HM Inspectorate of Probation
Arolygiaeth Prawf EM

Inspection of Adult Offending Work
Arolygiad o Waith Troseddu Oedolion

Inspection of Adult Offending Work in **Norfolk and Suffolk**

An inspection led by HMI Probation

independent inspection of adult offending work

March 2014

Foreword

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

This inspection is the second of six where we are enhancing our focus on the work of Probation Trusts to protect children. Our sample encompasses work with a range of people who have offended; in each case inspected we expect to see an assessment of whether the individual may present a risk of harm to a child or children, and appropriate action taken where this is required.

In all cases we also consider the general assessment and management of risk of harm to others, and we examine the progress in addressing factors that have contributed to the offending behaviour, thereby reducing the likelihood of reoffending.

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

The case sample for this inspection was drawn from those cases managed by Norfolk & Suffolk Probation Trust. Overall, we found that probation services in Norfolk & Suffolk were supported by a culture of improvement. With a strong strategic leadership, the Trust had earned the respect of its partners, staff and service users, and there was evidence of an ongoing commitment to develop and deliver appropriate provision.

The Trust took account of the individual needs of offenders to prepare for and deliver sentences. Staff were particularly good at assisting the courts with sentencing decisions; reports were of sufficient quality in content and style and contained appropriate proposals. While there was a need for more consistency in the quality of assessments and planning, the Trust offered an adequate range of constructive interventions. In the main, objectives were being delivered as intended and offenders were encouraged to meet the requirements of their sentences.

There are a number of key areas on which the Trust should focus its efforts to enhance services, many of which managers have already identified and are working to improve. More needs doing to improve practices to address the risk of harm posed by offenders and the management oversight of this work. This includes the quality of assessment and planning, and the level of purposeful home visits in high risk of harm cases. Statutory victim contact was working well in cases involving adult offenders, but other aspects of work to protect victims were not given as much priority. Review processes relating to assessment, planning and work need strengthening, especially in response to significant changes in a case.

The Trust will wish to take a careful look at the quality of processes to protect children and young people and the management oversight of these.

The Trust's commitment to improvement gives us confidence that it will meet our recommendations.

Paul McDowell
HM Chief Inspector of Probation

March 2014

Summary

Outcomes	The proportion of work judged to have been done well enough
Assisting sentencing	**85%**
Delivering the sentence of the court	**77%**
Reducing the likelihood of reoffending	**66%**
Protecting the public by minimising the risk of harm to others	**67%**
Delivering effective work for victims	**70%**

Outcome 1: Assisting sentencing

Overall, 85% of work to assist sentencing was done well enough.

Almost all court reports were based on, and provided sentencers with, sufficient information to aid sentencing, including an assessment of the risk of harm posed to others and the likelihood of reoffending. However, more needed to be done before sentence to ensure that checks were made to identify issues relating to the safety of children and young people. Court reports routinely assessed the individual's level of motivation and capacity to comply with the proposed sentence, but did not always identify how best to address potential barriers to engagement and compliance. Proposals in court reports were appropriate in most cases and, in the great majority of cases, followed by the court. Sentencers were positive about the service that they received from Trust staff.

Outcome 2: Delivering the sentence of the court

Overall, 77% of work to deliver the sentence of the court was done well enough.

There were good, timely inductions at the start of sentence. In contrast to the drafting of court reports, the individual needs of offenders and potential barriers to engagement were identified and taken into account throughout the sentence. Where sentence planning took place, this was generally informed by assessments of the likelihood of reoffending and risk of harm to others. However, plans lacked the detail they needed to constitute effective working tools, such as who would do what and when. There was too little evidence that plans and work were reviewed sufficiently well, especially after a significant change in the offender's circumstances.

The resources allocated to the delivery of sentences, including the planned levels of contact, were appropriate. Offender managers investigated and responded to instances of non-compliance and took enforcement action where necessary.

In many cases, the individual's community integration needs were assessed at the start of the sentence, and assistance was provided where necessary.

The Trust was evidently committed to working with service users and partners to improve services.

Offender managers were confident that their managers had the skill to assess the quality of their work and considered that supervision, including observation of practice, promoted improvements in practice.

Outcome 3: Reducing the likelihood of reoffending

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

The quality of assessments of the likelihood of reoffending was variable. Most were completed on time and took account of previous relevant behaviour and the individual's home and social environment.

A good range of constructive interventions encouraged individuals to take responsibility for their actions and maintained a focus on offending behaviour. Offenders were often sufficiently prepared for interventions and routinely helped to access local services to support rehabilitation.

Resources were used appropriately in most cases and approved premises staff worked well with the Trust to help prevent further offending. We found many examples of individuals making progress in addressing the factors linked to their offending behaviour.

A number of reviews of likelihood of reoffending were either insufficient or not completed. This was most noticeable in cases where there had been a significant change.

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

Overall, 67% of work to protect the public by minimising the risk of harm to others was done well enough.

Almost all of the risk of harm classifications were correct but, overall, analysis of risk of harm was not good enough and there was too little evidence that the Trust recognised the importance of reviews. There was an insufficient response to changes in risk of harm factors in more than one-third of relevant cases.

Delivery of interventions took account of the risk of harm offenders posed to others and the use of restrictive interventions (such as curfews and approved premises) contributed well to the management of risk of harm. However, initial home visits were not always carried out in high risk cases or in response to child protection concerns, nor were they repeated often enough.

Almost all cases that met the criteria for Multi-Agency Public Protection Arrangements were correctly identified. Those cases requiring a higher level of Multi-Agency Public Protection Arrangements were well managed. Joint working contributed effectively to the management of risk of harm.

Strategic relationships with partner agencies were strong. The Trust, held in high regard by its partners, was seen as making a significant contribution to the management of the risk of harm posed by offenders.

Outcome 5: Delivering effective work for victims

Overall, 70% of work to deliver effective services to victims was done well enough.

In the great majority of relevant statutory victim contact cases, the quality of the contact with victims was satisfactory. Victims who responded to our questionnaire were mostly positive about their experiences of the Trust and reported that they felt safer as a result of their contact.

The large majority of risk management plans addressed risks to victims, but too few described how the case objectives would address relevant risk of harm issues. There is a need to give more priority to the safety of victims, and to take into account more often their concerns or the likely impact of the offender's behaviour on them.

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

Recommendations

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

1. risk of harm to others is assessed accurately and takes account of information actively sought from relevant staff and other agencies
2. a plan to manage risk of harm factors is in place where appropriate and this addresses all factors identified in the assessment and includes appropriate contingency planning
3. additional attention is given to work to protect children and young people
4. assessments, plans and work are reviewed appropriately, and offender managers recognise events that should trigger this action
5. effective management oversight is clearly evidenced in the records of all cases involving the protection of children and young people and of those classified as posing a high/very high Risk of Serious Harm to others.

Contents

Assisting sentencing

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Outcome 1: Assisting sentencing

What we expect to see

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

Case assessment score

Overall, 85% of work to assist sentencing was done well enough.

Key strengths

1. Most court reports were of good quality. Overall, they contained the right information and were well written. Report writers drew on a range of relevant information to analyse accurately the circumstances of the offence. Almost all reports contained appropriate proposals that took the offender's level of motivation and capacity to comply with their sentence into account.
2. Sentencers were positive about the service they received from the Trust.

Key areas for improvement

1. In many cases, report writers had not sought information from children's social care services or undertaken other checks to identify issues relating to the safety of children and young people.
2. Many reports did not include action to address the barriers to engagement and compliance that had been identified while preparing the report.

Explanation of findings

1. Assessment and planning to inform sentencing

1.1. Our sample of cases included 37 where a report had been prepared to assist the court with sentencing decisions; 23 were typed reports. Most of these were based on sufficient information about the risk of harm the offender posed to others, the likelihood they would reoffend and their social and home environment. However, there were 18 reports that should have been supported by checks to children's social care services, or other agencies, in order to identify risks to relevant children and young people, and these had been made in only nine. Checks were more likely to be made in cases where the offender was assessed as posing a high risk of harm to others and where a probation officer rather than a probation service officer (PSO) held the case. They were also generally made more often in Norwich & Kings Lynn local delivery unit (LDU) than across the rest of the Trust area.

1.2. The overall quality of almost all of the typed reports was sufficient. Report writers were particularly good at assessing the factors linked to reoffending and writing clearly and concisely. We noted that the quality of reports was highest in cases where the offender had been identified as posing a medium risk of harm. In the few cases where the report was insufficient, this tended to involve cases where the individual was assessed as posing a high risk of harm to others.

