver effective services to victims was done well enough.

The assessment and planning to minimise risk of harm to others paid insufficient attention to safeguarding children and the risks to actual and potential victims. However, the delivery of interventions to minimise risk of harm to victims generally gave priority to victims' safety and took account of concerns expressed by victims. A wide range of appropriate interventions was available.

Victim contact work was undertaken appropriately, and the quality of the work was good. Victims who responded to our questionnaire about their experience had very positive views about the work undertaken with them. The Probation Trust had strong strategic relationships in place to support effective work with partner agencies in public protection.

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; information from other organisations and the safety of actual and potential victims is taken into account
2. additional attention is given to work to protect children and young people
3. 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
4. offenders are actively involved in their sentence planning; reviews are timely and used to support progress, and reinforce objectives and commitment to the sentence.

Contents

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, 79% of work to assist sentencing was done well enough.

Key strengths

1. Court reports were generally based on sufficient information for the court appearance, and indicated the individual's motivation and capacity to comply with the proposed sentence.
2. Most reports contained an appropriate proposal for a community sentence, and the sentence imposed by the court broadly followed the proposal.
3. Sentencers were satisfied overall with the quality of reports, and with the quality and enthusiasm of probation staff working in court.

Key areas for improvement

1. Nearly one-third of court reports lacked a sufficient risk of harm screening and/ or assessment, and some contained a description rather than an analysis of the offending.
2. Many reports lacked information about how any particular barriers to compliance and engagement would be addressed.
3. Inadequate probation accommodation in court buildings prevented the Trust from meeting the desire of sentencers for more pre sentence reports to be completed on the day.

Explanation of findings

1. Assessment and planning to inform sentencing

1.1. The sample we inspected included 44 cases where a report had been prepared for the courts to assist them in passing appropriate sentences. Two of these were oral reports and the remainder were typed reports, of which half were full reports and half were shorter reports that were typically prepared within a shorter timeframe.

1.2. There was a written copy available in the case file for only one of the oral reports.

1.3. Almost all of the typed reports were written in a clear and accessible style, although a small number could have been more concise. This was often caused by insufficient editing of reports, as they were generated by the Offender Assessment System (OASys) template, a point noted by one of the sentencers we met.

1.4. Overall, 79% of the full and shorter reports were based on sufficient information for the court appearance. Of the nine reports that were not, six had been prepared in the short report format. Generally, the sources were indicated and verified, where necessary, and most were based on the

required assessment of likelihood of reoffending and relevant information about the offender's home and social environment.

1.5. However, 31% of written reports had not been based on the required risk of harm screening or assessment. Not all of the shorter format written reports were derived from use of the OASys assessment, and this may have contributed to this finding. The Trust planned to move to the production of all written reports from OASys following the introduction of OASys-R.

1.6. The quality of the content of reports was judged to be insufficient in 26%, and the most frequent area for improvement was the need for a more accurate analysis of the risk of harm posed by the offender. Some reports placed too much reliance on the offender's account of their offence, or gave a description of the offence and did not contain enough objective analysis of the offender's behaviour and the risks they posed. This was remarked upon by some sentencers and offender managers we met. They considered that sometimes this was caused by access to prosecution information not being available for reports prepared at court on the day of sentence.

1.7. At the Crown Court, sentencers were more concerned to know about the offenders' attitude to victims rather than the impact of the offence on the victim, which they knew directly from the Crown Prosecution Service. Overall, however, the sentencers we met considered that victims' issues were well covered in most reports and they thought the quality of court reports was very good.

1.8. Of the written reports 79% contained an appropriate proposal for a community sentence. Nearly all included clear and specific proposals, which generally followed logically from the main content of the report, and were proportionate to the seriousness of the offence.

1.9. Over three-quarters of the proposals were for a community order. There were six proposals for a suspended sentence order, of which two resulted in the making of a community order, along with the single proposal for custody. Of the remainder, only two reports did not contain any specific proposal and these both resulted in community sentences.

1.10. The proposal for the type of sentence was broadly followed by the court in 86% of cases. In only two cases was there a differing assessment from the court of the seriousness of the offence. However, the Crown Court sentencers we met observed that reports might sometimes be improved by taking greater account of the sentencing council guidelines.

1.11. Most proposals were appropriate to the nature of the offending, and to the offender's circumstances, including their motivation and ability to complete the proposed sentence. Most reports indicated the offender's motivation and capacity to comply with the proposed sentence, and the district judge we met observed that the probation service always communicated any concerns there might be about an offender's motivation to comply. However, nearly half of the reports inspected failed to identify how any particular barriers to compliance and engagement would be addressed.

1.12. In 85% of written reports the planned outcome of the proposed sentence was clear, and related to the intended purposes of the proposed sentence, and the district judge we met observed this generally to be the case. Crown Court sentencers noted that sometimes report authors could be more specific as to what was intended to be done within a supervision requirement. Similarly, 85% took full account of the assessed likelihood of reoffending and the risk of harm posed by the individual.

1.13. In four cases in our sample, a community sentence was passed without evidence of any report having been prepared or other information being made available to the court. Two of these related to suspended sentence orders initially managed at Tier 4. A third case was a community order consisting of unpaid work and curfew requirements made for an imitation firearm offence. The individual was known to the Trust to have a range of problems relating to drugs and poor thinking skills, but a request to the court to adjourn the case for a report was declined. This, and some related issues, is covered more fully in Section 4 of this report.

2. Leadership and management to support sentencing

2.1. We met with three representatives of sentencers and court personnel, including the judge with probation liaison responsibilities and a district judge.

2.2. The liaison judge reported a good working relationship with the Probation Trust, supported by formal liaison meetings every six months, and informal meetings in between. The Trust considered working relationships were good were operating well.

2.3. The Trust published a bi-monthly newsletter providing general information about its service. It was keen to increase circulation by sending it direct to sentencers electronically, but only half of them were said to have email access.

2.4. Pre-sentence reports (PSRs) were supported by appended leaflets giving details of any specific interventions proposed where necessary. Judges had been able to visit the domestic violence and sex offender group programmes, arranged through the liaison judge. The Trust had a small opportunity for input into the twice-yearly sentencer training, but this was very restricted due to the increased amount of other material sentencers had to cover.

2.5. The district judge indicated that the strategic relationship between the Trust and the district judges may not have been as good as that with the lay magistrates and Crown Court sentencers, and since her appointment she had received little formal contact from the strategic leadership of the Trust.

2.6. The District Judge observed that all of the probation liaison staff were 'enthusiastic, keen and helpful', and as noted above, the sentencers we met thought the quality of court reports was very good. They considered the Probation Trust had been responsive to their demand to deal with more cases by way of oral reports.

2.7. The Trust considered it could produce a significantly higher proportion of reports at court on the day of sentence, but for the lack of suitable accommodation at court to work in. Both the senior managers of the Trust and the sentencers we met expressed their frustration at the total lack of appropriate accommodation for probation liaison activities within all of the criminal court buildings in Merseyside. This was a longstanding and intractable problem that prevented more effective delivery of court liaison services and more timely sentencing. The Trust was increasingly concerned about this, anticipating that court liaison work would be even more central to the business of the Trust in the future.

2.8. The inspection did not reveal any significant differences in the quality of liaison work between probation officer (PO) and probation services officer (PSO) staff. A recent internal review of the work had indicated a need to refresh and restructure the internal and external working relationships of liaison staff in readiness for changed organisational structures in the near future. The Trust had been a part of local arrangements for early adoption of the electronic transmission of pre sentence disclosure packages.

2.9. As noted above, the quality of PSRs was generally sufficient, although the formal arrangements for the 'gatekeeping' of reports had fallen into disuse in St Helen's and Liverpool North local delivery units (LDUs).

2.10. Sentencers thought that in the magistrates' court they sometimes needed more detailed information as to whether ordering a curfew was or was not appropriate. They also noted that they now received far less information than in the past on bail cases, and that the Bail Accommodation Support Service was not well publicised. This echoed a key finding from our recent thematic inspection on women offenders[1].

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1 HMI Probation, (October 2011), *Equal but different?: An inspection of the use of alternatives to custody for women offenders*, Ministry of Justice, London

Comments from sentencers:

"In court probation staff are there when you need them, we rarely have to wait more than five minutes for one."

"The probation staff are fabulous! If there are any problems, I raise these with [the local probation manager] and they are sorted."

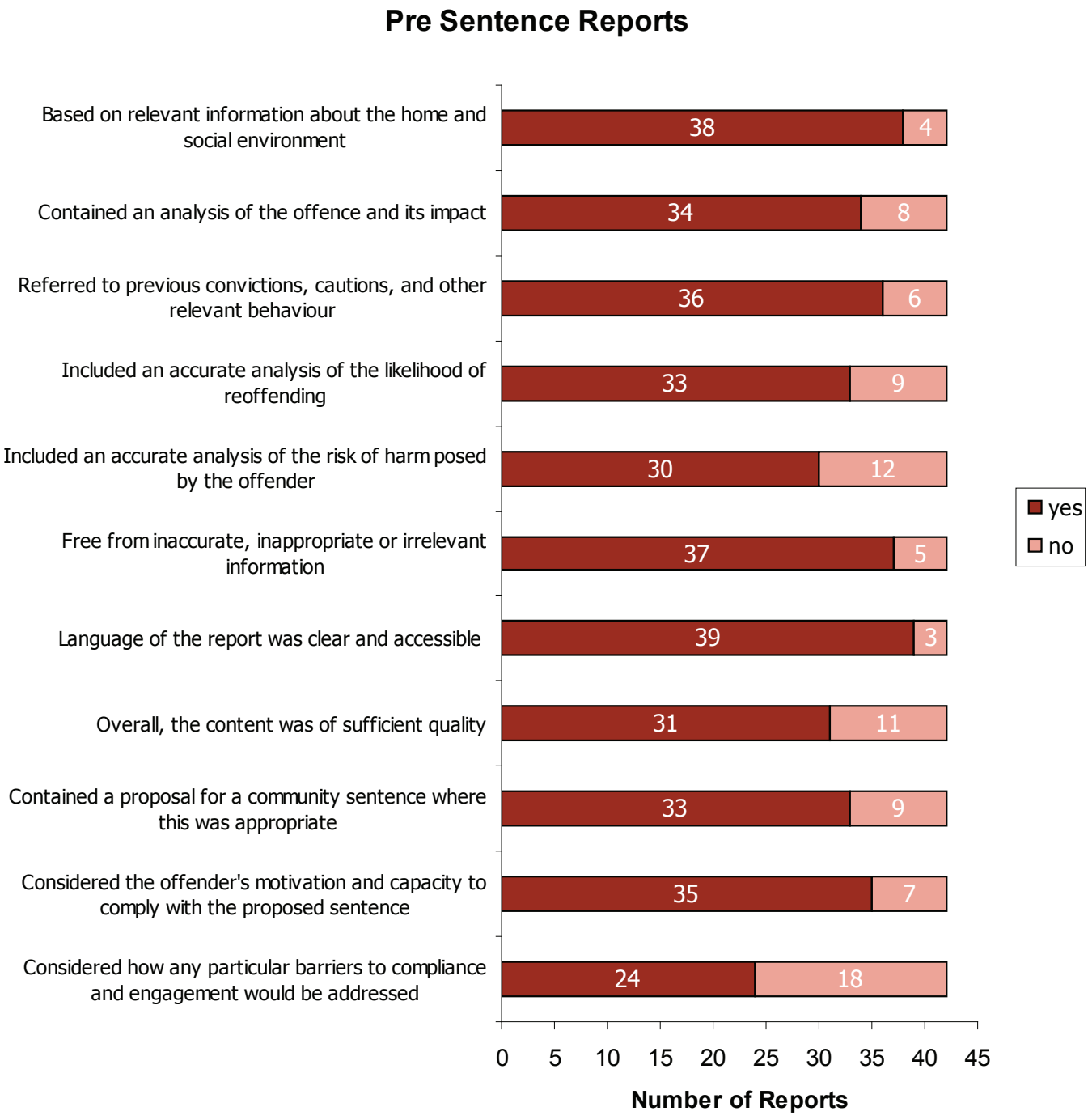
3. Summary

Overall, 79% of 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: 72 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 of the court

2

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, 83% of work to deliver the sentence of the court was done well enough.

Key strengths

1. Contact with offenders usually started promptly following sentence or release, and induction generally worked well. There was good assessment of individual needs and potential barriers to engagement, and usually sufficient assessment of factors to assist rehabilitation.
2. The quality of initial sentence plans was generally sufficient, and individuals were involved in the planning process. Objectives were usually appropriate to the purposes of sentencing and tackled issues linked with the likelihood of reoffending, risk of harm to others and alcohol issues. Planned levels and patterns of contact were generally appropriate and recorded.
3. In most cases interventions were delivered in line with the sentence plan and help was given to improve the individual's social networks and sources of support. People were encouraged to engage with their sentence and their individual needs were taken into account.
4. Sentence requirements were generally carried out as intended and sentence plan objectives were achieved fully or partly in almost all cases. Most people had not been charged with, or convicted of, a new offence during their sentence.
5. People on supervision were largely positive about their experience of contact with the Probation Trust.
6. Offender managers had good oversight of their cases. Attendance was monitored and effective action taken if there were missed appointments. Judgements about absences and behaviour, and warnings and enforcement proceedings or recall were used appropriately.
7. Offender managers received regular formal supervision and almost all held positive views about the quality and support of line managers. Most had opportunities to discuss practice issues with colleagues and many were involved in professional development activities. Nearly all thought the Trust promoted a culture of learning and development.

Key areas for improvements

1. In some cases initial sentence planning should have been more timely and better informed. In a number of cases no initial sentence plan had been produced.
2. More attention needed to be paid to the individual's motivation and capacity to change, and the methods most likely to be effective in working with them.
3. Some plans did not include objectives to manage child protection or other multi-agency risk management work, and did not include actions to deal with barriers to engagement. In many instances it was unclear when the case would be reviewed.

4. Sentence plan reviews were not sufficiently timely in many cases, and some had not been reviewed at all. More use could have been made of reviews as an opportunity to encourage the individual's commitment to their sentence, and enable them to participate fully.
5. Case records were well kept but they did not always fully reflect the work carried out with individuals.

Explanation of findings

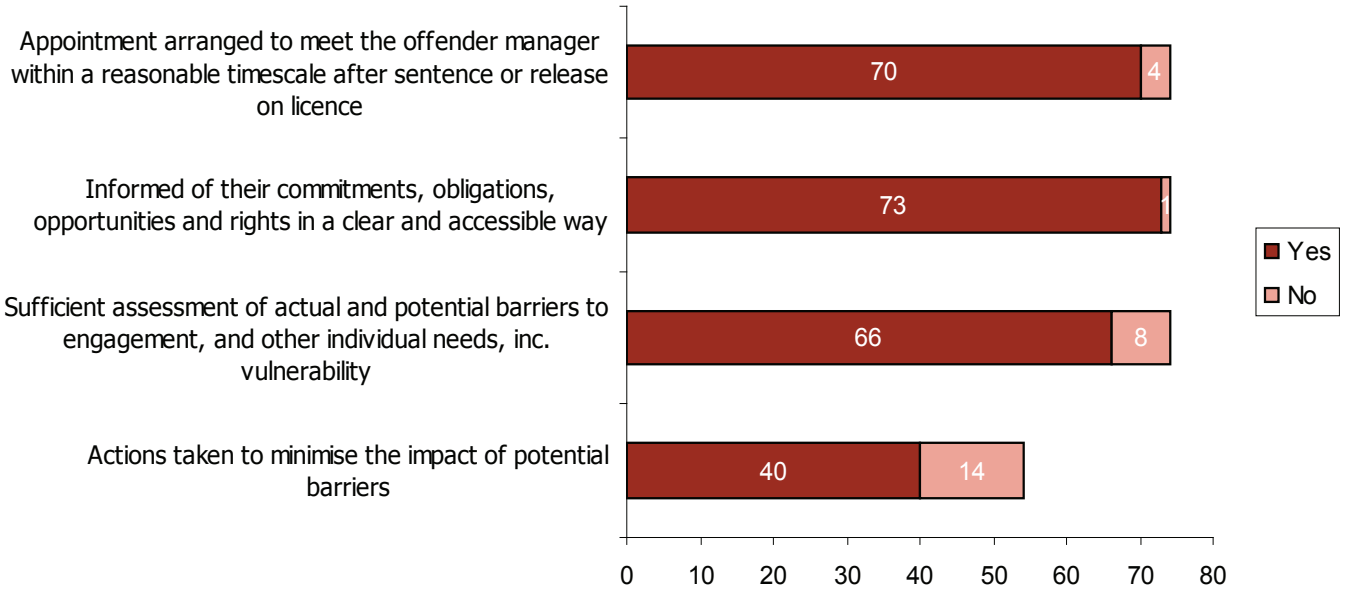
1. Assessment and planning to deliver the sentence

1.1. We assessed 74 cases as part of this inspection, of which 67 were clearly allocated to the correct tier of service at the start of sentence or release on licence or transfer into the area. The indicative tiering had not been followed in ten cases, but a valid reason for this had only been recorded in five of them.

1.2. In all but four of the cases an appointment was arranged for the individual to meet their offender manager soon after sentence. In all but five there was evidence they were offered a full, timely and individualised induction at the start of their order or licence.

1.3. Almost everyone starting supervision was clearly informed, in an understandable way, of their commitments, obligations, opportunities and rights in relation to their order or licence. In most cases there had been a sufficient assessment of the person's individual needs. This included any vulnerability issues and potential barriers to that person engaging with their sentence and completing it successfully, such as mental health problems or being homeless. The process was helped by the Trust's standard assessment form to identify potential diversity and engagement issues on induction.

Engaging people at the start of sentence



1.4. In sentence planning, we expect to see that individuals are actively and meaningfully involved in their drawing up their plan. We saw evidence of this in 73% of the cases, and this was reflected in the National Offender Management Service (NOMS) Offender Survey results for the Trust (see below). Overall, we found that a timely and informed sentence plan had been completed in 70% of cases, while in 18% the plan should have been done earlier and/or been better informed by the assessment of the individual's likelihood of reoffending, risk of harm or other issues. In 12% there was no initial plan at all.

1.5. In more than three-quarters of relevant cases there was sufficient assessment of factors likely to assist with rehabilitation. This included education, employability, accommodation and potential sources of support within the family or community.

1.6. However, in one-quarter of cases there was no evidence of a current Skills for Life screening or an assessment of the individual's access to primary health services. The latter is important given that the health of those who have offended is generally poorer than that of non-offending groups.

