

HM Inspectorate of Probation



'Not Locked up but Subject to Rules'

An inquiry into managing offenders in
Approved Premises (hostels)
following the *Panorama* programme
broadcast on 8 November 2006

March 2007

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Foreword

In November the BBC broadcast an edition of *Panorama* in which the key allegation was that the probation service claimed to supervise and monitor offenders to keep the public safe but that it was failing to do so.

The Home Secretary asked us to inquire into the specific allegations made in the programme, and to make any recommendations necessary to improve arrangements for the management of dangerous and other offenders.

Our findings have to be understood in the context of what the public can fairly expect to be achieved by those managing offenders in the community. The programme makers made the fair point that general talk of "*close supervision and monitoring of offenders*" can give a misleading impression to the general public of what is being done on their behalf. Clearly it is not helpful to make it sound as if community supervision is like 'prison in the community', which it plainly is not. Instead, it may be helpful to confirm that when an offender receives a community sentence, or is released from a custodial sentence, the offender is 'Not Locked up, but is Subject to Rules'. People who are not locked up obviously have the means and ability to commit offences in the community, and the officers who supervise offenders are by no means necessarily failing to do their job properly if such offenders take the opportunities available to them to reoffend. But officers would be failing to do their job properly if they did not 'enforce the rules' properly, or if they did not take all reasonable action to keep to a minimum the offender's Risk of Harm to others.

In this context we found that the hostels in Avon & Somerset were generally well managed within some substantial constraints, and most of the individual cases we examined were also generally well managed. We found one specific case to have been managed poorly over a long period of time, a matter which does raise wider systemic issues. We have also made recommendations to promote improvement in the management of hostels and of individual offenders.

ANDREW BRIDGES

HM Chief Inspector of Probation

Contents

	PAGE
FOREWORD	2
ACKNOWLEDGEMENTS	5
SUMMARY OF CONTEXT	6
1. ORIGINS AND STRUCTURE OF THE INQUIRY AND REPORT	16
1.1 Origins of the inquiry	16
1.2 Inquiry structure	17
1.3 This report	17
1.4 A note on language	18
2. THE PANORAMA PROGRAMME	19
2.1 The reporter	19
2.2 Description of allegations made and issues raised	19
3. THE ROLE OF THE PROBATION SERVICE	21
3.1 The role of the Probation Service in England and Wales	21
3.2 The supervision of offenders	21
3.3 Community penalties	23
3.4 OASys	23
3.5 Drug rehabilitation as part of a community sentence	24
3.6 Release from prison on licence	25
3.7 Lifers	26
4. PUBLIC PROTECTION	28
4.1 The role of the probation service in protecting the public	28
4.2 Multi-Agency Public Protection Arrangements	28
4.3 The Supporting People programme	29
4.4 Sex offender registration	29
4.5 Sex Offender Treatment Programme	30
4.6 Serious Further Offences	30
5. THE ROLE AND PURPOSE OF HOSTELS	32
5.1 The purpose of hostels	32
5.2 The current national position	32
5.3 Inspection of hostels	33
5.4 Developments since 2001	34
5.5 Enhanced supervision	35
5.6 Constructive interventions	35
5.7 Restrictive interventions	36
6. PUBLIC EXPECTATIONS	38
6.1 The public's raised expectations	38
6.2 The proximity of hostels to schools and family homes	38
6.3 The Brigstocke Road Campaign Group	39
6.4 The benefits and costs of exposure to the public view	40
7. OFFENDER MANAGEMENT IN AVON & SOMERSET PROBATION AREA	41
7.1 Leadership and management	41
7.2 Resources	41
7.3 Offender management and public protection	42
7.4 Accommodation for offenders	44
7.5 Serious Further Offences	44
7.6 The cases	44
7.7 The internal reviews	46
8. HOSTEL ARRANGEMENTS IN AVON & SOMERSET	47
8.1 The hostels	47
8.2 Management of the hostel estate	47
9. ASHLEY HOUSE (managed by a voluntary committee)	50
9.1 The voluntary management committee	50
9.2 The management of Ashley House hostel	51

9.3	Staffing	51
9.4	Referrals and admissions	52
9.5	Offender management and constructive interventions at Ashley House	52
9.6	Drug treatment regime in Ashley House	53
9.7	Security and restrictive interventions at Ashley House	53
10.	THE MANAGEMENT OF CASES RAISED IN THE PANORAMA PROGRAMME IN ASHLEY HOUSE	56
10.1	Introduction	56
10.2	Resident C	56
10.3	Resident D	57
10.4	Resident E	57
10.5	Resident F	58
10.6	Resident G	58
11.	BRIGSTOCKE ROAD (managed by the probation area)	59
11.1	The management of Brigstocke Road	59
11.2	Staff	59
11.3	Referrals and admissions	60
11.4	Offender management and constructive interventions in Brigstocke Road	60
11.5	Security and restrictive interventions at Brigstocke Road	61
12.	THE MANAGEMENT OF CASES RAISED IN THE PANORAMA PROGRAMME IN BRIGSTOCKE ROAD	65
12.1	Resident H	65
12.2	Resident I	65
12.3	Resident J	65
13.	HOSTELS SUMMARY	67
14.	BRIDGE HOUSE and GLOGAN HOUSE	68
14.1	Bridge House hostel	68
14.2	Glogan House	68
15.	THE CASE OF RESIDENT K	69
15.1	Introduction	69
15.2	The original offence	70
15.3	Significant events over 25 years	70
15.4	Assessment in prison	70
15.5	The decision of the Parole Board to release on licence	71
15.6	The role of the home probation officer	72
15.7	Offender management on release	72
15.8	Liaison between Brigstocke Road and the offender manager	73
15.9	The role of the police	75
16.	SUMMARY OF FINDINGS AND RECOMMENDATIONS	77
16.1	Findings in relation to the national context:	77
16.2	Findings in relation to offender management in the Avon & Somerset Probation Area:	77
16.3	Findings in relation to hostel arrangements in Avon & Somerset	78
16.4	Recommendations:	78
16.5	Findings in relation to Ashley House (managed by a voluntary committee):	78
16.6	Recommendations:	79
16.7	Key findings in relation to the management of cases raised in the <i>Panorama</i> programme in Ashley House:	80
16.8	Findings in relation to Brigstocke Road (managed by the probation area):	80
16.9	Recommendations:	81
16.10	Key findings in relation to the management of cases raised in the <i>Panorama</i> programme in Brigstocke Road:	82
16.11	Key findings in relation to Resident K:	82
17.	CONCLUSION	83
	GLOSSARY	85
	ANNEX A	91
	REFERENCES	94
	ROLE OF HMI PROBATION	95

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Summary of Context

I. The *Panorama* programme

- (i) The programme's central premise was that nationally politicians and the probation service claimed to supervise and monitor offenders to keep the public safe, but that the service was failing to do so. To illustrate this it used film from two hostels housing residents presenting very different types of offending and other difficult behaviour. The footage inside the hostels was obtained by a reporter working undercover as a relief assistant hostel manager.
- (ii) The two hostels were in Bristol. One was managed by Avon & Somerset Probation Area and predominantly housed offenders assessed as posing a high Risk of Harm to the public. The other was managed by a voluntary committee and was intended for offenders who were less likely to pose a high Risk of Harm and more likely to need the drug treatment programme available there.
- (iii) Much of the programme was filmed outside of the hostels and made the point that, once outside, staff did not know what residents were doing.
- (iv) We therefore looked at the role and purpose of hostels and whether offenders and hostels in Avon & Somerset were managed to the standard that the public ought to be able to expect.

II. The role of the probation service

- (i) It was important to describe the work of the service to promote public understanding about what its duties are and how it carries them out. The regulatory framework is complex and the probation service is now formally linked with the prison service to form the National Offender Management Service. We have attempted to summarise only the main elements.
- (ii) The role of the offender manager, who is either a probation officer or probation service officer, is key: their role is to assess, plan and review the needs of the case in relation to reducing reoffending and managing any assessed Risk of Harm to the public.
- (iii) Offenders are supervised in the community as part of a community order or licence on release from prison. Their order or licence will contain requirements which can be *constructive*, e.g. drug, alcohol or mental health treatment or *restrictive*, e.g. prohibitive activity and curfew. They can also be intended solely for punishment, e.g. unpaid work. A period of residence in a hostel can be one such condition. It is the only non-custodial intervention offering a measure of *control*, whereby a resident is restricted to secure premises under curfew at night and subject to rules at all times. A hostel also has the potential to contribute to all of the other three purposes of sentencing: *punish*, *help* and *change*.

III. Assessment

- (i) Accurate and timely assessment of the Risk of Harm posed by offenders, factors linked to their offending and likelihood of reoffending are at the heart of the work of offender managers. Without these, the probation service cannot be said to be doing its job properly. They are the basis for the sentence plan which sets the level and type of contact necessary to meet the objective of reducing reoffending.

IV. Drug rehabilitation as part of a community sentence

- (i) A number of residents identified in the *Panorama* programme were known to have a chronic problem with substance misuse and to commit a high level of offences to support their habit. Some were engaged in treatment as part of their order or licence.
- (ii) The programme implied that continued drug misuse should lead automatically to breach or recall to prison. But the evidence is that treatment can be effective over a period of time even though abstinence may not be a realistic short-term goal for many. It is also clear that relapse and reoffending rates will be high. Offenders may have to start treatment many times. Courts make decisions about whether offenders, subject to some orders, should be breached or not and are likely to take the view that, provided an individual is engaging with treatment, the order should continue as a return to prison would more likely mean continued offending and substance misuse on release (the 'revolving door').

V. Release from prison on licence

- (i) The majority of hostel residents had been released from prison on licence. They included lifers – people sentenced to life imprisonment. Most prisoners will be released at some stage; we acknowledge that here again it is the individual assessment of Risk of Harm that is crucial in determining when and how long-term prisoners can be managed safely in the community. Lifers released on licence sometimes comment that they had fewer restrictions in open prison than on release due to the nature of the restrictive requirements in their licences.

VI. Public protection

- (i) The probation service works closely with other agencies to contribute to public protection. It has expertise in the assessment and management of potentially dangerous offenders and works with them in prisons and in the community.
- (ii) The general public might be surprised to learn of the range of interventions – *constructive* and *restrictive* – that are available to the agencies charged with managing dangerous offenders. The police, prison service and

probation service share responsibility for Multi-Agency Public Protection Arrangements in every area.

VII. Serious Further Offences

- (i) A small number of people are known to be dangerous and will commit the most serious offences unless they are locked up: but it is not possible to eliminate risk entirely where the offender is at liberty. A Serious Further Offence occurs when someone currently supervised in the community commits a new offence that is above a certain level of seriousness.
- (ii) It is fair that people should ask the question each time "*Could this offence have been prevented in this case?*" It was stated in the Panorama programme that the reason for choosing the two Bristol hostels to film was that there had been two residents who had each committed a murder whilst living there two years previously. It is the responsibility of the probation service and other agencies involved to follow their own procedures and assess and manage offenders properly. We examined the two cases to see if this had been done.

VIII. The Role and purpose of hostels

- (i) Hostels have always housed among their residents some of the most dangerous offenders supervised in the community, particularly those who have become rootless by virtue of serving a long prison sentence. What has changed is their systematic use, *primarily* for the accommodation of those who pose a high risk of serious harm to the public. Some residents, previously deemed too difficult or dangerous to house in a hostel, were in the past accommodated in whatever private provision there was available, often bed and breakfast accommodation or direct access hostels found by the offender themselves. This cannot be right.
- (ii) At the beginning of 2007 there were 101 probation hostels in 37 of the 42 English and Welsh probation areas. The size of premises varied from ten to 44 bed spaces, with most in the mid 20s; approximately 2,200 beds are available in total.
- (iii) We have inspected hostels periodically in thematic inspections and also during our general inspection programmes. In 1998 and 2004 we found that the reoffending rate amongst hostel residents was significantly lower during a period of supervision than for offenders who were not living in a hostel. Of the first seven areas inspected during our Offender Management Inspection programme, all hostels visited operated a satisfactory regime of restrictive interventions but the provision of constructive interventions was more variable.
- (iv) The creation of a National Probation Service in 2001 was an opportunity to bring consistency to the hostel estate, and investment was made over a number of years in developing a national strategy which was embedded in the Public Protection and Licensed Release Unit. In 2005 a Probation

Circular defined the role and purpose of hostels and the level of enhanced supervision necessary to manage residents safely. Whilst work on this continues, the centre has drawn back from developing a national regime of constructive interventions and national staffing model. Another review, being conducted at the same time as this inquiry, will inform some elements of regime development.

- (v) In the transition from the former National Probation Directorate to the National Offender Management Service, it is clear that there has been some planning blight affecting the development of hostels nationally. Decisions now need to be made by the National Offender Management Service about whether to develop hostels in future as a single national system, or within an approach led by regional commissioning arrangements. The Inspectorate view is that the hostels need to be managed as a national system.

IX. Enhanced supervision in hostels

- (i) What this means is defined in the Probation Circular mentioned above and is reproduced as Annex A to this report. We look in the section on the role of the probation service at what supervision entails. The 'enhanced' element is what is offered over and above 'normal' supervision.
- (ii) As stated in the title of this report, hostel residents are not locked up but they are subject to rules all of the time. The constructive interventions could, in a well-run hostel, include programmes to address both offending behaviour and rehabilitation. They always involve individual work with hostel staff keyworkers and the (usually office-based) offender manager.
- (iii) The restrictive interventions provide the element of control that is not present in other forms of community supervision. A combination of night time curfew and day time regular reporting-in can be actually more restrictive than open prison for some. Such a high level of restriction would normally be under the supervision of Multi-Agency Public Protection Arrangements. Other restrictions are available under 'normal' supervision (e.g. not to have contact with a named person), but the main difference is that hostel residents are always subject to hostel rules governing every aspect of their life. And they can be made to live in a hostel as a condition of release from prison as opposed to choosing to do so.

X. Public Expectations

- (i) The *Panorama* programme made the fair point that general talk of 'close supervision and monitoring of offenders' can give a misleading impression to the general public of what is being done on their behalf. The programme's investigative approach has brought about some benefits including engendering some useful debate about the nature of supervision and the challenges posed by some offenders. However, there have also been some 'costs' to the service being provided for the public.

- (ii) The Home Office and individual agencies often find themselves portrayed in the public eye as responsible for some aspect of public policy that has been seen to go wrong. The implicit expectation continues to grow that risk to the public can be eliminated if only supervision in the community can be made effective enough.
- (iii) It will be clear from this report, and our other reports, that we take a different view. We say that when supervising an offender in the community it is simply not possible to eliminate risk to the public, and we do not criticise staff for failing to achieve the impossible. But it is right for the public to expect that public servants will do their job properly.
- (iv) We saw in Bristol the impact that high profile newspaper and other media headlines can have in destabilising the arrangements made by the police, probation and other relevant authorities to keep to a minimum the Risk of Harm to the public. Whilst a particular offender may no longer be in one neighbourhood's 'back yard', by definition they have to go to another, and it is both necessary and more difficult for the police and others to do their public protection work in such circumstances. Hence, there is a cost as well as a benefit to doing public protection work increasingly in the public eye.
- (v) We welcome, however, any opportunity for the public to become clearer about what can be achieved in the supervision of offenders if they can have confidence in what is being done on their behalf. We think therefore that if these difficult issues are discussed in a more open and well-informed manner than previously, then the public might gain a fuller understanding of what it is possible for the authorities to achieve on the public's behalf.

XI. Offender management in Avon & Somerset

- (i) The probation area had been inspected as part of our routine Effective Supervision Inspection programme in January and February 2006. We found a number of strengths and areas for improvement and made recommendations accordingly. The area had addressed these within a detailed action plan and work was in hand to make improvements.
- (ii) We had found that its leadership and planning were strong. There had been concerns at that time about the potentially negative impact that its strategy for managing the budget of maintaining a 10% level of vacancies could have on service delivery. There was evidence, however, of it having employed other measures to make savings and to generate income. Despite being as assessed as a well-managed area, we had also been concerned about the quality of case risk assessment, risk management and supervision planning and review.
- (iii) Multi-Agency Public Protection Arrangements were well developed and founded on strong inter-agency links. There were good examples of partnership working with the police in relation to sex offenders and others.
- (iv) Offender management had been reorganised as required to meet the national model, with those cases posing the highest Risk of Harm and

complexity being allocated as required. However, we had concerns about what we were told about the size of offender manager caseloads, including those with a preponderance of high-risk cases. They were too high and set to grow higher in some parts of the area. In addition, the span of control of middle managers was too great to be effective. There was also a post of senior practitioner that was meant to bring depth to staff development and supervision; in most teams this had in effect disappeared as they too had been required to take on a full caseload.

- (v) Despite this, most of the cases we read during this inquiry were managed to a satisfactory standard. Enforcement was a strength. The majority of offender managers and middle managers we met impressed us as being experienced, knowledgeable and committed to doing their job well. They were concerned however about their continuing capacity to do this.
- (vi) The area recognised that its lack of ability to invest in offender management staff left it vulnerable to mistakes happening. Whilst it did prioritise high Risk of Harm cases, its capacity to supervise at middle manager level meant no routine checking that all high Risk of Harm cases had been properly identified as such. In addition, its procedures for managing lifers made the assumption that they would not pose a high Risk of Harm on release.

XII. The two Serious Further Offences in Avon & Somerset

- (i) These were cases where offenders released on licence, one to each of the hostels shown in the programme, each committed a murder within a few weeks of release. Whilst there was room for improvement in the management of each case, our judgement was that there was nothing in the offender's past or current behaviour at the time to suggest that such serious offences were about to be committed. It is not reasonable to conclude that the probation service could have prevented the tragic death in either of these cases.
- (ii) Each case was properly reviewed by the probation area and an action plan established to address the lessons that needed to be learned. There was a satisfactory process to ensure that the Board retained oversight until the actions had been completed.

XIII. Hostel arrangements in Avon & Somerset

- (i) There were four hostels, a relatively high number in an area this size. One of these, Ashley House, was one of only 12 in the country managed by a voluntary committee. It had very close cooperation from the probation area including some joint management arrangements. The probation area subsidised its three hostels to a certain extent so that they were relatively better resourced.

XIV. Ashley House

- (i) The management committee was made up mainly of local residents. A Probation Board member and the area performance manager for hostels attended its meetings to give advice.
- (ii) At the time of this inquiry the Ashley House Committee found itself at a crossroads. It was struggling to conform to the changing requirements of the National Probation Service and did not want to lose the focus on substance misuse and rehabilitation in favour of working with high risk of serious harm offenders, including sex offenders. It had long established a drugs treatment regime via a partnership arrangement between a local general practitioner, the Bristol Drugs Project and the probation service. However, despite this unusual level of in-house provision, it was not being fully used. During our inquiry only five of the 24 residents were engaged with this programme.
- (iii) The mismatch was due to the poor quality of referrals and the operation of the admissions procedures. Whilst all hostels need to keep up occupancy rates to secure full funding, this did not seem to be a problem at the other three Avon & Somerset hostels.
- (iv) Staff had been through a difficult year with a lot of uncertainty about their future. Despite this, they appeared to be well motivated and committed to doing a good job. They did not however have access to sufficient training to support them in their roles – a situation we also found in Brigstocke Road.
- (v) The hostel did take some high Risk of Harm cases. We found that staff and offender managers had a consistent view of the Risk of Harm posed by residents and responded appropriately to changes. There appeared to be a high level of communication between keyworkers and offender managers, by telephone if not in the hostel. Overall, the resident profile did not meet what was intended in the national hostel strategy.
- (vi) It was not an expectation that participants in the programme would start their period of residence drug-free. They were not allowed to use illegal drugs on the premises and were expected to show a commitment to the programme through participation and, ideally, a reduction in misuse as demonstrated through drugs tests. It was accepted that progress would often be slow. This was realistic for some offenders.
- (vii) The building was difficult to manage securely, but residents did say that there was a safe feel about the hostel. There was a range of standard security measures and checks which were satisfactory on the whole.

XV. The management of cases raised in the *Panorama* programme in Ashley House

- (i) We deal with five cases in this section. Four had a chronic substance misuse problem and we saw in the programme how difficult three of them were to deal with. In one case in particular, Resident C, we saw how he

continued to misuse illegal drugs, tried to manipulate staff and other residents and he was filmed apparently shoplifting. Two cases could not cope with their brief periods on licence and were quickly recalled to prison, but actually Resident C was engaging with treatment.

- (ii) What we saw in the programme was the very unpromising material that probation and hostel staff deal with every day. The alternative is a swift return to a short prison sentence which does little to protect the public except for very brief periods ('the revolving door').
- (iii) In four of the five cases we found that on the whole they had been satisfactorily managed. Staff recognised that there would be set backs but were prepared to work patiently with difficult people towards rehabilitation. There was a good level of liaison between offender managers and hostel keyworkers and enforcement procedures were used properly.

XVI. Brigstocke Road

- (i) Brigstocke Road was one of three hostels managed by the probation area and operating within a similar management structure up to area performance manager level.
- (ii) Its working arrangements for staff had been subject to review and change over the past year. Nevertheless, we saw committed and enthusiastic staff doing a difficult job in difficult circumstances. As with their Ashley House colleagues, they did not receive a satisfactory level of training.
- (iii) Referrals were said to be appropriate on the whole and were mainly for prisoners released on licence who posed a high or very high Risk of Harm which met national guidance. The area had also on occasions accepted Critical Public Protection cases, which meant taking dangerous offenders who needed to be moved from another area to protect the public. Brigstocke Road, though not an easy building to manage, was well suited to the task of isolating one individual if necessary.
- (iv) There were as yet no programmes delivered at the hostel – accredited or otherwise. Residents could have access to in-house accommodation advice or education, employment and training staff but this was limited. On the whole they seemed to spend much of their time in the hostel alone in their room; hostel staff were stretched and would struggle themselves to do more.
- (v) We were concerned that whilst hostel staff knew that they were supervising high-risk offenders, they appeared to have had insufficient training or experience to look for and then record signs that levels of risk were increasing, to ensure that small details were recorded to build up a picture. We did see some well-managed cases where hostel keyworkers worked closely with offender managers but also one case where, because the offender manager did not direct hostel staff appropriately, they also did not pick up the correct signs.