1.3. Almost all of the typed reports contained a clear proposal for a community sentence that followed logically from the main body of the document and addressed the offending behaviour. The great majority outlined the intended objectives and outcomes for the work being proposed. While most reports considered the offender's motivation and capacity to comply with the proposed sentence, less than one-half indicated how barriers to compliance and engagement could be addressed.

1.4. An oral report had been presented on the day of sentencing in 14 of the cases we looked at. There was a copy on file of almost all of these, prompted by a helpful entry on nDelius. These records provided a clear and helpful picture of the thinking and analysis supporting the proposals made to sentencers.

2. Leadership and management to support sentencing

2.1. We met with sentencers and noted the positive working relationship that had been established together with the Trust. There was a well developed liaison structure in place. This helped to ensure that things ran smoothly on a day-to-day basis and enabled the Trust and sentencers to respond to the strategic and operational challenges they faced. Generally, communication was two-way, ongoing and effective. Sentencers received emails and telephone calls to inform them of changes and developments. There was also an established system of meetings and probation forums, at which they had the opportunity to discuss issues and learn more about services.

Practice illustration – keeping sentencers informed

The probation forums were a well received opportunity for magistrates to hear about probation services. Probation staff were invited to present examples of their work. Offenders also attended to speak about their own experiences of sentence requirements, for instance the drug rehabilitation requirement and Women's Emotional Well-being specified activity requirement (SAR). Sentencers valued the opportunity to speak with service users about the benefits and disadvantages of these interventions that, they felt, helped them with their sentencing decisions.

2.2. Sentencers found the Trust responsive to their queries and complaints. They valued the gatekeeping structures that helped maintain the quality of reports written by local staff and also by Probation Trusts outside of the area. The Crown Court, for instance, dealt with cases involving offenders living in London. When court reports were received early enough, local Trust staff would quality assure these and identify areas, for instance issues relating to domestic abuse, that the judiciary might consider needed further exploration.

2.3. There was also praise for the Trust's efforts to meet the diverse needs of offenders, not only to meet the needs of individual cases but also at a programme level. An example given was the Trust's adaptation of a low level internet sex offender programme to meet the time frame of a suspended sentence order.

2.4. On the whole, sentencers considered they received an informed, timely service from the Trust and that staff went *"that extra mile"*.

Comments from sentencers

"Meetings always provide info that is engaging, and [we] get value out of them. It's very different from the past. [We] feel we get our money's worth for turning out in the evening. We get people talking to us who are enthusiastic & involved".

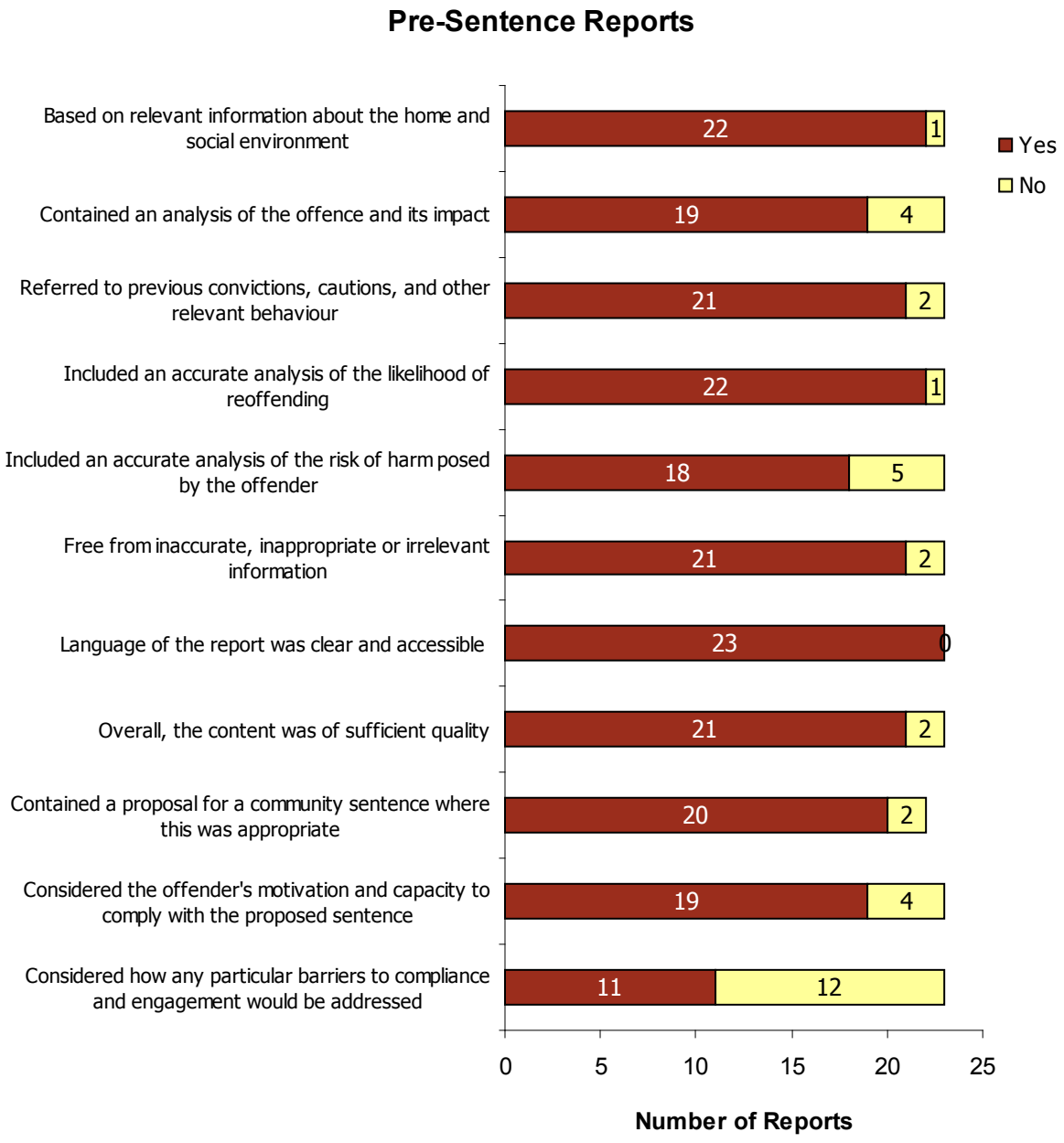
Summary

Overall, 85% of work to assist sentencing was done well enough.

For a summary of our findings see page 2

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: data refers to the 23 cases for which a written report had been prepared for court. However, the total answers may not equal this, since some questions may not have been applicable to every case.]



Delivering the sentence of the court

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Outcome 2: Delivering the sentence of the court

What we expect to see

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

Case assessment score

Overall, 77% of work to deliver the sentence of the court was done well enough.

Key strengths

1. Senior managers had an evident commitment to understand the Trust's strengths and weaknesses, and improve services. They had worked hard to establish effective relationships with partners to support this process.
2. The level of contact with offenders was largely appropriate. The first appointment between offender managers and offenders, post-sentence, was arranged in good time and there was evidence of good and timely, individualised inductions.
3. Where planning took place, the process was timely and informed by relevant assessments of factors linked to offending, risk of harm and the needs of the individuals and their potential barriers to engagement.
4. Action was taken to deliver interventions and to take account of pertinent issues, such as the offenders' risk of harm, the need to enhance their community integration and any diversity factors. Overall, an appropriate level of resource was allocated throughout the sentence.
5. In most instances offender managers were managing and monitoring the range of work being undertaken with the individual. They took appropriate action to help offenders engage with work being undertaken with them and to enforce compliance.
6. Service users were positive about their experience of contact with the Trust.
7. Offender managers had confidence in the operational skill of their managers. A range of methods was being used to help improve practice, such as observations, action learning sets and formal training opportunities. Most offender managers had attended child safeguarding courses in the last two years.

Key areas for improvement

1. There were some important gaps in planning. Many plans needed more detail about how the objectives would be delivered. Some key objectives were missing, especially in relation to the protection of children and young people.
2. Decisions on reviewing cases were not always clear, nor was there enough clarity about the changes that might prompt reviews. Overall, work was not being reviewed sufficiently well and in many cases it had not been reviewed at all.
3. Some offender managers and their managers were handling a considerable workload. A number of offender managers felt caseloads were not managed fairly and that their managers were not providing them with enough oversight to ensure they were practising effectively.