1.7. In nearly three-quarters of cases where such issues had been identified, sufficient action had been either taken or included in sentence planning to enhance the impact of these factors. The individual had been signposted to an appropriate service in most cases where that was required.

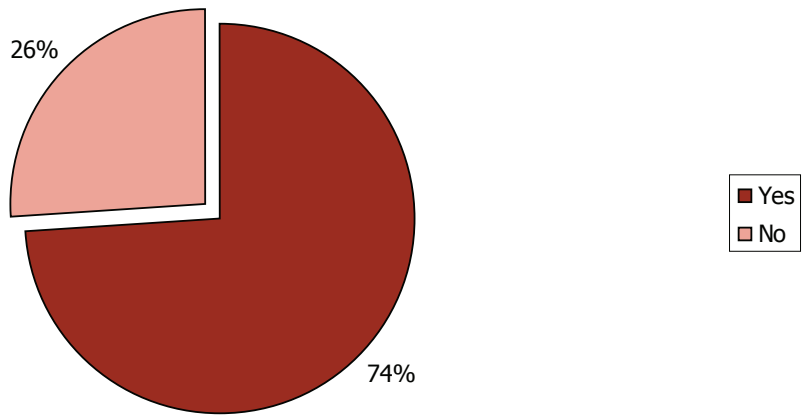
Practice illustration – diversity and engagement

Josh was convicted of domestic violence against his mother and older sister, and blamed his behaviour on his Asperger's syndrome. At the start of his community order the offender manager took time to research Asperger's in advance of meeting Josh so as to be well prepared. She also encouraged him to explain to her how the condition would affect his ability to engage with supervision and carry out the unpaid work included in his order. In fact, his condition was well managed. He had a good employment history but it led to difficulties within his family setting when emotions ran high, as at the time of the offence. The offender manager was sensitive to a bereavement and encouraged him to consider bereavement counselling. When he declined she signposted him towards family counselling as part of preparing for the end of supervision. This approach to working with diversity and promoting engagement was fully reflected in the sentence plan and risk management plan.

1.8. Sentence planning could have paid more attention to factors which might promote the individual's engagement and compliance with their sentence in one-quarter of the cases we inspected. In particular, in one-third, insufficient attention was paid to their strengths and aptitudes and the methods most likely to be effective in work with them. More attention was needed to the individual's level of motivation and capacity to change in one-quarter.

1.9. Consequently, actions needed to minimise the impact of potential barriers to engagement were not included in relevant planning documents in one-quarter of the cases.

Sentence planning paid sufficient attention to factors which may promote compliance



1.10. Sentence planning set appropriate objectives in nearly three-quarters of cases. Plans usually contained objectives which were appropriate to the purposes of sentencing and which tackled the factors linked with the likelihood of reoffending and risk of harm to others. However, there were no objectives to manage child protection concerns in 39% of relevant cases, or to address required actions from multi-agency risk management procedures, for example from Multi-Agency Public Protection Arrangements (MAPPA), in one-third of relevant cases.

1.11. The contribution of alcohol misuse to the offence was tackled sufficiently in sentence planning in most of the 46 relevant cases.

1.12. We expect to see sentence planning objectives which are clearly and simply worded, outcome-focused and set out achievable steps, but almost half of the plans did not meet these criteria. In more cases it was clearer what the individual had to do to achieve the objectives, but there were still more than one-third where it was hard to tell what was actually expected. The Trust anticipated that implementation of the new OASys-R with its range of improved standard sentence plan objectives would improve the quality of objective setting.

Practice illustration – sentence planning

Jon had committed a serious offence of wounding and had substance addiction problems, coupled with physical health concerns. His offender manager took a thoughtful approach to implementing his licence conditions. He sequenced the sentence plan so that work started first to tackle the drug and alcohol issues, as he believed that this would increase Jon's ability to complete the Thinking Skills Programme (TSP) which was a condition of his licence. Another sentence plan objective was to form friendships with non criminal people, and his ill health meant he no longer socialised with old criminal associates. To sustain this as his health improved the offender manager arranged for him to undertake education and training activities as an alternative, and used learning from the TSP programme to help him reflect on how he managed his life.

1.13. Planned levels of contact with the individual were generally appropriate to the case and were recorded.

1.14. In three-quarters of the cases there was a clear record of the contribution to be made by all workers in the case to achieving sentence planning objectives, and evidence that relevant parts of the plan had been communicated to other people involved.

1.15. In 43% of cases it was unclear when the sentence plan would be reviewed. The timescale for reviewing progress against objectives was unclear in 41%, and there was no indication of what changes might prompt an unscheduled review in 71%. 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. Interventions were delivered according to the requirements of the sentence and in line with sentence plan objectives in 82% of cases.

2.2. In most cases presenting a medium or high risk of harm to others, this was taken into account in the delivery of interventions, but this was not taken into account in one-third of cases posing a low risk of harm.

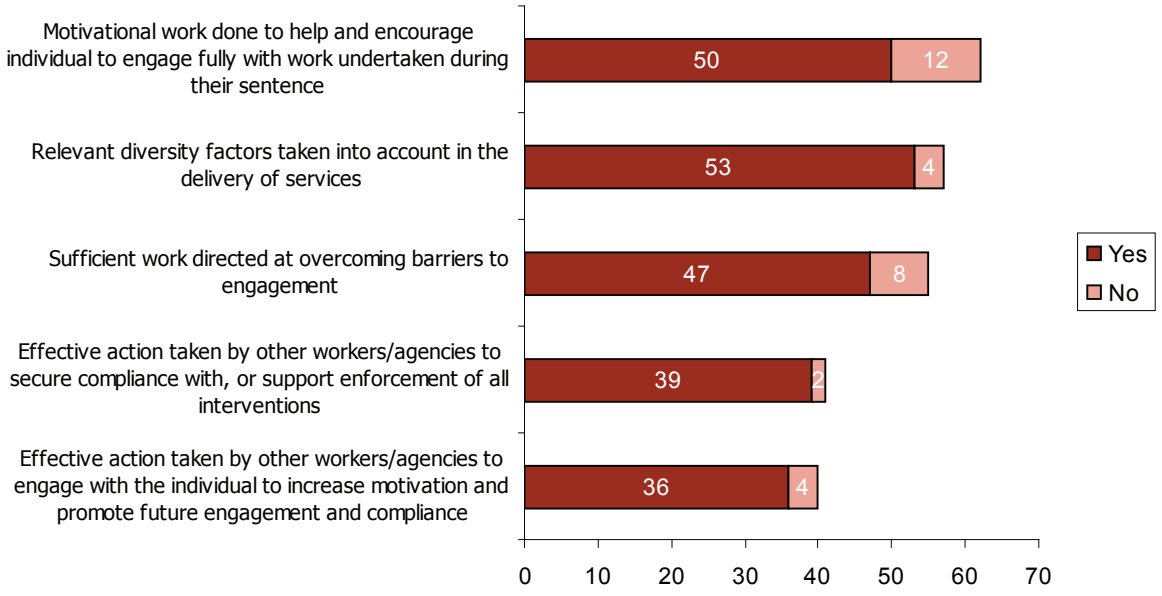
2.3. Most individuals also received sufficient help to improve their social networks and sources of support within the family and community where this was needed. But help was not always provided, where needed, in relation to education, training and employment (ETE) issues.

2.4. In most cases motivational work was done with individuals to encourage them to engage fully with their sentence, and any diversity factors and other individual needs were taken into account in the delivery of services in nearly all cases. In most cases sufficient work was done to help individuals

overcome any barriers they faced in getting through their order or licence, for example lack of settled accommodation, or mental health issues like depression.

2.5. The Trust had set up link workers from the interventions unit to liaise regularly with offender managers to support the management of the case, and provisional start dates for accredited programmes were provided to offender managers automatically after the making of a relevant order. There were also monthly 'interface' meetings between offender management and interventions staff to discuss possible barriers to offender engagement. Interventions unit link workers also visited Offender Management Units (OMUs) with 'netbooks' loaded with video recordings featuring experiences from accredited programme 'graduates', aimed to support and motivate prospective participants to attend.

Increasing motivation and promoting compliance with the sentence



2.6. The level of contact arranged with individuals was sufficient to promote positive outcomes in almost all cases. It was also sufficient to facilitate the delivery of the sentence, achieve sentence plan objectives and monitor changes in dynamic risk factors. There was enough contact with individuals to tackle their likelihood of reoffending and take full account of their level of risk of harm. The level of contact maintained with offenders in custody was enough to contribute to the post-release planning and case management in most licence cases.

2.7. Overall, sufficient resources were allocated throughout the sentence to address the purpose of the sentence, the likelihood of reoffending and risk of harm to others, and any relevant diversity needs.

2.8. In nearly all cases the offender manager took a leading role in relation to other workers in managing the sentence, and monitored attendance at appointments for supervision, rehabilitation work or for unpaid work.

2.9. 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.

2.10. In 42 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 every one of these cases, and the decisions made were reasonable, consistent and clearly recorded.

2.11. In all cases, a clear and timely formal warning was given to the individual, and enforcement

proceedings or recall were used appropriately in all cases where necessary. Clear explanations were always given to the individual about why they were being returned to court or recalled, and proceedings were started promptly. In most cases sufficient effort was made to re-engage the offender with their sentence plan, and encourage their commitment to continued engagement.

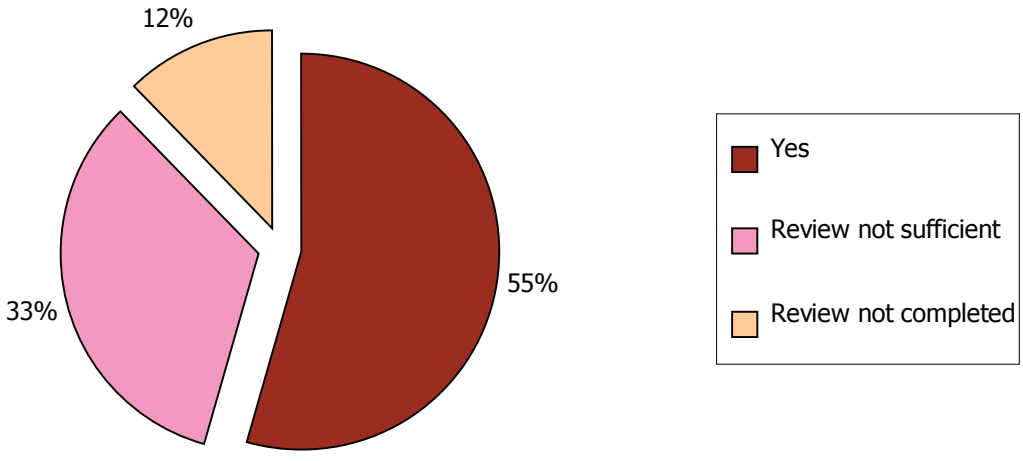
2.12. We expect to see sentence plans reviewed within the timescale stated in the initial plan or within a reasonable period. Where a review was required, this had been done sufficiently well in only 55% of cases. One-third were of insufficient quality, and in 12% no review had been undertaken at all.

2.13. In relation to timeliness, one-third of sentence plans had not been reviewed within a reasonable interval after the initial sentence plan or last review (given the specific nature of each case), and half had not been reviewed in line with the timescale stated in the initial plan. The leadership of the Trust was aware that this was a problem, and further information is given below.

2.14. The 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. However, reviews had not been done promptly following any significant change (such as completion of a key component of the sentence or a significant change of circumstances) in more than half of the relevant cases, nor used to allocate additional resources if required in almost half of those where necessary.

2.15. The Trust had issued guidance on events that should typically trigger a review of the case. Interventions staff were routinely passing to offender managers the details of cases that had and had not started specific planned interventions, so that they could be reviewed. However, middle managers we met observed that it was difficult routinely to check all cases to ensure this was occurring as required. Where they occurred, overly long intervals between initial assessment and planning and the first review may have contributed to the late delivery of interventions.

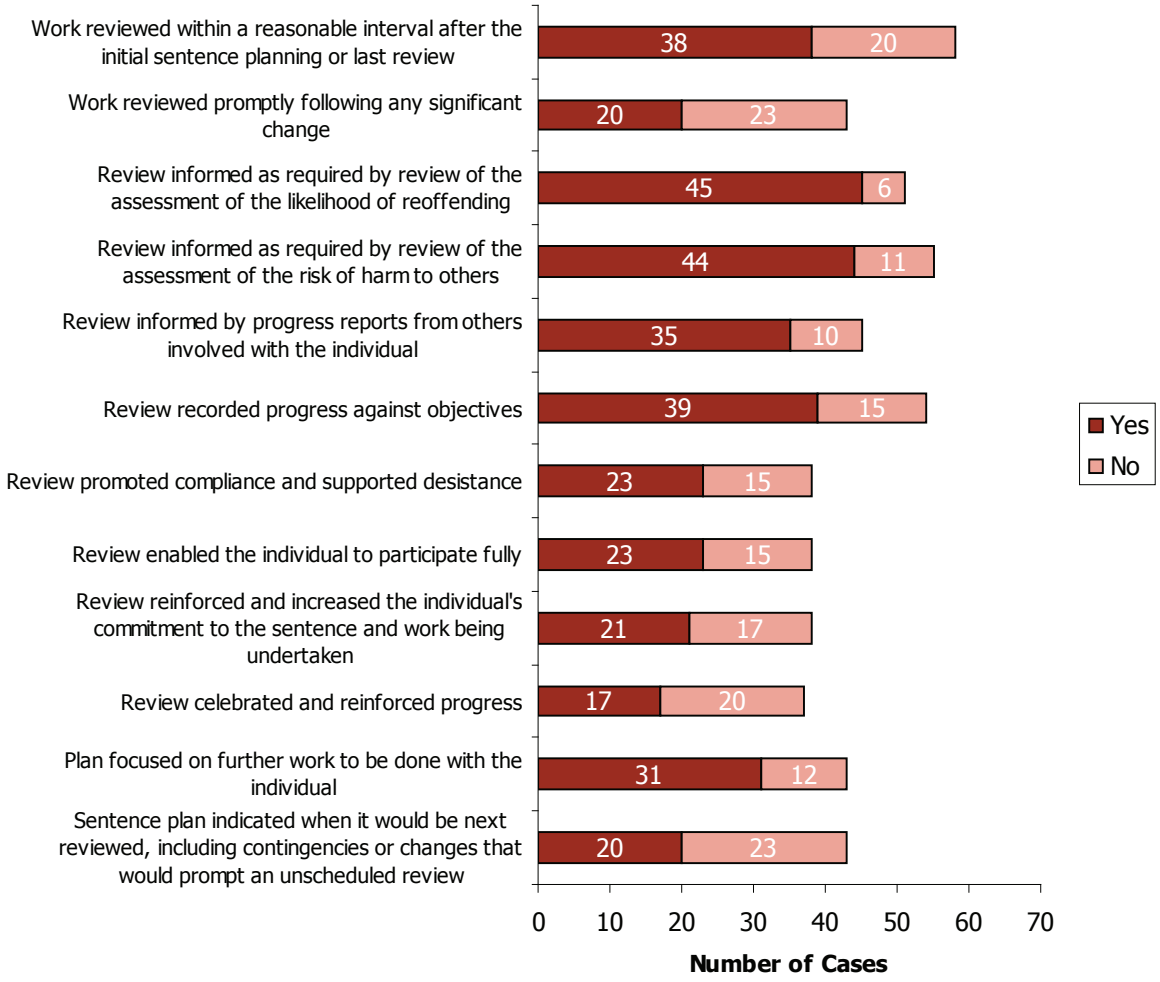
Sufficient review of the sentence plan



2.16. In more than one-third of cases sentence plan reviews were not being used to reinforce and increase the individual's commitment to their sentence, and not undertaken in a way which enabled the individual to participate fully. Less than half were used as an opportunity to celebrate the individuals' progress. These were missed opportunities to encourage individuals in their efforts to complete their sentence and desist from offending.

2.17. In more than one-quarter of cases reviews did not focus on the further work to be done with the individual, and did not describe the ongoing level and pattern of contact. Only half indicated when the sentence plan would be next reviewed, including a record of any contingencies or changes that would prompt an unscheduled review, or set a period for further reviews appropriate to the case. Seven cases had not been reallocated to a different level of service where a review had indicated this was necessary.

Reviewing sentence plans and reinforcing progress



2.18. Only four cases in our sample had been transferred between different Trusts or other organisations. All had been transferred into the Trust following a move of geographical area, and in all cases this had been handled appropriately by the Trust. In particular, the Trust had made an appointment with the person as soon as possible on arrival, and in two high risk of harm cases had undertaken a home visit to the offender's new address as soon as possible following notification of them living in the area.

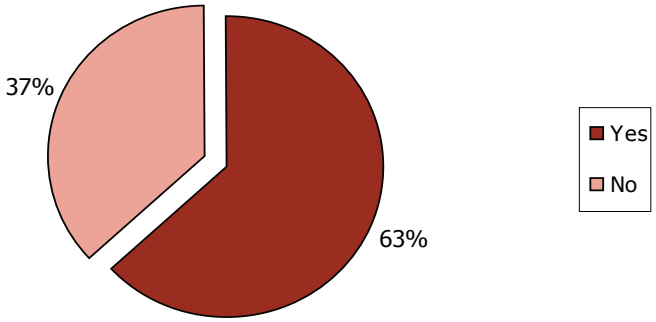
2.19. In most instances the case records (both electronic and paper) held sufficient information to support the management of the order or licence, and relevant information was usually accessible by or communicated to other workers involved in the case. Records were generally well organised and the recording of information was clear and timely, although some files lacked relevant documents. In one-fifth of the cases the records did not fully reflect the work carried out with the individual, and from discussion with offender managers it was clear that more work had gone into the cases than was actually evidenced.