- (vi) There was a similar approach to creating a restrictive regime at Brigstocke Road as at Ashley House with physical security measures, curfew and searches. There needed to be improvements here however both to the quality of some security measures and a tightening up of procedures. Whilst relationships with the police were good, we were also concerned about the level of cooperation in Sexual Offences Prevention Orders.
- (vii) In a Home Office decision-making process that was separate from this inquiry, this hostel and two others in other areas were added to the list of hostels that should no longer accommodate paedophiles because of their close proximity to schools or nurseries.

XVII. The management of cases raised in the *Panorama* programme in Brigstocke Road.

- (i) There was one case that featured substantially in the programme that merited consideration on its own – Resident K – so he is not considered in this section, but our findings in that case are summarised overleaf in paragraph XVIII. Here we mainly look at two other cases and mention a third who was not actually seen in the programme.
- (ii) These were three cases assessed at some stage as presenting a high Risk of Harm to the public and who were all properly assessed and managed through a good level of liaison between the hostel keyworker, offender manager and other agencies, e.g. police.
- (iii) Two were shown exhibiting potentially dangerous behaviour: both were convicted paedophiles. What the programme did not show was the effective way that knowledge of their behaviour was used to contain it in the first instance and to take action leading appropriately to recall when that was not effective. These were good examples of just how hostels can be used to contribute to public protection.

XVIII. The case of Resident K.

- (i) Unfortunately this was a case where some staff did not do their job properly and the public was not protected. We are not aware, however, of any offence having actually been committed, due to his early recall to prison. In his case *Panorama* did appear to give a reasonable picture of what he was up to and how he was able to manipulate some staff.
- (ii) Resident K had served 38 years as a life-sentenced prisoner for the murder of a ten year old girl. He had been resident at Brigstocke Road on life licence for about a year when the reporter went undercover. As the vast majority of prisoners are released at some time, this length of time in prison in itself indicates an unusual case.
- (iii) In our view there was insufficient evidence available during his time in prison to support the view that K could be managed safely in the community. He was assessed on many occasions, and one of the problems

we read about was the wide variation in opinion about the level of risk he posed and to whom. There was evidence of some making assessments without using all of the evidence available to them. Significantly, the sexual element to his offending was often overlooked, as were other indicators of risk to women as well as to children.

- (iv) In particular, at no point during K's sentence was a specialist psychopathy assessment undertaken. This was an important prerequisite for consideration for the release of a violent sex offender such as this.
- (v) For the 2005 hearing the Secretary of State argued that such an assessment should be undertaken before a final release decision was made. Clearly this should have been done earlier in the prisoner's time in custody, but the need for it was valid. The Parole Board determined otherwise and directed full release. We thought that decision placed the public in a position of avoidable risk.
- (vi) Release on licence had been strongly supported by K's offender manager who had supervised him for several years. Her assessment of him and planning were inaccurate and incomplete and she did not refer him to the Multi-Agency Public Protection Panel. Nor did her line manager think that was appropriate. Whilst she had a high workload, this case should have been a priority. Unfortunately, there were also no systems in place to ensure that this case could not fall below the radar of more senior staff, as procedures assume that life-sentenced prisoners are not released when they still pose a Risk of Harm to the public.
- (vii) Following release there was a good level of liaison between the offender manager, hostel staff and the offender and his wife. There was however a catalogue of incidents known to staff and all identified before his release from prison as indicators of a rising level of Risk of Harm to the public. These included the strain in his relationship with his wife and being found with a pen knife. Each was dealt with as a separate incident and no-one undertook an overall re-assessment of risk. An incident was mentioned on film to the reporter that was so serious that K should have been recalled to prison immediately in our view. At the same time, unknown to staff, *Panorama* was filming him apparently befriending children. Only when the reporter rang the police to report this and identified himself to them was action taken.

XIX. Conclusion

- (i) *Panorama* did accurately and vividly illustrate the difficult nature of some of the offenders that probation and other staff routinely have to deal with. This is especially the case in hostel settings. The programme showed how challenging it can be for staff to do the difficult work we described earlier, and we do not criticise staff for failing to achieve the impossible. But in the main we have found staff to be working hard and conscientiously and to good effect, and 'achieving what is possible'.

1. ORIGINS AND STRUCTURE OF THE INQUIRY AND REPORT

1.1 Origins of the inquiry

- 1.1.1 In October 2006 the chief officer of the Avon & Somerset Probation Area received a letter from the British Broadcasting Corporation (BBC) to tell her that a reporter had been working under cover in two hostels in Bristol for the previous five months. It mentioned a number of concerns about the management of offenders who pose a high Risk of Harm (RoH) to the public and those misusing illegal drugs. She was invited to respond to the points made in the letter and was interviewed for the programme which was screened on 8 November.
- 1.1.2 The correct term for what previously was known as an Approved Probation and Bail Hostel is now just 'Approved Premises'. The *Panorama* programme referred to them as bail hostels. For ease of understanding we use the term 'hostel' throughout.
- 1.1.3 The programme generated a good deal of publicity before it was screened. As a consequence the Home Secretary asked the Chief Inspector of Probation to conduct an urgent inquiry. The following terms of reference were agreed, before the programme was broadcast:
1. To inquire into the specific allegations about practice in Avon & Somerset that are made as part of the broadcast Panorama programme on 8 November 2006.
 2. Whether or not any broadcast evidence of poor practice is representative of all staff practice filmed in the area.
 3. To make any recommendations necessary to improve arrangements for the management of dangerous and other offenders in the area and any national recommendations or learning points for the National Probation Service (NPS).
- 1.1.4 Later, the Home Secretary agreed to set aside item 2 above, since in the event that aspect proved not to be the basis of the programme's allegations (a point the programme makers confirmed). Instead the programme touched on a wider range of issues relating to the management of offenders. These included broad statements about the national strategic approach to the management of dangerous offenders and of offenders who misuse drugs. The reason for selecting Avon & Somerset was stated at the beginning of the programme as the fact that previously two residents in Bristol hostels had killed whilst on licence.
- 1.1.5 There was also reference to two cases from outside of Avon & Somerset. These were discounted as being outside of our terms of reference and, in any event, one of the cases had already been the subject of a detailed Her Majesty's Inspectorate of Probation (HMI Probation) review⁽¹⁾ earlier in the same year.

1.2 Inquiry structure

1.2.1 Following a meeting in the probation area and a brief reading of some of the cases mentioned, the following inquiry structure was developed:

- (a) discussion with the National Offender Management Service (NOMS) about public protection and hostels to clarify national expectations;
- (b) meetings with the Avon & Somerset Probation Board and senior and middle managers to discuss offender management and hostels;
- (c) a meeting with members of the Ashley House Management Committee;
- (d) an assessment of the quality of the regime and management of the two named hostels by spending time in each with staff and residents;
- (e) assessment of the quality of offender management in relation to the cases brought to our attention as a consequence of the programme. To do this, we read case files and discussed them with staff from both probation offender management teams (including former staff) and keyworkers from the hostels;
- (f) discussions with the Prison Service Psychology Department and NOMS Lifer Review and Recall Section about issues raised in one case;
- (g) the Parole Board was helpful in supplying all information requested about Resident K, but objected to any examination by us of its panel's release decision in principle on the grounds that the quasi-judicial decision of a court-like body should not be examined by someone reporting directly to Ministers;
- (h) meetings between Her Majesty's Inspectorate of Constabulary (HMI Constabulary) and Avon & Somerset Police to discuss the issues raised about their work in these cases.

1.3 This report

1.3.1 Whilst the allegations made in the *Panorama* programme were based around hostels and cases in Avon & Somerset, there were statements made throughout that were about the capacity of the probation service to protect the public and relate to the role of the service nationally.

1.3.2 The first half of the report therefore outlines the purpose of the probation service and hostels and the role they play in public protection.

1.3.3 The second half assesses the work of Avon & Somerset Probation Area in relation to offender management and to hostel management as raised in the *Panorama* programme.

1.3.4 A summary of our overall view of the national and Avon & Somerset picture precedes this section.

1.3.5 We list our key findings and recommendations towards the end of the report in Section 16. We make no recommendations here in respect of national issues, as

it would be wrong to make broad conclusions based on hostels in one area only. It is our intention to carry out a thematic inspection of probation hostels during 2007/2008 when we will be better placed to address wider issues. Findings from this inquiry will instead inform the methodology for the thematic inspection.

1.4 A note on language

- 1.4.1 The report aims to be understandable to the general public and avoids some terms and acronyms commonly used in the probation service but not easily recognised by those outside. Sometimes we therefore use plain English instead of the relevant official term. For example, we say 'lifer' for life-sentenced prisoner.
- 1.4.2 In particular we have used the term 'hostel' throughout this report. The hostels we refer to in this report are now formally called Approved Premises (previously they were Approved Probation & Bail Hostels, being 'approved' by the Home Secretary for the purpose). We only say 'Approved Premises' when making a technical distinction or quoting an official document. The term 'Bail Hostel' has no current formal meaning.
- 1.4.3 It might be helpful to note at this stage that, although all four of the hostels which appear in this report have the status of 'Approved Premises', only three of them are managed by the Probation Board, while Ashley House is managed by a voluntary committee.
- 1.4.4 Reference to individual offenders: although some individual offenders were named in the programme, we have decided not to use real names in this report. A number of the cases we examined were named and some were not and we refer to them all by letters, i.e. Resident A through to Resident K. This is not primarily an inquiry into individual cases and in some there is still a need to protect the privacy of victims.
- 1.4.5 A glossary can be found at the end of the report.

2. THE PANORAMA PROGRAMME

2.1 The reporter

- 2.1.1 The TV reporter was employed as a relief assistant manager at Ashley House hostel which is run by a voluntary management committee, not by the probation area. Their first contact with him was when he applied for a permanent staff post. The recruitment process was managed by the probation area and the application form used by Avon & Somerset at that time asked for previous experience but not for dates. The reporter was therefore able to complete the form partially i.e. he missed out the fact that he was a reporter. He gave two references and the area took up only one which was against normal practice. His Criminal Records Bureau (CRB) check came back showing no previous convictions.
- 2.1.2 At interview he was deemed to be appointable but not the best candidate on the day. On that basis he was offered a place in the pool of relief staff. Whilst Ashley House is managed separately from the other Avon & Somerset approved hostels, it does have aspects in common including a shared pool of relief staff. The reporter worked mainly in the evenings at Ashley House, and during the day at Brigstocke Road, but did do various shifts at each.
- 2.1.3 The programme made a number of allegations about the capacity of hostel staff to manage residents between May and October 2006. To illustrate his point the reporter filmed occurrences that, as an employee he ought – if he had witnessed them inside or outside of the hostel – to have done something about. On two occasions residents were shown apparently committing offences (shoplifting and loitering for the purposes of prostitution). On several more, residents with convictions for sexual offences against children were filmed engaging in behaviour that could potentially have led to harm. Recognising this, on three occasions he telephoned the police; the third time action was taken when he disclosed his identity.
- 2.1.4 In addition, hostel staff were aware that medication could be converted into currency, or be taken in an unsafe manner and contribute to an overdose. For these reasons prescribed medication had to be taken in controlled and supervised conditions. The reporter filmed a resident with a clear drug problem hiding his medication when, as a member of staff, he was meant to be ensuring that this did not happen.

2.2 Description of allegations made and issues raised

- 2.2.1 The programme was called: *Exposed: The Bail Hostel Scandal*. Its central premise was that the probation service claimed to supervise and monitor

offenders to keep the public safe but that it was failing to do so. To illustrate this it used film from two hostels housing residents presenting very different types of offending and other difficult behaviour.

- 2.2.2 Approximately 18 months before the journalist went into the hostels an Ashley House resident did commit a murder whilst he was living there. Around the same time a resident at Brigstocke Road also committed a murder. Both were on licence and had a history of substance misuse. These offences were said to be the reason for the BBC selecting Avon & Somerset as the focus.
- 2.2.3 In relation to Ashley House the issues were about offenders who misused drugs and who continued to commit offences to support their habit. This was a hostel with a regime intended for offenders who were prepared to engage with treatment; it was not a 'dry house', i.e. a hostel for those who had already stopped using drugs. The programme did imply that there was illegal drug use on the premises but that staff were powerless to prevent it. The programme makers also strongly implied that testing positive for drugs should lead to breach action.
- 2.2.4 Footage of residents at Brigstocke Road was used to illustrate the point that probation hostels house potentially dangerous offenders including those who have committed violent and sexual offences against children. Residents were shown outside of the hostel to demonstrate that once they leave the premises, staff did not know what they were doing. There was also a suggestion that staff were negligent in allowing a resident, whose offending was said to be linked to alcohol, to go to a public house. It made the point that hostels had previously housed less serious offenders.
- 2.2.5 There were suggestions that appropriate breach action was not taken by probation staff in several cases.
- 2.2.6 Reference was made to Multi-Agency Public Protection Arrangements (MAPPA). The reporter rang the police three times to make allegations about Resident K's behaviour, wrongly believing that he was subject to management under MAPPA (see Section 5 Public Protection). On the first two occasions nothing appeared to be followed up.
- 2.2.7 Points were made about an apparent lack of resources to do what was necessary in hostels to contain or work safely with potentially violent offenders, in particular those with mental health problems. The reporter appeared to have little or no training before he did a shift at Ashley House (he was not the only worker on shift).
- 2.2.8 Questions were raised about why a hostel housing offenders convicted of sexual offences against children should be close to two nurseries and overlook one.
- 2.2.9 There was an acknowledgement that offenders did have to be accommodated somewhere; but were probation hostels and MAPPA sufficient to protect the public?

3. THE ROLE OF THE PROBATION SERVICE

3.1 The role of the Probation Service in England and Wales

- 3.1.1 In one form or another there has been a statutory probation service for 100 years. Whilst the breadth of its remit and the way it has been structured have changed over the years, at its centre has been the supervision of offenders to prevent reoffending. This has not always been an explicit aim: for most of its existence the purpose of the service was to 'advise, assist and befriend' offenders; preventing reoffending was implicit.
- 3.1.2 The Criminal Justice and Courts Services Act (2000)⁽²⁾ abolished the previous local probation services and created the NPS in 2001, with local Boards responsible for 42 probation areas corresponding to police boundaries. Avon & Somerset was one of several 'new' areas created through amalgamation as part of restructuring at this time. Reduction in reoffending and protection of the public from harm are the stated aims of the service.
- 3.1.3 There are approximately 160,000 offenders under supervision in the community at any one time. Three-quarters of these are subject to community orders, the balance being released on licences.⁽³⁾
- 3.1.4 This report was compiled during the passage of the Offender Management Bill⁽⁴⁾ through its second reading and committee stages. This is the statutory framework for the transition to NOMS which will combine responsibility for both prison and probation services to foster continuity of management of each case from start to end of sentence, and hence across both prison and probation. It will also allow the Secretary of State to commission the services currently reserved to Probation Boards from a range of different providers in a 'contestable' market environment, thus ending the monopoly of the probation service in the management of offenders. NOMS has been in existence since 2004 at headquarters and regional levels. The functions of the former National Probation Directorate (NPD) have recently been taken over by NOMS. Accordingly, we refer variously to NPD, NOMS or to NPD/NOMS as relevant.

3.2 The supervision of offenders

- 3.2.1 The Criminal Justice Act (2003)⁽⁵⁾ redefined the purposes of sentencing as:
- the punishment of offenders
 - the reduction in crime
 - the reform and rehabilitation of offenders
 - the protection of the public, and

- the making of reparation by offenders to persons affected by their crimes.

3.2.2 In order to achieve this, the National Offender Management Model 2005⁽⁶⁾ and associated National Standards 2005 specify the objectives of offender supervision under four broad headings. Dependent on the assessed level of RoH posed to the public, the likelihood of reoffending and the complexity of need, offenders are deemed to require between one and four of the following approaches:

- Punish
- Help
- Change
- Control.

3.2.3 The sentencing options available that underpin this are complex and it is not necessary for the purposes of this report to go into much detail. A number of offenders filmed in the two hostels were subject to licence on release from prison. Two were subject to a drug treatment and testing order (DTTO – pre-dating the 2003 Act) and a community order with a drug rehabilitation requirement (DRR). One was on bail only, which means that he was required to live at the hostel as an alternative to being remanded in custody pending a court hearing.

3.2.4 In current language, every offender subject to supervision is allocated to an offender manager. This is either a probation officer (PO) or a probation service officer (PSO); the first has a probation qualification and the second does not. The choice is normally dependent on the assessed level of RoH to the public and complexity. Their role is to assess, plan and review the needs of the case in relation to reducing reoffending and managing any assessed RoH to the public. They might deliver the entire plan, or some parts of it, themselves through individual meetings for supervision. They are increasingly more likely to manage the plan and refer the offender to others for elements of supervision, e.g. an accredited programme, drug treatment, or residence in a hostel.

3.2.5 Little mention is made of the role of approved premises in the national offender management model, although the contribution of other interventions, notably accredited programmes, is dealt with at length. It is the only non-custodial intervention offering a measure of *control*, whereby a resident is restricted to secure premises under curfew at night and subject to rules at all times. A hostel also has the potential to contribute to all of the other three purposes of supervision: *punish, help and change*.

3.2.6 The minimum level of contact is determined by the *National Standards 2005*⁽⁷⁾. This forms a framework, adjusted by assessed risk and need. The sentence plan produced within 15 days of sentence or release (five for high RoH and the most complex cases) will set the level of contact for the different elements of supervision. For most cases, the minimum level of contact is weekly for 16 weeks and monthly thereafter. Supervision requirements are meant to be strictly

enforced with a final warning after one unacceptable absence and a return to court after two (two warnings are possible in licences with a direct return to prison after a third unacceptable absence).

- 3.2.7 The national standards requirements and methods used are similar for those released on licence and those subject to a community order. The possible *constructive* or *restrictive* requirements contained in the individual licence or order differ somewhat. Information about release on licence will be dealt with later in this section.

3.3 Community penalties

- 3.3.1 On a community order supervision can be combined with any of the 11 other possible requirements and some, e.g. curfew and certain programmes, can stand alone without supervision. Requirements can be *constructive*, e.g. drug, alcohol or mental health treatment or *restrictive*, e.g. prohibitive activity and curfew. They can also be intended solely for punishment, e.g. unpaid work.
- 3.3.2 Typically, an offender will be seen weekly by their offender manager whilst waiting for inclusion in a group work programme which could take up to three months to become available. During that time if unemployed they may also undertake basic skills work as many offenders have very low levels of literacy and numeracy. Accredited programmes normally require weekly attendance for 12 to 20 weeks, more for sex offender treatment programmes (SOTPs). Once engaged in any of these activities the role of the offender manager is to motivate the offender, to liaise with other workers and meet periodically to review progress – unless it is a high RoH or complex case which needs individual supervision in addition.
- 3.3.3 The key to successful offender management is assessment, planning, review and evaluation. This is undertaken through the Offender Assessment System (OASys), the assessment tool common to the probation and prison services.

3.4 OASys

- 3.4.1 OASys is a comprehensive system designed to help:
- assess how likely an offender is to be reconvicted
 - identify the factors associated with an offender's own offending, such as attitudes and behaviour, and social and economic factors
 - assess the RoH to others and of self-harm
 - link assessments with supervision and sentence plans
 - indicate the need for further specialist assessments
 - measure how an offender changes during their sentence.

3.4.2 The RoH assessment classifies an offender according to one of four levels:

- Very High – there is an imminent risk of serious harm. The potential event is more likely than not to happen imminently and the impact would be serious
- High – there are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious
- Medium – there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse
- Low – current evidence does not indicate likelihood of causing serious harm.

3.4.3 All those subject to supervision should have a sentence plan and those assessed as medium, high or very high RoH should also have a risk management plan which informs the sentence plan. Consideration of referral to MAPPA would be anticipated in high RoH cases and expected in the few very high RoH cases. It is the assessment and management of medium risk cases that poses the greatest challenge to probation areas. At a time when resources are scarce, they will not be allocated the same priority as high-risk cases and the signs of change may be missed. Typically about a half of an area's caseload will be assessed as posing a medium RoH.

3.5 Drug rehabilitation as part of a community sentence

3.5.1 There is a national initiative being taken forward locally under the auspices of area community safety arrangements to identify and work with those offenders responsible for the highest volume of offending. This is the Prolific and other Priority Offender (PPO) scheme. A high proportion of those individuals identified as PPOs are problematic drug users committing a high volume of acquisitive crime to support their dependency. This can mean over a 100 convictions for each offender, typically for shoplifting and burglary or loitering for the purposes of prostitution.

3.5.2 There are several strands to the scheme:

- Prevent and Deter – to stop young people entering the pool of prolific offenders
- Catch and Convict – actively tackling those who are already prolific offenders and
- Rehabilitate and Resettle – working to increase the number of such offenders who stop offending by offering a range of supportive interventions.

Recognising the harm (not necessarily serious harm from violence) caused by this relatively small group of offenders, criminal justice agencies are expected to deliver a 'premium' service to them to achieve deterrence, conviction or rehabilitation.