Explanation of findings

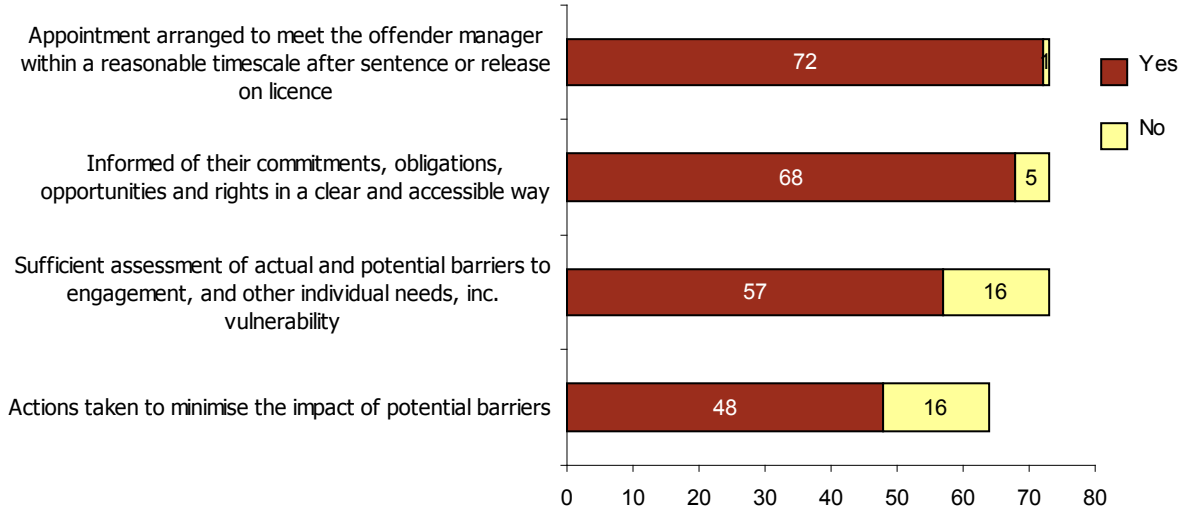
1. Assessment and planning to deliver the sentence

1.1. We examined 73 cases during this inspection. The National Offender Management Service (NOMS) guidance had been used to allocate cases to the correct tier and a valid reason had been given in the one case where there had been a departure from the indicative tiering.

1.2. The chart below provides a breakdown of our findings relating to the engagement of individuals at the start of supervision. We found that the first supervision session was appropriate and timely. The Trust had responded positively to service user views and had introduced a new induction pack which had received positive feedback from offenders. This included six sessions that covered completion of the self-assessment questionnaire, diversity and barriers to engagement. The pack was to be used to help inform sentence planning. While two sessions were compulsory, we understand four were discretionary, depending on the needs of the case.

1.3. We found that individuals were being informed of their commitments, obligations, opportunities and rights. In the large majority of cases, there had been sufficient assessment of barriers to engagement, vulnerability and other individual needs.

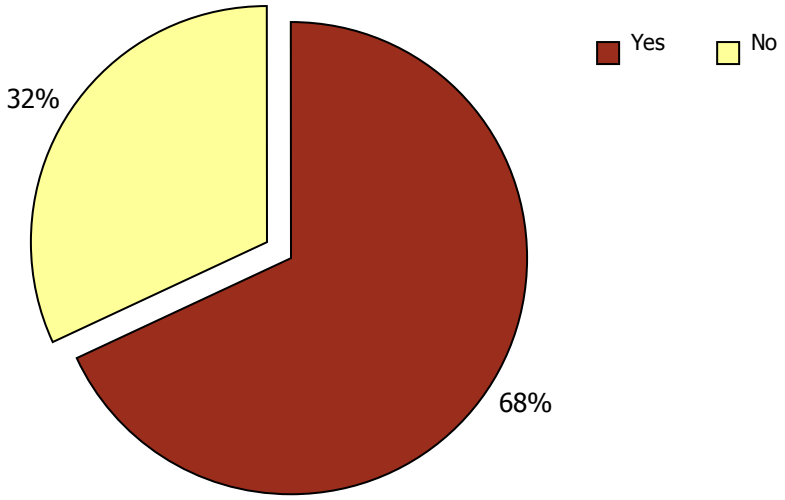
Engaging people at the start of sentence



1.4. Initial sentence planning sets the direction and pace for the delivery of a sentence and is an important tool for the offender manager and for the individual with whom they are working. There had been no planning in one-quarter of the cases we looked at. However, where planning had taken place, in most cases it was completed in a timely way and informed by relevant assessments of the factors linked to offending behaviour and the offender's risk of harm to others. A clear majority of plans were new or had been sufficiently updated from a previous plan.

1.5. Service users were not always actively involved in planning processes. There was evidence that their personal strengths and aptitudes and the methods likely to be most effective for delivering interventions were taken into account in less than two-thirds of cases. Capacity to change was also taken into account in two-thirds. Offender managers were more likely to consider the individual's level of motivation and readiness to change. Offender managers considered how best to help individuals meet the requirements of their sentence in just over two-thirds of cases (see the chart below). They planned, and took action, to minimise the impact of potential barriers to engagement, vulnerability and other needs in three-quarters of cases.

Sentence planning paid sufficient attention to factors which may promote compliance



1.6. The best sentence plans were those that contained objectives that targeted the desired outcomes for the sentence. Just under two-thirds of sentence plan objectives were clear about what the individual had to contribute to achieve these.

1.7. We also expect sentence planning objectives to be focused on what will help individuals integrate into their community, which can be an important factor in their desisting from committing crime in the longer-term. We found this had been taken into account in about three-quarters of cases. The greatest focus had been given to accommodation needs, but offender managers also assessed the offender's employability, education needs, access to primary health services and potential sources of support from family or community members. Offender managers took, or planned, action to improve support in these areas, in about two-thirds of the cases where they identified a need.

1.8. Overall, less than two-thirds of sentence plans set appropriate objectives. Many contained objectives to address the likelihood of reoffending. However, only 66% of sentence plans included objectives, where relevant, to address the risk of harm the individual posed, 52% to meet obligations from multi-agency risk management procedures and only 45% to manage the protection of children and young people. It is worth noting that sentence plans managed in the Ipswich/Bury St Edmunds LDU were not of as good quality as those managed elsewhere. There were fewer cases, proportionately, where sentence plans provided sufficient detail or good quality objectives, including those to protect children and young people.

Practice illustration – Effective planning for change:

Nicky served a 27 month custodial sentence for supplying Class A drugs. The offender manager drew on sound probation knowledge and a good grasp of individual need and the case benefited from a strong initial assessment of both the likelihood of reoffending and risk of harm. The sentence plan flowed from the assessment, and was clear about roles and responsibilities, and factors which would help to change risk levels. Objectives were prioritised and sequenced according to the individual's capability and capacity for change, and the plan was clear on how progress would be measured.

1.9. Offender managers had planned and recorded an appropriate level of contact with the individuals they were working with in the large majority of cases.

1.10. While the Trust's Practice Framework advises that reviews should take place every six months, one-third of cases did not indicate a timescale for regular review and only 20% indicated changes that would initiate an unscheduled review. It was not clear that offender managers had a good understanding of changes in an offender's life that would prompt a review.

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

2.1. In most of the cases we examined, interventions had been delivered according to the requirements of the sentence and in line with sentence plan objectives.

2.2. There was evidence that more than two-thirds of offenders either failed to attend one or more of their appointments, or that they attended but behaved inappropriately. There was a strong focus across the Trust to help individuals comply with their sentences. The chart below shows the various strands of this work. In the vast majority of cases, offender managers and others working with offenders took steps to motivate and help them engage with the work being undertaken, and to meet their diversity needs. We found, however, that there was less evidence in Norwich/Kings Lynn cases that individual needs had been taken into account or work undertaken to overcome barriers to engagement.

Practice illustration – Taking account of diversity needs

Example 1: Tré was convicted of driving with too much alcohol in his blood and given a community sentence with one requirement of unpaid work. He did not speak, or easily understand, English and an interpreter was engaged to help with probation interviews. In assessing the appropriate work placement for Tré, the offender manager considered possible domestic abuse and Child Protection issues relating to the case, and the constraints that language barriers would place upon the offender's access to work placements. The case was reviewed well and, when necessary, warning letters were sent in an appropriate language.