3. Initial outcomes are achieved

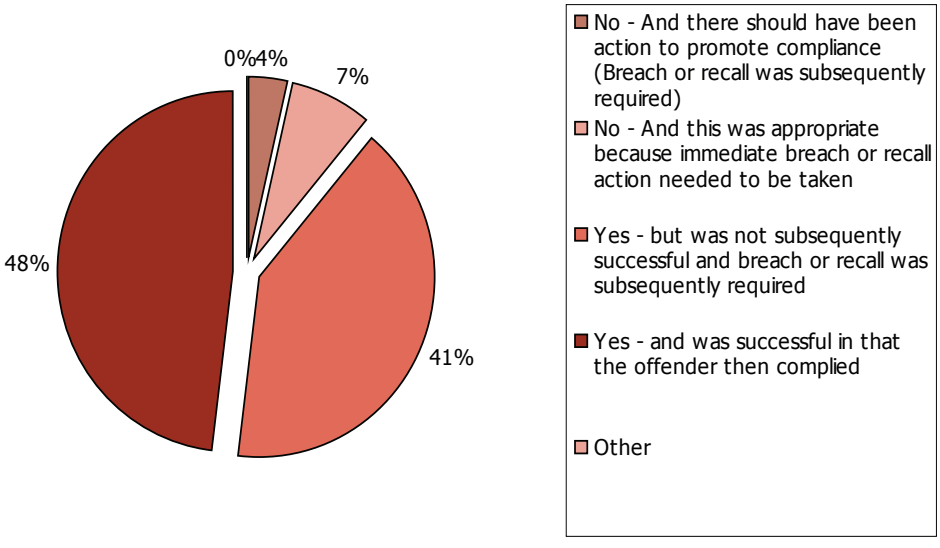
3.1. The requirements of the order or licence were delivered as intended in 81% of the cases in the sample. In those where they were not this was often due to the late delivery of specific interventions. In almost all cases reporting instructions given to individuals were sufficient for the purpose of carrying out the sentence of the court.

3.2. In 63% of cases the individual complied with the sentence without the need for additional action by the offender manager. In the remainder, either immediate breach or recall action was taken, or steps were taken by the offender manager to promote compliance. This was successful in half of the cases where undertaken, while in the others breach or recall action had to be taken subsequently. The offender manager did not take sufficient steps to promote compliance in only one case.

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

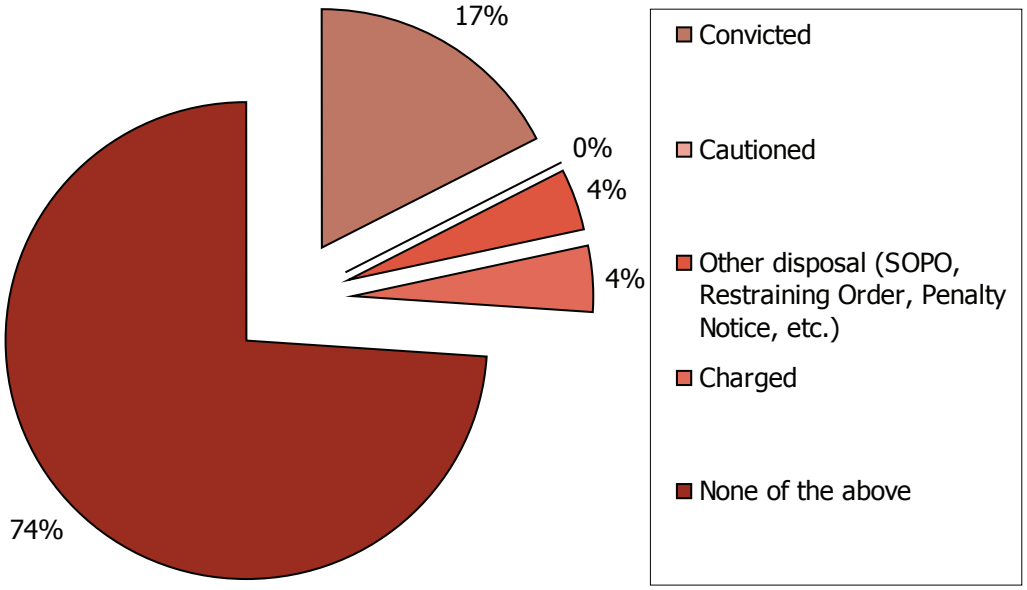


Action taken to promote compliance



3.3. In the case sample, 74% of individuals had not been cautioned for, charged with, or convicted of a further offence during the period of supervision we inspected.

Further offending committed since the start of the sentence or release on licence



3.4. Sentence planning objectives had been achieved fully in 15%, and partially in 59% of cases. The delivery of the sentence plan had usually been maintained when there was a change in offender manager.

3.5. Four cases in the sample had been appropriately terminated early for good progress, and we identified a further three cases that could have been but an application had not been made to the court. One case been terminated early but should not have been.

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

NOMS conducts an annual survey of the views of people in contact with Probation Trusts. For 2012, Merseyside received 586 responses for the three LDUs covered by this inspection, the data from which is given below.

- The findings were largely positive. The survey found a strong level of individuals' involvement in their sentence planning, consistent with our inspection findings. Their experiences of being on supervision were very positive, and this is also consistent with the generally positive findings of this inspection in relation to the achievement of positive outcomes.
- The large majority indicated they felt they had received sufficient help, and this was consistent with our finding that sentence planning objectives had been fully or partly achieved in three-quarters of cases.
- Most had no suggestions for improvement, but a number commented on the need to reduce the waiting time in reception before they were seen for their appointments. One remarked that the waiting room felt intimidating and he didn't feel safe there. These comments illustrate the potential for practical issues to undermine the positive work being done by many offender managers to motive people and engage with them positively.

Some comments from individuals

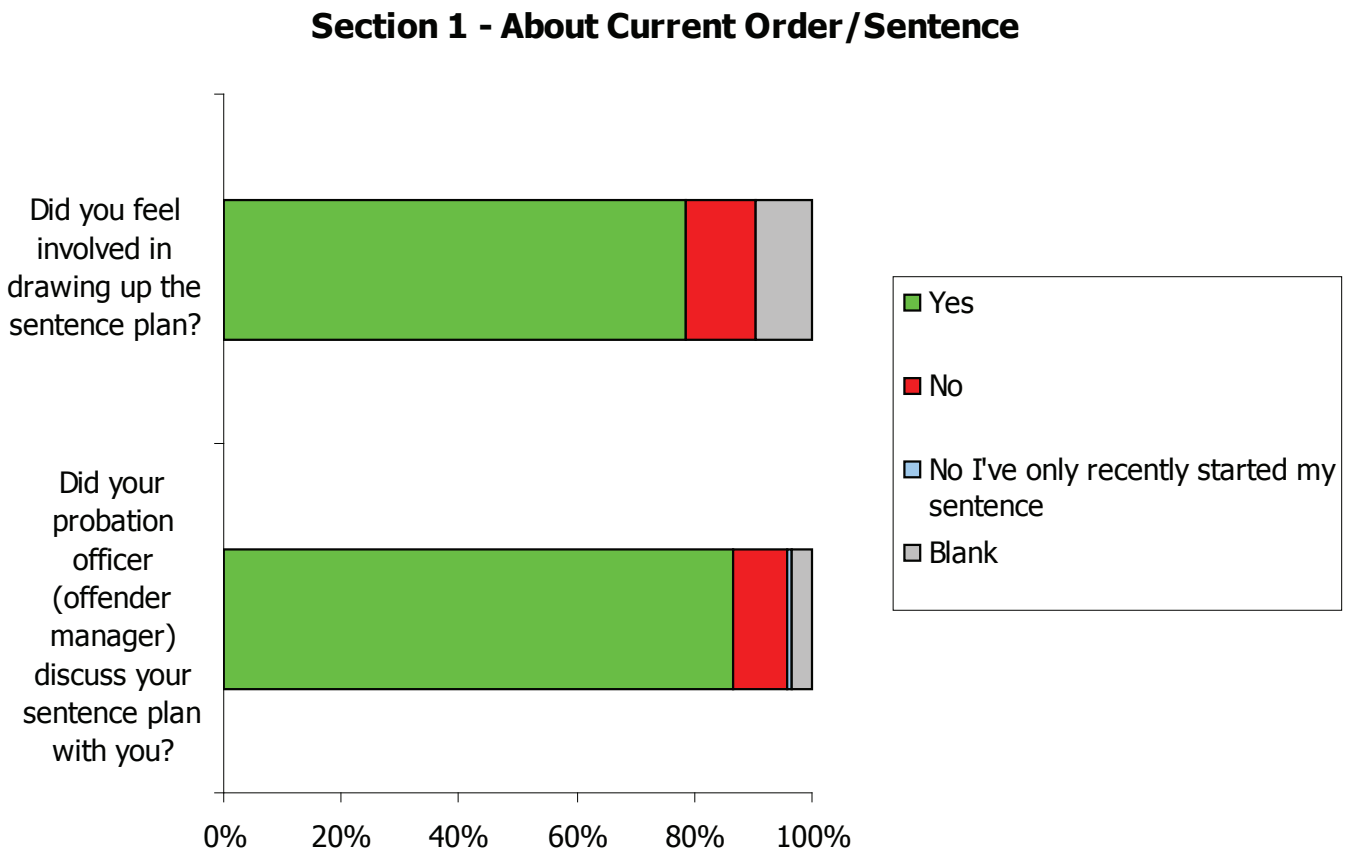
"I enjoy my meeting with my Probation Officer and she has tried to help me. I am grateful for all the help she has given me."

"I am glad I had this experience and I know in my heart I will no longer offend."

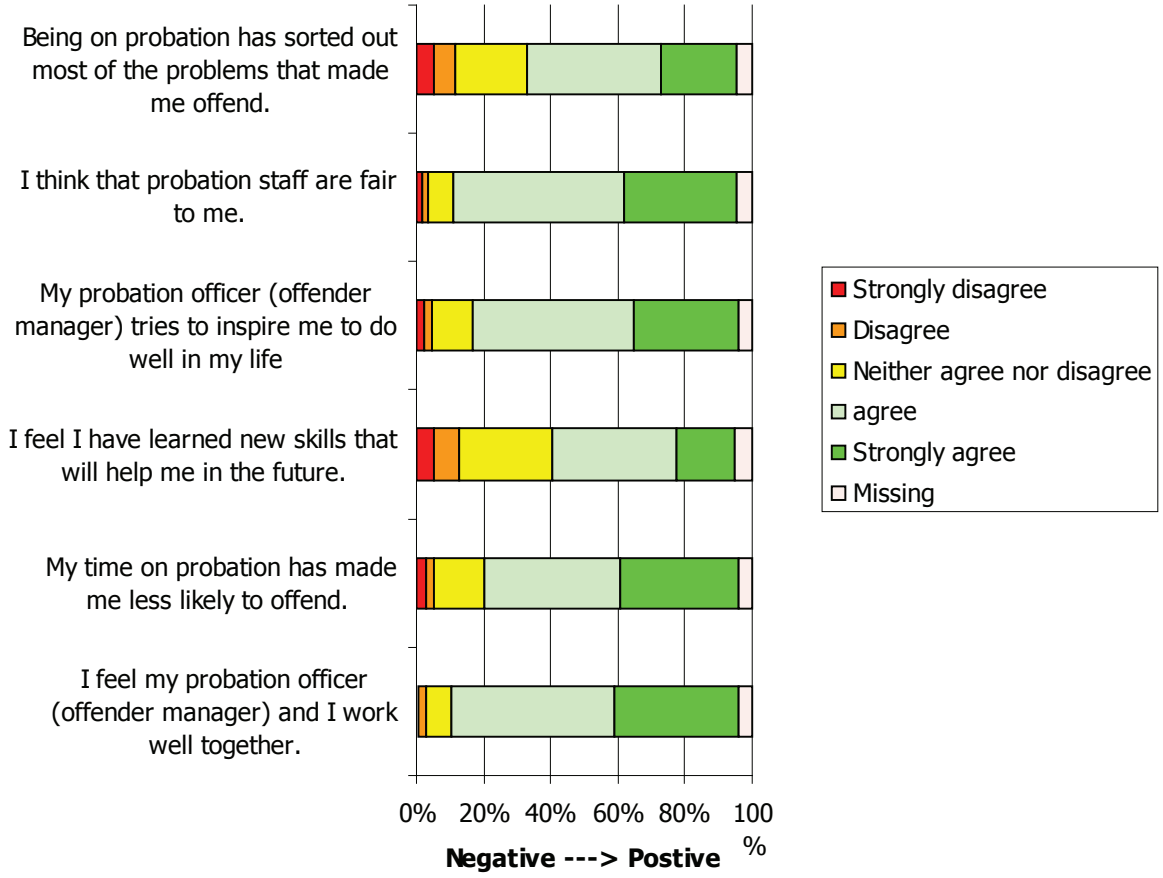
"My offender manager has given me so much support I have trusted her so much. I have talked about things I hadn't before. She is fair and honest and sincerely understanding. Thank you."

"I have found probation staff to be very helpful and it has been a pleasure to engage with them. They have been very supportive and have given good advice. I commend what they have achieved in the way of encouraging and motivating myself and others."

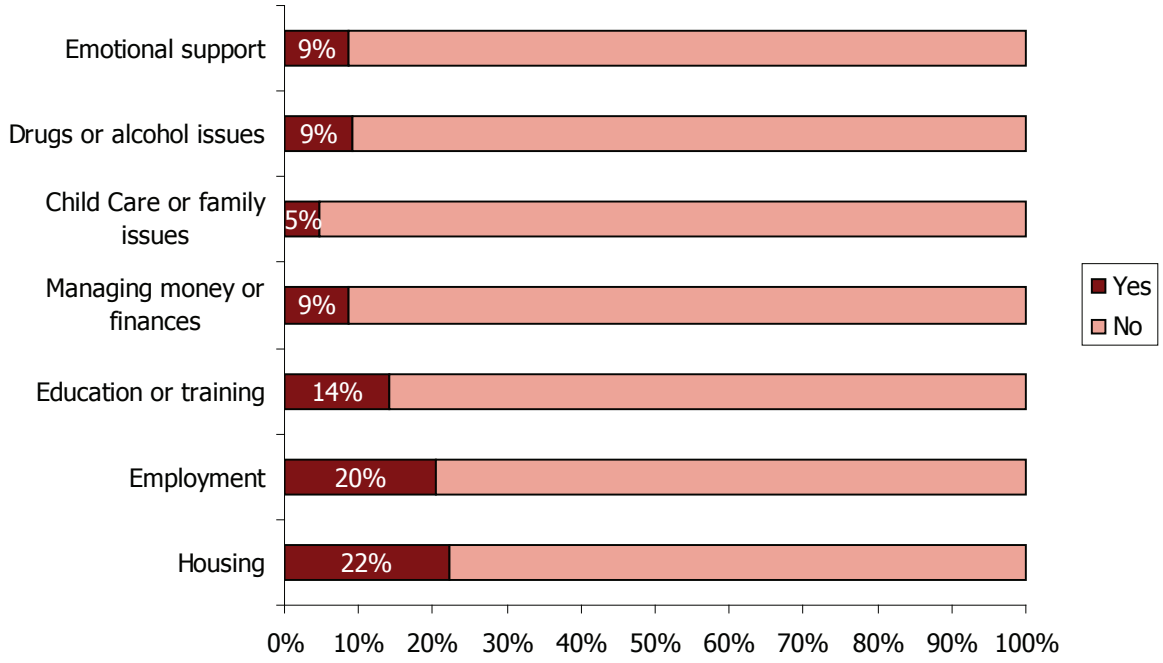
The charts below show some of the responses from the survey:



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 53 offender managers during the inspection (as part of the inspection of the 74 cases in the sample) to gain their views about their experience of working for the Trust. When asked about workloads, most thought that these were actively monitored, and two-thirds thought that they were managed in a fair and transparent way.

4.2. With respect to staff absences, 86% thought that planned absences, such as holiday leave or long-term sick leave, were managed in an effective way to minimise any disruption to the continuity of offender management. In relation to unplanned absences (such as short notice sickness), 78% thought they were handled to ensure that offenders were still seen as planned. The Trust had set out to improve performance on this issue following two Serious Further Offences (SFOs) two years ago, and guidance had been issued to reallocate cases as soon as it become apparent an offender manager could be away from work for longer than three weeks. Before the three week point, a 'buddy' system of shared oversight applied to Tier 4 cases, but arrangements for other cases were informal and commonly involved use of a duty officer system.

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 their development and support them. All but two thought that their manager was actively involved in helping them improve the quality of their work. Three-quarters thought that routine countersigning of their work and management oversight was an active process.

4.4. Of the offender managers we interviewed, half had regular, professional supervision (line management meetings) with their manager at quarterly intervals, with only five having supervision less frequently. The remainder had meetings more often, typically at six-weekly intervals.

4.5. Case discussion, personal well-being, and training and development featured in supervision for most of the staff we met, while career development was discussed with one-third.

4.6. Twenty of the offender managers had received mentoring or coaching at some time, given variously by managers, senior practitioners or other people. Sixteen reported that their practice had been observed, mostly by their manager, followed by feedback and discussion, and 16 had also been involved in action learning sets or similar structured learning.

4.7. The Trust had been implementing the Skills for Effective Engagement and Development and Supervision (SEEDS) project during the period of work covered by this inspection, and had moved progressively to have all offender managers trained in the SEEDS approach to offender engagement and their managers trained in reflective supervision.

4.8. This had started to encourage different approaches to offender contact and supervision, promoted by the strap line 'Doing thing differently – seeing beyond the risk'. The Trust was planning to develop service user councils and already had service user council groups for unpaid work and group programmes.

4.9. All line managers had received training in coaching and had been encouraged to change the focus of their management oversight from the auditing of progress against targets to reflective supervision on the quality of the personal interactions between offender managers and their cases.

4.10. Most offender managers thought that the particular methods used in supervision had promoted improvements in their practice, and only ten thought they had not. Of the 28 who indicated that they had relevant diversity needs, 26 of them thought that these had been reasonably addressed by the organisation.

4.11. In respect of learning and development opportunities, most offender managers either held or were working towards a relevant professional qualification. Nearly all thought that arrangements for ongoing training and development were sufficient to equip them to do their current job, but were slightly less positive about them meeting future development needs.

4.12. Just over half reported receiving 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, mental health problems or issues relating to offenders in the 18-21 age range.

4.13. All those who were interviewed felt confident that they could identify and work with child protection and safeguarding issues, although as noted later in this report, insufficient attention was paid to child safeguarding in relation to the offender's contact with any children in more than one-quarter of cases. This suggested further work was required to improve practice in the area of work.

4.14. Most offender managers spoke positively about formal opportunities to discuss practice issues with colleagues, and nearly all thought arrangements to share the earning from SFOs and Serious Case Reviews were sufficient or excellent. Overall, almost all the offender managers interviewed thought that the Trust promoted a culture of learning and development.