- 3.5.3 A number of residents identified in the *Panorama* programme were designated as PPOs and were also subject to licence, a DTTO or a community order with a DRR.
- 3.5.4 Most involved with those who use drugs illegally recognise that compulsion to take part in treatment can work, but that abstinence may not be a realistic short term goal for many. It is also clear that relapse and reoffending rates will be high. Offenders may have to start treatment many times. The alternative is the 'revolving door' of offending and short prison sentences that give the public respite for a few months at a time but solve nothing substantive.
- 3.5.5 Since 2005 all hostels have been required to test residents who have had a drug habit or who they suspect of relapsing into use. Offenders subject to DTTOs or DRRs are required to undertake treatment and testing on a regular basis. In both cases, reviews of their progress are presented to a court (normally the sentencing court) on a monthly basis for a decision to be made about whether the offender is complying with the order. This includes the results of all drug tests during a period. A positive test for a proscribed drug does not necessarily on its own lead to a breach, though persistent test failures that indicate a failure to engage with supervision should however lead to breach proceedings. Failure to engage would lead to re-sentencing and a probable prison sentence.
- 3.5.6 Contact levels for DRRs depend in part on the seriousness of the offences that led to an order. For the most serious they are at a minimum of 15 hours per week including treatment and contact with the offender manager. DTTOs were introduced in 2001 and had more stringent requirements which meant they could be used less flexibly than a DRR. These are no longer generally available to courts.

3.6 Release from prison on licence

- 3.6.1 There are approximately 80,000 prison spaces, mainly occupied by people who will be released at some stage. Only in a very few cases will a decision have been taken that someone should never be released.
- 3.6.2 All young offenders and those aged 21 and over serving sentences of 12 months or over are released on licence, i.e. to the supervision of the probation service (or Youth Offending Service for those aged under 18 years). The minimum length of licence is three months and the maximum life. In between, the length of licence varies enormously due to many factors including the authority of the sentencing court to order an extended period of supervision or to a prisoner having extra days added to his sentence for infringement of prison rules.
- 3.6.3 A licence is similar to a community order in that it contains standard conditions in relation to good behaviour and the necessity to keep in touch as required with the offender manager. There is also the capacity to include one of 11 additional

requirements of a *restrictive* (e.g. not to contact a former victim) or *constructive* (e.g. to reside in a named hostel or engage in work to address offending behaviour) nature. Exceptionally, the Release and Recall Section of NOMS can agree bespoke conditions in order to protect the public.

3.7 Lifers

- 3.7.1 This is the term commonly used to refer to those sentenced to life imprisonment.
- 3.7.2 The rules governing release on life licence are complex. In this report, the minimum information necessary to understand the case of Resident K is included.
- 3.7.3 The trial judge, when passing a mandatory life sentence, normally specifies a period of imprisonment for punitive purposes – referred to in the Criminal Justice Act (2003) as the ‘minimum term’ and known as the ‘tariff’ date. This is the date at which the prisoner is eligible to apply for release. It is commonly misunderstood as it is often reported in the media as if the date were when the prisoner *is quite likely to be released*. After the tariff date the length of time to be served is dependent on assessment of the level of RoH posed to the public by the prisoner. Section 28(6) of the Crime (Sentences) Act 1997 provides that the Parole Board shall not direct the release of a prisoner who has been referred to it by the Secretary of State unless it is “*Satisfied that it is no longer necessary for the protection of the public that the prisoner should be confined*”. Directions under this Act specify that “*The test to be applied by the Parole Board in satisfying itself that it is no longer necessary for the protection of the public that the prisoner should be confined, is whether the lifer’s level of risk to the life and limb of others is considered to be more than minimal*”. Where the offence is so serious that the offender should never be released, the judge should make an order to that effect.
- 3.7.4 Whilst the rules governing the tariff have changed over time, the principle of it being that period necessary for punishment as opposed to rehabilitation remains the same.
- 3.7.5 Most lifers ‘progress’ through the prison system with a view to moving to an open prison when their level of RoH is assessed as being suitably reduced. Prisoners transferred to open conditions should not need to start new offending behaviour work but be ready to focus on resettlement.
- 3.7.6 Transfer to open conditions is agreed by the Secretary of State following a recommendation by the Parole Board. The purpose of open conditions is to prepare lifers for release and a prisoner is meant to spend approximately two years there⁽⁸⁾. During that time they will be encouraged to work in the community and to apply for temporary release on licence for up to five days at a time. This enables prisoners to maintain family ties and links with the community and to make suitable arrangements for accommodation, work and training on release on life licence.

- 3.7.7 The relationship at this stage between the lifer, their home PO (offender manager in the area intended for a release address) and the PO seconded to the open prison is an important one: they contribute reports to the Parole Board hearings and practical arrangements for eventual release will be made by them. The decision to move to open conditions is a key decision since in effect it starts the progression to release due to the stated purposes of open prisons.
- 3.7.8 Open prisons, as the name suggests, do not require prisoners to be locked up at all times unlike other categories of prison. The prisons are a series of buildings within an open site, like a military base. There is security but prisoners must be assessed as not likely to abscond as well as posing only a low level of RoH to the public before being transferred there. They will be locked into their residential building at times, including during the night, but are at liberty to walk around the site at others. Many will go out to work each day, either for a charity or for an employer who may be prepared to take them on following release. Others will work in the prison or be otherwise occupied for much of the time, e.g. with education or a substance misuse treatment programme. Lifers released on licence sometimes comment that they had fewer restrictions in open prison than on release due to the nature of the restrictive requirements in their licences.
- 3.7.9 The next stage is release. The Parole Board may direct the release of a tariff-expired lifer only if it is satisfied that it is no longer necessary for the protection of the public that the prisoner should remain in prison. The decision is based amongst others on assessments by prison staff, psychologists and the probation service. Release for a lifer often means to a hostel as a halfway stage to full liberty. This is particularly important for those who have spent many years in prison.

4. PUBLIC PROTECTION

4.1 The role of the probation service in protecting the public

4.1.1 The probation service works closely with other agencies to contribute to public protection. It has expertise in the assessment and management of potentially dangerous offenders and works with them in prisons and in the community.

4.2 Multi-Agency Public Protection Arrangements

4.2.1 The Criminal Justice and Court Services Act (2000) imposed duties on the police and probation services in each of the 42 areas to establish the MAPPA. This provides the statutory framework for inter-agency cooperation in assessing and managing violent and sex offenders in England and Wales. The Criminal Justice Act (2003) included the prison service as one of the responsible authorities for each area, and placed a duty to cooperate on a number of agencies, including health, housing, social services, education, Youth Offending Teams, Jobcentre Plus and electronic monitoring providers.

4.2.2 MAPPA work on three levels below a strategic management board:

- Level 1 – ordinary risk management, where the offender can be managed by one agency. All registered sex offenders are managed in MAPPA, often at Level 1 as they are monitored by the police alone if they are not subject to any other form of supervision
- Level 2 – where the active involvement of more than one agency is required to manage the risk. These will mainly be offenders subject to supervision by the probation service or about to be released from prison. Local police and probation managers generally convene meetings held at this level. They will be attended typically by hostel managers, children's services, mental health and drug treatment providers. Risk should be assessed using an up-to-date OASys, an action plan made and built into a sentence plan and a date set for review. This should be recorded and placed on an offender's record
- Level 3 – the Multi-Agency Public Protection Panel (MAPPP). This is responsible for the management of the 'critical few' who are assessed as being a high or very high risk of causing serious harm and can only be managed by a plan which requires close cooperation between agencies at a senior level. In an area at any one time there might be only a handful of such cases requiring such a high level of management.

4.2.3 There is a small number of offenders, some of whom are no longer subject to statutory supervision, who are deemed to be so dangerous that they are

designated as Critical Public Protection cases. They are managed through local MAPPA, supported if necessary by the Public Protection Unit. This may involve a change of identity and a move to other areas should an offender's whereabouts be disclosed. This highlights the point that there are a number of different circumstances in which the relevant authorities can find that they are required to manage difficult or dangerous offenders in the community.

4.3 The Supporting People programme

- 4.3.1 Supporting People is the mechanism through which supported public housing is commissioned and funded. It is a multi-agency approach requiring local organisations to work together to develop strategies to identify and address priority needs.
- 4.3.2 At a senior level, the same people will often represent their agencies on MAPPA and Supporting People strategic boards. The two should be closely linked and the needs of offenders taken into account in the commissioning process. It is vital that someone who can represent local authority housing and Supporting People is an active member of MAPPA at Levels 2 and 3.
- 4.3.3 Residence in a probation hostel is often an appropriate short or medium-term placement. A probation hostel offers the highest level of restriction possible outside of a closed prison and should be reserved for those who need this level of supervision. It is a limited resource however (2,200 bed spaces in England and Wales) and for all, but a very few, residents have to move on ideally six to 12 months after moving in.
- 4.3.4 There are times when offenders stay longer than they need to in a hostel; they may no longer pose a high RoH but their record of offending is such that housing providers are not prepared to take them. Where offenders are being managed through MAPPA, move on should be agreed at the beginning as part of the individual management strategy. Through Supporting People arrangements there should be access to a range of accommodation including other hostels and access to independent living assessed as 'safe', i.e. not near vulnerable people.

4.4 Sex offender registration

- 4.4.1 The Sex Offender Act (1997)⁽⁹⁾ defines sex offenders as those offenders convicted or cautioned since September 1997 for certain sexual offences, or who at that point were serving a sentence for a like offence. Registration requirements were updated by the Sexual Offences Act (2003)⁽¹⁰⁾. Offenders must register with the police and notify them of a change of address, and a police officer may call periodically at their home. There is very little more in this provision in terms of monitoring and supervision.

4.5 Sex Offender Treatment Programme

- 4.5.1 This programme runs both in prisons and in the community as a condition of licence or a community order. The Core programme runs for 86 two-hour sessions. It is a cognitive-behavioural approach to treatment and focuses on deviant arousal, distorted thinking patterns, lack of empathy, denial and minimisation, and patterns of offending. The primary purposes of the programme are to increase offenders' motivation to avoid reoffending and to develop the self-management skills necessary to achieve this. This is aimed at medium to very high RoH offenders.
- 4.5.2 There is a Rolling programme for those assessed as posing a low RoH. This runs for 45 to 60 sessions.
- 4.5.3 If a prisoner is assessed as having extra treatment needs, he would undertake a second stage of treatment on the Extended SOTP. The goals of this programme are to identify and challenge patterns of dysfunctional thinking, improve the management of emotions, improve relationships and intimacy skills, address deviant fantasy and sexual arousal and to understand the links of these to sexual offending.
- 4.5.4 For sex offenders who have completed the SOTP in custody, but who have a long gap before their eventual release, a Booster programme can be completed.
- 4.5.5 Following release, the offender can complete a Relapse Prevention Programme in the community.

4.6 Serious Further Offences

- 4.6.1 A Serious Further Offence (SFO) is when someone under current supervision in the community commits a new offence that is above a certain level of seriousness. It is fair that people should ask the question each time "*Could this offence have been prevented in this case?*" but it is not possible to eliminate risk entirely where the offender is at liberty. A small number of people are known to be dangerous and will commit the most serious offences unless they are locked up. The relevant authorities have to decide (where the court sentence actually allows them the authority to do so) which offenders have reached a point where they can reasonably be safely managed in the community.
- 4.6.2 Where an offender under supervision commits an SFO, the officer in charge of the case should be able to demonstrate that all reasonable action had been taken in that case to keep to a minimum that offender's RoH to others. If they can do that they have done their job properly. But this is easier said than done. In some cases there are factors that can be recognised, assessed and managed so that the offender's opportunity to commit a serious offence is substantially reduced, but in other cases there are factors and events that could not reasonably have been foreseen. Hence a further offence is not in itself a 'failure' by the supervisor. But although it is not possible to eliminate risk to the public entirely, it is a failure if the supervising authorities have not done their job properly, as defined here.

- 4.6.3 It is the responsibility of the probation service to follow its own procedures and assess and manage offenders properly. In this way, people belonging to the first group will be managed within MAPPA, and if they are in the community will have appropriate resources allocated to them. If there are warning signs relating to other offenders under supervision detected through regular assessment then all reasonable action should be taken to keep the level of RoH to a minimum. This might mean action to prevent harm to a child via the police and children's services or a move to a hostel on release from prison.
- 4.6.4 The year 2004/2005 is the latest full year for which statistics are available about SFOs. This is because some cases in the following year are still progressing through the courts. It was during this period that two of the offenders identified by *Panorama* committed murders in Bristol. In this year there were 326 people under supervision who committed serious offences including murder and who were eventually convicted. Whereas that number represents approximately 0.2% of the national probation caseload at the time, nevertheless each one represents a tragedy for those people and their families.
- 4.6.5 Supervising offenders is in many ways scientific, but it is not an exact science. About 7% of the caseload at any one time are assessed as posing a high or very high risk of serious harm to the public, and they commit 20% on average of SFO, which is why they rightly attract priority attention. But this means that the other 80% of SFOs are committed by offenders who were of medium and low RoH, and this is why probation areas, and we in our inspection programmes, put such an emphasis on regular and accurate assessment of *all* cases.
- 4.6.6 Where an offender commits a further serious violent or sexual offence (from a published list), there is a procedure that areas must follow to ensure rigorous scrutiny both internally and by the NOMS Public Protection and Licensed Release Unit. HMI Probation also has a role in working with this unit to quality assure its work from time to time. The assessment and management of such cases is reviewed in order to ascertain whether procedures were followed and defensible decisions made that were based on all the evidence available.

5. THE ROLE AND PURPOSE OF HOSTELS

5.1 The purpose of hostels

- 5.1.1 The introduction to the *Panorama* programme included these comments: "There comes a time when even the most dangerous offenders are freed from jail" and "There are 2,000 offenders living in bail hostels across the UK, including rapists and killers. There may be a hostel in your street. We're told those living there are supervised and monitored to keep us safe – but is it true?" It was followed by footage of offenders and staff filmed undercover in two hostels and various locations in Bristol and an interview with the chief probation officer.
- 5.1.2 It is an important point that most offenders are released from prison at some point. Halliday⁽¹¹⁾, in his review of the sentencing framework in 2000, referred to hostels as part of an 'intermediate estate' between prison and liberty with a relatively restrictive but supportive programme of resettlement. Hostels are not prisons but residents are subject to rules, breach of which can lead to a return to prison or court. Halliday recommended a review of how far the hostel could be developed as part of a sentence or licence, but it was not followed up.
- 5.1.3 The probation service has not advertised the location of its hostels widely but local residents and organisations are aware that they are there, and have often had some insight into their running through the medium of a local liaison group. These can serve several purposes including being a conduit for airing and ironing out problems, e.g. hostel residents congregating in the street.
- 5.1.4 Hostels have always housed among their residents some of the most dangerous offenders supervised in the community, particularly those who have become rootless by virtue of serving a long prison sentence. What has changed is their systematic use *primarily* for the accommodation of those who pose a high risk of serious harm to the public; this has altered the balance between high-risk offenders and those posing less of a risk. Some residents, previously deemed too difficult or dangerous to house in a hostel, were in the past accommodated in whatever private provision there was available, often bed and breakfast accommodation or direct access hostels found by the offender themselves. This cannot be right. These include those who, like Resident K, will test every aspect of provision but who, in a hostel, must be obliged to live within the rules or return to prison.

5.2 The current national position

- 5.2.1 The statutory authority for the establishment of Approved Premises is currently contained in the Criminal Justice and Courts Services Act (2000). Section 9(1) gave the Secretary of State power to approve premises in which accommodation

is provided for persons granted bail in criminal proceedings, and for, or in connection with, the supervision or rehabilitation of persons convicted of offences. The *Approved Premises Handbook 2002*⁽¹²⁾ pulls together the regulatory requirements and turns them into a set of guidelines and procedures. Whilst this document is in need of updating, it is still a valuable guide to all aspects of hostel management.

- 5.2.2 Initially, certainly in the 1960s, hostels were being used primarily as homes for young offenders from 15 years up to age 21. This was the case in one of the Bristol hostels, Ashley House. The emphasis was on addressing housing need and rehabilitation. The upper age limit was withdrawn and the lower limit in practice became 18 (although in theory some hostels will accept referrals in relation to 17 year olds). Given the resident mix, probation hostels are now rarely suitable for young and potentially vulnerable offenders.
- 5.2.3 At the beginning of 2007 there were 101 probation hostels in 37 of the 42 English and Welsh probation areas. There was a limited female hostel estate (seven premises) and a dwindling mixed estate (national policy is that mixed hostels should become single sex). The size of premises varied from ten to 44 bed spaces, with most in the mid 20s; approximately 2,200 beds are available in total, as mentioned above.
- 5.2.4 Of the 12 hostels that are managed by voluntary bodies, only four, including Ashley House, stand alone as single enterprises with most being managed as part of a larger social housing association. These bodies receive a grant from the NPD and are expected to adhere to national guidelines.
- 5.2.5 All aspects of probation service funding are based on national formulae. Until recently the hostel grant itself was separately allocated on a national basis. As a consequence probation areas that wanted to avoid being obliged to supplement the budget of the hostels in their area tended to require that their hostels were managed within that annual grant. To achieve the full grant hostels must maintain average bed space occupancy of 90% over a full year or lose a proportion in the following year. Conversely, they can claim extra funding as a reward for even higher levels of occupancy.

5.3 Inspection of hostels

- 5.3.1 From time to time HMI Probation undertakes a thematic inspection of hostels, the last two being in 1993⁽¹³⁾ and 1998⁽¹⁴⁾. This inquiry is different in kind from these thematic inspections, but we intend to return to this topic again in the coming year 2007/2008.
- 5.3.2 In 1998, the first Finding in our report was: "*Hostels, including those managed by voluntary committees, unquestionably demonstrated their ability to accommodate and work successfully with some of the most difficult, damaged and potentially dangerous defendants and offenders within the criminal justice system, in a manner which gave due regard to public safety*".

- 5.3.3 At that time 65% of beds were occupied by bailees. We raised the question of whether this was the best use of an expensive resource intended to provide an enhanced level of supervision. We advised that there was a need for a national strategy to determine what hostel provision was needed and how that could be provided in a consistent manner across England and Wales.
- 5.3.4 It should be noted that we found that the rate of reconviction amongst hostel residents was low. In 1998 we reported that 4% were charged with an offence during their period of residence nationally. In 2004 we carried out an inspection of offender accommodation in eight areas as part of our Effective Supervision Inspection (ESI) programme⁽¹⁵⁾ and found that amongst hostel residents 3.1% were reconvicted for offences committed during their period of supervision. During the first nine months of 2006/2007 14 of the SFOs notified to the Public Protection Unit were by hostel residents, i.e. a significantly lower rate than for those who were not living in a hostel.
- 5.3.5 It is inevitable that if hostels house the most dangerous offenders, any reoffending will include very serious offences. Bearing in mind what we have said about the impossibility of eliminating completely their RoH to others⁽¹⁾⁽¹⁶⁾, those assessed as posing such a risk will reoffend from time to time. What is at issue here is whether hostels provide a regime where responsible authorities can demonstrate that they have taken all reasonable action within the law to keep to a minimum each offender's RoH to others.
- 5.3.6 In our current core probation inspection programme (Offender Management Inspection [OMI]), recognising their significance, we visit at least one hostel per area and meet residents; we also include hostel staff and managers in the meetings and a number of cases in the inspection sample are hostel residents. In respect of offering activity that can help or assist in changing behaviour, from the seven published OMI reports, four were found to offer a good level of *constructive* engagement to the residents whose management we assessed. Two had some provision on offer and one had an unsatisfactory level of provision. All were found to offer a satisfactory level of *restrictive* measures.

5.4 Developments since 2001

- 5.4.1 The NPS came into being in April of that year. The level and type of hostel provision then varied as each probation service had previously been able to respond as it thought appropriate to local need. The creation of a national service was an opportunity to bring consistency.
- 5.4.2 Responsibility for hostels has been located within what is currently called the Public Protection and Licensed Release Unit of NOMS. As we had recommended, hostels were increasingly regarded as an expensive but crucial element in supporting the role of the probation service to protect the public. An internal review of the resident mix in 2004 found that it had already changed significantly from what we had found in 1998 and that licensees now made up the majority.
- 5.4.3 Investment was made centrally in establishing a national strategy for the management of hostels as part of the housing strategy for offenders posing a

high RoH to the public. At the same time a resources review made proposals about changes to staff roles in part to acknowledge the challenges posed by accommodating dangerous offenders. It also aimed at improving the training and skills of the grade of staff who were spending most time with residents and therefore were most likely to have an impact on their behaviour.

- 5.4.4 The recommendations were far reaching and implementation began in 2005. The central plank of the strategy, i.e. the use of the hostel estate primarily to supervise offenders posing a high RoH, was implemented. However, in the context of the development of NOMS, regionalisation, commissioning and contestability a decision was taken in 2006 not to develop a national regime further until there was greater clarity about commissioning arrangements. The exception to this was in relation to double waking night cover. Patterns varied but many hostels employed one person to be awake during the night and another, likely to be a member of the day staff paid an allowance, sleeping in, in a staff apartment. Areas were required to implement this level of night time staffing by March 2007. The arguments for this are that it contributes to ensuring that the public is adequately protected during night hours, through the rigorous monitoring of the curfew, and that it is safer for staff and residents.

5.5 Enhanced supervision

- 5.5.1 The *Panorama* programme made the point that once out of the front door, no-one was supervising residents. By this it meant that no-one was watching them. In all but the most extreme cases, this is correct. (The police have the authority to undertake surveillance but only in narrowly defined circumstances and it is also very expensive.) Residents are however *under supervision* for the duration of their licence, community order or period of bail.
- 5.5.2 In Section 3.2, *The supervision of offenders*, we summarised the purposes of supervision and some of the methods used. A *Frequently Asked Questions*⁽¹⁷⁾ document says that hostels provide an enhanced level of supervision through a range of restrictive measures. It does not over play the role that hostels can play in protecting the public. A Probation Circular issued in May 2005: *The role and purpose of Approved Premises*⁽¹⁸⁾ defines what the minimum provision for constructive as well as restrictive interventions should be, but recognises that not all hostels would meet the standard required yet. The list is extensive and is reproduced at Annex A.

5.6 Constructive interventions

- 5.6.1 The aims and objectives of an individual's supervision should be defined in a sentence plan. The supervision of all offenders on licence or a community order is managed by an offender manager who is likely to be based in a probation office rather than in the hostel. An important element of enhanced supervision is provided by the relationship between them and the member of hostel staff who acts as keyworker to the resident.