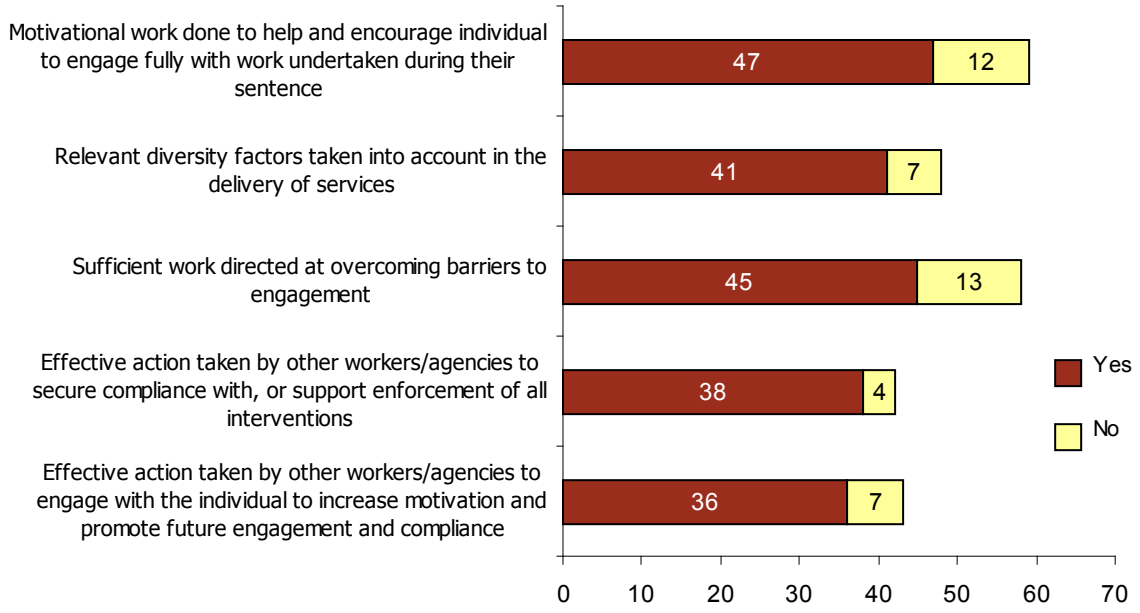
Example 2: Monica was convicted of possessing Class A drugs and received a community order with a single requirement for unpaid work. She was a lone parent, and the offender manager took care to identify if this could be a barrier to completion of the order and to take account of Monica's childcare responsibilities when allocating the unpaid work hours and placement. This worked well for Monica and she completed her hours quickly and successfully.

2.3. Most individuals received sufficient help to access community support services, such as primary healthcare or accommodation services. We noted that there was not as strong a focus on education, for which adequate assistance was provided in less than one-half of cases. We considered that some individuals, whose sentences included a single requirement of unpaid work, would have benefited from signposting or referrals to community services. There was no evidence that offender managers were expected to consider these needs in such cases and in a small number we judged this to have been an important oversight.

2.4. The level of contact offered by offender managers promoted positive outcomes in the majority of cases. Contact levels also helped to facilitate the delivery of sentence requirements, meet sentence planning objectives, monitor changes in dynamic risk factors, and take account of the individual's likelihood of reoffending and assessed level of risk of harm.

2.5. The level of resource allocated was appropriate in most cases. Services were supported by the work of a dedicated mental health worker in Norfolk, whose role was to assess mental health needs post-sentence. However, he had extended his role to deliver short-term well-being interventions in some cases and attended Multi-Agency Public Protection Arrangements (MAPPA) meetings to ensure that planning took account of relevant mental health issues.

Increasing motivation and promoting compliance with the sentence



2.6. An essential element of successful offender management is to ensure that all of the work being undertaken with an individual is coordinated effectively. In most of the cases we inspected the offender manager took a leading role in managing the sentence and the work being undertaken by all involved with the offender. They monitored attendance at appointments for supervision, rehabilitation work or for unpaid work in nearly every case.

2.7. Offender managers took a timely and investigative approach when individuals missed appointments and took effective action to increase motivation and secure compliance on almost every occasion that this was needed. Judgements about absences, or other unacceptable behaviour, were reasonable, consistent and, for the most part, clearly recorded. In most cases, a clear and timely formal warning was issued as necessary. In all but one case that needed it, appropriate enforcement action was taken to address absences or inappropriate behaviour.

Practice illustration – Encouraging compliance with sentence requirements

Stuart was convicted of assault against his partner and had previous assaults against close members of his family. He had a history of mental health problems with diagnosed Attention Deficit Hyperactivity Disorder and depression. After failing to attend group sessions breach was instigated. On reviewing the case and in conjunction with discussions with her manager, the offender manager correctly identified that non compliance was most likely due to mental health issues. The case was taken back to court to have Integrated Domestic Abuse Programme (IDAP) group work amended to more appropriate one-to-one work. This was a case where effective management oversight was evident and had made a positive difference to the outcomes of the case.

2.8. Enforcement procedures and recall were used in 32 cases. In almost all cases where legal proceedings or recall had been instigated, action had been taken promptly and a clear explanation given to the individual. Sufficient subsequent effort was made to reengage the individual with their sentence plan in 63% of these cases.

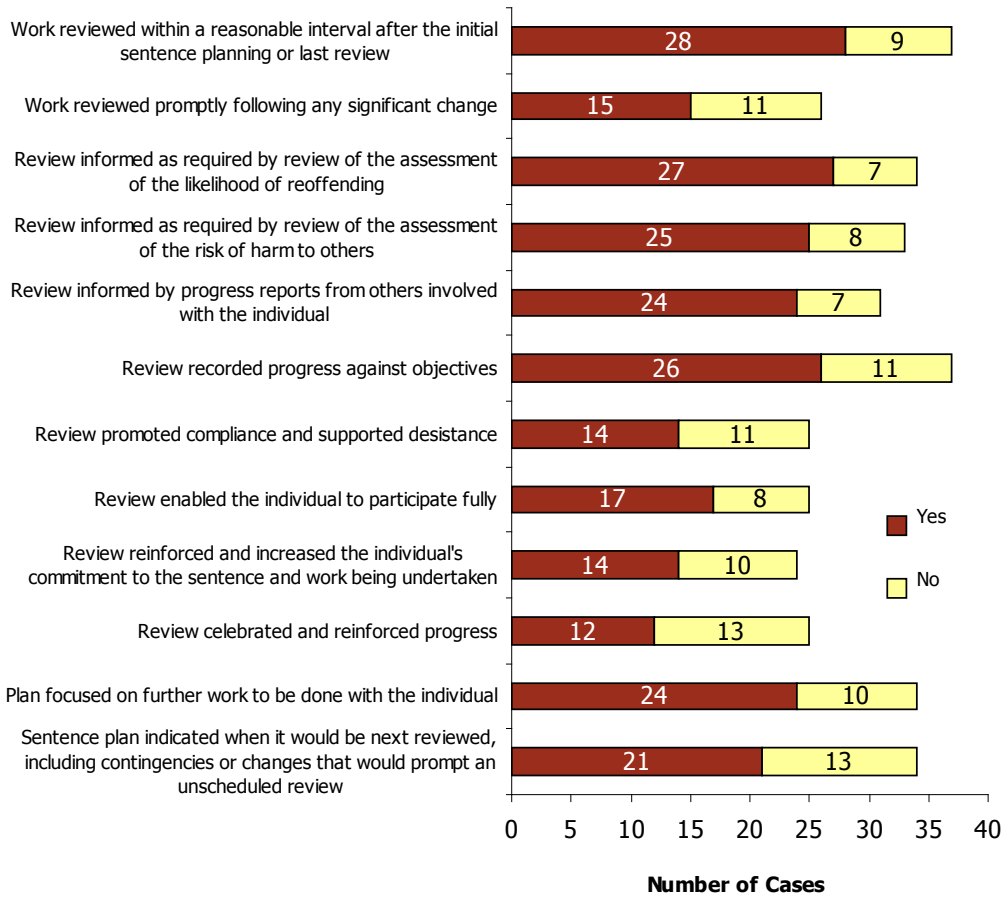
2.9. The Trust had a compliance SAR. This could be proposed as a breach outcome for offenders whose chaotic lifestyle affected their likelihood of completing their sentences successfully. The requirement comprised a series of sessions that combined the need to deal with compliance issues and identify

how to overcome barriers to engagement with the delivery of structured offending behaviour work. This model appeared to be a sound one and we were surprised to find the compliance SAR was mentioned and used infrequently.