4.15. The Trust shared the services of a diversity manager with Cheshire Probation Trust. In response to the needs of working with ethnic minority offenders, and particularly foreign nationals from eastern European and those seeking asylum, the Trust had set up a mentoring project consisting of two paid staff plus volunteer mentors to provide additional support in working with these cases. As noted above we found that more attention could have been paid to factors which might promote the individual's engagement and compliance in some cases, but the Trust was running a number of projects to address this.

4.16. Work was being done to improve written materials to make them more accessible for people with dyslexia and to use more simple English. There was a strategy to develop a more consistent approach to the needs of women offenders, including the use of specialist offender managers working in conjunction with voluntary providers or in partnership with other agencies, along with the development of tailored interventions. The unpaid work unit undertook work projects in faith centres and interpreters were used routinely where required for unpaid work induction and health and safety training sessions.

4.17. As noted above, the Trust was aware that some cases were not being reviewed when required following the move to the new National Standards, either within a reasonable timescale given nature of the case or following a specific event.

4.18. The Trust had issued guidance on specific events that would typically trigger a review of the case, and interventions staff were routinely feeding details of cases that had or had not started specific planned interventions. However, middle managers we met observed that it was difficult to routinely check all cases to ensure this was occurring as required.

4.19. The Trust had sought to address this along with the need to improve the learning opportunity presented by SFOs. They had circulated a test case to offender management teams asking them to submit a document identifying what they would have done differently in the case.

4.20. Strategic leaders thought that the creation of Practice Development Officer posts 18 months ago had made a significant impact on the quality of OASys entries, and staff responded well to them, viewing them as a resource to their own learning.

Summary

Overall, 83% of work to deliver the sentence of the court was done well enough.

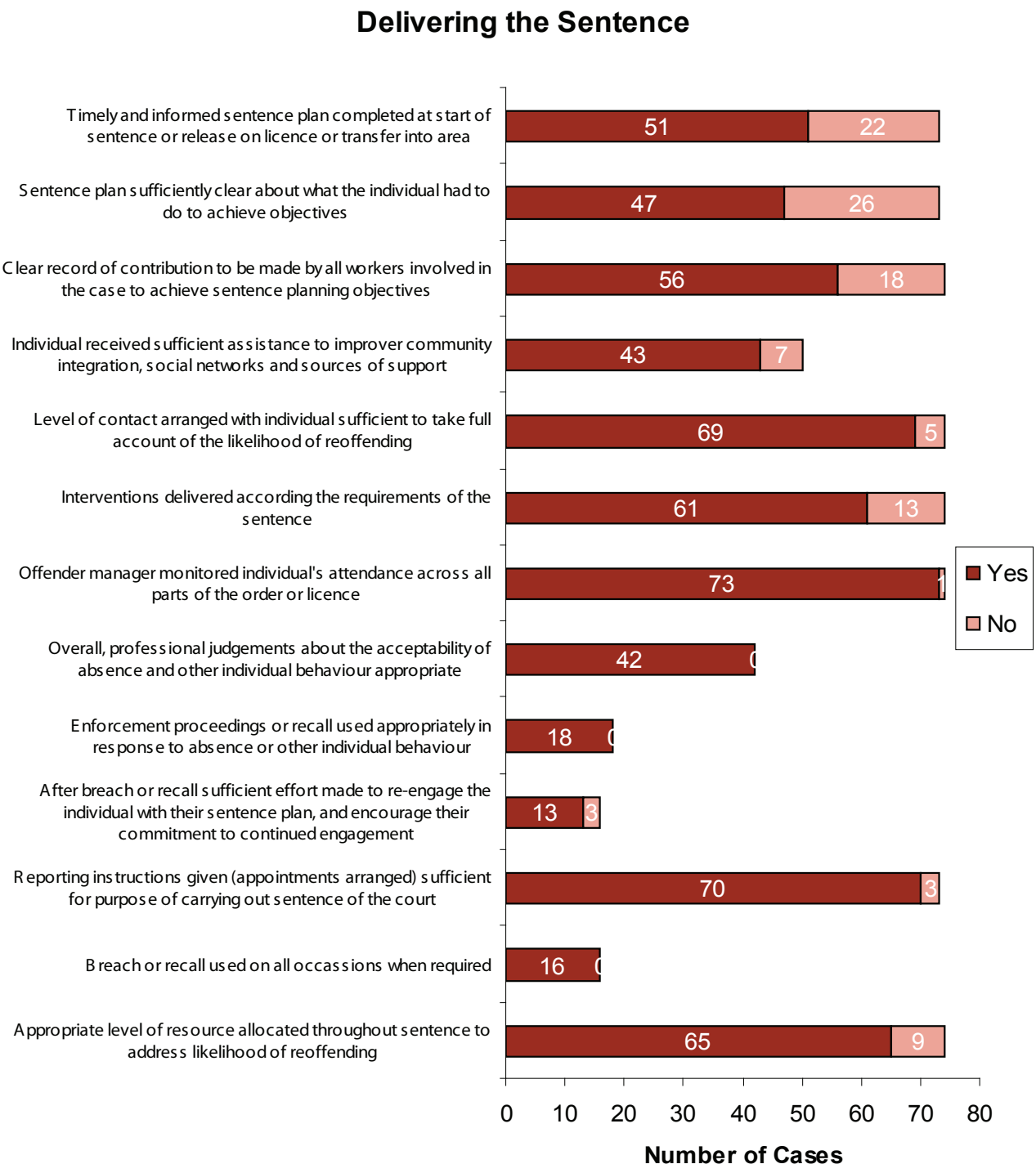
We have recommended that post-inspection improvement work focuses on ensuring that:

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

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: 74 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case].



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 75% of work to reduce the likelihood of reoffending was done well enough.

Key strengths

1. Assessments of the likelihood of reoffending were generally sufficient, taking into account relevant previous behaviour and information from the individual's home and social environment and the factors which contributed to offending.
2. In many cases, alcohol misuse was a factor which made the individual more likely to reoffend, and it was nearly always considered sufficiently in assessments.
3. Individuals were well prepared for the interventions delivered throughout their community order or licence, and in most cases the offender manager regularly reviewed with the individual the work they had done in other parts of their order or licence. Most individuals were informed of local services which could support them in their rehabilitation, and were referred if this was needed.
4. More than 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.
5. Resources had generally been used efficiently to achieve the planned outcomes with the individual.
6. The provision of group and other structured interventions was well resourced by the Trust. A range was provided to tackle local patterns of offending, many in partnership with other organisations. These included programmes covering domestic and other violence, and addressing alcohol and drug misuse and mental health issues.

Key areas for improvement

1. Individuals were not always actively and meaningfully involved in the assessment of their likelihood of reoffending.
2. Interventions to address alcohol problems were lacking in one-quarter of relevant cases.
3. 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

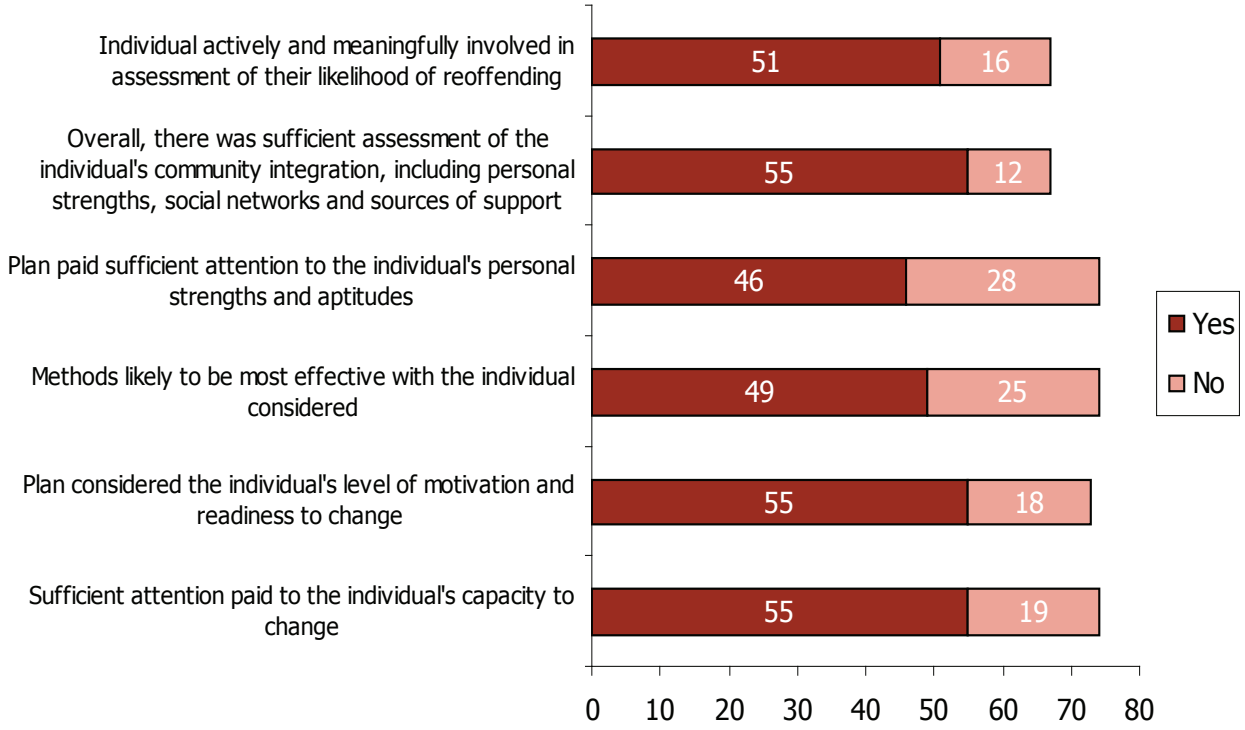
1.1. An assessment of the factors which may contribute to the likelihood of further offending was required in 66 of the cases in our sample (the other cases being a community order or suspended

sentence order where the only requirement was unpaid work). In six cases no such assessment was completed. In the other cases, all but eight assessments of the likelihood of reoffending were judged to be sufficient.

1.2. Generally, completion of assessments was timely, and they 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. Slightly more could have drawn more fully on all available sources of information.

1.3. We expect that individuals are actively and meaningfully involved in the assessment of the factors related to their offending and of what will help them to desist from reoffending. Evidence of this was lacking in one-quarter of the cases. In some instances this might have been due to minimal recording of such activity.

Involving people in assessing the likelihood of them reoffending

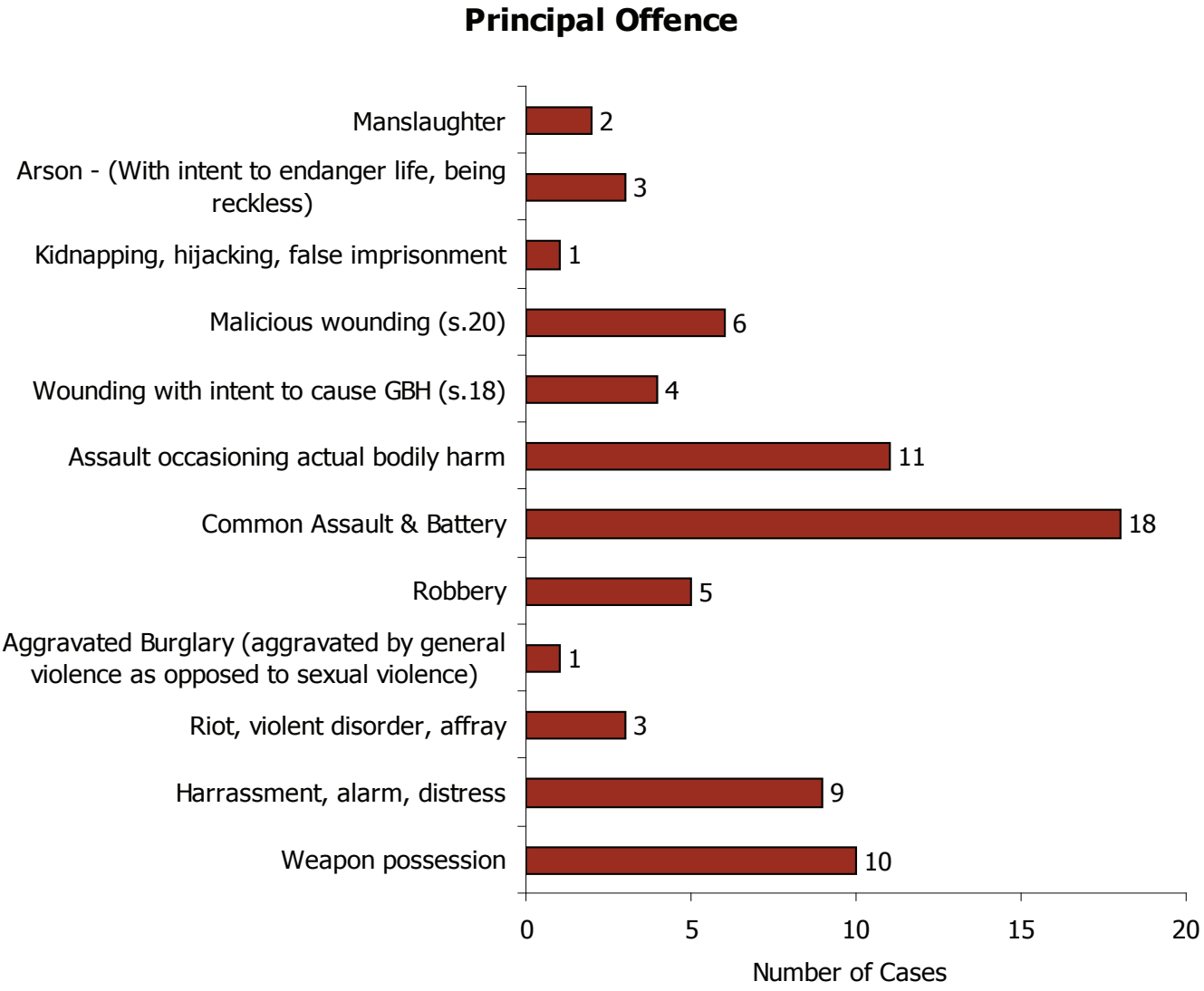


1.4. If offending-related factors are not recognised in the assessment then it is unlikely that the right interventions will be provided. Over the 74 cases, there were a variety of factors which were related to the likelihood of reoffending. Based on our assessment of the cases the most prevalent were thinking and behaviour (89% of the cases), followed by alcohol misuse (68%) and difficulties handling relationships (62%).

1.5. 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. Of the 46 cases where we judged that alcohol misuse was a factor which made the individual more likely to reoffend, this was taken into account sufficiently in the assessment in all but four.

1.6. In addition to those factors listed above, more than one-third of the cases had problems relating to emotional well-being (including mental health and behavioural issues), attitudes to offending, and lifestyle and associates.

1.7. Offenders in our sample were convicted of a range of offences, counting the 'principal' (most serious) of the offences for which the current sentence been passed. A detailed breakdown of the principal offences is given in the chart below.



1.8. While in ten cases the principal offence related to possession of a weapon, in a total of 24 cases (one-third of the sample) the offence(s) had involved the use, carrying or possession of a weapon (in 14 cases alongside more serious offences).

1.9. In one-third of the cases the offences had involved domestic violence. Half of the cases were likely to have resulted in psychological harm, while 55% involved physical violence. Race, religion or other hate appeared to have been a motivating factor in only four cases.

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 80% of cases. A similar proportion of cases showed that work with the individual kept a focus on the changes they needed to make to their behaviour.

2.2. The Trust had an appropriate range of accredited programmes available to address the different types of offending, and broadly there was sufficient capacity to deliver programmes to address both domestic and other violence. In many cases that were ineligible or unsuitable to undertake a group programme we saw evidence of planned and structured work being done individually to address offending-related factors.

2.3. Overall, the Trust had a broad selection of interventions available to address the range of violent offending found in our sample.

2.4. Twenty-seven cases in the sample included the planned delivery of an accredited programme. These included Community Domestic Violence Programme (CDVP) (14 cases), TSP (nine cases) and Controlling Anger and Learning to Manage it (CALM) (one case). A small number of other programmes were also delivered to address alcohol problems or sexual offending. This range of interventions used in the sample both reflected and was appropriate to the range of offending behaviours noted above. Where generic interventions were being used, such as the TSP, it was usually clear that the programme was intended to address specific and relevant behaviours, such as poor consequential thinking in the handling of disputes and arguments leading to violence.

2.5. In three-quarters 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. In the remainder it was in equal proportions either delivered later than planned or had not yet been delivered but should have been, some nine months in to the order or licence. There were a variety of reasons for this, but all of them related to factors concerning the individual and not the arrangements for the delivery of the programme itself.

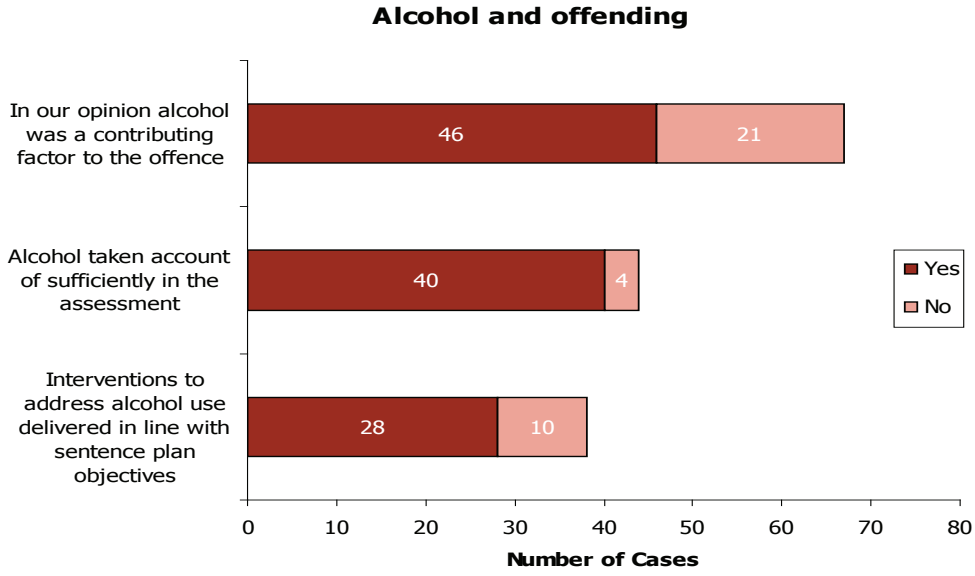
2.6. The general arrangements for the delivery of accredited programmes provided some flexibility as to when and where particular programmes were delivered, with issues of geography, transport and conflicting gang membership taken into account.