- 5.6.2 It is expected that there should be a reason for a period of residence in a probation hostel beyond the simple provision of accommodation. That reason might be public protection or it might be part of a resettlement plan for an offender with multiple needs. The sentence plan should state which worker is responsible for which elements of the plan. Communication is a key element in effective offender management.
- 5.6.3 The offender manager will meet the offender at a frequency governed by the assessed level of risk and national standards, and the key worker will normally meet the resident individually weekly. They are likely to meet jointly with the offender from time to time. Most probation areas have an electronic case record which is accessible in their hostels; recording by both is required to be timely, accurate and concise.
- 5.6.4 Staff in hostels see residents every day on an informal basis. They are required to maintain a hostel 'log' noting significant events and summarising how each resident has been that day. Staff work shifts and there is a handover meeting where residents are discussed. They ought to be aware of the assessment of each resident so that they can pick-up small occurrences that might indicate change – positive or negative – when added together.
- 5.6.5 In well-run hostels, even where there may only be the minimum staffing levels, imaginative managers and staff have brought in resources from outside or have created the space to run programmes. Basic skills is a good example; a high proportion of residents, if they are not in employment, will have this need and providers do agree to arrange sessions in hostels. Accredited programmes are run in some hostels with sufficient space. Providers of drug or alcohol treatment may also find it useful to organise sessions on the premises. In others there are sometimes resettlement linked activities around practical skills run by staff and/or residents. It is equally positive to develop links with local groups in order to encourage residents to engage in legitimate activities outside the hostel.
- 5.6.6 One of the most constructive outcomes to a period of residence in a probation hostel is moving on to independent or other suitable accommodation.

5.7 Restrictive interventions

- 5.7.1 There should be a minimum of two staff on the premises at all times.
- 5.7.2 As a minimum requirement hostel residents must observe a curfew between 11pm and 6am. This can be extended, in theory, only by either the Parole Board or court. It is common for the curfew to be enforced by electronic monitoring or tag. In practice, hostels sometimes impose longer curfews on individuals by means of having local 'hostel rules' which residents are required to sign up to. This is most likely to happen under the auspices of MAPPA and to be a specific part of a RoH management plan. The curfew is further enforced by physical security measures including closed circuit television (CCTV) and alarms.
- 5.7.3 In addition hostels often require residents to 'sign in' at specified periods during the day; this can be as often as hourly.

- 5.7.4 Offenders subject to licence may have a number of *restrictive* conditions written into their licence, e.g. not to contact a victim or take-up employment with people under the age of 18. This can apply to all licensees.
- 5.7.5 Residents' rooms and property are liable to be searched on a regular or irregular basis, dependent on the assessment of risk. However, a staff member may not conduct in person a body search of a resident; only police and prison staff have the legal authority to do this. If possession of an illegal substance is suspected, the police should be called.
- 5.7.6 Testing for illegal drugs can be carried out regularly as part of a condition in an order or licence.
- 5.7.7 All hostel residents should have a condition of residence as part of their licence, community order or bail notice. In this way, if their behaviour is such as to warrant eviction, they will be returned to court or prison. In licence cases where there is evidence of an imminent RoH to the public, an offender can be recalled to prison within hours.
- 5.7.8 Increasingly, the police and probation services share intelligence, particularly in cases posing a risk of serious harm to the public. This is often carried out through frequent contact at the hostel by public protection or other designated police officers with both staff and residents. Sex offenders subject to licence, etc. who have to register with the police and PPOs are often jointly managed by the two services and can be resident in hostels.
- 5.7.9 Sexual Offences Prevention Orders are issued by courts on the application of the police with evidence that there is a risk of a sexual offence against a child under the age of 16 years being committed if someone already convicted of a similar offence is not prevented from engaging in certain activities where children are likely to be present e.g. visiting a swimming pool.
- 5.7.10 In the second half of this report we assess how far two of the hostels in Avon & Somerset operated a regime of enhanced supervision and the quality of management of 11 hostel residents.

Key points in relation to hostel development nationally:

- Following the creation of the NPS there was a significant amount of investment at national level following up the recommendations in the 1998 HMI Probation thematic inspection of probation hostels.
- A national strategy for their use and development was drawn up which re-positioned the hostel as a key element in the management of dangerous offenders.
- In 2005 a Probation Circular defined the role and purpose of hostels and the level of enhanced supervision necessary to manage residents safely. Whilst work on this continues, the centre has drawn back from developing a national regime further until there is greater clarity about commissioning arrangements.
- There is also the decision to be made by NOMS now whether to develop hostels in future as a single national system, or within an approach led by regional commissioning arrangements. The Inspectorate view is that the hostels need to be managed as a national system.

6. PUBLIC EXPECTATIONS

6.1 The public's raised expectations

- 6.1.1 Most people are rarely directly affected personally by the issues outlined in this report, but for understandable reasons there is widespread public concern in response to the periodic reporting of violent deaths of children or adults at the hands of previously convicted offenders.
- 6.1.2 As a consequence, the Home Office and individual agencies often find themselves portrayed in the public eye as responsible for some aspect of public policy that has been seen to go wrong. The implicit expectation continues to grow that risk to the public can be eliminated if only supervision in the community can be made effective enough. The linked expectation has grown that if an offender under supervision (or even for some time after supervision has ended) has reoffended the supervisor must in some way necessarily be at fault.
- 6.1.3 It will be clear from this report, and our other reports, that we take a different view. We say that when supervising an offender in the community it is simply not possible to eliminate risk to the public, and we do not criticise staff for failing to achieve the impossible. But it is right for the public to expect that public servants will do their job properly. By that we mean that POs and others involved in the supervision of offenders must take all reasonable action to keep to a minimum each offender's RoH to others. If it can be shown that they have done that, then they will have 'achieved the possible'.

6.2 The proximity of hostels to schools and family homes

- 6.2.1 Hostels tend to be located in residential areas. They are often former family homes, too large for modern use and sold off many years ago for conversion. They are likely to be near schools, churches and nurseries, etc. as a consequence.
- 6.2.2 It is entirely understandable that the public should be concerned about the whereabouts of convicted paedophiles in the community, and want to know that the risk to their children is being kept to the minimum possible. The proximity of a hostel in which paedophiles sometimes live is bound to raise local concerns, often further stimulated by a national or local press campaign. However, there is a level of risk to children – albeit statistically small – that exists both near to and far from where hostels are located. What makes potential victims either more or less safe is not the proximity of the hostel, but whether or not each individual case is being properly assessed and managed.

- 6.2.3 For in most cases proximity is not in itself a significant factor. Children are statistically at greater risk from a family member or friend than from strangers. Children attending nursery school by virtue of their age are always delivered and collected by an adult and are always under supervision. Many hostels work positively with local groups to ensure that the 'stranger-danger' message is aired periodically and that parents and schools take appropriate precautions to safeguard the children in their charge, whether they happen to live near a hostel or not.
- 6.2.4 Nevertheless during 2006, in order to build public confidence, a decision was taken by the Home Office to list 12 probation hostels where those who had committed sexual offences against children aged under 16 years could no longer be admitted due to their close proximity to schools or nurseries. This decision was taken to address public concerns during a national newspaper campaign, although proximity is, as we have said, not the key issue in managing potentially dangerous offenders. Arrangements were therefore made to move these offenders out and to replace them with other residents.
- 6.2.5 However, not surprisingly, this immediately raised the question of how close was 'close enough to qualify' for the exclusion of sex offenders against children. Some groups of local residents unhappy about a hostel in their neighbourhood therefore pursued their own campaigns. One such, Brigstocke Road, was in Bristol and was one of those filmed by *Panorama*. In a development quite separate from this inquiry, a review of the hostels on the Home Office list was undertaken in December 2006 and for reasons of consistency Brigstocke Road and two other hostels (in two other areas) were added to the list of those from which paedophiles were henceforth to be excluded.

6.3 The Brigstocke Road Campaign Group

- 6.3.1 This was the name of a group which was formed in May 2006. It was led by the manager of a nursery whose garden and play area were visible from the rear windows of the Brigstocke Road hostel in Bristol. During the inquiry we responded to being given copies of correspondence sent to various people including the Home Secretary, probation service, police service and councillors by requesting a meeting with the group and we did meet two representatives including the nursery manager.
- 6.3.2 The group appeared to have come together when it was informed that a man released after being sentenced to 14 years imprisonment for the manslaughter of a child was being managed in Bristol as a Critical Public Protection case and was living at Brigstocke Road. Its aim was to stop the probation service housing offenders who had committed sex offences against children under 16 at that hostel. This man's whereabouts were disclosed by the *News of the World* and he had therefore to be moved for his own safety. The *Bristol Evening Post* also ran its own campaign against sex offenders. This happened on two more occasions in 2006, the last time during the main work of our inquiry in Avon & Somerset.

- 6.3.3 The group's campaign grew when it realised that it was not on the list of 12. Not satisfied with the responses given by the various bodies, it carried out an eight hour demonstration outside the hostel in August 2006.
- 6.3.4 We confirmed that Brigstocke Road hostel does overlook the nursery garden as claimed and is situated near to another (the latter nursery did not make any representations). In this case there was also the issue of privacy. Residents could look out and watch the children at play. However, since our visit to Bristol, the Brigstocke Road hostel has been added to the Home Office list as described above.

6.4 The benefits and costs of exposure to the public view

- 6.4.1 The *Panorama* programme made the fair point that general talk of "*close supervision and monitoring of offenders*" can give a misleading impression to the general public of what is being done on their behalf. The programme's investigative approach has brought about some benefits, including engendering some useful debate about the nature of supervision and the challenges posed by some offenders. However, there have also been some costs to the service being provided for the public.
- 6.4.2 The programme did a very good job of illustrating vividly the nature of some of the offenders that hostels, and probation in general, have to work with day by day. It showed that for staff to achieve change with many offenders they have to work with a long, slow, patient but persistent approach. If the public can become clearer about what can be achieved in the supervision of offenders and have confidence in what is being done on their behalf then everyone benefits. We think therefore that if these difficult issues are discussed in a more open and well-informed manner than previously then the public might gain a better understanding of what is possible for the authorities to achieve on the public's behalf.
- 6.4.3 However, this leads us to confirm again that risk to the public cannot be eliminated. The public can reasonably expect that those employed to manage offenders in the community will do their jobs properly.
- 6.4.4 Meanwhile, while we support transparency and the benefits of public exposure, we also note that the cost of exposing this work to the public is at times that this job has been made more difficult by the negative reaction of people to hearing that, for example, a convicted paedophile is living nearby.
- 6.4.5 We saw in Bristol that the impact of high profile newspaper and other media headlines can have in destabilising the arrangements made by the police, probation and other relevant authorities to keep to a minimum the RoH to the public. Whilst a particular offender may no longer be in one neighbourhood's 'back yard', by definition they have to go to another, and it is both necessary and more difficult for the police and others to do their public protection work in such circumstances. Hence there is a cost as well as a benefit to doing public protection work increasingly in the public eye.

7. OFFENDER MANAGEMENT IN AVON & SOMERSET PROBATION AREA

7.1 Leadership and management

- 7.1.1 Avon & Somerset Probation Area had been inspected during January and February 2006 as part of our routine ESI programme⁽¹⁹⁾. We found a number of strengths and areas for improvement and made recommendations accordingly. The area had addressed these within a detailed action plan and work was in hand to make improvements.
- 7.1.2 Leadership and planning had been assessed as 'Well met'. Its promotion of diversity as an integral part of organisational processes in particular had been found to be impressive. It was on target to achieve most national targets by the year end, and achievement in basic skills and offender employment in particular was strong.
- 7.1.3 There had been concerns at that time about the potentially negative impact that its strategy for managing the budget of maintaining a 10% level of vacancies could have on service delivery. There was evidence, however, of it having employed other measures to make savings and to generate income.
- 7.1.4 Planning and policy development procedures were clear and we saw evidence during this inquiry of a thorough approach at strategic level to planning generally and to managing RoH specifically. Its responses to its own findings in the SFO cases and to ours in the ESI were thorough and there was evidence of progress being monitored.
- 7.1.5 There was a low key approach from Board members to oversight of the hostel estate, although one Board member did attend the Ashley House Committee regularly to give advice. Others visited the three probation area managed hostels from time to time.
- 7.1.6 During the period that the Brigstocke Road group was active chief officers from the probation and police services met with the group and a joint briefing for local media was developed in an attempt to get more balanced reporting.

7.2 Resources

- 7.2.1 Two years earlier, at the time of the SFOs by Residents A and B, there had been considerable difficulties experienced in the offender management teams (called OMATs – offender management and assessment teams). Both offender managers and their managers in Bristol had had very high workloads; one of the consequences was that the quality of staff supervision was not always sufficient so offender managers, including newly qualified POs, were left to manage

without oversight in most cases. This position had been rectified as part of the area's response to its internal review of these cases. We found that an appropriate action plan had been drawn up and there was evidence that the plan had been carried out. This included an increase in middle managers and a redefined role for senior practitioner POs in staff supervision and development.

- 7.2.2 At the time of the ESI we had found that the area had an efficient way of managing resources by building in a 10% level of vacancies over the year, but we had concerns about the impact on service delivery. Despite being assessed as a well-managed area, we had been concerned about the quality of case risk assessment, risk management and supervision planning and review.
- 7.2.3 Since that time there had been a higher level of staff movement out of the OMATs, in Bristol in particular, than from other areas of work. These teams therefore had had to take and sustain staffing cuts of more than 10%. In addition, there was evidence of the workload increasing significantly during the year in relation to court reports and community orders. The area was in discussion with courts about this in view of the limited nature of its resources.
- 7.2.4 There was also some evidence of a higher than average number of high RoH cases transferred in to Avon & Somerset, the equivalent of a whole caseload per year according to the area. This was due to the relatively high number of hostels in the area. The presence of an open prison in the area also attracted a relatively high number of lifers transferred in due to their preference to be released locally once other ties had been lost.
- 7.2.5 By December, the advantages experienced following the earlier improvements in staffing levels seemed to have been lost in most of the OMATs and the workload levels were again a cause for concern. From what we were told caseloads were too high in some teams for offender managers to be able to deliver a quality service to many of the offenders for whom they had responsibility.
- 7.2.6 Chief officers and the Board were aware of this and were monitoring the situation; they had identified it as their highest risk to the organisation. They believed that they had made all possible cuts and, as the greatest proportion of spending was on staff, vacancy management was then the only option. Other measures had been undertaken: they had invested in a post at head office to generate income and this had been successful; they had also drastically reduced a high level of sickness to around the national target in the last year.

7.3 Offender management and public protection

- 7.3.1 Earlier in 2006 we had found that MAPPAs were well developed in Avon & Somerset and founded on strong inter-agency links. There were good examples of partnership working with the police in managing sex offenders and PPOs. This view was shared by the police. There was also a prison officer seconded to the probation service who undertook liaison work between prisons and MAPPAs about high RoH prisoners before release.

- 7.3.2 Prior to early 2006 there had been a Public Protection Unit with probation and police officers co-located to manage sex offenders. The team and its work had been dispersed within the OMATs to facilitate the possibility of one worker managing a case from start to finish as required by the national offender management model; this was not felt to be compatible with having specialisms. The police members were also dispersed within local units. Whilst this had had a negative impact on the quality of some liaison with the hostels, it was outweighed by the benefit of spreading expertise in high RoH work around all teams.
- 7.3.3 Most of the cases we read during this inquiry were managed to a satisfactory standard. The majority of offender managers and middle managers we met impressed us as being experienced, knowledgeable and committed to doing their job well. They were concerned however about their continuing capacity to do this. The senior practitioner role had almost disappeared, as most now had full caseloads themselves and were unable to add the intended depth to staff supervision and development. There were also vacancies amongst this grade. The span of control of most middle managers was once again too great to be effective after a period when the extra resources had made a difference.
- 7.3.4 There was evidence of the area directing its offender management resources at the highest RoH cases as it was attempting to manage the shortfall through prioritisation and had suspended national standards for many lower risk cases. The danger in employing this strategy, however, is that it relies on good quality RoH assessment in every case to have the confidence that resources are being invested appropriately. Given the concerns that we had had in January 2006 about the quality of the assessment and management of cases and of high RoH cases in particular, and the subsequent significant reduction in resources allocated to offender management, the area cannot have this confidence. In terms of public protection, it was unfortunate that the offender management teams appeared to be having to support a higher level of vacancies than teams delivering interventions.
- 7.3.5 There was a system for tracking lifers through their sentence and for reviewing their progress after release which was managed by the ACO for offender management. However, it did not include a review, around the time of release, of the assessments and arrangements made for supervision on licence. Procedures assume that lifers will not be released unless they do not pose a high RoH to the public which experience tells us is by no means always the case.
- 7.3.6 There was an ESI action plan that had led to some improvements, e.g. in audit systems and planning to increase access to mental health resources for offenders, but the case of Resident K illustrates the critical point that with poorly focused offender manager resources, and without quality staff supervision and management, a probation area is vulnerable to things going wrong. There are too many cases, particularly in the group assessed as medium RoH, where no-one apart from the offender manager will read and check that the assessment is appropriate. Whilst offender management was seen as effective once cases were referred to MAPPA, the area could not have confidence that all the right cases had been referred.

7.3.7 On a more positive note, the proper enforcement of orders and licences was a strength. Most of the cases read were enforced in a timely manner. Avon & Somerset had a high rate of recall to prison: for instance, in July and August 2006 (the latest available period) Avon & Somerset recalled 89 people to prison which was the fifth highest number of recalls out of the 42 probation areas.

7.4 Accommodation for offenders

7.4.1 The probation area had not previously been well represented in Supporting People partnerships. However, the area performance manager (APM) with responsibility for hostels had relatively recently been given responsibility for all offender accommodation and was attempting to support the five strategic groups in the area.

7.4.2 There was an accommodation officer who prioritised offenders posing a high RoH through a multi-agency arrangement with the nine local authorities. This was a positive partnership approach where all nine were willing to look for suitable accommodation under MAPPA and it was successful in most cases. Move-on accommodation, as will be seen, was said to be a problem however for most of the residents that we met.

7.5 Serious Further Offences

7.5.1 There were two cases mentioned in the *Panorama* programme that were said to be the reason for the BBC choosing Avon & Somerset as the base for the investigation; they were cases where offenders, living in Bristol hostels and subject to licence on release from prison, had each committed a murder. Although the further offences had been committed almost two years earlier, we read the files and discussed the cases with the offender manager and with the senior manager who had reviewed their management and who had produced her own SFO report.

7.6 The cases

7.6.1 The case of Resident A

- Resident A had been released on licence in late 2004 to Brigstocke Road and was arrested for murder two months later. He was not a sex offender but had served prison sentences for violence.
- The quality of assessments was sufficient; they were fully completed and evidenced and undertaken in a timely manner. There was evidence of good liaison with hostel staff and police as well as with A's partner. Probation contact records were also sufficient.
- It was recorded that the police suspected A of having been involved in a robbery, but they indicated to the offender manager that they were not planning to question him about it due to lack of evidence. He missed a drugs test but we were informed that his licence did not include drugs testing as a requirement; we were unable to verify this. Brigstocke Road

at that time did not offer drug testing and it was therefore not a condition of his residence either. A's partner also rang several times to give sometimes positive and sometimes negative and contradictory information. None of it was provable. The offender manager always passed this on to the police. In addition, there was evidence of this partner giving false information to the probation service about another offender's, her son's, drug taking: he was subject to a DTTO and she accused him several times of using drugs despite him testing negative at these points in time. Reports of A's behaviour in the hostel were positive and he was cooperating with staff.

- The offender manager in this case was a newly qualified PO managing a high workload and whose senior probation officer (SPO) also had a high workload; this meant that it was not possible to discuss all relevant cases in supervision. This was accepted by the area and was addressed as referred to in the section above. Had the officer raised concerns or had her senior read the case, we considered that an experienced manager may have thought there was sufficient cumulative evidence to recommend recall.
- On the basis of the evidence available to the offender manager at the time, we consider that there was, perhaps, a borderline case for an executive recall to prison. But this evidence made by no means a clear cut case for recall, as the programme makers implied, and although the murder was a dreadful matter our assessment is that the area's handling of this case was defensible.

7.6.2 *The case of Resident B*

- Resident B was released from prison on licence to Ashley House in late 2004 and was arrested for murder three months later. His licence was for three months only. The case started badly as the hostel accepted transfer from another area on release from prison but did not discuss it with the offender management team or tell them he had arrived for some days. The area policy was that any request to accept a transfer should be raised with the probation team who would have responsibility for managing it. Given this delay, it was inevitable that the initial assessment would be late; its quality was sufficient however.
- Resident B had had a problem with substance misuse. He had previous convictions, mainly for theft associated with substance misuse, but also for violence. He was drug-free when released from prison. We judged that the classification of RoH was incorrect and should have been medium rather than low. Nevertheless, given that his offending was drug-related, the sentence plan was appropriate and focused on relapse prevention. He did relapse eight weeks after release.
- The period of residence in Ashley House was not trouble-free. There had been some problems of confrontation with staff in the hostel and he was threatened with eviction. He reported feeling down about his relapse but was working with the drugs programme to address this. He was also in full-time employment. He left the hostel at the end of his licence, but it

was after that that his involvement in the murder a few days earlier was discovered.

- There was nothing in this case, in his past or current behaviour, which could have been seen as a warning sign, that B would commit such a serious offence. Whilst there was room for improvement in the management of the case, there was nothing that – done differently – would have prevented the tragic death. Recall was not indicated at any stage as B had broken no requirements in his licence.

7.7 The internal reviews

7.7.1 Both cases were reviewed and recommendations made to address identified areas for improvement. These were sent to the NPD's Public Protection Unit, as required. The area also demonstrated that it takes such cases seriously in that a Board subcommittee oversees progress until all recommendations for improvement have been addressed.