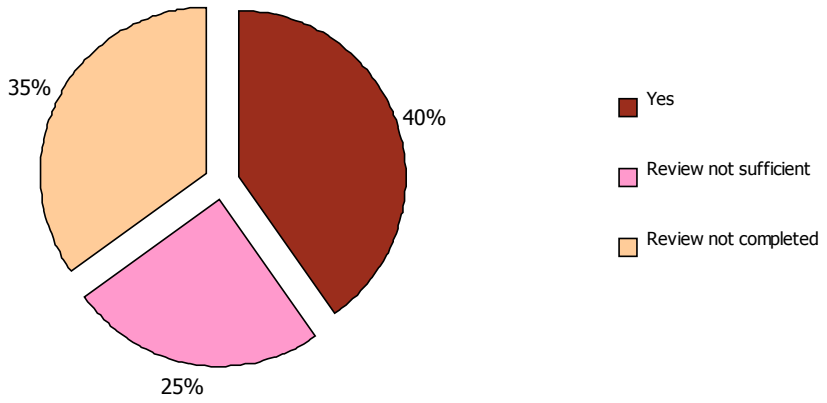
2.10. Trust managers and staff voiced concern that the demographics of the area led to difficulties in accessing some of its services. A minority of service users advised that they had found it difficult to travel the distances required during their sentences and others suggested that they would have welcomed more flexibility to help them meet their job commitments. The Trust acknowledged that the distance some people had to travel to attend programmes could contribute to their failure to meet the requirements of their sentences. Sentencers had also identified travel as an issue. They added that breach reports were measured, provided a fair assessment of progress and appropriate proposals for hearing outcomes. They also expressed their concern that the Government's *Transforming Rehabilitation* strategy agenda might reduce the number of appropriate breaches.

2.11. We expect to see work reviewed within a reasonable period, and in response to significant changes in a case. One-quarter of the reviews that were undertaken had not been completed well enough, and in 35% of cases there had been no review. Reviews can provide the opportunity to mark progress, reflect changes in the case, reshape plans and ensure the focus of work reflects appropriate priorities. Too many cases did not capitalise on this. Although many of the reviews undertaken focused on identifying work that needed to be completed in the future, only about half were used to promote compliance and support desistance, or to celebrate and reinforce progress. Overall, a greater proportion of cases had been reviewed in Norwich/Kings Lynn than in the other LDUs. However, we noted that a review had taken place in both the cases managed by Waveney and Yare LDU, where there was evidence of a significant change. The graph and pie chart below set out the different aspects a review should include and how often the Trust considered these.

Reviewing sentence plans and reinforcing progress



Sufficient review of the sentence plan



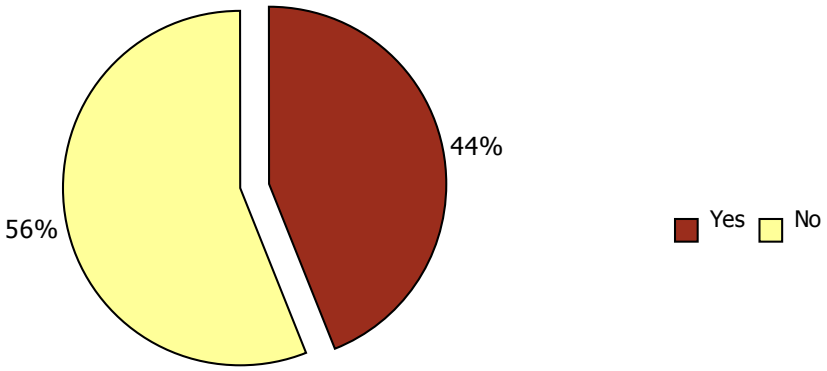
2.12. We looked at a small number of cases where individuals had moved between Trust areas during their sentence. Four offenders had moved out of Norfolk & Suffolk. It had been right to seek a transfer in two of these cases in order to avoid the use of enforcement or recall. The Trust had ensured the external area received up to date assessments, plans and information relating to multi-agency child protection procedures for two of these cases.

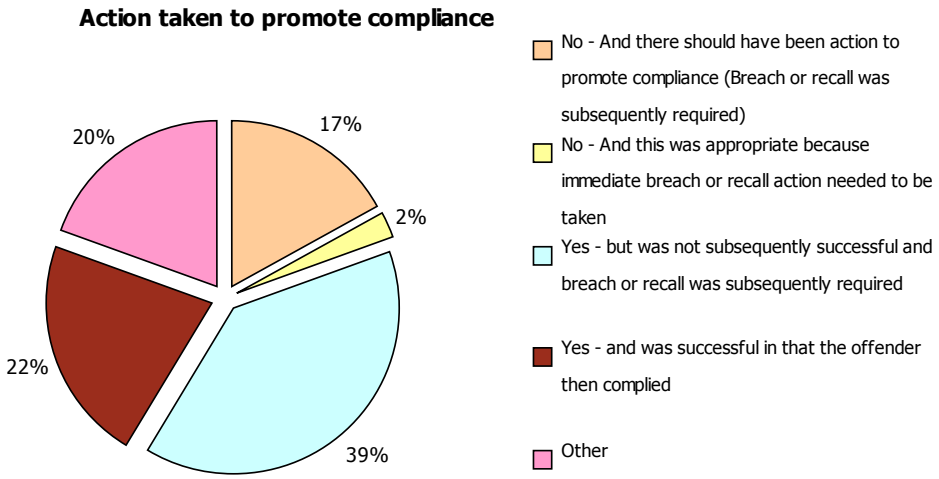
2.13. Case recording was generally good and supported the overall management of the case. Case files were well organised and recording of information was almost always timely. Generally, recording was clear and easy to follow, with the exception of information relating to enforcement.

3. Initial outcomes are achieved

3.1. We found that reporting instructions were sufficient for the purpose of carrying out the sentence of the court in almost all cases. In most cases, the requirements of the sentence had been delivered as intended. The charts below show how often action had to be taken to promote compliance. In nearly half the cases, the individual complied with the sentence without the need for additional action by the offender manager. There were a number of cases where action could have been taken to promote compliance and was not, and breach or recall was required as a consequence.

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





3.2. Sentence planning objectives had been either fully or partially achieved in almost three-quarters of cases. A large majority of cases had been managed by more than one offender manager. Twelve cases had been managed by three or more. However, this had had little impact on the delivery of the sentence and we found, in most cases, that there was appropriate continuity in the work being undertaken to meet planned objectives.

What people who had offended thought of their experience:

NOMS conducts an annual survey of the people in contact with Probation Trusts. For 2012, Norfolk & Suffolk received 591 valid responses, the data from which is given below.

The survey results were largely positive, with many people making constructive comments about their experiences.

The survey found, as we did, that there were good working relationships and communication between offender managers and offenders. Offender managers were more likely to discuss sentence plan objectives with individuals than include them in designing the plans, and were good at motivating and supporting them to undertake the work needed to fulfil objectives.

In the main, individuals were content with the assistance they received, for instance, drugs and alcohol and employment services. The most common areas they identified as needing more support related to accommodation, emotional health and employment. Some asked for more flexibility of appointment times around their employment needs and for fewer delays and shortened supervision sessions.

Their experiences of being on supervision were consistent with the general findings of this inspection.

Comments from individuals:

"I kind of enjoyed my time on Probation".

"It has taken a lot of time but we have built up a lot of trust and I don't hide any thing. Thanks".

"…has been a good experience. I have been treated like a human being…".