2.7. The overall balance of daytime and evening provision of programmes was appropriate to the circumstances of the caseload, with more evening provision of the CDVP and Drink Impaired Drivers (DID) programmes, which typically had higher numbers of employed participants.

2.8. There were four approved premises in the Merseyside Probation Trust area, providing controlled accommodation for offenders under supervision. Fifteen cases in the sample involved people who had been resident in approved premises, and constructive interventions had been provided for 11 of these. In other cases, the use of approved premises was only to provide restriction or emergency accommodation to manage risk of harm.

2.9. In 20 cases, the individual's sentence contained a specified activity requirement, for example in relation to tackling alcohol use. In 15 of these the delivery of the specified activity made the intended contribution to the planned work with the person who had offended.

2.10. In one-quarter of those cases where we judged that alcohol misuse was a factor which made the individual more likely to reoffend, relevant interventions to address this had not been delivered.



2.11. In almost all cases, individuals were well prepared for the interventions delivered throughout their community order or licence, for example accredited programmes including work that needed to be done by the offender manager with the individual before they started the group work element of the programme. In 82% of cases, the offender manager then regularly reviewed with the individual the work they had done in other parts of their order or licence.

2.12. Interventions staff reported that most offender managers maintained regular contact with their cases even when the main focus of the offender's supervision was weekly attendance on a programme. There was evidence in case records of ongoing contact between programme providers and offender managers to monitor compliance and support learning, and involvement of offender managers in programme review meetings.

Practice illustration – delivery of interventions

Matt was on a licence that included attendance on the TSP, and during the programme he had said he thought his mother and family were people in his life that would help him not to reoffend and support him not to drink – a key factor in his violent offending. However, his offender manager was aware of evidence that his mother was also a heavy drinker and there was a history of violent and abusive behaviour between Matt and his mother, dating from when he was a child. Moreover, his mother had also been in a number of violent relationships with men who had physically and possibly sexually abused Matt in the past. Following a three way meeting between Matt, his offender manager and the programme tutor, the offender manager made a home visit to meet the mother and other family members. This helped her to get a clearer and objective picture of the dynamics in the family and to focus her assessment and planning, including work with Matt to increase his awareness of the triggers for conflict within the family.

2.13. To support and sustain their desistance from offending, four-fifths of individuals were informed of relevant local services that could assist them, and were then referred to these services if relevant.

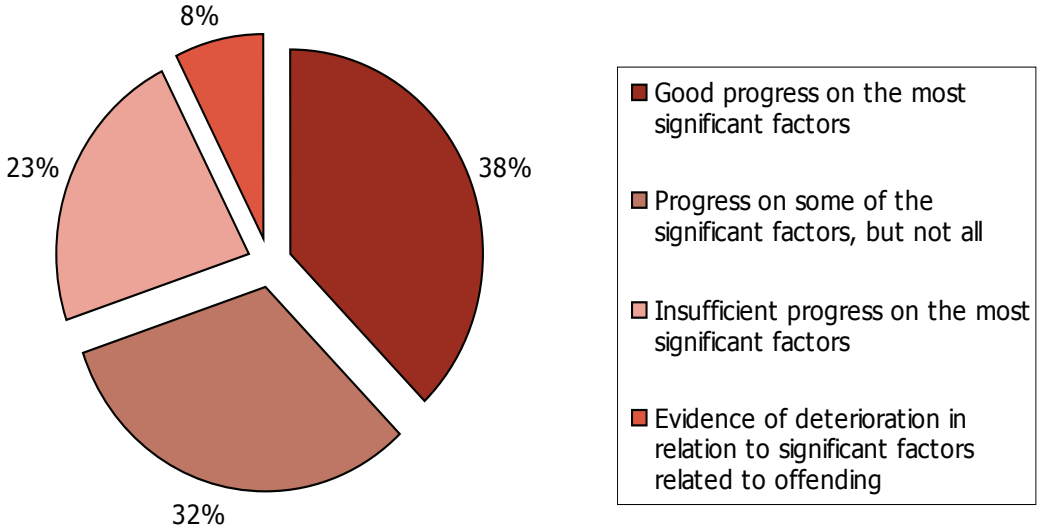
2.14. We expect to see the assessment of the likelihood of reoffending reviewed thoroughly when required, but in only just over half of the cases had there been a sufficient review. In nearly one-third of cases the review was insufficient, and ten cases it had not been reviewed at all. Whilst changes in relevant factors were taken into account in most cases where reviews were done, in many cases the assessment was not reviewed within a reasonable interval after the initial assessment or following any significant change. As noted in Section 2, where they occurred, overly long intervals between initial assessment and planning and the first review may have contributed to the late delivery of interventions.

3. Likelihood of reoffending is reduced

3.1. There was a sufficient record of the degree of progress or change made by the offender in 78% of the cases. If planned work with the individual had been completed, we would expect to see improvements in factors associated with the likelihood of reoffending, by the time of our inspection some nine months into the sentence or release from custody.

3.2. We found 38% had made good progress and a further 32% some progress on the most significant factors. In 23% of the cases we thought that there had been insufficient progress in respect of the most significant factors for that individual, while in a few there was evidence of deterioration.

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



3.3. The overall amount of progress made, given the relatively short length of time since sentence or release from custody, was sufficient. This reflected the findings noted earlier, that in a large majority of cases orders and licences were delivered as intended and sentence plan objectives fully or partially achieved.

3.4. In relation to those factors associated with offending (as noted above), we assessed whether, by this point in the sentence, sufficient interventions or services had been delivered, and sufficient progress had been made. The proportions of cases were as follows:

	Of those cases where the factor was identified, the % where	
Prevalent offending-related factor (and number of cases identified by us where this applied):	**Sufficient interventions or services were delivered was:**	**Sufficient progress was made:**
Most prevalent factors:		
thinking and behaviour (66)	65%	59%
alcohol misuse (50)	60%	52%
difficulties handling relationships (46)	59%	46%
Other common factors		
emotional well-being (29)	48%	45%
attitudes to offending (26)	58%	46%
lifestyle and associates (27)	44%	44%

3.5. Resources had been used efficiently to help the individual achieve the planned outcomes in 82% of cases, but only two-thirds of cases showed improved integration into the community or improved family relationships. Where relevant, in a similar proportion of cases, no action had been taken or plans put in place to ensure that positive outcomes were sustainable beyond the end of the sentence.

4. Leadership and management to reduce the likelihood of reoffending

4.1. The Trust had a strong focus on the delivery of interventions and on developing new provision and piloting new ways of working. Offender managers had positive views about the range of interventions available to them, with 83% of those we met rating it as sufficient or excellent. Offender management teams in Merseyside were broadly generic, but with specialist offender managers for women offenders and drug rehabilitation cases. Each LDU had a prolific or other priority offender (PPO) or Prolific Offender Unit.

4.2. The Trust delivered a range of accredited programmes including CALM, CDVP, Building Skills for Recovery (BSR), Northumbria Sex Offender Groupwork (NSOG), TSP and DID programmes, and had reviewed the NOMS offence segmentation data to check that the range of available interventions matched local needs. A gap in provision for 18-24 year old males was identified and being addressed specifically by the Board who had recently co-commissioned a review of Youth Offending Team to probation transition. The Trust planned to pilot the use of Footsteps (a personal development programme) with this group.

4.3. The Trust was also aware that some CDVP participants were not mature enough for that programme and were looking at developing an alternative. There was no programme provision for same sex domestic violence, but the Trust planned to deliver the Building Better Relationships (BBR) programme as a replacement for CDVP as soon as possible.

4.4. While the Trust was not running any specific gun and gang crime interventions, it had established specialist offender manager posts to work with these issues. The Trust was also developing a project with others to deliver a multi-agency response to gun and gang crime which involved structured intervention.

4.5. The relatively local nature of the population in nearby prisons supported both the delivery of some programmes by the Trust in prison, and the release of prisoners on temporary licence to attend programmes delivered in the community.

4.6. Some staff we met remarked on the closure of the Trust's library of resources that could be used in individual work with cases. There was a particular need for material for work on violent offending. While there was material available and staff could use Electronic Probation Information System (EPIC) as a source of information, the Trust recognised work needed to be done to prevent IT system security blocking access to such material.

4.7. The Trust had concentrated the resources devoted to the delivery of specified activity requirements to a small number of interventions that filled specific gaps in provision. These included the Footsteps programme, a 'healthy relationships' course that could be used for those who did not meet the eligibility criteria for the CDVP and a programme focused on promoting human dignity as a tool to address hate crime. The approved premises were delivering a general ETE programme jointly with The Manchester College, that worked with residents to focus on their goals and support them towards employment.

4.8. A dedicated accommodation unit provided a range of accommodation services and was working to sustain work done by the approved premises residents in placing offenders in move-on accommodation, and was tracking the longer term outcome of tenancies.

4.9. The provision of specialist offender managers to work with women was being supported by a variety of projects that were provided according to different local need in each LDU. This included the

provision of special placement for women on unpaid work based on sharing resources at Adelaide House approved premises for women, and dedicated DIDs and drugs programmes when numbers allowed.

4.10. A specialist 'Resettle Project' was working with those with identified personality disorders, including those who were not formally diagnosed, and who fitted the eligibility categories for MAPPA. The project took over the offender management of cases referred and provided coordinated services from a range of organisations, including forensic psychology.

4.11. A joint NOMS/Department of Health funded project was running a project in Stafford House approved premises based on a similar model to a therapeutic community. Using a range of psychological and behavioural concepts it sought to increase offender engagement, and use everyday personal interactions to promote change in behaviour and desistance from offending.

4.12. The SEEDS project, noted in the previous section, had started to encourage different approaches to offender contact and supervision. It had begun to change the approach to risk management and recall on licence, with a greater pre-emptive effort being made to work alongside and sustain offenders in the community, to avoid the need to recall in the future.

4.13. The partner organisations we met were unanimous in their praise for the Trust's longstanding commitment to joint working and support for innovative joint projects. However, reducing resources in recent times had not gone unnoticed by some partners, who appreciated that in the future the Trust's contribution of resources to joint projects might be reduced.

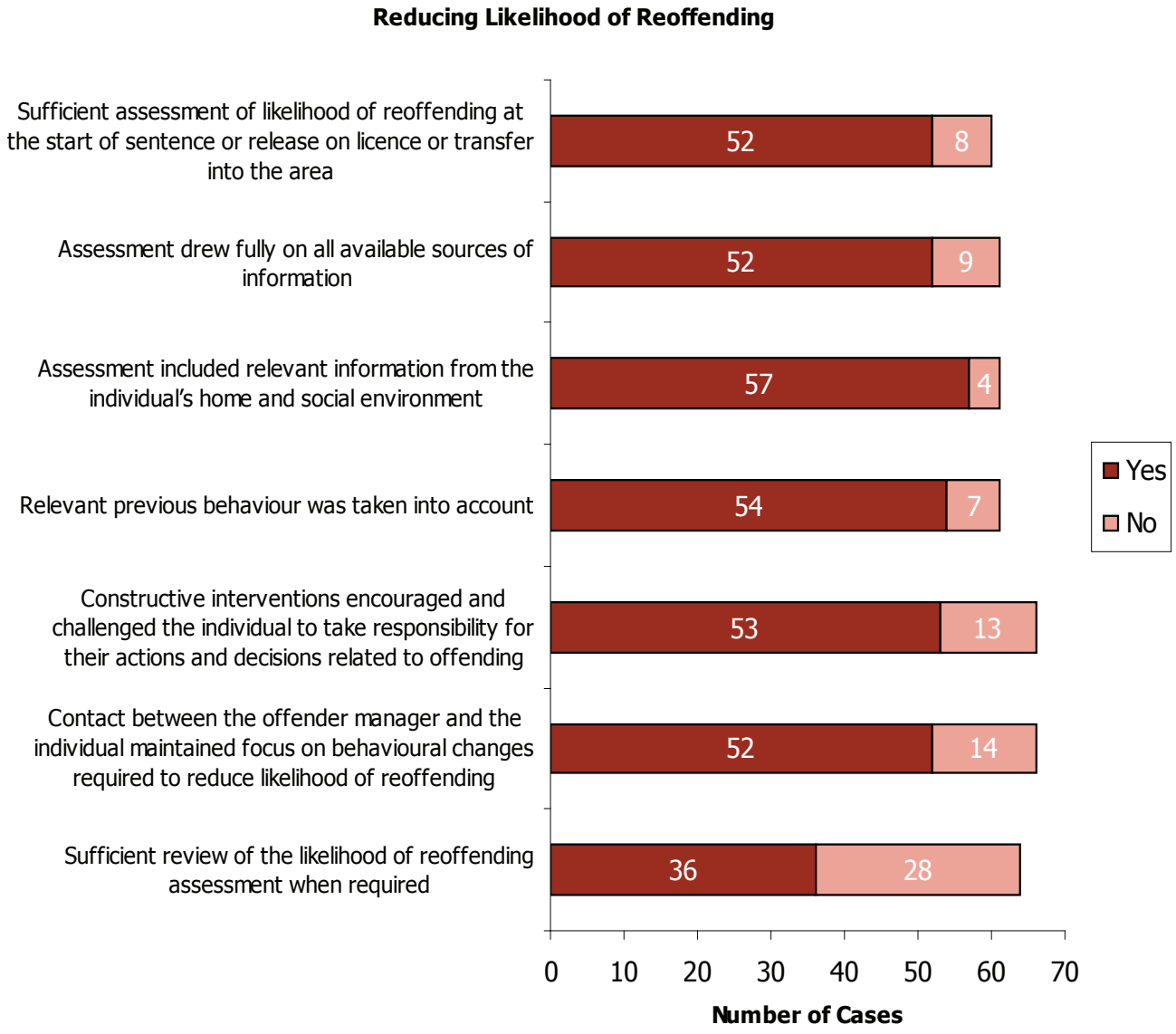
Summary

Overall, 75% of work to reduce the likelihood of reoffending 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: 74 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 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.

Case assessment score

Overall 76% of work to ensure the protection of the public was done well enough.

Key Findings

1. The Trust made a strong contribution at a strategic level to multi-agency work to protect the public, and was well regarded by the partner organisations with which it worked. The contribution by probation staff to MAPPA was effective.
2. The Risk of Serious Harm (RoSH) classification (low, medium, high or very high RoSH to others) was correct in most cases, and key risk of harm information had been passed between all relevant staff and other agencies involved.
3. Restrictive requirements or conditions were monitored fully in most cases and approved premises were used effectively to manage risk of harm to others.
4. Almost all cases which met the criteria for MAPPA had been correctly identified, and appropriate referrals were made in a timely way where case management was needed at higher levels within MAPPA. Decisions taken within MAPPA were generally clearly recorded, followed through and acted upon.

Key areas for improvement

1. Initial RoSH screenings were missing or not completed sufficiently well in some cases. Full details of the current offence and relevant previous behaviour were not always taken into account.
2. Where required an initial full risk of harm analysis was either not done or not done well enough in more than one-third of cases. Some cases needed to draw more fully on available sources of information. There was insufficient analysis of the offending in some cases.
3. Risk management plans were either not done or of insufficient quality in more than one-third of cases. Many did not anticipate possible changes in risk of harm factors or set out the actions needed. More than one-third did not accurately describe how the objectives of the sentence plan would address risk of harm issues and protect actual and potential victims.
4. Risk of harm assessments and risk management plans were not reviewed in a timely way or promptly after a significant change in circumstances or risk of harm factors in one-third of cases.
5. In some cases the use of multi-agency child protection procedures was less effective and decisions were not clearly dealt with. Improvement was needed in work with Children's Services and MARAC.
6. There was insufficient evidence of effective management scrutiny in nearly half of the cases classified as posing a high RoSH or where there were Child Protection issues.

Explanation of findings

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

1.1. The initial RoSH screening was completed sufficiently well in 72% of cases. In 17% 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. In a few cases the screening was completed late. However, in nine cases there was no record of an initial screening having been completed at all.

1.2. In 87% of cases in the sample, we judged there was a correct RoSH classification recorded. No classification had been recorded in four cases.

1.3. Having an accurate assessment at an early stage of the order or licence is important to enable all staff to understand what level of risk of harm is present and what factors might increase or lower that risk. However, in nine cases where it was required, there was no record of an initial full risk of harm analysis having been completed – the same cases where there was no record of an initial RoSH screening. Given the nature of the offences in our sample, most (if not all of them) should have triggered a full analysis of the risk of harm to others (or use of the override to decide not to complete one).

1.4. Five of these cases were made subject to a community or suspended sentence order with only unpaid work or unpaid work plus a curfew requirement. In these cases the practice at court was for a RoSH screening to be competed in paper format where the court indicated it intended to make an order with only an unpaid work requirement. The case would be adjourned for a full OASys assessment if this was triggered by the screening. However, probation staff and managers were aware that, in this event, in some cases the court had proceeded directly to sentence rather than adjourn the case as requested. This had led to orders being made with the requirement to start the unpaid work promptly after sentence, but no risk of harm assessment in place to permit the safe allocation of the offender to an appropriate work placement. There was a local arrangement to complete such an assessment by transferring the order to a local OMU if required; however, in our sample, this arrangement had failed, possibly due to the fact that the outcome of the paper RoSH screening had not been communicated to the unpaid work unit.

Practice illustration – assessment of risk of harm

Chris had profound communication difficulties and it was necessary for the offender manager to be supported by provision of an interpreter throughout the order, despite the high cost of weekly sessions. Chris was assessed as presenting a high risk of harm to others, due to his offence of arson. The offender manager had carefully worked with Chris over time on the motivation behind the offence and was able to bring him to understand it was not simply a suicide attempt, as he originally claimed, but also in part motivated by revenge against a former friend. This careful, investigative approach was well documented in thorough reviews of OASys, enabling the true risks to be properly managed.

1.5. In the other four cases court orders were made containing supervision (and other) requirements and reasons for the failure to complete an initial risk of harm assessment post-sentence were located within the OMU. As noted above, not all shorter format written reports were based on an OASys assessment, and this may have contributed to this finding. The Trust planned to move to the production of all written reports from OASys following the introduction of OASys-R.

1.6. In respect of all of these cases, the Trust had been working with individuals who may have posed a significant risk of harm to others without first having undertaken the required assessment. The Trust was aware of this weakness in the process and had taken steps to prevent its occurrence.

1.7. In 65% of cases there was a sufficient initial risk of harm analysis, but in 13% (the nine cases noted above) no analysis had been completed. In the remainder (nearly one-quarter) the analysis was insufficient. For all assessments, the largest area for improvement was for the analysis to draw fully on all available sources of information, such as full details of current and previous offences, and information from Children's Services. A number did not take relevant previous behaviour into account, or contained insufficient analysis, as distinct from description. Smaller numbers were not timely or contained incorrect risk categories.