7.7.2 We found that the reviews did accurately reflect the content of the files. They both identified work that had been done and shortfalls in either area systems or the offender manager's work or judgements. The learning points in both were appropriate and focused on the area systems. The same was true of the recommendations, and we can confirm that the recommendations had been implemented.

Key points in relation to offender management in Avon & Somerset:

- There was evidence of Avon & Somerset being a generally well-managed probation area that was performing reasonably well against national targets during the period under scrutiny.
- But we judged that its use of vacancy management to balance the budget created a risk of cutting staffing and management of offender management teams to unsafe levels.
- And there was no system of oversight by senior managers of the management of lifers or other prisoners released from long sentences.
- MAPPA were well developed, as were relationships between the police and probation services. However, the area could not be confident that its systems and staffing levels were sufficiently robust to ensure that all appropriate case were referred into it.
- The two SFO cases involved offenders who had not been assessed as posing a high RoH to the public and who both committed murder. They had each been living at one of the Avon & Somerset hostels.
- Whilst there was room for improvement in the management of each case, our judgement was that there was nothing in the past or current behaviour at the time to suggest that such serious offences would be committed. It is not reasonable to conclude that the probation service could have prevented the tragic death in either of these cases.

8. HOSTEL ARRANGEMENTS IN AVON & SOMERSET

8.1 The hostels

- 8.1.1 There were four hostels (Approved Premises) in Avon & Somerset. They were all able to accommodate residents subject to licence, community order or bail. Their respective predominant purposes were described as follows in an extract from the area's Admissions and Offender Management Policy dated 2006:

"Ashley House takes both male and female residents who are subject to supervision on community orders or licences and also takes bailees. Ashley House has ASPA Board approval for Medium Risk drug users, and as such has close links with a local GP and is able to offer both drug testing and access to treatment.

Bridge House is a drug free hostel managing mainly high and very high risk offenders who may have had a past history of drug misuse.

Brigstocke Road manages the high and very high risk offenders in the Bristol area and predominately takes residents who have been released from Prison on Licence.

Glogan House is situated in Bridgwater and takes high and very high risk offenders predominately on licence."

- 8.1.2 Four hostels in one probation area was an unusually high number outside of the Metropolitan areas. Bristol therefore attracted a relatively high number of requests for case transfers in relation to high RoH offenders unable to return to their home areas due to victims' issues or to having become rootless during a long prison sentence.

8.2 Management of the hostel estate

- 8.2.1 The Assistant Chief Officer for Interventions had strategic responsibility for hostels. An APM, who was a member of the senior management team, had operational responsibility for hostels including budgets. His brief also included offender accommodation and staff seconded to prisons. Two hostel managers had day-to-day responsibility for two of the four hostels each. They met regularly with the APM as a management team. Although the strategic management and funding of Ashley House was outside the authority of the local probation service, there was an agreement that operationally they would work to the same procedures; this was expressed in a formal Partnership Protocol document.
- 8.2.2 Managers monitored performance against a range of internal targets which were intended to measure quality in certain aspects of hostel life. These included whether OASys was completed regularly by offender managers, monitoring of

race and ethnicity of referrals and residents, recording of keyworker sessions and whether induction had been carried out within 24 hours of arrival.

- 8.2.3 In many probation areas hostels have to operate within their centrally-allocated budget. This was not the case in Avon & Somerset where the probation area itself subsidised the three statutory premises at over £150,000 per year. Whilst this demonstrated commitment by the area, particularly given its general budget position, the funding was still not enough to enable the hostels to function as they would have wished. As generally within the probation area, the bulk of funds were invested in staff. All of the hostels made substantial use of the pool of relief staff; use of such staff was less costly than employing more permanent staff but they had less training, supervision and experience. Lack of funds made an impact in several aspects of the management of the hostels, as will be shown.
- 8.2.4 Staff in all four hostels undertook an inadequate level of training. As a consequence, not all had yet had the opportunity of undertaking the RoH training made available by the NPD earlier in 2006. The area had prioritised training to run the *Living in Here Moving On* programme and RoH training; there was little evidence of all but a few hostel staff undertaking any other training during 2006.
- 8.2.5 In order to comply with the NPD's requirements around the purpose of hostels, it had been necessary to restructure staffing arrangements in 2006. A review had been undertaken over a period of a year, during which time there had also been a national job evaluation scheme which, at the time of this inquiry, had not yet been fully implemented. All of this had led to much uncertainty amongst staff. There had been consideration of a national staffing model but, in the end, areas were only required to implement double waking night cover. This had been implemented only in October 2006 in the three probation-run premises and had not yet been implemented in Ashley House. There had been a one-off payment from the centre to support the extra cost of night cover, but ongoing costs had had to be met from efficiency savings.
- 8.2.6 The area's admissions policy conformed to the national strategy defining the role and purpose of approved hostels in terms of prioritising offenders assessed as posing a high or very high RoH to the public. In principle, the decision to admit offenders assessed as medium RoH to Ashley House could also have conformed to the strategy. To do that the hostel would have to have provided an intensive level of interventions that could only be delivered in the context of a residential setting and to offenders needing enhanced levels of supervision e.g. prolific offenders. However, such admissions should only have been made when a bed was not needed for an offender posing a high RoH.
- 8.2.7 The area had common policies across all four hostels and attempted to manage offenders by moving them when necessary between premises. We saw that this did not apply to Ashley House, however, as the differences in resident groups were too great.
- 8.2.8 The policy referred to above set out a framework for offender management by describing the respective roles in sentence planning and review of the offender manager and the hostel operational manager, i.e. deputy. The keyworker's role

was to implement objectives in the sentence plan. Liaison and recording were implied rather than defined as a requirement in this policy.

- 8.2.9 There was a lot of contact between the police from different units and staff in hostels. Responsibility for liaison about individual hostel residents lay with offender managers, with a 'cluster' approach of three-way communication between the police, offender manager and keyworker.

Key Points in relation to hostel arrangements in Avon & Somerset:

- The Probation Board managed a relatively high number of hostels which were viewed as a resource within the South-West Region and to a certain extent, nationally.
- The Board invested a small but significant amount of its main area budget to supplement the budget allocated nationally to each hostel in the area (although this did not apply to Ashley House).
- The level of training delivered to hostel staff was inadequate.
- Where cases were being managed within MAPPA, we saw evidence of strong partnership work.

9. ASHLEY HOUSE (managed by a voluntary committee)

9.1 The voluntary management committee

- 9.1.1 Ashley House was one of only 12 voluntary managed probation hostels remaining in England and Wales. Like most hostels the building was a large former family home in a residential street. It had been left in trust to a committee to run it as a home for boys and young men in trouble in the 1940s. It had been a probation hostel for over 25 years and its Deed of Trust had been amended to enable the committee to admit older men and women, in effect to respond flexibly to changing need.
- 9.1.2 The managing committee had always had a local focus and two of the six members at the time of the inquiry lived in the same street as the hostel. Individual members had had no operational experience of running a hostel but drew on their experience as, for example, a solicitor and a Justice of the Peace for an understanding of the issues associated with the residents. The treasurer also acted as committee secretary and was an accountant by profession. It had a Probation Board member and the APM for hostels attended its meetings to give advice.
- 9.1.3 It was committed to the rehabilitation of offenders and had changed the hostel regime some years ago as needs changed. Recognising the prevalence of substance misuse amongst the resident group and finding a GP who was prepared to become involved, the current drug treatment regime was established some years ago.
- 9.1.4 At the time of this inquiry the Ashley House Committee found itself at a crossroads. It was struggling to conform to the changing requirements of the NPS and did not want to lose the focus on substance misuse and rehabilitation in favour of working with potentially dangerous and sex offenders. In practice it also provided most of the female beds in the region in an annexe across the road, although advice from the NPD had been that all mixed hostels should become single sex and most had done so. The view of the Directorate had been that Ashley House should become an all-male hostel with the South-West Region re-designating one of its male hostels as a female house. In the meantime, Ashley House would continue to accommodate women.
- 9.1.5 It was also struggling financially and had as yet to move to double waking night cover. It acknowledged that it had to do so by the end of the financial year.
- 9.1.6 Talks had stalled with the NPD but the committee had to decide very soon which avenue to pursue. They were aware that proposals for the probation service to become part of NOMS and the establishment of a commissioning/provider environment were going to be even more demanding of its limited resources. It

had not recruited new committee members due to the uncertainty, so this year meetings had often been inquorate. An alternative to giving up control of the hostel would be to be taken over by a larger charity not reliant on the probation service for funding. Most of the other voluntary sector hostels were part of a larger umbrella organisation therefore better able to make economies of scale.

- 9.1.7 Following the *Panorama* programme the Chair of the management committee had taken up the local police beat manager's invitation to attend the beat surgery and together had answered local concerns. Residents had been angered by the assertion in the programme that sex offenders were accommodated there; they were not but others posing a high RoH were.

9.2 The management of Ashley House hostel

- 9.2.1 Although financially independent of the local probation service, it was clear that in many respects the hostel was managed according to Avon & Somerset Probation Area policies. Managers benefited from advice and support from the service, in relation to human resources for instance.
- 9.2.2 The hostel manager had responsibility for both Ashley House and Bridge House, which was one of the statutory managed hostels. He was supported by a full-time deputy or operational manager in each hostel. Discussion with the managers at Ashley House revealed a lack of knowledge and understanding about changes in offender management despite the fact that one was a member of the area management group.
- 9.2.3 There were 16 beds for men in Ashley House and six for women in an annex across the road where there was a small kitchen area and TV lounge as well as bedrooms and bathrooms.

9.3 Staffing

- 9.3.1 There were six assistant managers at Ashley House and the equivalent of two full-time night supervisors. Although plans were in hand, it did not yet have two waking night staff required by the centre and recently adopted elsewhere in the area. It still had one waking member of staff and one sleeping in. In addition relief staff were frequently used which is how the reporter had the opportunity of spending so much time there. This hostel was less well staffed than the others, as it did not benefit from extra resources from the probation service locally to top-up its national funding.
- 9.3.2 Staff had been through a difficult year with a lot of uncertainty about their future as they were aware of discussions between the committee – their employer – and the probation service about the future of the hostel. They were also aware of changes planned for the other three hostels and were unsure about what impact that would have on their own working conditions.

- 9.3.3 Despite this, staff appeared to be well motivated and to be committed to doing a good job. Those seen reported that they did receive supervision. They did not, however, have access to sufficient training to support them in their roles.

9.4 Referrals and admissions

- 9.4.1 It was intended that Ashley House would adhere to the area's *Admissions and Offender Management Policy 2006* which in turn reflected national requirements; although a voluntary body, the committee, by accepting the probation service grant, was expected to adhere to the national strategy as defined in Probation Circular 37/2005. However, it did not in relation to the profile of those accepted as residents.
- 9.4.2 Whilst the hostel did accept referrals in respect of some offenders who posed a high RoH and/or needed the treatment on offer at Ashley House, most did not appear to meet either of these criteria. Instead, offenders subject to community orders tended to become resident part-way through a period of supervision due to a housing crisis. This was an inefficient use of an expensive resource as they did not tend to have either the level of RoH or drug related need that the hostel drug treatment regime was designed to address.
- 9.4.3 The need to keep occupancy rates up applied to all hostels. As far as we could tell the other three received appropriate referrals. The Ashley House Committee was not aware of this mismatch between stated purpose and actual use. Also, although there was limited resources for females within the region, female occupancy levels had been very low at times during the year.

9.5 Offender management and constructive interventions at Ashley House

- 9.5.1 The deputy manager prepared a local risk management plan and supervision plan. Neither was based on OASys but on issues relevant to work in the hostel. Where residents had transferred into the hostel after the start of an order, offender managers did not re-visit sentence plans and bring them up to date.
- 9.5.2 The hostel had relatively recently had the electronic case record and eOASys installed and this was making the sharing of information relating to RoH much easier. The hostel did take high RoH cases though not sex offenders. We found that staff and offender managers had a consistent view of the RoH posed by residents and responded appropriately to changes.
- 9.5.3 Assistant managers were allocated four residents to work with as keyworkers. They had responsibility for liaison with and about offenders and for arranging one individual session per week with each, as in all of the area's hostels. Meetings did take place and were recorded. There appeared to be a high level of communication between keyworkers and offender managers, by telephone if not in the hostel. This was not always recorded however.
- 9.5.4 Whilst most offenders did not take advantage of it, there was an emphasis on a rehabilitative regime in Ashley House and this was the first of the hostels to run

the *Living in Here Moving On* programme developed by the probation service nationally as a constructive element of rehabilitation.

- 9.5.5 There was an enhanced level of positive contact in some cases, particularly those involved with the Avon & Somerset Prolific Offender Scheme (ASPOS) where a high level of contact with several agencies was required. Even in some of these cases, however, it was hard to see why they were resident at the hostel other than that accommodation had been a problem; their needs were being primarily catered for by the offender manager, police and drugs project.
- 9.5.6 Staff and residents reported that there was limited availability of move-on accommodation and that, as a consequence, residents again used this expensive resource when, strictly speaking, they did not need it.

9.6 Drug treatment regime in Ashley House

- 9.6.1 There was a drugs treatment programme facilitated by a partnership arrangement between Ashley House, a local GP, the Bristol Drugs Project and the probation service. Having a GP who was willing to visit the hostel and prescribe was unusual and potentially very valuable. There was potential for activity aimed at reducing substance misuse on four days per week, including a weekly GP appointment at the hostel. However, despite this unusual level of in-house provision, it was not being fully used. During our inquiry only five of the 24 residents were engaged with this programme.
- 9.6.2 It was not an expectation that participants in the programme would start their period of residence drug-free. Residents were expected to show a commitment to the drug treatment programme through participation and, ideally, a reduction in misuse as demonstrated through drugs tests. It was accepted that progress would often be slow. This was realistic for some offenders.

9.7 Security and restrictive interventions at Ashley House

- 9.7.1 At times there were residents who did pose a high RoH to the public; the majority did not, however. The same approach to safe offender management as at Brigstocke Road was in place at Ashley House but with less emphasis generally on restrictive interventions. Neither building was easy to manage securely.
- 9.7.2 It was not always possible to control access to the building due to staff not always being available to sit in the reception area. We saw that it was possible for residents to let visitors in unobserved which had the potential to be problematic. There were 32 cameras in the CCTV system activated by movement. These were shown on screen in the reception area; staff were not always available to watch however. Staff had an established satisfactory process for curfew-checking at night.
- 9.7.3 Residents themselves said there was a safe feel about the hostel.

- 9.7.4 Rooms were searched by two staff either on a weekly or a random basis as seemed necessary. Several checks of the building were made each day. Given that a number of residents were known to be using illegal drugs, it was feasible that at times there would be drugs or drug taking paraphernalia on the premises at times. The *Panorama* programme did imply that there was illegal drug use on the premises but that staff were powerless to prevent it. However, it also showed that searches of the rooms and communal areas were made regularly and suggested that any paraphernalia found would be confiscated.
- 9.7.5 Residents engaging with treatment were tested for substance misuse. There were two levels of testing: the first, where treatment was by the hostel GP, was a urine test that was not supervised. This was intended to give an indication only of whether the self-reported use of drugs was truthful. The Drugs Project relied on supervised testing and some use of oral swabs and this was more reliable. Treatment and tests were not, however, enforceable.
- 9.7.6 The procedure for handling prescribed medication conformed to national expectations: residents would come into the office one at a time and their medication was made available and consumed with staff observing them. This procedure was clear, although the reporter filmed himself not following it in order to imply that this element of supervision was lax.
- 9.7.7 Staff used red and yellow warning letters to residents in common with the other hostels for breaches of rules. The issuing of these had been tightened up recently to ensure a consistent approach from all staff.
- 9.7.8 Some residents were required to sign into a book in the general office at intervals that could change over time, e.g. four or two hourly or even hourly if there were particular concerns. The decision to require this sat with the offender manager and the frequency was determined by them. If liaison between offender managers and keyworkers was good, this was not a problem, but staff reported inconsistencies between individual offender managers and between some teams and this was clearly resented by residents.
- 9.7.9 Similar systems of requiring residents to sign-in during the day were in place in all Avon & Somerset hostels. Whilst there was no explicit authority for this practice in the *Approved Premises Handbook 2002*, it is common practice in many probation hostels. Avon & Somerset had no written practice guidance for staff about when it was appropriate, nor did it give anything in writing to residents.
- 9.7.10 There was evidence that recall to prison or return to court in breach of an order was undertaken appropriately. Cases requiring a review by a court were also managed as required.
- 9.7.11 Liaison with the local police was positive, with beat managers calling in every week.

Key Points in relation to the management of Ashley House:

- Ashley House Committee was aware that it needed to make a decision urgently about how it saw its future.
- The beds for women were not always well used even though there were few in the region.
- The quality of referrals and admissions was unsatisfactory. Managers tended to accept referrals because of a need to keep occupancy high rather than managing the process better. There needed to be a better understanding in offender management teams about what constituted an appropriate referral, and hostel managers should ensure that offenders who did not fit this profile were not accepted.
- Managers seemed to be unfamiliar with developments in the main service which had a negative impact on the regime on offer.
- Of the hostels visited, Ashley House offered the most in terms of constructive enhanced supervision. There was a drug treatment programme which was unusual in a probation hostel. However, whilst a high proportion of residents had a substance misuse problem, their admission to the hostel was usually not part of a treatment plan and they tended to undertake treatment elsewhere in Bristol.
- Offender management worked most successfully in Ashley House with PPOs. Even so, not all of these cases needed to undertake this work in a hostel setting.
- The management of cases posing a RoH to the public was carried out in a satisfactory manner.
- Keyworker sessions were carried out as intended and there was a high level of communication between offender managers and keyworkers.
- However, staffing levels were stretched and they were not sufficiently well trained to undertake the job they did.
- An enhanced regime of restrictive interventions was clearly in place.
- Residents reported that they felt safe at Ashley House.
- The method and purpose of drug testing needed clarification.
- There was a sound system for managing prescribed medicines properly.
- There was no written guidance to hostel staff or offender managers about the use of signing in as a restrictive intervention. Nor was there anything in writing to inform residents about why and how it would be used.
- Review and recall or breach were generally used appropriately.

10. THE MANAGEMENT OF CASES RAISED IN THE *PANORAMA* PROGRAMME IN ASHLEY HOUSE

10.1 Introduction

10.1.1 Some of the cases that we read were not identified in the programme but they had been informed by *Panorama* that they had been filmed. We included the cases in order to comment further on offender management at Ashley House.

10.2 Resident C

10.2.1 Resident C was seen in the programme to hide his medication, appear to go shoplifting and take money from Resident D. He was a prolific offender supervised by ASPOS which was jointly managed by the police and probation services. He was actually resident at Ashley House as a condition of bail for offences committed during the life of a community order with a DRR. His previous convictions for acquisitive crime and some violence, and his subsequent behaviour, were what one might expect in an offender leading such a chaotic life.

10.2.2 The quality of offender management in this case was mixed. There had been a good assessment and sentence plan at the start of the DRR, but this had not been updated when C moved to the hostel. He was assessed as posing a medium RoH to the public, which was an appropriate assessment, but there was no risk management plan.

10.2.3 The work done with C was appropriate and comprehensive. He was supervised twice per week at the ASPOS and had two drugs appointments per week. In addition he was tested regularly. The question was raised in the programme about why he was not breached. DRRs are reviewed regularly by the sentencing court and it is the court that makes the decision about whether the order should continue. Difficult as C was, he was still engaging with treatment, so within the rules of a DRR it was reasonable to continue supervision. Whilst the programme showed the negative aspects of this case, the alternative of breaching him and returning him to prison would increase the prospect of further offending on release – the “revolving door”. Hostel staff had reported the offender manager’s suspicions that C was shoplifting; they in turn had reported it to the police.

10.2.4 Overall, much of the management of this case was satisfactory. Given that most offenders cannot be kept in prison, it demonstrated the ability of probation and other services to engage with difficult offenders and to keep the door open against the day that the offender decides to change. Patient persistent long-term active offender management, throughout the regular setbacks that always arise, without resorting too quickly to the ultimate sanction, is the most effective

approach to achieving lasting change with some of the most difficult frequent offenders. This approach was being applied well with this difficult offender.

10.3 Resident D

- 10.3.1 Resident D was released on licence and spent eight days only at the hostel before disappearing and having her licence revoked. As with Resident C, D had a significant drugs problem and her offending was connected with that, mainly consisting of theft, burglary and loitering for the purposes of prostitution. She was seen to be soliciting and apparently share the proceeds of prostitution with Resident C and another woman. We do not know what the extent of their relationship was or why she would share her money with others in this way.
- 10.3.2 There had been a good level of contact with her prior to her release and plans to support community reintegration through appropriate drugs-related and accommodation services. The quality of the initial assessment, plan and risk management plan was satisfactory. The planned interventions started on release and when it was clear that D had relapsed into taking drugs she was challenged about this and offered assistance. Clearly she was not ready to take this up at that time and recall was instituted promptly. Within the very short time available this was a well planned and managed case.

10.4 Resident E

- 10.4.1 The case of Resident E posed problems for the hostel in two ways. He had been subject to a DTTO made in another area. As part of the treatment plan in place for that order he was placed in a treatment facility in Bristol without Avon & Somerset Probation Area being made aware by his own probation area that the man was living in its area. It was E himself who made contact with the area, to request contact with a PO. The area responded to this quickly and identified the RoH issues in the case. The treatment placement had been in a drug-free hostel and, towards the end of the order, this broke down when E relapsed into drug taking.
- 10.4.2 Resident E's behaviour was also problematic. He was filmed when angry and swearing at the TV reporter. Accepting him as a resident at Ashley House was a difficult choice due to his previous convictions for violence to women (This comment was made in the programme by a female member of staff.) He had previously served substantial prison sentences and had had a serious problem with drug misuse. However, the probation service managed the case safely through MAPPA and the period of residence at Ashley House was intended to contribute to his safe management in the community. This was achieved although he had been difficult to manage; both the keyworker and offender manager worked hard to liaise fully about the risks he posed. E could have been evicted from the hostel on a number of occasions, but the decision was made to keep him resident there, as this maximised the ability of the area to manage the risks he posed. The period of residence was for just over two months and was completed without major incident. So this was a difficult case, managed sufficiently well.