Less positive comments:

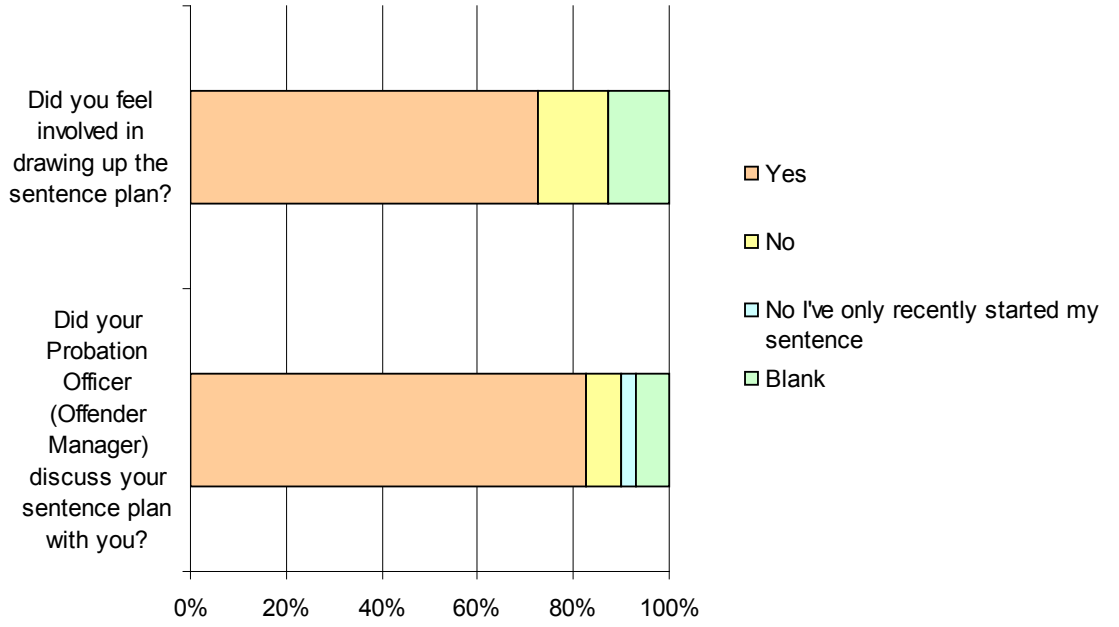
"…get my paperwork from LPS to Ipswich Probation sooner than what it has taken so far".

"More staff as sometimes they are rushed or late".

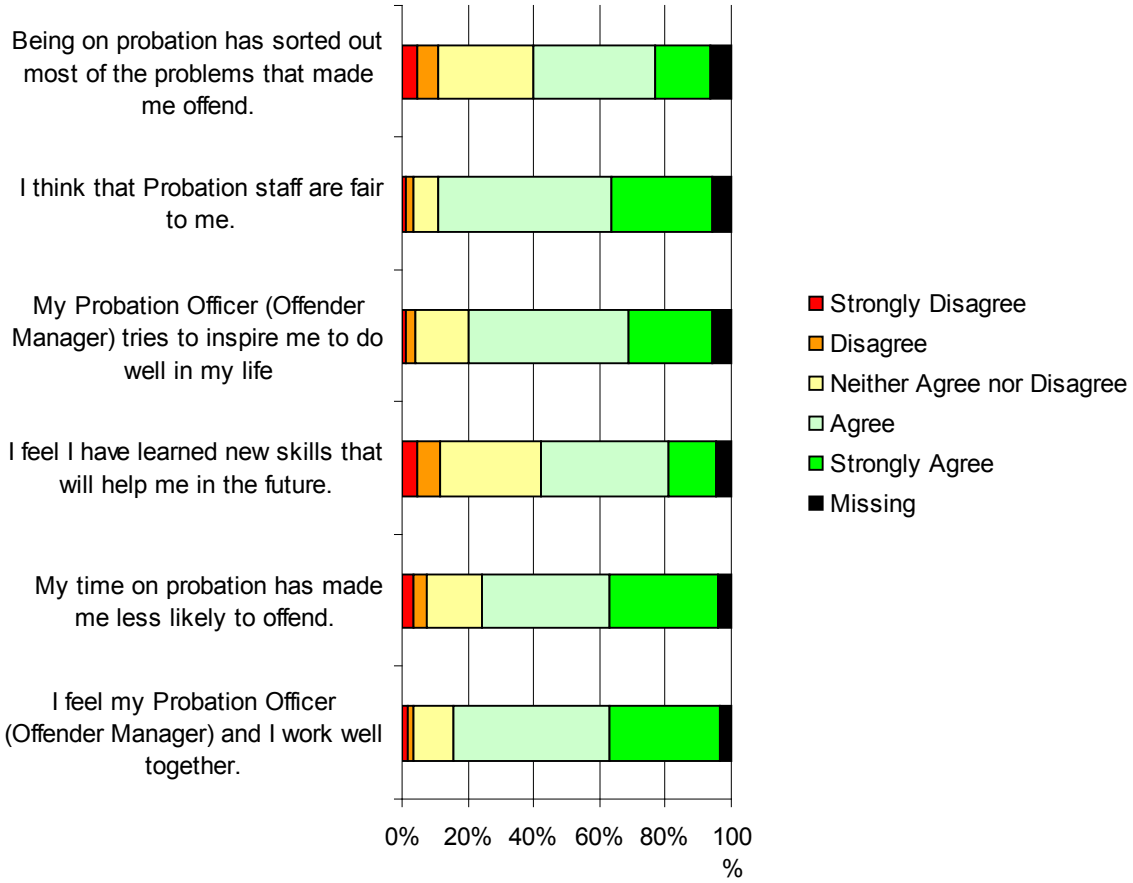
"To have had a plan in place that would help me to progress".

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

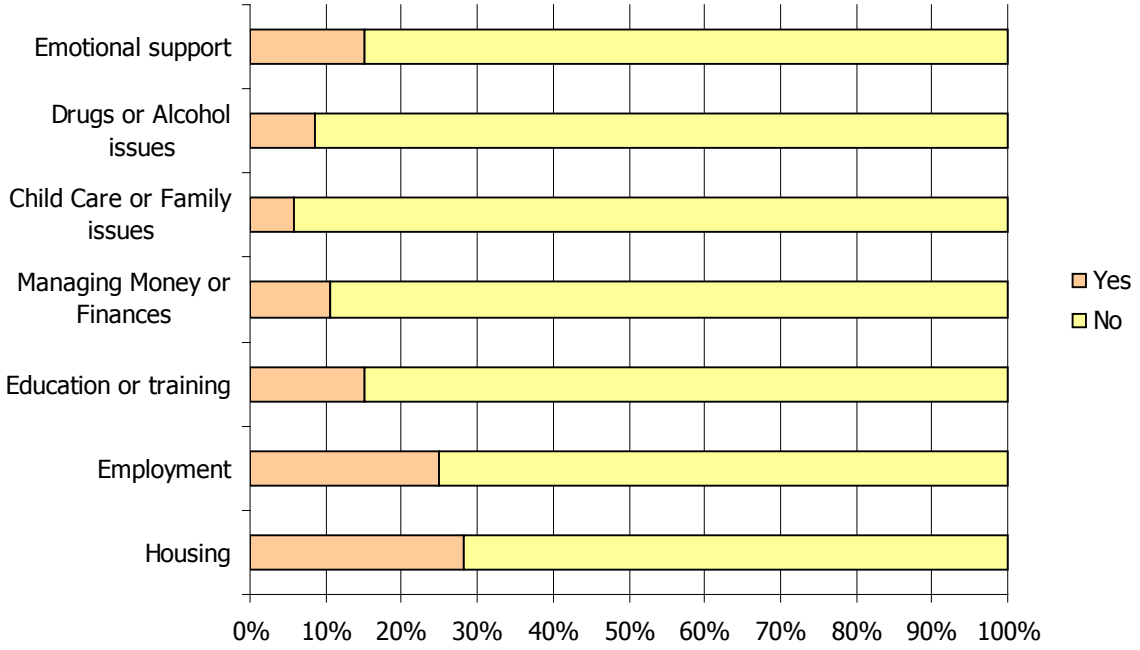
Section 1 - About Current Order / Sentence



Section 2 - About Experience on Probation



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



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

4.1. We asked 53 offender managers about their experience of working for the Trust.

4.2. About three-quarters who had a diversity need felt this had been reasonably addressed by the Trust. When asked about workloads, about two-thirds thought these were monitored, but less than half considered that this was done in a fair and transparent way. A high proportion of offender managers held fairly high or high caseloads. Senior managers acknowledged that some offices were struggling to cope with their work. Sickness levels amongst probation staff in Norwich & Suffolk had been low, but had risen sharply since the introduction of Transforming Rehabilitation. Senior managers were concerned for their staff; they felt the Transforming Rehabilitation agenda was paralysing them and had affected staff resilience. Many offender managers commented on the additional pressure the uncertainty and sickness of their colleagues created for them in their work. They said they had a sense of hopelessness and fait accompli about the outcomes of the national agenda. Despite this they continued to demonstrate positive commitment to the individuals with whom they worked, and to their colleagues and other agencies.