1.8. Information was actively sought, as appropriate, from other relevant staff and agencies involved with the offender in 80% of cases, although information was not always received or made sufficient use of. Adequate attention was paid to child safeguarding in relation to the offender's contact with any children in only 71%. Although, as we noted earlier, all of the offender managers we interviewed felt confident that they could identify and work with child protection and safeguarding issues, this suggested further work was required to improve practice in the area of work.

Practice illustration – multi-agency work to manage risk of harm

Daryl was subject to a community order with supervision and a requirement to complete the CDVP for a domestic violence assault. He was not known to the probation service and the PSR assessment made good use of information sources including Children's Services and the Police Vulnerable Persons Unit to obtain relevant information and open up positive lines of communication. This created a strong foundation for the subsequent order, where assessments, plans and other information was shared in a timely way with partner organisations, increasing the level of protection for the potential victims. This good multi-agency working and coordination extended across local authority boundaries when Daryl began a new relationship with a woman in another area.

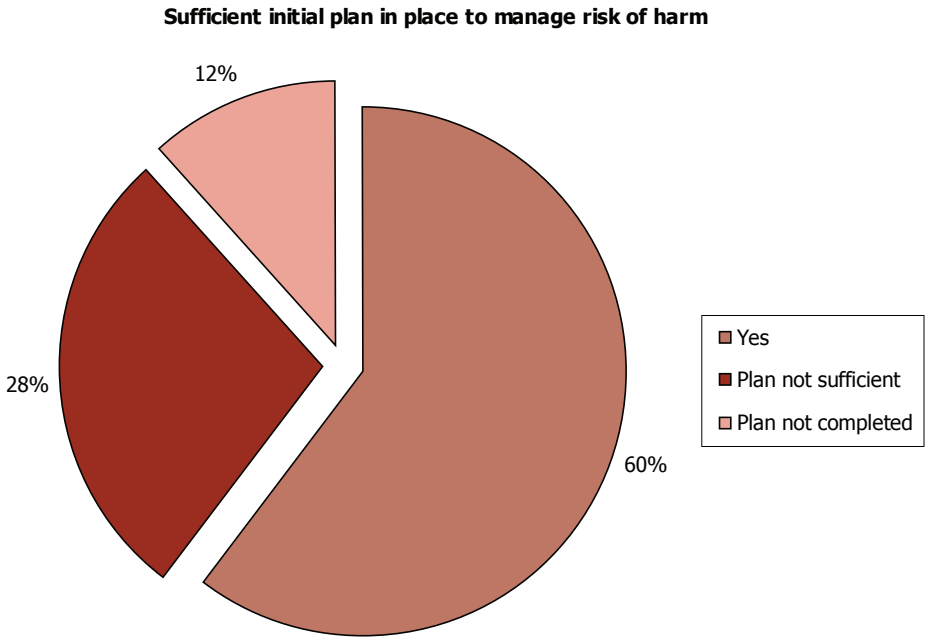
1.9. In the 30 cases where restrictive requirements (such as a curfew or electronic monitoring or restraining orders) were in place, their use was judged to be appropriate in almost all instances. They were generally proportionate to the risk of harm and the likelihood of reoffending, although they did not contribute to minimising the risk of harm to actual or potential victims in five cases.

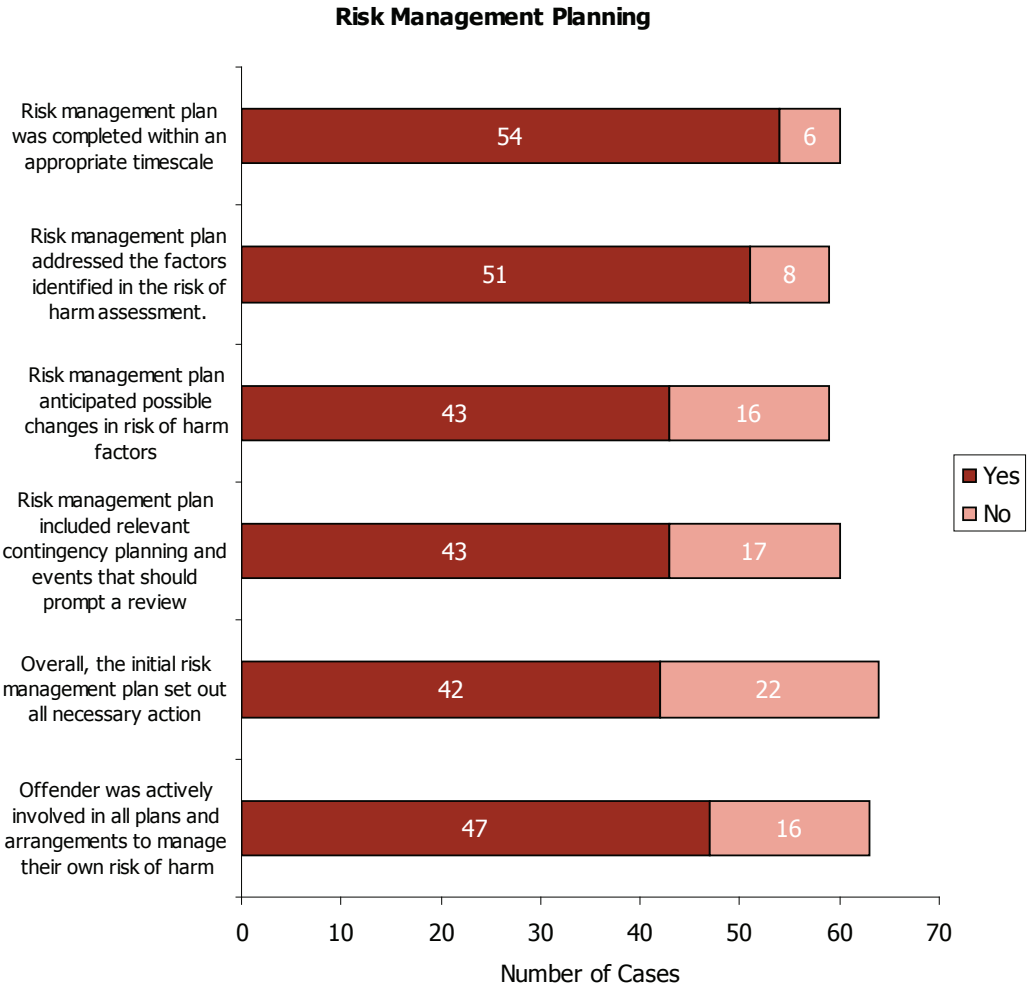
1.10. Eight community or suspended sentence orders included an electronically monitored curfew. In seven it was seen as providing a significant punishment, but it was used to contribute to the protection of the public from risk of harm or further offending by the individual in only three.

1.11. We saw effective use of restrictive licence conditions to support public protection work and HMP Liverpool had adopted a general position of not granting Home Detention Curfew in domestic violence cases.

1.12. Risk management plans are required in cases where the RoSH classification is medium or higher, but only 60% of such cases in the sample contained a sufficient plan. In 12% there was no initial plan at all. The remaining 28% were of insufficient quality. Most completed risk management plans were timely and addressed the factors identified in the full risk of harm analysis. However, many did not anticipate possible changes in risk of harm factors, include contingency planning and a note of all events that should prompt a review, or address all relevant factors, including the risks to any specific victims. The biggest need, in more than one-third of plans, was to describe accurately how the objectives of the sentence plan and other activities would address risk of harm issues and protect actual and potential victims.

1.13. Overall, only two-thirds of risk management plans set out all necessary action. Many plans were not clear about who would do what and when, and could have been clearer about how information would be shared. However, in four-fifths of the cases, the plan and any key risk of harm information was communicated to all relevant agencies. There was evidence in three-quarters of the cases that the offender was actively involved in all plans and arrangements to manage their own risk of harm, including constructive and restrictive interventions.





1.14. Seven cases in the sample should have been recorded on Violent and Sexual Offender Register (ViSOR) (the information system managed by the police to share information in some cases where there has been sexual or serious violent offending), but only four had been. Both probation and

police staff we met felt that the potential usefulness of the system was stifled by the lack of ready access, and information between police and probation was passed more quickly by other means. This was possible because of the close and well integrated working relationships between the two organisations, but meant that practitioners could not be sure that key information on ViSOR would be available to all those that needed to know it.

1.15. Twenty-eight cases met the criteria for MAPPA, and in all but one of these this was identified accurately. In of all the cases that were identified, the initial level of MAPPA management was appropriate. Seven cases needed management at higher levels within MAPPA, and for all of these an appropriate referral was made and actions agreed by MAPPA had been included in all relevant planning documents, such as risk management plans. The referral was untimely in only one case and the details of the case or MAPPA category inaccurate. 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. The response by the offender manager to changes in the risk of harm posed to others was inappropriate in more than one-third of relevant cases. In a significant proportion of cases, changes were not identified swiftly, not acted upon by all relevant staff and other agencies were not notified where needed.

2.2. Where there were restrictive requirements or conditions in community orders or licences, they were monitored fully in almost all cases. For the ten 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. Statutory partners we met acknowledged the effective role of the approved premises in public protection and their cooperative joint working with difficult cases.

2.3. We expect to see an initial home visit carried out in cases classified as posing a high RoSH to others or where there were child protection concerns. This was not done in 11 out of 41 cases where we thought that it should have been. In our view, home visits should have been repeated in 39 cases, but this was only done in 11.

2.4. There were 14 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. In all except one case, this was done appropriately and sufficient efforts were made to re-engage the individuals with their sentence plan.

2.5. There was ongoing management at MAPPA Level 2 in six cases and this worked effectively for all of them. Decisions taken within MAPPA were generally clearly recorded and followed through and acted upon in all of them. In one case actions were not reviewed appropriately, and in two cases not all relevant staff working with the offender contributed effectively to the MAPPA.

2.6. ViSOR was used effectively in the four cases that had been recorded on the system.

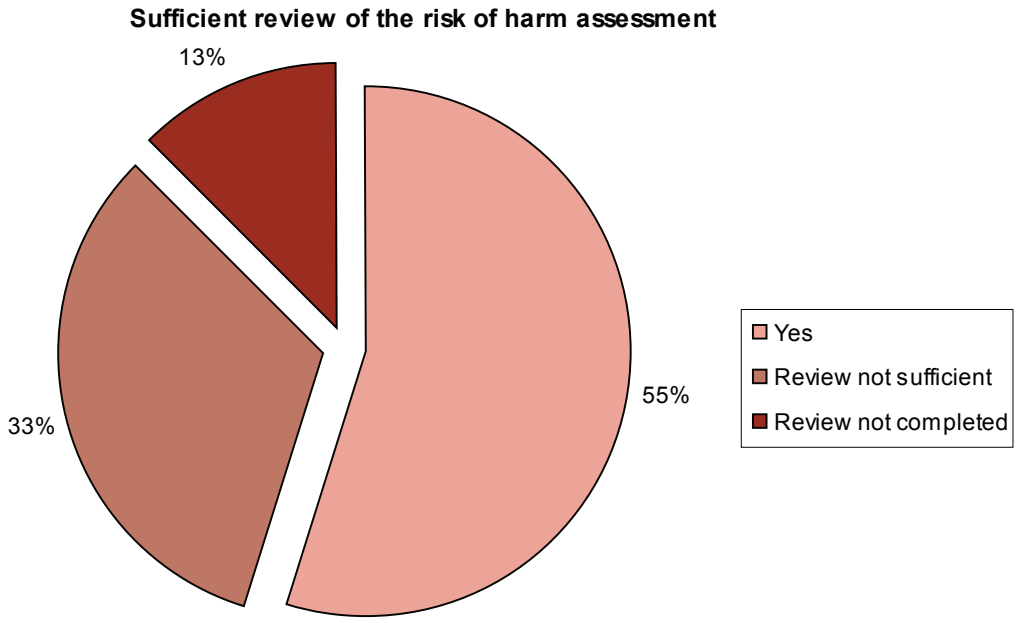
2.7. Multi-agency child protection procedures were used effectively in 10 out of the 14 relevant cases. In the remaining four cases, decisions had not been recorded clearly; communicated, followed through and acted upon; or reviewed appropriately.

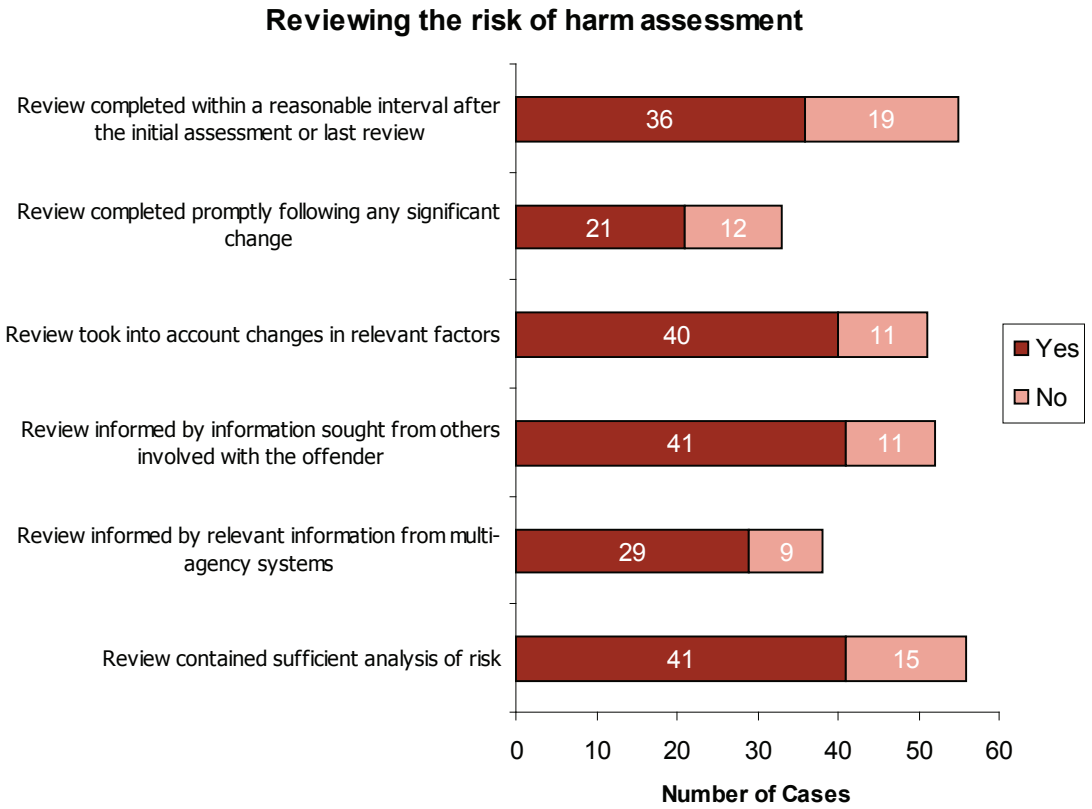
2.8. Sufficient priority was accorded to the safety of current and potential victims by the offender manager and any other workers in 84% of relevant cases. There was evidence that the offender manager took into account any concerns expressed by the victim and the likely impact of the offender's behaviour on the victim in 77% of relevant cases.

2.9. 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 (55%) there was a sufficient review, but in 13% there had been no review at all.

2.10. In general, one-third of reviews completed were not timely or done promptly after a significant

change in circumstances or risk of harm factors. In a smaller number of cases greater account needed to be taken of relevant factors and more information sought from others involved with the case. One-quarter contained insufficient analysis of risk.

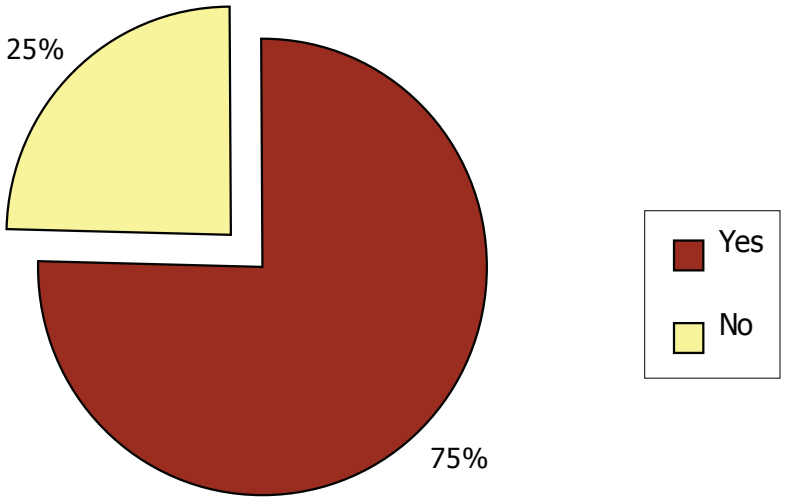




2.11. Actions set out in risk management plans were carried out, as required, in 78% of cases. The plans themselves, however, were not sufficiently well reviewed in half of the cases. In 15% there had been no review at all. The key areas for improvement were essentially the same as for the review of risk of harm assessments noted above. For any further reviews the planned review period was not appropriate to the risks posed by the case in one-third of the cases.

2.12. 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 insufficient evidence of this in 44% of such cases. For example, in some cases work had been countersigned by a manager when there were clear gaps in quality, such as in the risk management planning. Oversight arrangements had also failed to identify and remedy those cases where no risk of harm assessment or plans had been done or reviewed at all.