10.5 Resident F

- 10.5.1 There had been a good level of pre-release contact with Resident F and plans were made to support his community reintegration through an appropriate range of interventions. These included addressing problems such as: drugs, accommodation, health, mental health, and employment, training and education (ETE) services. He too was a prolific offender managed under ASPOS. F was released to Ashley House and inducted as required. Within two days there was evidence of problems of compliance with the hostel regime. F refused to participate in various activities and was aggressive to staff. Warnings were issued and recorded; he breached his licence within a week of release and was promptly returned to prison.
- 10.5.2 Whilst there was a thorough general assessment and detailed plans were made, there had been no RoH assessment. The offender manager appeared to have overlooked some of F's previous convictions for violence in deciding that there did not need to be a full RoH analysis. In our view he should have been assessed as presenting a medium RoH. Whilst this was an important gap, the case was otherwise well managed and there was a good level of liaison between offender manager and hostel staff.

10.6 Resident G

- 10.6.1 The case of Resident G was poorly managed. He was at Ashley House as a condition of bail, but was already subject to a community order. There was little on file to indicate what work had been planned and done with him during his six months at the hostel. There was no risk management plan, although his level of risk was recorded initially as medium, changing to high. There was also little evidence of liaison between the hostel and the offender manager.

Key Points in relation to the management of cases raised in the *Panorama* programme:

- These cases illustrate the range of offenders referred to Ashley House. What we were shown in Ashley House looked chaotic, with prominence given to Resident C who was actually chaotic and Resident E who appeared to be violent. The reporter colluded with C in relation to him not taking his prescribed medication to illustrate his allegation that residents were not being well managed. What our reading of the case files and discussion with staff demonstrated, however, was that in fact these difficult people were being well managed on the whole, within their own limited capabilities. Staff were doing a difficult job with difficult individuals and, with the exceptions we have identified, in the cases shown they could not have reasonably done more.
- With the exception of Resident G, hostel staff had worked positively with the cases whose files we read.
- Prolific offenders had the opportunity of a comprehensive programme to support them to cease illegal drug misuse and offending, despite the difficulties they often presented.
- The quality of offender management was more mixed. There was often no or very poor links between the sentence plan and hostel plans when the offender managers in the cases we read did not see the hostel as anything more than respite accommodation. They did not tend to update plans or make the best use of the facilities on offer.

11. BRIGSTOCKE ROAD (managed by the probation area)

11.1 The management of Brigstocke Road

- 11.1.1 The hostel in Brigstocke Road comprised four terraced houses that were linked together at the back through a series of offices but separated at the front. It had been a hostel for male offenders since 1974. Accommodation for the 28 residents was partly on a self-catering basis. There could be progression into the self-catering units as part of the rehabilitative process.
- 11.1.2 One manager had responsibility for both Brigstocke Road and Glogan House, supported by a full-time deputy or operational manager in each.
- 11.1.3 Double waking night cover had been introduced in October 2006. The NPD had made a one-off payment per area of £40,000 as a transitional payment to put this into effect. As part of a hostel resources review a decision had been taken to reduce the assistant manager complement from six to five available for the day-to-day running of the hostel and contributing to the supervision of residents. Due to its need to make savings overall, Avon & Somerset had retained the same number of posts and substituted a less expensive approved premises assistant post for an assistant manager post. Instead of increasing its staff complement it reduced its day-time permanent cover to implement the national model. Whilst this arrangement had hardly had time to be reviewed, the impact was likely to be less time available to develop the enhanced regime also required by the centre.
- 11.1.4 As the hostel had been functioning as such for over 30 years it was surprising to find that there was no positive liaison group comprising some local residents and representatives from local groups or churches as well as staff. These often do exist and are useful vehicles for keeping people informed and for nipping problems in the bud. There appeared not to have been significant problems or offences committed against local residents until this current campaign. At the time of the inquiry progress had been made in identifying arrangements for liaison with community groups.

11.2 Staff

- 11.2.1 We saw committed and enthusiastic staff, doing a difficult job in difficult circumstances. They had had a lengthy period of press interest and the consequent activity outside the hostel which had involved them in some conflict. Despite this, and the staffing changes outlined below, they were positive about the work at the hostel.

- 11.2.2 There were 12 full-time staff with five assistant managers covering shifts between 8am-9.30pm and four approved premises assistants working nights from 9.30pm-8am. There was a pool of relief staff and at least one person from it was required at all times to cover for leave, sickness, courses, etc.
- 11.2.3 Staff reported that they struggled to be released to undertake training. Records indicated that they had had very little training during 2006 and that some had not undertaken the RoH training. This was due to the costs involved in paying relief staff to cover. Relief staff who were used extensively had only two days experience of shadowing as training, nothing thereafter and no supervision. (Some relief staff were employed by the area in other capacities so received other training.) The area was aware that this situation was unsatisfactory.

11.3 Referrals and admissions

- 11.3.1 Referrals were said to be appropriate on the whole and were mainly for prisoners released on licence who posed a high or very high RoH. These were not exclusively sex offenders. Where prisoners were being held reasonably locally, hostel staff would endeavour to visit them prior to release.
- 11.3.2 Guidance required an up-to-date OASys and sentence plan detailing how the period of residence fitted in with plans for moving on as part of the referral. Hostel staff suggested that up to 20% of cases did not have an OASys at this stage as there were problems in getting prisons to release the document. There had been a national technical problem with access to eOASys electronically across the probation and prison services. Local monitoring suggested that almost all cases had had an OASys prepared within five days of taking up residence.
- 11.3.3 Seeking to fulfil responsibly their designated role within the national system for hostels, the area rarely turned down a referral as being too dangerous though cases were sometimes referred to an assistant chief officer (ACO) for a decision. They had also on occasion taken Critical Public Protection cases and been given funding by the NPS to support them; this demonstrated that it had the confidence of the Directorate to manage difficult cases safely. Brigstocke House was thought to be suitable for this as it was possible to empty one unit or house at a time and to isolate one person. When this was done extra funding was made available to make up for the shortfall in revenue arising from keeping a bed space available.
- 11.3.4 The high RoH nature of the residents' group presented problems in achieving the occupancy target at times. At times a bed would have to be held pending release of a prisoner to ensure availability in advance. The publicity surrounding well-known cases leaked to the public had also had a negative impact on referrals at times.

11.4 Offender management and constructive interventions in Brigstocke Road

- 11.4.1 There was as yet no regular programme of *constructive* interventions at Brigstocke Road. There were no programmes delivered at the hostel, accredited

or otherwise, although there were plans to deliver *Living in Here Moving On*. Residents could have access to in-house accommodation advice or ETE staff but this was limited. Attention to offending-related issues was essentially the responsibility of office-based offender managers and those residents who did participate in accredited programmes did so at probation offices.

- 11.4.2 Keyworking was the means by which assistant managers each took responsibility for communication with and about up to five residents. They were meant to have an individual meeting with them each week which we confirmed did tend to take place. Keyworkers should also contribute to sentence plan reviews through discussion with offender managers; we were told that this varied enormously with some offender managers having no contact with them through to a high level of joint working. We were unable to verify this further other than in the specific cases we read – which we detail later.
- 11.4.3 Improvements to recording systems had been made in 2006 when the electronic case record and OASys were made available in all hostels. This supported one single record available to all. However, we were concerned about the quality of recording in the hostel log and the case record. A well-maintained log could present a picture of a resident over a period of time. Bearing in mind the challenges posed by some of the residents, what may appear to be insignificant on one day could turn out to be part of an emerging pattern.
- 11.4.4 Whilst staff knew that they were supervising high-risk offenders, they appeared to have had insufficient training or experience to look for and then record signs that levels of risk were increasing, to ensure that small details were recorded to build up a picture. The deputy had devised a document summarising the key risk management issues from OASys which was kept on file and used in team meetings to keep staff up to date with issues. However, we were concerned that important events did not always get into the hostel daily log or onto the case record; this was seen in the case of K also in relation to the knives we found, as detailed in the next section.
- 11.4.5 When shifts changed there was a full handover between staff and discussion about each resident. There was a handover summary sheet with notes on each individual resident. It included a brief statement of the nature of the risks presented by each resident and a column for day-to-day issues. The statement of the resident's RoH needed to be more precise in order to act as a reminder to staff about which risk indicators they should consider.

11.5 Security and restrictive interventions at Brigstocke Road

- 11.5.1 The building was a difficult one to make secure and it was not possible to have a sole entrance for residents that was easily policed. Efforts had been made to overcome this: it was served by the provision of 37 CCTV cameras that observed the external doors and key points throughout the hostel such as corridors, stairwells and residents' lounges. The monitors for each of the cameras were located within the front office of the hostel that also served as a reception point for signing in and out by the residents. However, the images presented by the

cameras were very small and clustered on to screens that were difficult to see from where staff needed to sit. The area acknowledged that this was a problem but that funding to replace the system had not been available. They were not well placed therefore to afford effective surveillance.

- 11.5.2 Daytime security for the two self-catering houses in particular was inadequate, as movement in and out was monitored solely by the cameras. Thus Resident K had been able to take a young woman in to his room undetected. Access was by key only, although there had been a key fob monitoring system until earlier in the year that would keep a record of all comings and goings through the locked doors by means of an electronic control panel in the reception area. Replacements had been authorised by the time of our inquiry.
- 11.5.3 At night after the curfew, however, security was satisfactory: each of the external doors was subject to an electronic sensor that activated a signal to the reception office if opened, together with an alarm that would activate if anyone tampered with the sensors.
- 11.5.4 Room searches were undertaken by two staff at a time on a weekly basis for some residents and on a random basis for others. There were several checks around the building on a daily basis.
- 11.5.5 As in Ashley House, residents were required to sign in at specified periods during the day. Given the inadequacies of the CCTV system, being required to sign in did mean that staff could verify that men were actually in the building. It also meant that residents who posed a risk to the public could be prevented from going out for other than short periods and it was used as such with some MAPPA cases. However, given that we have identified that little was done with residents within the hostel, hourly and two hourly signing effectively confined them to the building, often with nothing to do and prevented them from going out for constructive activity.
- 11.5.6 Staff were not following national guidance issued in 2004 in relation to handling residents' medication. There was a lack of confidentiality and risk of misuse built into the procedure with several residents present who were all expected to take their own medication from the secure cupboard. Only one resident should have been present in the room at the time that the medication was issued, and staff should have tried to ensure that the resident consumed the medication at that time.
- 11.5.7 There was no awareness that there should have been control systems for potentially dangerous implements, e.g. to prevent residents having knives in their possession. On our first day in the hostel, kitchen and Stanley knives were seen in the rooms of two residents. The explanation for this by staff was linked to self-catering and the desire to prevent utensils being stolen. Inspectors asked staff to return these to the kitchen and explained why. The next day, on another tour of the building, the knives were again in rooms and a different member of staff repeated the same explanation. If there was a decision that these residents could keep their knives with them, no risk assessment appeared to have been made to support it. Our finding had neither been communicated nor recorded in

the log or case records. Incidents such as these should have been logged. The cumulative effect of pieces of information can present a very different picture of an individual offender and the RoH they pose.

- 11.5.8 Licence conditions were used appropriately both to require residence at Brigstocke House and to restrict some activities, e.g. contact with named past victims or with potential victims. We saw examples in the cases referred to in the programme and in others that recall to prison for non-compliance with requirements was usually undertaken appropriately. Hostel rules generally were seen by residents to be fair and properly enforced.
- 11.5.9 Staff and the police both reported that they had a good working relationship. They worked closely in relation to individual residents assessed as posing a high RoH and had general liaison with local beat officers.
- 11.5.10 It was surprising to discover that staff and managers did not know how many residents were subject to Sexual Offences Prevention Orders. They thought there were two. On checking with their police contacts they discovered that there were currently five – and one of the residents thought to be on an order actually was not. It was not usual practice to have a copy of the order on the file, although the law required that the offenders should be given a copy. We sent for them and found them to be comprehensive; however, there could be no attempt to monitor behaviour in and around the hostel and relay relevant information back to the police if staff did not know what to look for. It was the case that many of the prohibitions in the orders were for activities away from the hostel and therefore beyond the reach of hostel staff; however, there were still signs that could signal potentially dangerous behaviour if linked to the intelligence behind the order, e.g. possession of a camera or certain clothing that might not otherwise be apparent. We therefore thought this a serious omission.

Key findings in relation to the management of Brigstocke Road:

- The quality of referrals was good and consistent with area policy. The process was well managed and built on effective liaison with offender management teams.
- The area was seen to play a positive role nationally in being prepared to take Critical Public Protection cases and Brigstocke Road had been used in this way.
- The recent loss of a post was likely to have a negative impact on the development of the regime at the hostel.
- Staff were committed to doing a good job and were striving to do their best with the resources they had.
- There was no programme of positive interventions in the hostel. The relationship between the keyworker and offender manager was crucial and was seen to work well in most cases with a high level of communication.
- There were insufficient staff and they were not well trained; their work would have been much enhanced by the investment of more staff and training.
- The hostel and its staff made positive contributions to managing some of the most dangerous people under supervision.
- An enhanced regime of restrictive interventions was clearly in place.
- A range of security measures was in place but there were limitations about the building that made it physically difficult to secure during the day. Some improvements would be possible but needed investment.
- Some residents were required to sign in during the day at intervals as frequent as hourly. This was seen to be useful to assist licensees to settle in after a period in prison or as part as a detailed risk management plan under MAPPAs. However, those obliged to stay in appeared to have nothing constructive to do.
- National guidelines for the safe handling of prescribed medication and knives were not consistently followed.
- Copies of residents' Sexual Offences Prevention Orders were not reliably on their files and referred to by staff.
- Recall or breach was generally used appropriately.

12. THE MANAGEMENT OF CASES RAISED IN THE PANORAMA PROGRAMME IN BRIGSTOCKE ROAD

12.1 Resident H

- 12.1.1 Resident H was on licence for very serious sexual offences against children. His case was well managed and recorded and there was evidence of good working relationships between the hostel keyworker and offender manager. The latter's SPO was also well informed and appropriately involved in supporting her.
- 12.1.2 Assessments were done on time and were of good quality. When the level of RoH was seen potentially to rise an early review was done.
- 12.1.3 In the programme it was alleged that use of alcohol was a problem. In relation to his offending behaviour towards children, we found that this was not the case. There was no evidence of a link between his offences against children and alcohol so there was no condition in his licence restricting use of alcohol.
- 12.1.4 In fact this was a good example of how a hostel could contribute to protecting the public from harm including oversight by MAPPA. It was one where any progress in relation to rehabilitation would be very slow, but where this level of restriction in the community could prevent reoffending.

12.2 Resident I

- 12.2.1 The case of Resident I was likewise well assessed and managed, also through MAPPA. He was shown on film apparently taking photographs in a shopping centre and the implication was that these were of children. Staff observing this kind of behaviour have a responsibility to report their concerns and this ought to have applied to the *Panorama* reporter who filmed it and was aware that it potentially represented a risk to children. Indeed, information of this kind shared by hostel staff at a later date was sufficient to raise the assessed level of RoH from medium to high, and for police to begin to collect evidence to apply for a Sexual Offences Prevention Order, which they successfully secured. By the time the programme was screened Resident I had been recalled to prison some months earlier for breaching this order.

12.3 Resident J

- 12.3.1 There had been mention of Resident J presenting risks associated with mental health problems, although his case did not actually feature in the programme. This case was fully assessed and well managed. He was being treated by a

psychologist for his problems and these were assessed as manageable in the hostel at that time.

Key points in relation to cases raised in the *Panorama* programme in Brigstocke Road:

- There was evidence of hostel staff and the regime making a positive contribution to the management of potentially dangerous offenders in conjunction with offender managers and through MAPPA.
- These cases posed a challenge to staff in the hostel and offender managers but they were dealt with appropriately and consistently. In the *Panorama* programme we saw only the challenges that two offenders who had committed very serious offences pose to the public and to staff. We were not shown how they were addressed by hostel staff and offender managers, i.e. containment in one case and a return to prison when containment was being breached in the other.

13. HOSTELS SUMMARY

Similarities between Ashley House and Brigstocke Road	Key Differences
<ul style="list-style-type: none"> • The management arrangements including having the APM in common. • Access to central advice and services, e.g. human resource management. • The hostel buildings are difficult to manage in themselves. • Hostel staff commitment. • Staff are not well trained. • Extensive use of relief staff. • A positive emphasis on security and restrictive measures. • There is joint work with the police in appropriate cases: with PPOs in Ashley House and sex offenders in Brigstocke Road. • Evidence in most cases of positive liaison between keyworkers and offender managers. • Enforcement is well managed. • Move-on accommodation is difficult to secure. 	<ul style="list-style-type: none"> • Ashley House is a voluntary managed hostel. • It is less well resourced as a consequence of having access to NPS core funding only. • Therefore it has less staff and at the time of the inspection did not have double waking night cover. • The resident admission criteria and actual profiles differ. • Referrals and admissions are well managed at Brigstocke Road. • Links with offender managers appear to be better at Brigstocke Road where hostel residence is more likely to be a condition of a licence and to feature in sentence planning. • Ashley House has a greater emphasis on offering a rehabilitative regime. • It offers a drug treatment programme on site.

14. BRIDGE HOUSE and GLOGAN HOUSE

14.1 Bridge House hostel

- 14.1.1 We were able to make a visit of half a day to Bridge House, but there was insufficient time to look in any detail at what was on offer there.
- 14.1.2 Bridge House was a 12 bed hostel, housing ten men at the time of our enquiry, all on licence with conditions of residence. It had previously housed offenders subject to DTTOs, i.e. with an emphasis on the rehabilitation of substance misusing offenders, but had changed as required by the *National Approved Premises Strategy* and was now clearly aimed at those posing a high RoH to others. It was managed by the Ashley House manager with a full-time operational manager.
- 14.1.3 There had previously also been a six bed cluster unit which had been closed as required. This had had a negative impact on the ability of offenders to be found suitable move-on accommodation. Residents seen expressed a fear that they would have found no accommodation at the end of their licence and could face homelessness.
- 14.1.4 We found an emphasis on containment and enforcement – the restrictive regime – but there was nothing constructive on offer, as at Brigstocke Road. Offending behaviour work and rehabilitative work had to take place elsewhere.
- 14.1.5 Discussion with staff and residents suggested that liaison between offender managers and keyworkers was positive, as was liaison with local police.

14.2 Glogan House

- 14.2.1 We could not fit a visit to Glogan House into our programme, but were informed that they had that week begun to implement the *Living in Here Moving On* programme.
- 14.2.2 This was a hostel that was said to specialise in taking residents who had usually served long terms of imprisonment and who had been released either with physical disabilities or who were elderly and needed some care. We did confirm that this was the case with senior managers. Neither of these factors necessarily reduces the level of risk posed; suitable support for offenders who have other overriding needs ought to be negotiated through Supporting People arrangements and MAPPA if necessary.

15. THE CASE OF RESIDENT K

15.1 Introduction

- 15.1.1 This case featured very prominently in the programme and we invested a significant amount of time in assessing the management of it, but for this report we focus on the salient points of this complex and difficult case. To its credit, in this case the *Panorama* programme makers did discover an offender who posed a high RoH to the public, and they broadcast substantial footage of him in the community behaving in a way that was bound to cause public concern. We explored this case in detail to ascertain why he had been released and how he had been managed during that period. We found that he had not been well managed in the community, nor previously had he always been well managed during his long term of imprisonment.
- 15.1.2 As we have said earlier, it is not possible to eliminate risk entirely, but the public ought to be able to expect that the relevant authorities will do their job properly. In our view this was a case where a dangerous offender had been able to manipulate individuals over many years, and also to exploit loopholes in systems. We have ensured that this assessment has gone to the agencies concerned. But in that sense it is a very good illustration of the dangerous, difficult and manipulative offenders hostels sometimes have to deal with.
- 15.1.3 The decision to release K was made after over 38 years in prison and after many assessments by people working for the different agencies involved. Most of these readily agreed to assist with our inquiry and we are grateful for the cooperation of: the NOMS Lifer Review and Recall Section and NOMS Public Protection and Licensed Release Unit, HM Prison Service and a prison Psychology Department. The Parole Board was helpful in supplying all information requested about Resident K, but objected to any examination of its panel's release decision in principle on the grounds that the quasi-judicial decision of a court-like body should not be examined by someone reporting directly to Ministers.
- 15.1.4 Resident K was not charged with any offence during his period on licence but he was recalled shortly before the *Panorama* programme was screened. At the time of writing the question of whether he should be released on licence is to be assessed again. We do not presume to be better equipped to assess the level of dangerousness posed by offenders than others involved in the criminal justice system. However, there were inconsistencies in assessments made which were there for anyone to read in the documentation available.

15.2 The original offence

15.2.1 In 1966 when he was 21 years old, Resident K sexually assaulted and in a frenzied attack murdered a 10 year old girl who was known to him as the daughter of his neighbours. In this attack the weapons used were a knife and an iron. There was clear forensic evidence of sexual assault, a fact that was often overlooked by some who carried out assessments during the sentence and denied for many years by K. At the time of his trial he was assessed by both the defence and independent psychiatrists as being psychopathic under the definition of the Mental Health Act 1959. He was sentenced to life imprisonment with a tariff of 20 years in July 1966.

15.3 Significant events over 25 years

15.3.1 During this time K moved prisons but remained in closed conditions. We do not know why he had not been released at his tariff date of 20 years other than that records refer to an unspecified 'risk'. It was clear that at times elements of his prison file had not caught up with him, including the details of his original offence.