4.3. In relation to staff absences, about three-quarters thought planned (due to, for instance, annual leave) and unplanned absences (such as sickness leave) were managed so as to help maintain the continuity of offender management.

4.4. The majority of offender managers were positive about the skills of their line managers, with most indicating that they had the ability to assist them to develop their work and to support them. Almost all considered their managers had the skills to assess the quality of their work but less than half advised that routine countersigning and management oversight of their work was always an active process. Nearly one-quarter felt that it was not active enough. We identified that this was more of an issue for PSOs, of whom over one-third would have liked more active management oversight. Only 9% of POs identified this as an issue.

4.5. Nearly two-thirds of the offender managers we interviewed had formal supervision with their manager every six weeks or more often. Case discussion featured strongly in supervision, as well as training and development issues, discussion about personal well-being and feedback about

performance targets. At a time when Transforming Rehabilitation was high on the Trust's agenda it was notable that less than one-quarter advised that their career development was discussed during supervision. Skills for Effective Engagement, Development and Supervision (known nationally as SEEDS) had been introduced to the Trust recently. About 45% of offender managers reported that their practice had been observed by their manager and they had been given feedback about this. Action learning sets had also been introduced, but were more embedded in the Norwich office than elsewhere. Most thought that these processes had promoted improvements in their practice. Just under one-third would have liked to have had more formal opportunities to discuss practice with colleagues. Many praised the informal discussions and relationships with their colleagues that they felt brought benefits to their practice. Just over one-half thought that the Trust's processes for disseminating the findings from Serious Further Offences or Serious Case Reviews were sufficient.

4.6. The majority of offender managers either held, or were working towards, a relevant professional qualification. Many staff felt that they had sufficient knowledge about diversity factors but several reported being less confident in identifying issues relating to culture and ethnicity, learning needs, mental health and young offenders. Most had attended training relating to the protection of children and young people within the last two years and almost all felt they would be able to identify and work with relevant issues.

4.7. A large majority of those interviewed considered that arrangements for ongoing training and development were, at least, sufficient to equip them to do their current job. While they were less positive about the extent to which their future development needs were met, three-quarters said their organisation promoted a culture of learning and development.

4.8. The Trust works hard to understand and improve its performance and ensure consistency of practice across LDUs. It continues its efforts to align policies and procedures, has made recent management changes and now has a performance lead manager in each LDU. Despite this, there is still more to be done. Senior managers acknowledge this but, with finite resources, are currently having to balance work on the *Transforming Rehabilitation* agenda with other priorities.

4.9. The Senior Management Team focuses not only on meeting national performance targets, but also makes efforts to identify and address the needs of the community it serves. We were pleased to see the Trust was aware of the demographics of the area it covers and had prepared and was using documents prepared in relevant languages. The Trust has also scrutinised Offender Assessment System (OASys) assessments and caseload profile management reports to identify local trends. In line with the criminal justice joint inspection of women offenders[1], it had identified the need to provide more specialised services for women offenders and had developed a women's emotional well-being SAR, which we understand is well regarded and being adopted by other Trusts.

4.10. Difficulties during the introduction of nDelius have been a national issue. In Norfolk & Suffolk, delays in its roll out had negatively affected the difficult merger of two of its offices. Additionally, the Trust had lost valuable time when carefully prepared case flags were lost during migration.

Summary

Overall, 77% of work to deliver the sentence of the court was done well enough.

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

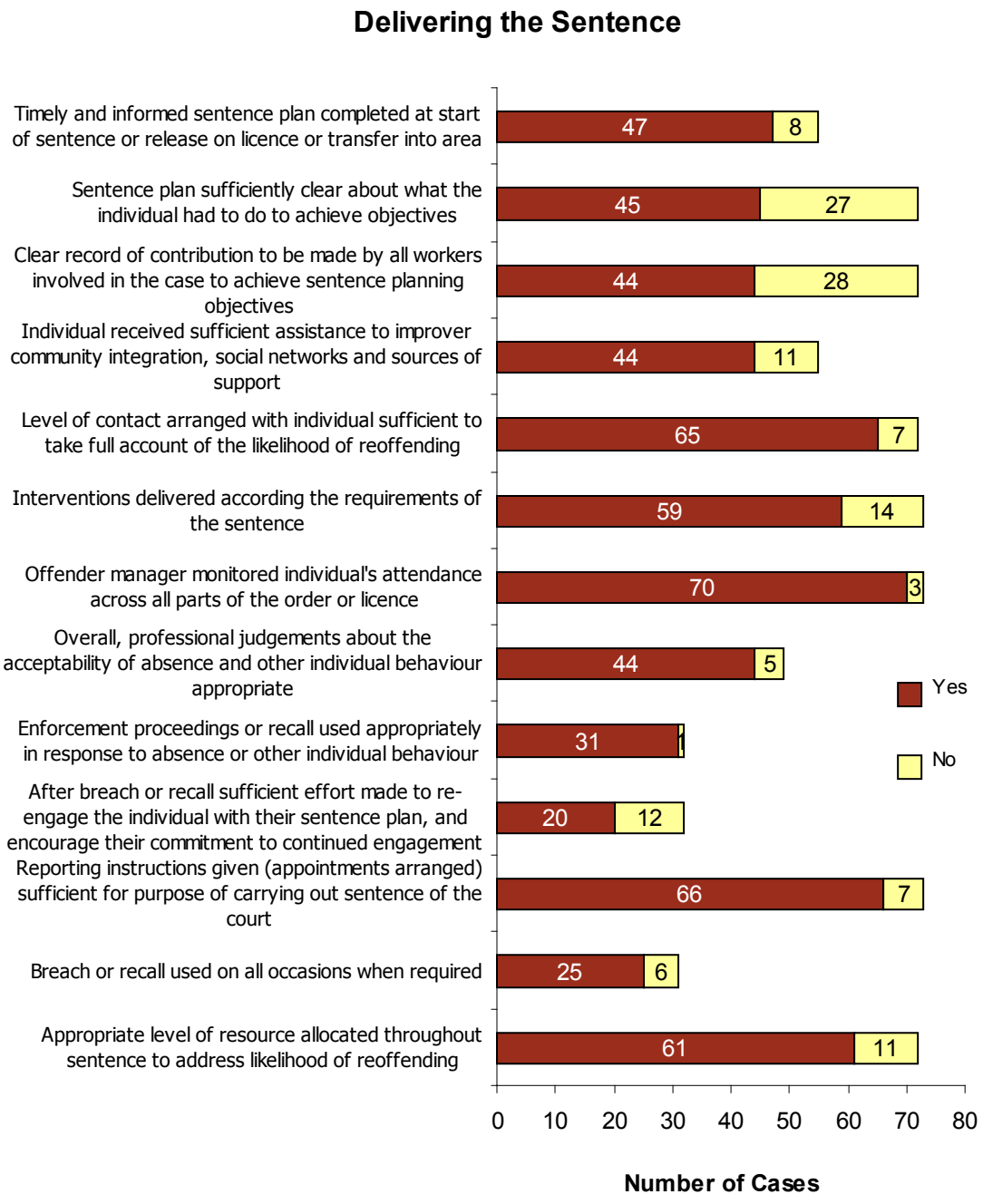
- assessments, plans and work are reviewed appropriately, and offender managers recognise events that should trigger this action.

For a summary of our findings see page 2

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

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 73 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Reducing the likelihood of reoffending

3

Outcome 3: Reducing the likelihood of reoffending

What we expect to see

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

Case assessment score

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

Key strengths

1. An appropriate level of resource was allocated throughout the sentence to address issues relating to the individual's likelihood of reoffending.
2. Overall, interventions encouraged individuals to take responsibility for their actions and maintained a focus on offending behaviour. This work was actively supported by staff in approved premises.

Key areas for improvement

1. There were too few good quality reviews of the assessments relating to likelihood of reoffending. Many reviews, especially in response to significant changes in the individual's circumstances, had not been completed.
2. The Trust was unable to access appropriate interventions consistently, in a small number of key areas, or make enough use of some of the services available.