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



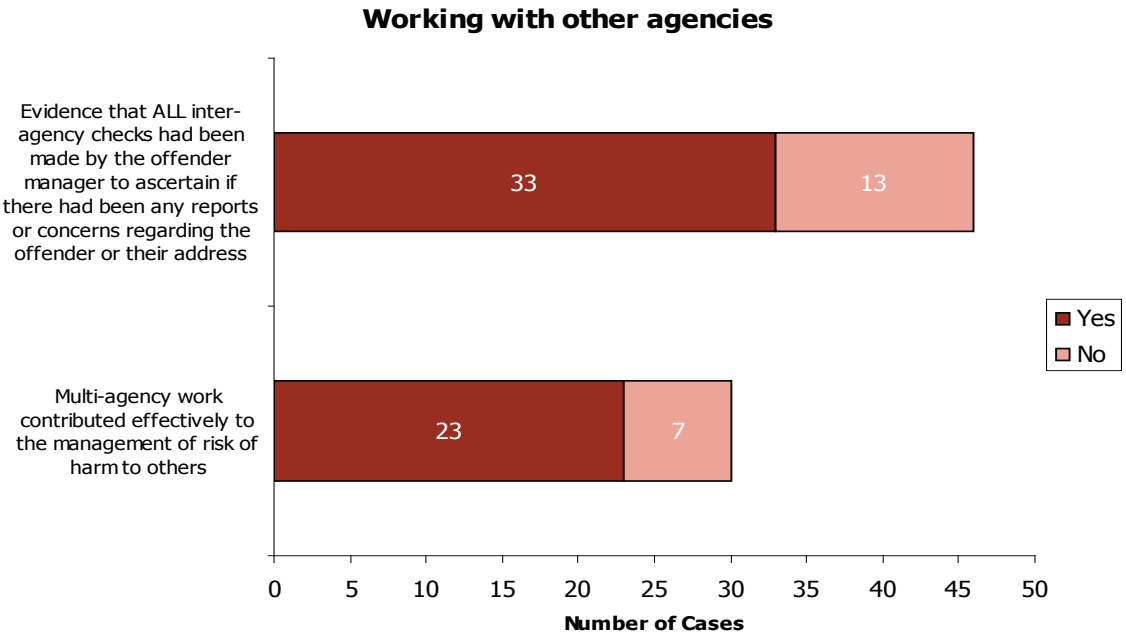
3. Risk of harm is minimised

3.1. In three-quarters of cases, all reasonable action had been taken to keep to a minimum the offender's risk of harm to others.

3.2. We saw a number of domestic violence cases where the only requirement of the community or suspended sentence order 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.

3.3. Senior managers confirmed that they would expect such liaison to take place in these cases, with the offender manager using their authority as the 'responsible officer' for the order. The Trust was taking steps to ensure this was done, recognising that this required either that there was a suitably competent offender manager holding the case within the unpaid work unit, or that the case could be quickly transferred to the local OMU. However, we observed that all of this was dependent on such cases having had a RoSH screening and an adequate assessment in place to start with, in order for the domestic violence concerns to have been identified.

3.4. Where multi-agency work had taken place, it had contributed effectively to the management of risk of harm in 77% of cases. However, we were concerned to find that in 13 out of 46 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 nine cases, checks had not been made with police regarding domestic violence callouts, and in ten no check had been made with Children's Services. More positively, where the checks had been done and there was new information, the offender manager took appropriate action in 13 out of 16 cases.



3.5. 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 Thematic inspection Putting the pieces together: An inspection of Multi-Agency Public Protection Arrangements, November 2011[1]). There was evidence of this in all four cases where it was relevant.

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

4.1. Partnership organisations commented very positively on the role of the Trust in inter-agency work to support public protection, and we saw evidence of effective partnership working, especially in relation to Integrated Offender Management (IOM) and PPO cases.

4.2. As recorded above, we found good and effective use of MAPPA in the cases we inspected, supported by a strong strategic approach in this area of work. MAPPA were run with a tight focus, supported by appropriate protocols, that had led to a well run process. There were good working and strategic relationships with the police in all areas of public protection work, and MAPPA saw an increasing police input relating to the growing number of PPO cases falling within MAPPA due to gun crime. Work in MAPPA cases was supported by the 'Resettle Project' (which provided the offender management for some MAPPA cases with personality disorders, as described previously) and use of the forensic psychologist mainly in high risk and high profile cases. The approved premises were thought to make a positive contribution to the work of MAPPA, and we saw them used effectively in public protection work in specific cases, as recorded above.

4.3. For cases that merited a multi-agency approach to risk management but did not meet the criteria for MAPPA, there was a lower level multi-agency umbrella group, 'Compass', covering IOM, PPO and Drug Intervention Programme (DIP) cases that had been sentenced to less than 12 months custody. It included substance misuse agencies and mentoring services as well as statutory partners.

4.4. The current co-located IOM teams provided an effective means for the rapid exchange of information and joint management of cases between probation and police. In Liverpool there was a dedicated 'Violent OMU'. In addition to information exchange through IOM, probation staff could also contact the MAPPA co-ordinator direct. Systems were also in place for offender managers to check information with police intelligence and a Family Crime Investigation Unit, although this was not universal in all LDUs.

3 HMI Probation (November 2011) *Putting the pieces together: An inspection of Multi-Agency Public Protection Arrangements*, Ministry of Justice, London, p.8

4.5. As noted above, both probation and police staff felt that the potential usefulness of ViSOR was stifled by the lack of ready access to the system, which was caused by restrictions on the number of access licences. It was reasonably well used for the management of sex offenders, but could have been better used in the management of other, violent offenders.

4.6. In contrast to MAPPA, public protection partners felt that the MARAC arrangements were overwhelmed with too many cases and consequently less effective. Information exchange was thought to be less good, and there was insufficient follow up to check that action agreed had been carried out. Local authorities, the police and the Trust were working towards creating co-located Multi Agency Safeguarding Hubs which would have the victim rather than the offender as their primary focus.

4.7. Probation and police saw the potential of electronically monitored curfews to contribute to public protection and safety, but both agencies considered that the curfew monitoring data from the contractor was not sufficiently reliable. A sentencer observed the possibility of a court agreeing to an application to vary the times or address of a curfew without reference to the probation service to check the implication of the amendment for public protection.

4.8. HMP Liverpool acknowledged the important role of licence conditions in public protection work, and was working to ensure these were both proportionate and effective in protecting victims. As noted previously, we saw effective use of restrictive licence conditions to support public protection work.

4.9. In working to protect children and young people the Trust had strong strategic relationships with Children's Services departments and reported that their contribution was well regarded at the Local Safeguarding Children Board[2]. At operational level they felt probation received the same mixed quality of service as other criminal justice agencies, and considered that problems were generic rather than specific to probation.

4.10. We saw a mixed picture in our case inspections, with slow responses to requests for basic factual information in some cases (such as confirmation of addresses, or whether or not a case was closed or open to Children's Services). Clear escalation procedures were in place, but this often left the onus on probation (and police) to check for concerns, and repeatedly chase up unanswered enquiries, with all the potential risks if there was any oversight in doing so. The Trust was also concerned that even where initial inquiries to Children's Services produced a confirmed negative response, they could not safely assume that if Children's Services subsequently became involved with the offender's family they would advise them of this.

4.11. We noted above the significant number of cases where basic checks to Children's Services were not made, and a history of unanswered replies may well have contributed to a lack of motivation to make them. The Trust was aware that much of the critical communication between probation and Children's Services was by telephone call, rather than by email where there would be a clear and auditable record. This too was reflected in some of the work we inspected.

4.12. However, we also found that when information came to light as a result of such checks, appropriate action was usually taken by the offender manager. We also saw examples of good joint working, and the Trust was aware of good joint safeguarding work in relation to crime involving gangs and firearms.

4.13. The inspection identified a concern relating to some community and suspended sentence orders being commenced without risk of harm assessments in place. As described above, a number of linked factors may have contributed to this:

- The pressure on courts to sentence cases speedily.
- Insufficient facilities at court for probation liaison staff to complete thorough assessments quickly to meet this pressure.

4 Local Safeguarding Children Board: set up in each local authority (as a result of the Children Act 2004) to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children in that locality.

- Use of paper based RoSH screenings which reduced the reliability of offender management and interventions staff being able to access critical information before starting the order.
- Absence of appropriate checking to ensure all cases had a completed screening (and full assessment if indicated) in place promptly after the start of the order or release on licence.

One or more of these factors could lead to the risk of harm to others not being accurately identified and, as a result, the case not being safely managed. The Trust was aware of the problem, partly as a result of previous SFO inquiries, and was taking steps to rectify matters.

4.14. In relation to risk of harm work within the Trust, a strategy had been put in place immediately following publication of the OMI 2 inspection report, which had made recommendations to improve the quality of work in relation to risk of harm assessments, risk management plans, and management oversight of risk of harm work.

4.15. The strategy included mandatory workshops for all practitioners that placed the effective use of OASys assessments and plans at the centre of practice and coupled targeted performance improvement measures with a long term programme of quality assurance audits to monitor individual staff performance. Arrangements for management oversight sought to move the activity from a monitoring process to a professional development activity, with records being kept on the case contact log using a new dedicated code, and greater use of the OASys countersigning comments box.

4.16. These inspection findings indicated that countersigning was still not fully effective in too many cases, and while contact logs and comments boxes were being used as intended, the entries were often too brief to have a significant impact on quality improvement. However, while this inspection sample and our detailed findings are not comparable with those of the Offender Management Inspection 2 (OMI 2) programme, the general quality of work to assess and manage risk of harm to others did appear to have improved.

Summary

Overall, 76% of work to ensure the protection of the public was done well enough.

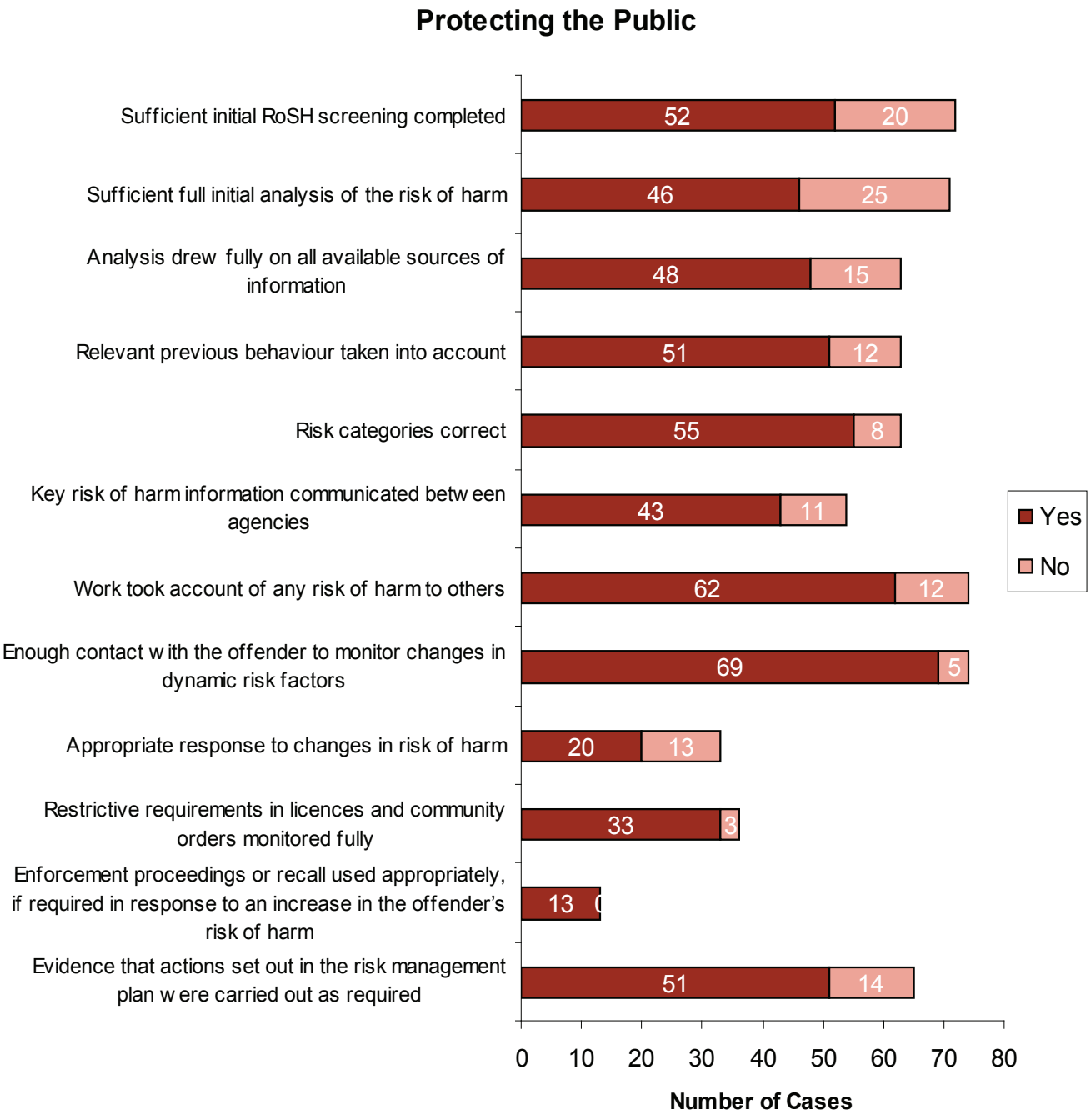
We have recommended that post-inspection improvement work focuses on ensuring that:

- risk of harm to others is assessed accurately and promptly, and is reviewed as appropriate; information from other organisations and the safety of actual and potential victims is taken into account
- additional attention is given to work to protect children and young people
- 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 RoSH 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: 74 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case].



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 87% of work to deliver effective services for victims was done well enough.

Key Strengths

1. The delivery of interventions to minimise risk of harm to victims generally gave priority to victim safety and took account of concerns expressed by victims.
2. Victim contact work was undertaken appropriately, and the quality of the work was good. Victims who responded to our questionnaire about their experience had very positive views about the work undertaken with them.
3. The Probation Trust had strong strategic relationships in place to support effective work with partner agencies in public protection.

Key area for improvement

1. The assessment and planning to minimise risk of harm to others paid insufficient attention to safeguarding children and young people and the risks to actual and potential victims.

Explanation of findings

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

1.1. We expect to see offender managers and others giving appropriate attention to risk of harm to actual and potential victims in their assessment and planning. As already noted in Outcome 4: Protecting the Public, the quality of this work was insufficient in too many cases.

1.2. A thorough assessment may require information to be sought from other agencies, and we found that one-quarter of cases did not draw fully on all available sources of information. Information from Children's Services was sought on a routine basis at the start of a new order of licence only in cases where it was believed there were children and young people living in the same household as the offender, or if there were children and young people, already known to Children's Services, connected with them.

1.3. As already noted, the response to such inquiries from Children's Services was variable. In view of this, it was unsurprising that we judged insufficient attention was paid to child safeguarding in relation to the offender's contact with any children and young people in nearly one-third of relevant cases.

1.4. One-quarter of risk management plans did not address the risk of harm to any specific victims, and one-third of plans failed to describe how the objectives in the sentence plan or other activities would protect actual or potential victims.

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

2.1. In ongoing work with offenders, appropriate priority was usually given to the safety of current and potential victims by the offender manager and any other workers, and in more than three-quarters of cases there was evidence that the offender manager had taken account of any concerns expressed by the victim and/or the likely impact of the offender's behaviour on the victim.

2.2. In most cases, restrictive requirements in licences and community orders were monitored fully, and there was evidence that the actions set out in the risk management plan had been carried out as required in more than three-quarters of cases.

3. Risk of harm to victims is minimised

3.1. In 81% of cases where there was an identifiable victim (or potential victim), we judged that the risk of harm to actual or potential identifiable victims had been managed effectively. But, where necessary, the safety of children and young people had not been promoted in one-quarter of cases. This conclusion was unsurprising given the shortcomings set out earlier in relation to work to protect children and young people. 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. They provide victims of certain crimes with information about the key points in an offender's custodial sentence, and give victims the chance to say what conditions they think should be included in the offender's licence when that person is released.

4.2. There were 19 licence cases in our sample where victim contact work was required and, in all of these, an offer of a face to face meeting with the victim contact worker was made. Only one offer was not made within eight weeks of the offender being sentenced to custody.

4.3. Ten victims took up the offer of contact and the quality of the work undertaken with them was sufficient in all cases. In all but one case there was regular and accurate information exchange between the offender manager and the victim contact worker and between the offender manager and prison staff.

4.4. Where relevant, all victims were given the opportunity to express their views on proposed licence conditions, and informed of any relevant events during the offenders sentence, and relevant conditions of the offender's release.

Comments from victims:

Sixteen victims of crime who were in touch with the victim contact scheme responded to our questionnaire. Amongst a number of very positive comments three victims wrote:

"We are very happy with the way we have been treated by VLO staff. It has been a great help and support."

"My VLO was excellent and gave me the support and time I needed. I was really happy with the service."

"The service has kept me fully informed, and helped set up an exclusion zone; this helps me feel a lot safer. I am really grateful for the service providers help. I have nothing but praise for the VLO, they were able to instil confidence in our family at a time when we felt really vulnerable. They were courteous and clear in support. I feel without this help we would have been living under a veil of fear. We had threats of violence against our family members and the VLO ensured an exclusion zone was put into place to protect us. They were always available and very professional."

Responses to the questionnaire were as follows:

- All but one 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 in all except one they thought that victim contact staff had a full understanding of the impact of the offence on them.
- All 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 10 cases where it was relevant, the victims confirmed that extra licence conditions had been added to keep them safer when the offender was released.
- The nine people who had reported concerns about the offender were satisfied with the response from the Probation Trust.
- Twelve thought that the work of the victim contact scheme had made them feel safer; the others felt it had made no particular difference.
- Fourteen were completely satisfied with the service provided, while the remaining two people were partly satisfied.

4.5. With regard to restorative justice, we identified 13 cases in the sample where a restorative justice intervention might have been appropriate. In two of these an intervention was offered to the victim of the offence, but in neither case was the offer taken up. The Trust was working towards embedding the wider use of restorative justice in its work, as noted below.

5. Leadership and management to deliver effective work for victims

5.1. The Trust had a well run and supported Victim Contact Scheme. There were good working and strategic relationships with the police and HMP Liverpool in all areas of public protection work, including MAPPA and IOM cases. Partnership organisations commented very positively on the role of the Trust in inter-agency work to support public protection.

5.2. The approved premises and other restrictive interventions such as exclusions were thought to make a positive contribution to the work of MAPPA, and we saw them used effectively in public protection work in specific cases, as recorded above. While strategic relationships with Children's Services were good, work to protect victims and potential victims could have better supported by more responsive communication at practitioner level between the two organisations. There was also scope to improve the operation of the MARAC.

5.3. The Trust was providing a good range of appropriate interventions to tackle violent offending, and to support potentially dangerous offenders with complex needs.

5.4. The use of restorative justice interventions by the Probation Trust was at an early stage. At the time of the inspection the Trust was steering a project through the Local Criminal Justice Board (LCJB) and multi-agency funding had been identified for a manager and admin post, to be employed by the Trust on a fixed term contract. This work formed part of the emerging LCJB reducing reoffending strategy. Four probation staff had been trained in restorative justice in collaboration with HMP Liverpool, Merseyside Police and the neighbouring Lancashire Probation Trust. The project was expected to be fully operational from autumn 2013.