15.3.2 He collected numerous adjudications for minor breaches of prison rules and there were many incidents of a sexual nature with other prisoners and workers he came across in the prison. There were also obscene letters and the acquisition of pornographic videos. At the same time he tended to be referred to by prison staff as likeable and warm.

15.3.3 Only in 1992 did K first accept – in a letter to his PO – that he had committed a sexual offence against the girl he killed. He was to deny this again many times and to create a number of differing versions of the event and of his own life before he killed his victim.

15.3.4 During this time in custody K changed his name three times by deed poll and married three times, the last time to a woman from Bristol.

15.4 Assessment in prison

15.4.1 In 38 years K was the subject of many assessments. From 1983 onwards there began to appear comments in them about K having nothing more to learn from prison or being as ready as he ever would be to be released. These were not based on evidence of a reduced level of RoH but their tone seemed to suggest an acknowledgement of the inevitability of release at some stage.

15.4.2 There were key points where there should have been an assessment of all the available evidence as the basis for the decision about whether to move to open conditions or release. From assessments on file it would appear that at many of the Parole Board hearings and the interim local reviews, those recommendations about the suitability for a move or release had not taken all the available information into account. Most frequently, the nature of the original offence was overlooked and the fact that until 2001 K did no work in prison to address his

offending behaviour. This applied at times to POs, psychologists, prison staff and psychiatrists as well as to the Parole Board itself. Recommendations to undertake specific programmes and undergo assessment in relation to fantasies directly related to his original offence were left hanging and no-one appeared to take responsibility for chasing progress.

- 15.4.3 In particular, at no point during K's sentence was a PCL-R (specialist psychopathy assessment) undertaken. This was an important pre-requisite for consideration for the release of a violent sex offender such as this.
- 15.4.4 On several occasions, however, an individual senior psychologist was given the task of assessing K and went out on a limb against what at times appeared to be an inevitable trend to release; his assessment did take into account all aspects of K's history and behaviour. These made a difference as outlined below. Over the years, the assessments made by different psychologists and psychiatrists differed widely from dangerous to safe and back to dangerous. Recommendations to the Parole Board were also often divided.
- 15.4.5 K was moved to an open prison in 1996 to begin preparation for release. Whilst there he was again assessed as dangerous by psychologists and also as needing to undertake a SOTP. Prisoners should not be in open prison if they are assessed as posing a high RoH or of needing to start a new type of offending behaviour work, but he did complete a programme whilst there. He also continued to misbehave generally and sexually. He was returned to a closed prison in 2002 following an assessment of this accumulation of issues by psychologists working with him on the Rolling SOTP and the chartered psychologist managing his case at that time.
- 15.4.6 In 2003 K returned to open prison after a further SOTP. Whilst being considered for release there were further incidents that the senior psychologist had earlier assessed would indicate signs of heightened risk. These were viewed as isolated incidents and their significance was overlooked.

15.5 The decision of the Parole Board to release on licence

- 15.5.1 It is for the Secretary of State to decide whether a lifer should transfer to open conditions, on the recommendation of the Parole Board. For the decision to release on licence the positions are reversed, i.e. the Secretary of State recommends and the Parole Board decides: *"The Parole Board may direct the release of a tariff-expired lifer only if it is satisfied that it is no longer necessary for the protection of the public that the prisoner should remain in prison."*⁽⁹⁾
- 15.5.2 For the 2005 hearing the Secretary of State argued that a PCL-R should be undertaken before a final release decision was made. Clearly this should have been done earlier in the prisoner's time in custody, but the need for it was valid. The Parole Board determined otherwise and directed full release. In our view, given the history of the case as a whole, of the conflicting assessments of K throughout, and K's continuing record of indicative behaviour, that decision to release without a PCL-R placed the public in a position of avoidable risk.

15.6 The role of the home probation officer

- 15.6.1 This is the PO working in the offender's home area during a custodial sentence. At some stage K became rootless in that his family had no contact with him and had moved. He was therefore allocated a 'home' PO from the then Inner London Probation Service. Not surprisingly, over such a long period, he had several changes of officer. However, records indicate a reasonable amount of contact by letter and in person by the nominated officer during the sentence. In 1997 his case was transferred to the then Avon Probation Service.
- 15.6.2 His home PO, who had supervised K for some years, completed an OASys in October 2004 but it was inaccurate. Worryingly, in the description of his offending she cited his motivation to offend as having been his decision to burgle the house and missed out the sexual element of the offence. There was no mention made of the use of weapons, nor of his previous conviction for arson. She assessed his RoH level as medium. She did not complete a risk management plan. We also felt that some offending related risk factors had not been addressed, although they were known, e.g. his use of alcohol and obsession with knives.
- 15.6.3 Once K had moved to open prison in 1996 he began to spend periods on temporary release at Brigstocke Road. These appeared to be successful in that he did not reoffend and he did keep to the rules.
- 15.6.4 By this stage there ought to have been a referral to MAPPa where the decision to recommend release, or not, should have been taken and a risk management plan including medium-term as well as short-term goals drawn up. We did not get a satisfactory answer to the question of why no referral was made. Given that K's wife had grandchildren and that he was a convicted child killer there ought to have been a multi-agency opportunity to consider the risks. There was also growing evidence of him posing a risk to adult females. A lifer should not be released until he is assessed as being managed safely in the community, but there was sufficient doubt in this case to make it imperative that K should have been referred to MAPPa. At a later stage there was evidence of the middle manager being aware of the case but she also did not consider it necessary to make a referral.
- 15.6.5 The PO strongly advocated release. The plan for release had been criticised at an earlier stage by the senior psychologist for its narrow focus on K's relationship with his wife. In June 2005 he was released on licence to Brigstocke Road.

15.7 Offender management on release

- 15.7.1 The assessment and management of this case, by all involved, was poor. There was evidence of his offender manager (the home PO), her manager and hostel staff being manipulated by K. The prison psychologist had identified the behaviours that would be an indication of 'raised risk' if they happened. There was a record of these behaviours or factors starting to happen within ten days of his release. Yet at no stage was he reassessed as potentially posing an increased

RoH. To do that would have required a new assessment of the evidence available and no-one took the initiative to do that.

- 15.7.2 There was no OASys written until two months after release. On the face of it, a medium RoH offender in a hostel may not be a hard-pressed offender manager's first priority. She had a very high workload and several other cases where risk to the public was more obvious to her. A newly released lifer should however always be a priority, and this lifer in particular as the offender manager had assured the Parole Board and other agencies that she would be actively managing the identified risk factors.
- 15.7.3 Resident K's offender manager had assessed him in 2004 as posing a medium RoH to the public. Using the OASys risk assessment tool this meant: 'there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse'. This could have been correct at the time of his release if a full and accurate assessment had been carried out and measures put in place to manager identified risks. This had not been done. The fact that behaviours predicting heightened risk then began to manifest themselves within days were clear examples of the changes in circumstances that an assessment of medium RoH warns the offender manager to be aware of. So using this definition the level of RoH should have been raised to high. In our view the RoH posed by K was always high.
- 15.7.4 As a medium RoH case, Resident K fell below the radar of Avon & Somerset's systems for involving others in RoH assessment. He was not a registered sex offender, as he had not been convicted of a sexual offence against a child under the age of 16 and his offence pre-dated the act by several decades. There was no system to ensure that anyone other than an offender manager would assess the risks in the case of a newly released lifer. Assessment as a medium RoH case, who was not a registered sex offender, also meant that the police would have no involvement in his further assessment.
- 15.7.5 When OASys was completed there was no risk management plan as was required. The assessment wrongly stated that there had been a referral to Level 2 MAPPA. It was said that the offender manager had had contact with social services and it had been agreed that there was no need for a child protection conference as K was living in a hostel. There should have been a child protection conference to address the fact that K's wife had grandchildren and an assessment made of the family's ability to protect them in the face of someone with K's history. It later transpired that his wife was assessed as a vulnerable adult and that there had been child protection concerns in the previous two years.

15.8 Liaison between Brigstocke Road and the offender manager

- 15.8.1 On release there were appropriate induction meetings at the hostel and probation office. The keyworker, offender manager, K and his wife were clear

about roles and what work would be undertaken by whom. There was mention of work on sex offending at this stage and also in OASys that a referral would be made to the programmes team for inclusion in the SOTP, but nothing about timing and sequencing with other work. This was not referred to again in the record until K was given a start date and began to do pre-programme work over a year later.

- 15.8.2 Levels of contact with Resident K were satisfactory during the period on licence. There was also some positive preventative work undertaken by the offender manager in relation to the local church through agreed disclosure to the local vicar.
- 15.8.3 There were examples over time of both offender manager and keyworker responding to a growing catalogue of problems presented by K. If these had been isolated incidents their responses – usually to issue a warning or to cut down on privileges – may have been appropriate. However, within a month of release K's relationship with his wife was under strain and he was being deceitful about his whereabouts. Both should have triggered a review of risk. At the same time he was being given positive messages about his behaviour by being allowed to spend the night at his wife's house, to move into ground floor accommodation and to buy a bicycle. In none of these instances was there evidence of a risk assessment.
- 15.8.4 In August he broke hostel rules and exhibited another risk factor by being found drinking alcohol on the premises. It was clear to staff that his responses to challenge were untrue – telling lies is another indicator of 'raised risk'.
- 15.8.5 Over the next few months this pattern of concerns for which K would never take responsibility continued to grow – primarily problems with his wife and her family and also disrupting what was supposed to be an agreed work pattern at a charity shop. He was caught out more than once having deceived everyone so that he could have time on his own. The systems were present for the hostel to know where he was most of the time through signing in and the supervision of the charity shop worker but he was able to evade them.
- 15.8.6 Evidence of liaison between the two primary workers – offender manager and hostel keyworker – was satisfactory on the whole. It was the continued absence of a thorough assessment that was problematic. They did sit down together with K or with him and his wife to review progress but this did not constitute a proper review.
- 15.8.7 In early May 2006 a room search uncovered women's clothing and a penknife. K's wife stated that their marriage was over. Given that these were indicators of his obsessions with sex and with knives, this represented a serious indication of escalating RoH. It was insufficient merely to issue a hostel warning. A full OASys ought to have been completed; a report to the Lifer Section for consideration of a warning or recall and a referral to MAPPA should have been made.
- 15.8.8 Two days later he was found to have taken what was said to have been a 17 year old girl into his room and to have taken photographs of her semi-naked. (It

was not known for some time that she was in fact 18. She also later confirmed that she had refused to have this photograph taken.) He was issued with another warning letter and had privileges withdrawn. No further action was taken. The extremity of this behaviour was such as to justify immediate recall in this case, and it was a serious misjudgement not to decide that.

- 15.8.9 Over two months later in July 2006 a report was sent to the NOMS Lifer Review and Recall Section mentioning the deteriorating relationship between K and his wife and most of the above, but not the discovery of the knife. The Section replied that it would want to see improvement.
- 15.8.10 Between May and October (when he was recalled) the pattern continued as before. All of the risk indicators mentioned by the senior psychologist as reasons for not allowing K to be released or to live in open conditions manifested themselves. All were dealt with as single issues rather than as a symptom of escalating dangerousness. All staff still thought that it was K who was naïve and that trouble kept happening to him and he should try to avoid it. He was recalled shortly before the *Panorama* programme was screened.
- 15.8.11 We drew our concerns about the management of this case to the attention of probation area and were satisfied that the case was re-allocated immediately and a thorough assessment undertaken.

15.9 The role of the police

- 15.9.1 The police and probation services had a positive working relationship in Avon & Somerset. They shared responsibility for MAPPA with the prison service and there was a high level of contact between them in relation to known dangerous offenders and with the hostels. This case exposed a number of flaws in their mutual information sharing procedures.
- 15.9.2 The correct notifications were sent to the police about the periods of temporary release and eventual release on life licence so they were aware of him. However, they were not aware of the details of the offence of murder and would have no cause to ask as he was assessed as posing a medium RoH and was not a registered sex offender. Lack of an information sharing protocol about hostel residents meant that there was no systematic opportunity for the police to consider information that might make them concerned about the accuracy of an assessment.
- 15.9.3 The telephone calls to the police by the *Panorama* reporter ought to have prompted a child protection referral and investigation even though they were made anonymously. The information was passed to the Intelligence Unit but no referral was made. Information recorded about K showed only that he had a conviction for murder, not that the victim had been a child. Therefore, if K's name was checked he would not have shown up as a posing a RoH to children.
- 15.9.4 HM Inspectorate of Constabulary spent two days with Avon & Somerset Police on our behalf and have noted their plans to make changes to information sharing systems to address these concerns.

Key points in relation to the management of Resident K:

- In this case we saw all of the restrictive measures available at Brigstocke Road put into action. There were sufficient controls in place to ensure that he had little opportunity to commit offences. When he did transgress he was punished by having privileges withdrawn and restrictions increased.
- K was an example of the most difficult kind of offender hostels have to try to contain. We saw from the record that he successfully manipulated everyone involved with him to enable him to minimise their impact on him.
- Hostel staff carried out their work with K diligently but they did not have the ability to make a full assessment of K's behaviour.
- The offender manager did not do her job properly; she did not carry out an accurate assessment of RoH or of the likelihood of reoffending, although the information was available to her as it was to us. In our view the evidence points clearly to an assessment of him posing a high RoH.
- We saw and heard an equally poor response from the offender manager's own manager which in turn left us with concerns about her ability to make assessments of offenders.

16. SUMMARY OF FINDINGS AND RECOMMENDATIONS

We have summarised below our main findings from the inquiry and the recommendations we are making as a result. In the main we restrict our findings to the element of the inquiry that was carried out in Avon & Somerset as we do not want to draw conclusions about offender management in hostels generally from the evidence of one area only. We intend to carry out a thematic inspection of hostels in 2007/2008.

16.1 Findings in relation to the national context:

- (ii) Following the creation of the NPS there was a significant amount of investment at national level following up the recommendations in the 1998 HMI Probation thematic inspection of probation hostels.
- (iii) A national strategy for their use and development was drawn up which repositioned the hostel system as a key element in the management of dangerous offenders.
- (iv) In 2005 a Probation Circular defined the role and purpose of hostels and the level of enhanced supervision necessary to manage residents safely. Whilst work on this continues, the centre has drawn back from developing a national regime of constructive interventions and national staffing model.
- (v) In the transition from the former NPD to NOMS, it is clear that there has been some planning blight affecting the development of hostels nationally. There is also a dilemma for NOMS now, whether to develop hostels in future as a single national system, or within an approach led by regional commissioning arrangements. The Inspectorate view is that the hostels need to be managed as a national system.

16.2 Findings in relation to offender management in the Avon & Somerset Probation Area:

- (i) There was evidence of Avon & Somerset being a generally well-managed probation area that was performing reasonably well against national targets during the period under scrutiny.
- (ii) We judged that its method of managing its budget created a risk of cutting staffing and management of offender management teams to unsafe levels.
- (iii) Whilst there was a system of oversight by senior managers of the management of lifers, this did not include a review around the time of release of the assessments and arrangements for supervision on licence.
- (iv) MAPPA were well developed, as were relationships between the police and probation services. However, the area could not be confident that its

systems and staffing levels were sufficiently robust to ensure that all appropriate case were referred into it.

- (v) The two SFO cases involved offenders who had not been assessed as posing a high RoH to the public and who both committed murder. They had each been living at one of the Avon & Somerset hostels.
- (vi) Whilst there was room for improvement in the management of each case, our judgement was that there was nothing in the past or current behaviour at the time to suggest that such serious offences would be committed. It is not reasonable to conclude that the probation service could have prevented the tragic death in either of these cases.

16.3 Findings in relation to hostel arrangements in Avon & Somerset

- (i) The Probation Board managed a relatively high number of hostels which were viewed as a resource within the South-West Region and to a certain extent, nationally.
- (ii) The Board invested a small but significant amount of its main area budget to supplement the budget allocated nationally to each hostel in the area (although this did not apply to Ashley House).
- (iii) The level of training delivered to hostel staff was inadequate.
- (iv) Where cases were being managed within MAPPA, we saw evidence of strong partnership work.

16.4 Recommendations:

Improvements are necessary as follows:

- (i) There should be a system that ensures that senior managers are aware of the assessment of lifers and other prisoners serving long sentences around the time of release.
- (ii) The priority given to the resourcing of offender management teams should be reconsidered to allow proper management oversight of the caseload.
- (iii) A protocol should be drawn up defining the arrangements for liaison between the police and hostels. This should include sharing information routinely about lifers and other offenders released from long sentences regardless of their assessed level of RoH.

16.5 Findings in relation to Ashley House (managed by a voluntary committee):

- (i) Ashley House Committee was aware that it needed to make a decision urgently about how it saw its future.
- (ii) The beds for women were not always well used.

- (iii) The quality of referrals and admissions was unsatisfactory. Managers tended to accept referrals because of a need to keep occupancy high rather than managing the process better. There needed to be a better understanding in offender management teams about what constituted an appropriate referral, and hostel managers should ensure that offenders who did not fit this profile were not accepted.
- (iv) Managers seemed to be unaware of developments in the main service which had a negative impact on the regime on offer.
- (v) Of the hostels visited, Ashley House offered the most in terms of constructive enhanced supervision. There was a drug treatment programme which was unusual in a probation hostel. However, whilst a high proportion of residents had a substance misuse problem, their admission to the hostel was usually not part of a treatment plan and they tended to undertake treatment elsewhere in Bristol.
- (vi) Offender management worked most successfully in Ashley House with PPOs. Even so, not all of these cases needed to undertake this work in a hostel setting.
- (vii) The management of cases posing a RoH to the public was carried out in a satisfactory manner.
- (viii) Keyworker sessions were carried out as intended and there was a high level of communication between offender managers and keyworkers.
- (ix) However, staffing levels were stretched and they were not sufficiently well trained to undertake the job they did.
- (x) An enhanced regime of restrictive measures was clearly in place.
- (xi) Residents reported that they felt safe at Ashley House.
- (xii) The method and purpose of drug testing needed clarification.
- (xiii) There was a sound system for managing prescribed medicines properly.
- (xiv) There was no written guidance to hostel staff or offender managers about the use of signing in as a restrictive intervention. Nor was there anything in writing to inform residents about why and how it would be used.
- (xv) Review and recall or breach were used appropriately.

16.6 Recommendations:

Improvements are necessary as follows:

- (i) Ashley House Committee needed to make a decision about whether the hostel's future lay with the probation service or another voluntary organisation. The rationale for the beds for women was linked to the committee's views about accommodating the kind of offenders prescribed by the national strategy and should be addressed as part of its decision-making process.
- (ii) If the current purpose of the hostel were retained, there should be a process to promote the hostel's potential better to offender management

teams. The referral and admissions process should be managed with prospective residents fulfilling admissions criteria in relation to both RoH and need.

- (iii) Hostel managers needed to have a better understanding of the management of the service as a whole.
- (iv) The training needs of hostel staff should be assessed and arrangements made for them to attend events in accordance with identified need.
- (v) There should be written guidance to hostel staff and offender managers about the use of signing in as a restrictive intervention. There should also be information in writing to inform residents about why and how it would be used.
- (vi) Drug testing should always be supervised. Participation in treatment and testing should also be enforceable.

16.7 Key findings in relation to the management of cases raised in the *Panorama* programme in Ashley House:

- (i) These cases illustrate the range of offenders referred to Ashley House. What we were shown in Ashley House looked chaotic, with prominence given to Resident C who was actually chaotic and Resident E who appeared to be violent. The reporter colluded with C in relation to taking his prescribed medication to demonstrate his allegation that residents were not being well managed. What our reading of the case files and discussion with staff demonstrated, however, was that, in fact these difficult people were being well managed on the whole, within their own limited capabilities. Staff were doing a difficult job with difficult individuals and with the exceptions we have identified, in the cases shown they could not have reasonably done more.
- (ii) With the exception of Resident G, hostel staff had worked positively with the cases whose files we read.
- (iii) Prolific offenders had the opportunity of a comprehensive programme to support them to cease illegal drug misuse and offending, despite the difficulties they often presented.
- (iv) The quality of offender management was more mixed. There was often no or very poor links between the sentence plan and hostel plans when the offender managers in the cases we read did not see the hostel as anything more than respite accommodation. They did not tend to update plans or make the best use of the facilities on offer.

16.8 Findings in relation to Brigstocke Road (managed by the probation area):

- (i) The quality of referrals was good and consistent with area policy. The process was well managed and built on effective liaison with offender management teams.
- (ii) Staff were committed to doing a good job and were doing their best with the resources they had. However, staffing levels were stretched and they

were not well trained.

- (iii) The recent loss of a post was likely to have a negative impact on the development of the regime at the hostel.
- (iv) There was no programme of constructive interventions in the hostel.
- (v) The relationship between the keyworker and offender manager was crucial and was seen to work well in most cases with a high level of communication. The hostel and its staff played a positive role in managing some of the most dangerous people under supervision.
- (vi) An enhanced regime of restrictive interventions was clearly in place.
- (vii) A range of security measures was in place, but there were limitations about the building that made it physically difficult to secure during the day. Some improvements would be possible but needed investment.
- (viii) Some residents were required to sign in during the day at intervals as frequent as hourly. This was seen to be useful to assist licensees to settle in after a period in prison or as part as a detailed risk management plan under MAPPA. However, those obliged to stay in appeared to have nothing constructive to do. There was no written guidance to staff or offenders about this.
- (ix) National guidelines for the safe handling of prescribed medication and knives were not consistently followed.
- (x) Copies of residents' Sexual Offences Prevention Orders were not reliably on their files and referred to by staff.
- (xi) Recall and breach were generally used appropriately.