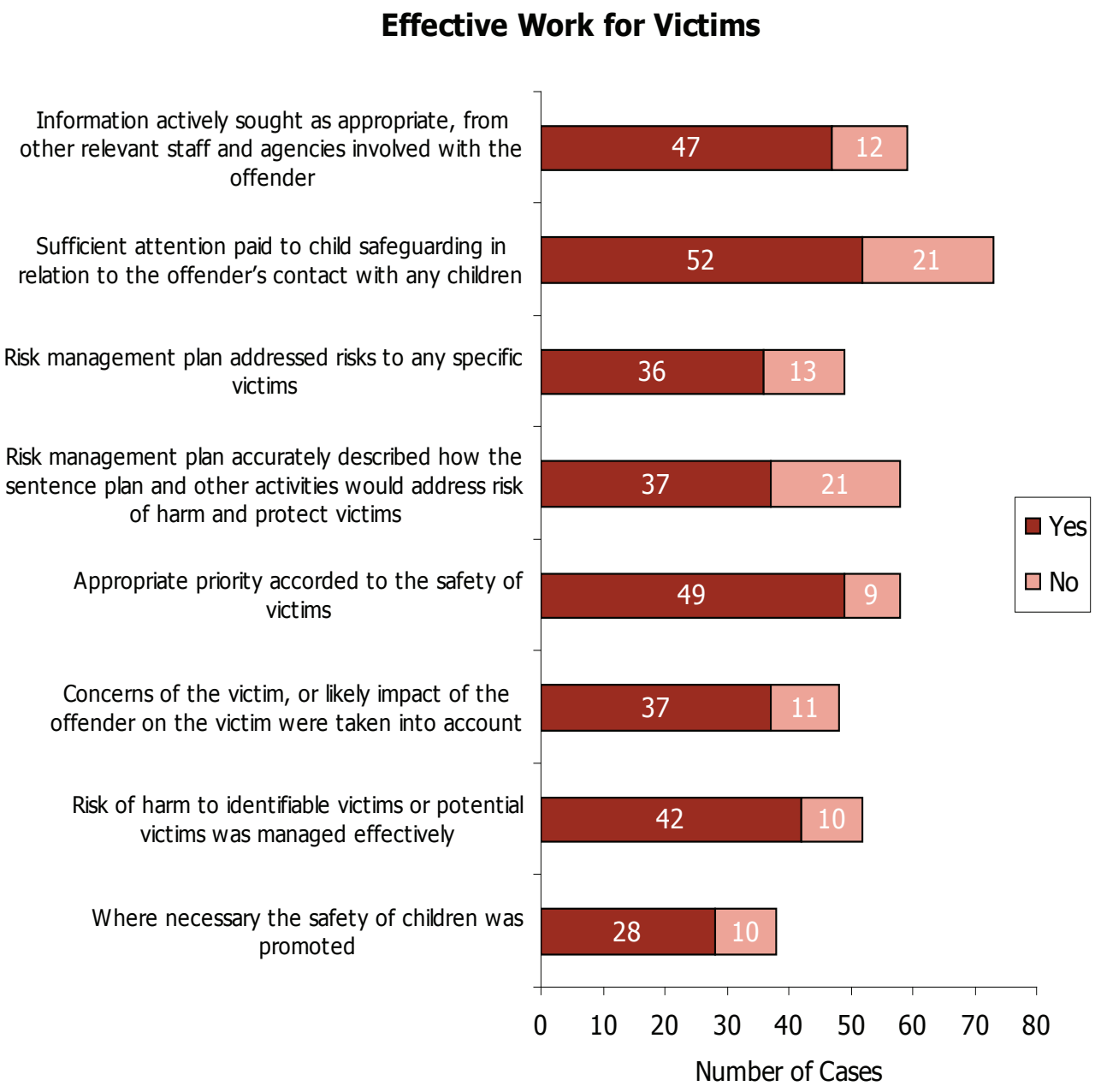
Summary

Overall, 87% of work to deliver effective services to victims 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: 74 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case].



Appendices

Appendix 1

Contextual information about the area inspected

Merseyside demographic data

Local Authority	Unemployment[1]	Population[2]	Black and minority ethnic population[3]
Knowlsey	12.8%	145,900	3.0%
Liverpool	11.7%	464,400	11.0%
Sefton	8.3%	273,800	2.5%
St Helens	8.8%	175,300	2.2%
Wirral	8.1%	319,800	3.1%
Merseyside	**9.9%**	**1,381,200**	**5.6%**
England and Wales	**8.0%**	**56,075,900**	**14.1%**

[1] Office for National Statistics Local Labour Market Indicators - Oct to Sept 2012
[2] Office for National Statistics 2011 Census
[3] Office for National Statistics 2011 Census

Crime Survey for England and Wales, 2011/2012

Offences per 1000	Merseyside	England and Wales
Violence against the person offences (rate per 1000 adults)	10	14

Probation Caseload Data

Total and by gender/ethnicity (Analytical Services, MOJ, October 2012)

Merseyside	Supervised in community and Pre-release	National average
Total caseload	8,127	n/a
% white	93.0%	77.1%
% black and minority ethnic	5.8%	19.7%
% male	90.0%	89.9%
% female	10.0%	10.1%

Appendix 2

Contextual information about the inspected case sample

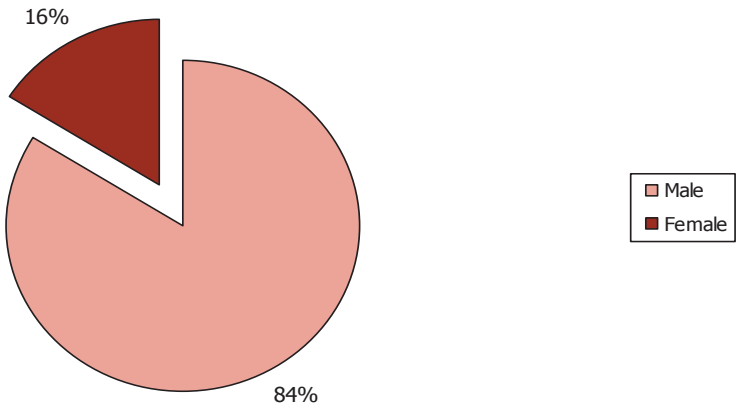
In the first fieldwork week we look at a representative sample of between 50 and 90 (depending on the size of the area) individual cases, which have been supervised for around nine months. These are community orders, suspended sentence orders and post-custody licences.

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.

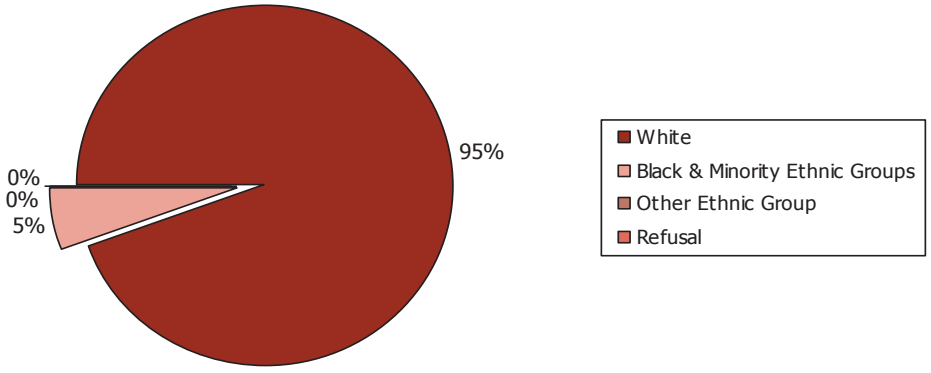
Between April and September 2013, the focus of the inspections is work with those who have committed violent offences.

In Merseyside we inspected a total of 74 cases drawn from three of the six LDUs that comprise Merseyside Probation Trust. These LDUs cover the areas of Knowsley, Liverpool North and Sefton. Inspection of work in the other LDUs will take place at a future date.

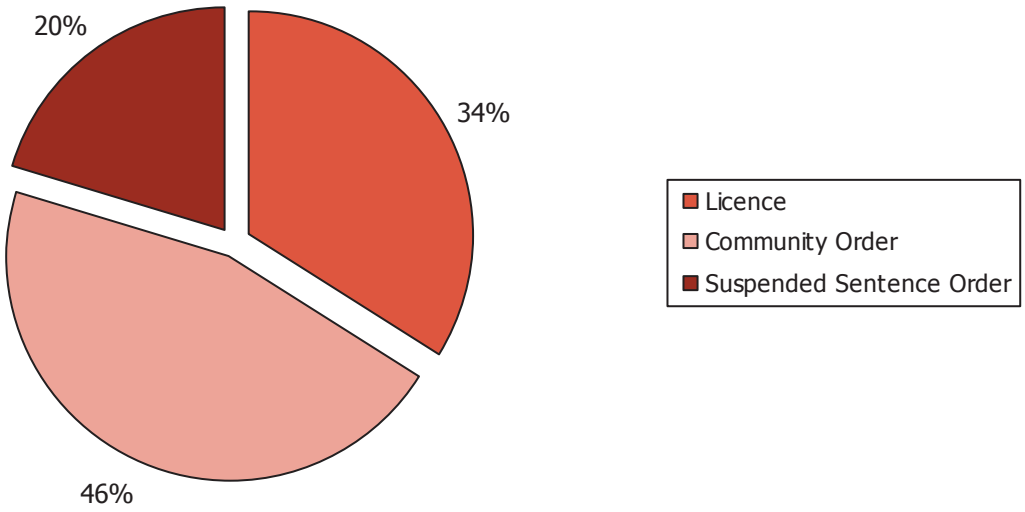
Gender



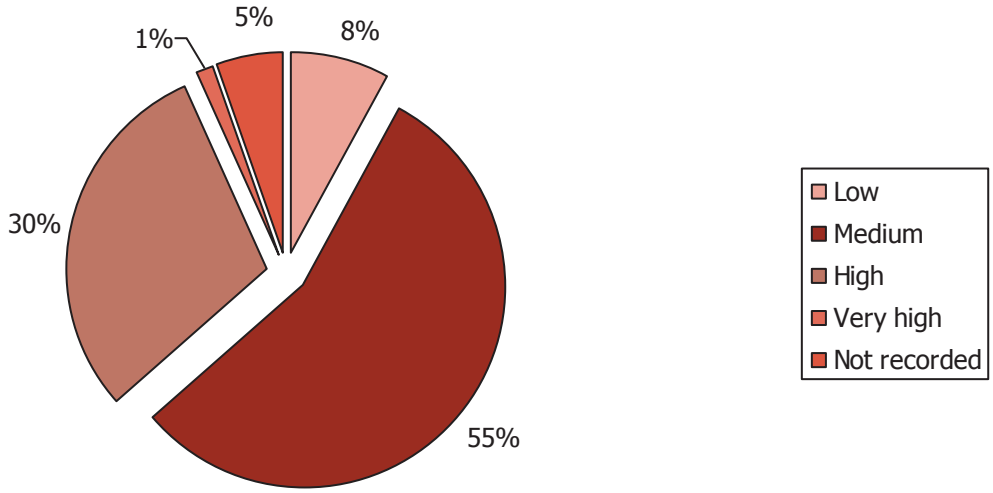
Race and Ethnicity



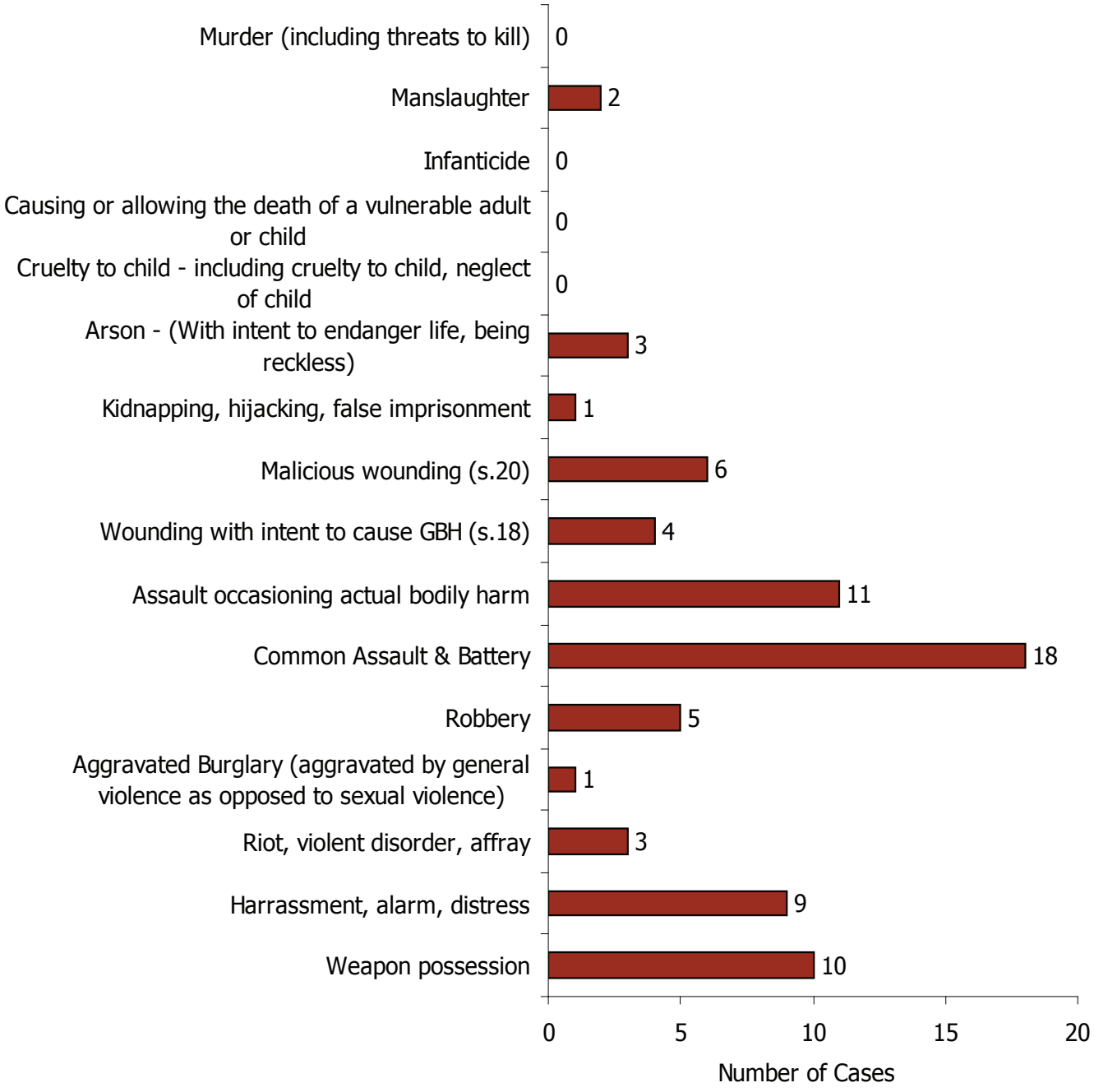
Type of Case



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



Principal Offence



Appendix 3

Acknowledgements

We would like to thank all the staff from Merseyside 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	Steve Woodgate, *HMI Probation*
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	Oliver Kenton, *Assistant Research Officer*
	Alex Pentecost, *Publications Manager*
	Christopher Reeves, *Proof Reader*
Assistant Chief Inspector	Sally Lester, *HMI Probation*

Appendix 4

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-offending-work

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 of 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.

Appendix 5

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.

Appendix 6

Criteria

CRITERIA for the INSPECTION of ADULT OFFENDING WORK											
		PROCESS									
Headline CRITERIA OUTCOMES		1	ASSESSMENT AND PLANNING	2	DELIVERY AND REVIEW	3	CASE OUTCOMES	4	LEADERSHIP AND MANAGEMENT	5	VICTIM WORK
1	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		
3	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		
5	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

Appendix 7

Glossary

Accredited programme	Structured courses for offenders which are designed to identify and reduce the factors related to their offending behaviour. Following evaluation, the design of the programmes has been accredited by a panel of experts
Approved premises	Approved premises provide controlled accommodation for offenders under supervision
BBR	Building Better Relationships: Nationally accredited group work programme designed to reduce reoffending by adult male perpetrators of intimate partner violence
BSR	Building Skills for Recovery: an accredited substance misuse programme
CALM	Controlling Anger and Learning to Manage it: an accredited programme to tackle anger management
CDVP	Community Domestic Violence Programme: an accredited programme to tackle domestic violence
CEO	Chief Executive Officer of a Probation Trust
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
Desistance	The process by which people stop offending and build a new, crime-free identity
DID	Drink Impaired Drivers programme: Nationally accredited group programme for offenders convicted of driving with excess alcohol.
DIP	Drug Intervention Programme: Multi-agency programme to tackle substance misuse
Dynamic factors	As distinct from static factors. Dynamic factors are the factors in someone's circumstances and behaviour that can change over time
EPIC	Electronic Probation Information System: Official website for the national Probation Service
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
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
LCJB	Local Criminal Justice Board

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
nDelius	National Delius: the national probation case management system which was completed in 2012, based on the earlier Delius system used by some probation trusts. The system is being rolled out through 2013
NOMS	National Offender Management Service: the single agency responsible for both Prisons and Probation Trusts
NSOG	Northumbria Sex Offender Groupwork Programme: an accredited programme to tackle sex offending
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
OMU	Offender Management Unit
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
SEEDS	Skills for Effective Engagement and Development and Supervision: an initiative in place across many Probation Trusts which emphasises the importance of the practitioners' skills in relationship building to ensure effective work with individuals. The development of these skills is supported by the observation of practice and reflective feedback by managers or others.
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
Static factors	As distinct from *dynamic* factors. *Static* factors are elements of someone's history that by definition can subsequently never change (i.e. the age at which they committed their first offence)
TSP	Thinking Skills Programme: an accredited cognitive skills programme to improve generic thinking skills and problem solving
ViSOR	Violent and Sexual Offender Register: the information system managed by the police to share information in some cases where there has been sexual or serious violent offending
VLO	Victim liaison officer: responsible for delivering services to victims in accordance with the Trust's statutory responsibilities
YOI	Young Offenders Institution: a Prison Service institution for children and young people remanded in custody or sentenced to custody
YOS/YOT/YJS	Youth Offending Service/Youth Offending Team/Youth Justice Service: these are common titles for the bodies commonly referred to as YOTs

Appendix 8

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:

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