16.9 Recommendations:

Improvements are necessary as follows:

- (i) The training needs of hostel staff should be assessed and arrangements made for them to attend events in accordance with identified need.
- (ii) Within the resources available in the area consideration should be made of what positive elements of supervision can be introduced to the hostel to enhance the constructive regime.
- (iii) There should be written guidance to hostel staff and offender managers about the use of signing in as a restrictive intervention. There should also be information in writing to advise residents about why and how it would be used.
- (iv) Investment was required to make improvements to the security of the building as outlined in this report.
- (v) National guidelines for the safe handling of prescribed medication and knives should be followed consistently.
- (vi) Copies of residents' Sexual Offences Prevention Orders should be on their files and referred to by staff.

16.10 Key findings in relation to the management of cases raised in the *Panorama* programme in Brigstocke Road:

- (i) There was evidence of hostel staff and the regime making a positive contribution to the management of potentially dangerous offenders in conjunction with offender managers and through MAPPA.
- (ii) These cases posed a challenge to staff in the hostel and offender managers but they were dealt with appropriately and consistently. In the *Panorama* programme we saw only the challenges that two offenders who had committed very serious offences pose to the public and to staff. We were not shown how they were addressed by hostel staff and offender managers, i.e. containment in one case and a return to prison when containment was being breached in the other.

16.11 Key findings in relation to Resident K:

- (i) In this case we saw all of the restrictive measures available at Brigstocke Road put into action. There were sufficient controls in place to ensure that he had little opportunity to commit offences. When he did transgress he was punished by having privileges withdrawn and restrictions increased.
- (ii) K was an example of the most difficult kind of offender hostels have to try to contain. We saw from the record that he successfully manipulated everyone involved with him to enable him to minimise their impact on him.
- (iii) Hostel staff carried out their work with K diligently but they did not have the ability to make a full assessment of K's behaviour.
- (iv) The offender manager did not do her job properly; she did not carry out an accurate assessment of RoH or of the likelihood of reoffending although the information was available to her as it was to us. In our view the evidence points clearly to an assessment of him posing a high RoH.
- (v) We saw and heard an equally poor response from the offender manager's own manager which in turn left us with concerns about her ability to make assessments of offenders.

We make no recommendations in relation to the case of Resident K as we drew the area's attention to the issues in the case and were satisfied that a proper response and assessment were quickly carried out.

17. CONCLUSION

- 17.1 The *Panorama* programme posed questions about the ability of the probation service to protect the public through housing offenders in hostels. It is our view that hostels can indeed provide an enhanced level of supervision, over and above anything else outside of prison. Most probation hostel residents are now on licence. Once released from prison they are no longer locked up but they can be required to live in a hostel and to adhere to the rules including observing a curfew.
- 17.2 In the two hostels in Bristol we saw how an enhanced regime of restrictive measures had been developed over the last few years and understand that its features are common to most if not all hostels. Whilst there was room for improvement in Ashley House and Brigstocke Road's security measures and procedures, we thought that for most offenders they provided an adequate level of restriction for housing offenders who are no longer locked up but are subject to a substantial number of rules.
- 17.3 At Ashley House there had also been investment in a drug treatment regime which had the potential to enhance the normal level of supervision delivered on a community order or licence. Whilst it was not being used effectively due to the poor management of referrals and admissions, it could still be used as an element of prolific offender management in particular. This hostel had also, despite its relatively poor level of resourcing, run a programme designed to enhance the rehabilitation of hostel residents. At Brigstocke Road there was no such programme of activity. We understand that this difference may be reflected nationally and will test this in our forthcoming thematic inspection of hostels. A more imaginative and entrepreneurial approach by managers at all levels can bring resources in from outside.
- 17.4 In both hostels, work with residents was driven by the offender manager as intended in the national offender management model. Most of the cases seen were managed to a satisfactory level and all three of the cases assessed as high RoH in Brigstocke Road were well managed; in all of these cases they had been properly assessed by their offender manager who was working constructively with the hostel keyworker. We think that hostels could probably contribute more if they were better staffed in terms of skill, experience and probably qualifications and will be interested to discover if there are other models in operation.
- 17.5 Accommodating an offender for up to a year in a hostel is potentially an excellent opportunity not only to contain the RoH they pose to the public but to contribute to their rehabilitation both in the hostel and through links with other organisations. Currently the hostel is the junior partner in the offender management relationship but could do much more with better and not just more resources. We do not criticise probation areas for prioritising restrictive interventions over constructive

measures if resources do not stretch to both. We felt that the staff available in Bristol hostels were stretched and understand that this is likely to be a common feature.

- 17.6 *Panorama* did accurately and vividly illustrate the difficult nature of some of the offenders that probation and other staff routinely have to deal with. This is especially the case in hotel settings. The programme showed how challenging it can be for staff to do the difficult work we described earlier, and we do not criticise staff for failing to achieve the impossible. On the other hand, during this report we found one poorly managed and worrying case, and we have criticised the work of the individuals concerned for not doing all that they could and should have done, and we have also raised issues about the implications for managing such cases in the future. But in the main we have found staff to be working hard and conscientiously and to good effect, and 'achieving what is possible'.

Glossary

<i>Accredited programme</i>	A programme to address offending behaviour and accredited by the joint Prison and Probation Accreditation Panel.
<i>ACO</i>	Assistant chief probation officer.
<i>Approved Premises</i>	The correct name currently for a probation hostel. See below.
<i>APM</i>	Area Performance Manager. Senior manager in <i>Avon & Somerset Probation Area</i> .
<i>ASPA</i>	Avon & Somerset Probation Area.
<i>ASPOS</i>	The Avon & Somerset <i>Prolific and other Priority Offender Scheme</i> .
<i>Avon & Somerset Probation Area</i>	Avon & Somerset Probation Area, one of the 42 Probation Areas of the National Probation Service for England & Wales. Each probation area is a corporate body.
<i>Basic Skills</i>	Literacy and numeracy screening and teaching offered to most offenders under supervision due to low levels of skill and employment amongst the offender population.
<i>BBC</i>	British Broadcasting Corporation.
<i>CCTV</i>	Closed circuit television.
<i>Cognitive-behavioural</i>	A <i>cognitive-behavioural programme</i> is one that seeks to change behaviour by improving or changing the thinking skills of participants.
<i>Constructive intervention</i>	As distinct from a <i>restrictive intervention</i> . A <i>constructive intervention</i> is where the <u>primary purpose</u> is to reduce likelihood of reoffending. In the new language of offender management this is work to achieve the 'help' and 'change' purposes, as distinct from the 'control' purpose.
<i>CRB</i>	Criminal Records Bureau check. An executive agency of the Home Office which vets applications for people who want to work with children and vulnerable people.
<i>Critical Public Protection cases</i>	Offenders under <i>MAPPA</i> supervision who either have a very high media profile or who present the highest levels of risk of imminent RoH when in the community.
<i>Curfew</i>	Period during which residents in a <i>probation hostel</i> must stay indoors. At a minimum this is between 11pm and 6am. This may be enforced by means of an electronic tag.
<i>Double waking night cover</i>	In a <i>probation hostel</i> by March 2007 there should always be two members of staff working through the night.

<i>Dry house</i>	Term used to describe a hostel specialising in alcohol or illegal drugs rehabilitation where it is not a condition that the residents must be abstinent before admission.
<i>DRR</i>	Drug rehabilitation requirement in a community order.
<i>DTTO</i>	Drug treatment and testing order. A stand alone order no longer available to courts.
<i>Electronic monitoring</i>	Offenders wear an electronic tag in order to enforce a <i>curfew</i> as part of a court order or release from prison on licence.
<i>Enforcement</i>	The minimum level of supervision on a community order or prison licence is defined by <i>national standards</i> . Failure to keep two appointments without an acceptable reason (three for licences) should lead to a return to court in breach of an order or recall to prison.
<i>ESI</i>	Effective Supervision Inspection: HMI Probation's previous programme of inspection of the 42 Probation areas over three years from 2003 to 2006.
<i>ETE</i>	Employment, Training and Education.
<i>GP</i>	General Practitioner.
<i>HMI</i>	HM Inspectorate (of) e.g. Probation, Prisons, Constabulary.
<i>Home PO</i>	The PO working in the offender's home area during the custodial phase.
<i>Keyworker</i>	In a <i>hostel</i> setting: a person employed as an assistant manager who takes responsibility for individual work with and liaison about several residents.
<i>Log</i>	Significant daily events are noted in the <i>hostel's</i> log as is a summary of how each resident has been each day.
<i>Lead responsibility</i>	In this report our point here is that many people have to carry out their assigned responsibilities in helping to ensure the effective management of a specific offender – but someone has to take <i>lead responsibility</i> for ensuring that the purposes of the sentence are achieved overall. This is in the old language either the supervising officer or the case manager, and in the new language the offender manager. We emphasise that the person undertaking this role should be expected to take the initiative in making the necessary decisions and acting on them in order to achieve this purpose.
<i>Lifer</i>	Offender sentenced to life imprisonment.
<i>Lifer Review and Recall Section</i>	Section within <i>NOMS</i> with responsibility for pre- and post-release issues on individuals sentenced to life imprisonment.
<i>Living in Here Moving On</i>	A programme developed for the <i>NPD</i> aimed at promoting rehabilitation for <i>hostel</i> residents.

<i>MAPPA</i>	Multi-Agency Public Protection Arrangements. Where probation, police and other agencies work together in a given area to manage some of the particularly high <i>RoH</i> offenders.
<i>MAPPP</i>	Multi-Agency Public Protection Panels. This forms part of MAPPA – see above.
<i>Metropolitan areas</i>	The probation areas delivering services in Greater Manchester, London, Merseyside, Northumbria, South Yorkshire, West Midlands and West Yorkshire.
<i>National Standards</i>	Minimum requirements for the supervision of community orders and licences.
<i>NOMS</i>	National Offender Management Service: The evolving single service designed to include responsibility for both the HM Prison Service and the NPS.
<i>NPD</i>	National Probation Directorate: Although a part of the Home Office, the NPD was also the 'Head Office' of the NPS until its role was absorbed by NOMS.
<i>NPS</i>	National Probation Service: Consisting of 42 Probation Areas, each run by its own Board, plus the NPD until recently.
<i>OASys</i>	Offender Assessment System: The nationally designed and prescribed framework for both the NPS and the prison service to assess offenders, implemented in stages from April 2003. eOASys is the electronic version.
<i>Offender manager</i>	In the new language of offender management, this is the term for the officer exercising lead responsibility for managing a specific case and as this role is currently expected to evolve in the future, in charge of managing the case 'from end to end'. See also, <i>supervising officer, PO and PSO</i> .
<i>OMI</i>	Offender Management Inspection. HMI Probation's current programme of inspection of the 42 Probation areas over three years from 2006 to 2009.
<i>OMAT</i>	Offender Management and Assessment Team.
<i>Paedophile</i>	Person convicted of a sexual offence against a child under the age of 16.
<i>Parole Board</i>	A panel of people appointed by the Home Secretary to make decisions about some prisoner releases on licence.
<i>Probation Circular</i>	Statutory instruction or briefing by the NPD – now NOMS – to probation areas.
<i>PCL-R</i>	The <i>Psychopathy Checklist – Revised</i> is a 20-item scale of assessment and is a tool designed to measure the presence or level of psychopathic traits. The revised version was developed in 1991. The PCL-R assesses two separate dimensions or factors: (1) Selfish, callous, remorseless use of others; glibness and grandiosity; (2) Chronically unstable, antisocial, socially deviant lifestyle, impulsivity and sensation seeking. (Campbell, T.W. 2005).
<i>PPO</i>	Prolific and other Priority Offender scheme. A government strategy introduced in 2004 to tackle those offenders who are

committing the most harm within communities through prolific offending. Often associated with illegal drug misuse. Partnership schemes between the police and probation services and managed under the auspices of Crime and Disorder Reduction Partnerships.

<i>Probation hostel</i>	Premises approved by the Secretary of State in which accommodation is provided for persons granted bail in criminal proceedings, and for, or in connection with, the supervision or rehabilitation of persons convicted of offences. All but 12 of the 101 hostels are managed by the probation service. The remainder are managed by voluntary committees. The correct term for a probation hostel is now 'Approved Premises'.
<i>PO</i>	Probation officer. An officer with a relevant probation qualification which has changed over time. Currently this is a two year Degree and Diploma in Community Justice. One of their duties may be to act as <i>offender manager</i> .
<i>PSO</i>	Probation service officer. An officer employed by the probation service to do many of the tasks undertaken by a <i>PO</i> , including offender management. They do not have a probation qualification and work at a lower level of responsibility.
<i>Public Protection and Licensed Recall Unit</i>	A unit within <i>NOMS</i> with the responsibility for policy development and advice to probation areas and Ministers in relation to public protection issues including: <i>hostels, serious further offending and recall</i> .
<i>Release and Recall Section</i>	A unit within <i>NOMS</i> with responsibility for considering probation service applications for recall and involvement in Parole Board processes. It gives advice about additional licence conditions.
<i>Restrictive intervention</i>	<p>As distinct from a <i>constructive intervention</i>. A <i>restrictive intervention</i> is where the <u>primary purpose</u> is to keep to a minimum the offender's <i>RoH</i> to others. In the new language of offender management this is work to achieve the 'control' purpose, as distinct from the 'help' and 'change' purposes.</p> <p>Example: With sex offenders, a <i>constructive intervention</i> (to reduce their likelihood of reoffending) might be to put them through an accredited sex offender programme; a <i>restrictive intervention</i> (to minimise his <i>RoH</i>) might be regular meticulous monitoring of their accommodation, and/or their employment and the places they frequent, imposing and enforcing clear restrictions as appropriate to the case. The sex offender programme will hopefully have some impact on <i>RoH</i> in the long-term, but its primary purpose is to reduce likelihood of reoffending. In the short-term; hence cases such as this require <i>restrictive interventions</i> as well.</p>
<i>RoH</i>	Risk of Harm. As distinct from <i>likelihood of reoffending</i> . If an offender has a medium or higher <i>RoH</i> it means that there is some probability that they may behave in a manner that causes physical or psychological harm (or real fear of it) to others. The offender's <i>RoH</i> can be kept to a minimum by means of <i>restrictive interventions</i> .

<i>RoH work</i>	<p>a) In the Inspectorate's existing language: planning and implementing <i>restrictive interventions</i>;</p> <p>b) In the new language of offender management: work to achieve the 'control' purpose (as distinct from the 'help' and 'change' purposes);</p> <p>Hence with <i>RoH</i>, the officer works to 'control' the offender, using <i>restrictive interventions</i> that keep to a minimum the offender's opportunity to behave in a way that is of <i>RoH</i> to others.</p>
<i>Seconded PO</i>	The PO working in the prison establishment (i.e. seconded to work with HM Prison Service).
<i>Secretary of State</i>	Home Secretary
<i>SPO</i>	Senior Probation Officer. A first-line or middle manager, in many instances one who manages a team of POs.
<i>SFO</i>	Serious Further Offence. Committed by an offender under current supervision.
<i>SOTP</i>	Sex Offender Treatment Programme. This is a <i>cognitive-behavioural</i> treatment programme for suitable sex offenders. It consists of several elements: the Core SOTP takes about 180 hours and aims to increase the sex offender's motivation to avoid reoffending, and to develop the self-management skills necessary to achieve this; an offender with extra treatment needs might undertake the Extended SOTP; later on an offender might go on to a Booster or a Relapse Prevention SOTP, or both.
<i>Sexual Offences Prevention Orders</i>	Orders issued by courts on the application of the police with evidence that there is a risk of a sexual offence against a child under the age of 16 years being committed if someone, already convicted of a similar offence, is not prevented from engaging in certain activities where children are likely to be present, e.g. visiting a swimming pool.
<i>Supervising PO</i>	The PO exercising lead responsibility for managing this specific offender's post-release Licence in this case. See also <i>Offender Manager</i> .
<i>Supporting People Programme</i>	Supporting People is the mechanism through which supported public housing is commissioned and funded. It is a multi-agency approach requiring local organisations to work together to develop strategies to identify and address priority needs.
<i>Tariff</i>	The minimum term to be served by a life-sentenced prisoner for punishment purposes before eligibility to apply for release. This period is set by the trial judge.
<i>Unpaid work</i>	Formerly called community service. Offenders can be required by a court to perform work which is unpaid and of benefit to the community as punishment for an offence.

Youth Offending Service

The Youth Offending Service works with children and young people aged between 10 and 17 years who are offending or at risk of offending. A partnership approach with workers seconded from children's services, police, probation, health, etc. Managed under the auspices of the Local Authority's Chief Executive's Office.

YOT

Youth Offending Team.

ANNEX A

Extract from Probation Circular 37/2005: 'The role and purpose of approved premises'

5. Enhanced supervision

- Approved Premises provide enhanced supervision in the interests of public protection. To assist Courts, the Parole Board, Multi-Agency Public Protection Panels and referring staff to make appropriate referrals, there should be a consistent, measurable definition of what constitutes enhanced supervision.
- As a minimum, enhanced supervision must include:
 - (a) Public protection measures
 - Rapid response arrangements with the police that can be activated on a case by case basis where appropriate
 - Surveillance measures as required by a multi-agency risk management plan or in order to enforce the conditions of an order or licence
 - Arrangements to facilitate regular liaison and intelligence sharing between probation, police and social services departments, and with other partner agencies (e.g. health, education, employment services) as required
 - The capacity to monitor residents suspected of misusing alcohol, drugs or other illegal substances
 - A minimum level of internal and external security, to include internal CCTV coverage, alarmed exits during standard curfew hours, restricted window openings and facilities for electronic monitoring
 - Robust community liaison arrangements to promote dialogue and increase public confidence in the role and work of Approved Premises.
 - (b) Staff arrangements
 - A minimum of two members of staff on duty at all times
 - At least one member of staff on waking night duty with a responsibility to conduct checks of the building and residents during the hours of curfew; the preferred model is two waking night staff, which all Areas should be working to implement by April 2006 subject to local negotiation or NNC agreement
 - Staff competent in the delivery of an enhanced regime, including the use of pro-social modelling, motivational interviewing techniques, one-to-one key working and other interventions as appropriate

- Staff trained to be able to reinforce the progress made on accredited programmes
- Staff equipped to provide assessment and progress reports to Courts, MAPP Panels and offender managers, supported by arrangements that facilitates timely delivery of those reports
- Staff competent to contribute to initial and updated risk management plans, supported by procedures to ensure that all relevant information is shared with offender managers
- Staff trained in basic First Aid procedures
- Staff trained in suicide/self-harm prevention in order to provide at least minimum levels of monitoring
- Staff competent to deliver services to the quality required by any nationally approved performance standards framework
- The capacity to support appropriate staff attendance at MAPPA Level 3 and Level 2 meetings
- On site, or on call, management cover 24 hours a day 365 days a year.

(c) Punitive and restrictive requirements

- A standard curfew from 11pm to 6am, which can be extended by the Parole Board, the Courts or (other than for bailees) the Approved Premises manager acting in accordance with local Probation Board policy
- The ability to supervise extended curfews, enforced where appropriate by electronic monitoring, in the interests of public protection and effective risk management
- The ability to issue formal warnings and to initiate immediate enforcement action, including 'fast-track' arrangements, in the event of a failure to comply with the conditions of a licence or order
- Daily monitoring and recording of incoming mail if required by the risk management plan.

(d) Supportive and rehabilitative requirements

- Delivery of a core regime that includes skills learning and preparation for move-on
- Delivery of formal, timetabled individual and/or group-work to meet the aims and objectives of supervision/risk management plans (counted as 'required contact' for National Standards purposes)
- Access to accredited programmes as required and a motivational regime that will support attendance
- The provision of a regime that meets the cultural, faith, dietary and health needs of a diverse resident population

- ❑ Delivery of any required performance standards for Approved Premises
- ❑ Routine observation and daily assessments of patterns of behaviour, and reliable procedures for those assessments to be recorded
- ❑ Safe systems for issuing essential medication and making medical appointments as required
- ❑ Access to suitable next-phase accommodation options in order to promote the safe and effective resettlement of residents.

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- (11) The Halliday Report: *Making Punishments Work: Review of the Sentencing Framework for England and Wales 2000*.
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Role of HMI Probation

HMI Probation is an independent Inspectorate, originally established in 1936 and given statutory authority in the Criminal Justice Act 1991. The Criminal Justice and Court Services Act 2000 renamed HMI Probation 'Her Majesty's Inspectorate of the National Probation Service for England and Wales. HMI Probation is funded by the Home Office and reports directly to the Home Secretary.

Home Office Objectives

HMI Probation contributes primarily to the achievement of Home Office Objective II:

- more offenders are caught, punished and stop offending, and victims are better supported
- and to the requirement to ensure that custodial and community sentences are more effective at stopping offending. We also contribute to the achievement of Objective III through scrutiny of work to address drugs and other substance misuse, and to other relevant criminal justice system and children's services objectives.

Role

- Report to the Home Secretary on the work and performance of the NPS and YOTs, particularly on the effectiveness of work with individual offenders, children and young people aimed at reducing reoffending and protecting the public.
- In this connection, and in association with HMI Prisons, to report on the effectiveness of offender management under the auspices of the NOMS as it develops.
- Contribute to improved performance in the NPS, the NOMS and YOTs.
- Contribute to sound policy and effective service delivery by providing advice and disseminating good practice, based on inspection findings, to Ministers, Home Office staff, the YJB, Probation Boards/areas and YOTs.
- Promote actively race equality and wider diversity issues in the NPS, the NOMS and YOTs.
- Contribute to the overall effectiveness of the criminal justice system, particularly through joint work with other criminal justice and Government inspectorates.

Code of Practice

HMI Probation aims to achieve its purpose by:

- undertaking its work with integrity in a professional, impartial and courteous manner
- consulting stakeholders in planning and running inspections and regarding reports
- forming independent inspection judgements based on evidence
- the timely reporting and publishing of inspection findings and recommendations for improvement
- promoting race equality and wider diversity issues in all aspects of its work, including within its own employment practices and organisational processes
- developing joint approaches with other Inspectorate and Audit bodies to ensure a coordinated approach to the criminal justice system.

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

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