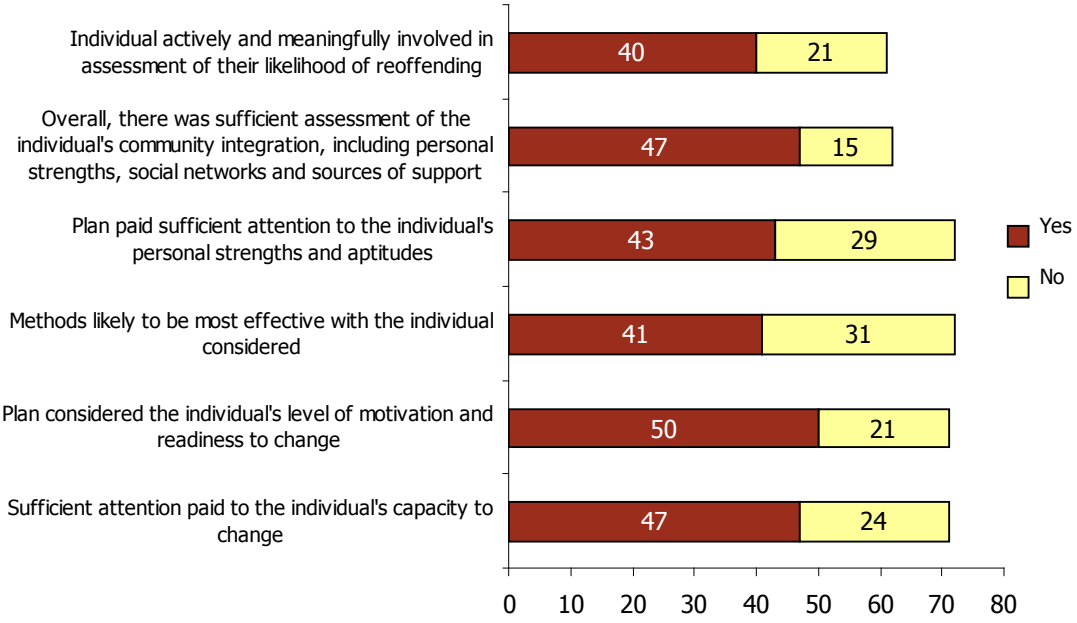
Explanation of findings

1. Assessment to reduce the likelihood of reoffending

1.1. We expect to see an assessment of factors that could impact on the likelihood that an individual will reoffend at the start of a sentence in 62 cases. Overall, we found that a sufficient assessment had been undertaken in 60% of these. There were ten cases that had no assessment.

1.2. The process to assess factors linked to the likelihood of reoffending involves a complex range of tasks. The chart below outlines our findings for some of these. In cases where assessments had been completed, we found evidence that the offender had been actively and meaningfully involved in this process in two-thirds. Most had been completed within a reasonable time following sentence and a large majority were new or had been sufficiently revised from a previous assessment. More than two-thirds drew fully on all available sources of information and more than three-quarters identified the factors related to the individual's offending. The great majority considered relevant information about the offender's home and social environment and their previous behaviour.

Involving people in assessing the likelihood of them reoffending

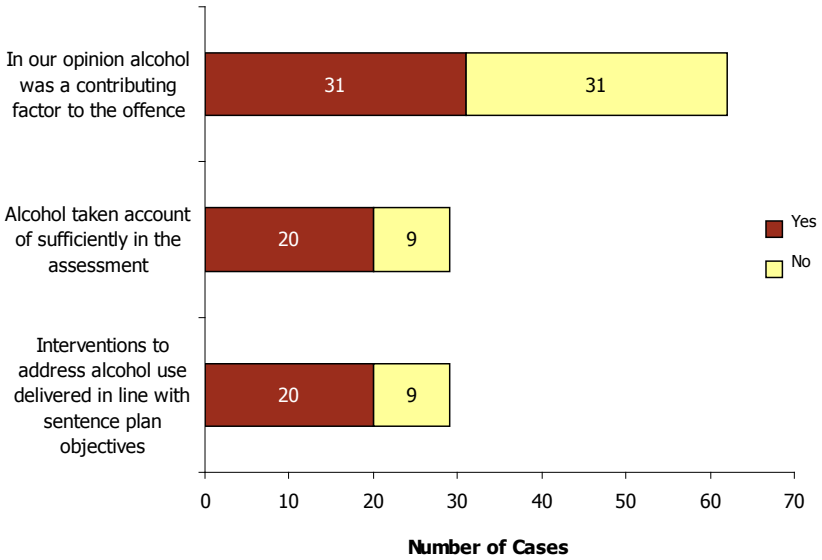


1.3. It is important for offending-related factors to be identified, in order to plan and deliver the right interventions. We judged that the most prevalent factors in the 62 cases we looked at were: thinking and behaviour (in 59 cases) followed by lifestyle and associates (33 cases), alcohol misuse (32), relationships (31) and drug misuse and attitudes to offending (30 cases each).

1.4. In addition to the factors listed above, many individuals in our sample had problems with their accommodation (28 people), their emotional well-being, and education, training and employment (ETE) (20 cases each).

1.5. In more than one-third of the cases we looked at, the index offence had involved violence. In more than 40%, the individuals were, or had been, a perpetrator of domestic abuse. There is a strong link between alcohol and violent offending and alcohol was a contributory factor in half of the sample. Given that the focus of this inspection was on the protection of children and young people, we were disappointed to find that alcohol had been addressed sufficiently in sentence plans in less than two-thirds of these cases.

Alcohol and offending



2. Delivery of interventions to reduce the likelihood of reoffending

2.1. Offender managers ensured that constructive interventions were delivered to encourage and challenge offenders to take responsibility for their actions and decisions relating to offending, and to reduce their likelihood of reoffending, in nearly three-quarters of cases we looked at.

Practice illustration – Delivering work to meet the needs of the case

Michael had been convicted of several charges of indecent assault, sexual assault and cruelty. He denied these offences and would not participate in any group work to address his offending behaviour. On release from custody, he resided in approved premises. Staff there undertook high quality work with him and reported the progress to his offender manager. The offender manager worked with a colleague to deliver blocks from the Facing Forwards manual, creating a semi-group environment. The offender's discriminatory attitudes to women were identified and staff challenged him about these repeatedly throughout his sentence. Sessions were thoughtfully prepared and reinforced and progress was recorded well. By the time of the inspection, the offender had made some progress on admitting the offence.

2.2. The Trust had an appropriate range of accredited programmes but these were only included on sentence plans in about one-quarter of cases. The most commonly used were the Thinking Skills Programme and IDAP. There were only two cases where the substance misuse course was applied. In nearly two-thirds of cases, individuals had completed the course, or were due to do so to meet the timing on their sentence plan. There were six cases where the offender had yet to join a programme and we considered they should have already done so. In most instances, this was because the individual had not cooperated with arrangements.

2.3. We saw examples of structured, one-to-one work being undertaken to address offence-related factors with individuals who were ineligible or unsuitable to undertake group programmes. However, there were many cases where offenders missed appointments and offender managers spent time dealing with their practical issues.

2.4. There were three approved premises in the Trust, providing supported accommodation for offenders under supervision and on licence. Ten cases in the sample involved people who had been resident in an approved premises for at least six weeks of the period being assessed; constructive interventions had been provided for nine of these cases. In other cases, the use of approved premises was primarily to provide restrictions or to help manage risk of harm. The Trust had undertaken work to harmonise approved premises procedures across the Trust area. They had also enhanced referral and induction processes, particularly for individuals from black and minority ethnic communities, to lessen their sense of isolation and raise their awareness of the facilities available in the area.

2.5. Just under three-quarters of individuals were well prepared for the interventions delivered throughout their community order or licence. However, offender managers were less good at reviewing the work offenders were doing in other parts of their order or licence, in order to promote and reinforce what they had learned from this. Such reviews had taken place in less than two-thirds of cases.

2.6. Offender managers provided individuals with information about relevant local services that could help support and sustain their desistance from offending and referred them to these services in about three-quarters of cases.

2.7. We expect to see the assessment of the likelihood of reoffending reviewed thoroughly when required. This had happened in less than half of cases. There was no review in 35% of the cases where one was needed. In 12 of the cases that had been reviewed this had not been completed to a high enough standard. The majority of reviews took into account changes in relevant factors,

were informed by information sought from others involved in the case and were completed within a reasonable time of the previous assessment. However, many had not been completed promptly after a significant change in the offender's circumstances. This mirrored the findings in relation to the review of sentence plans.

3. Likelihood of reoffending is reduced

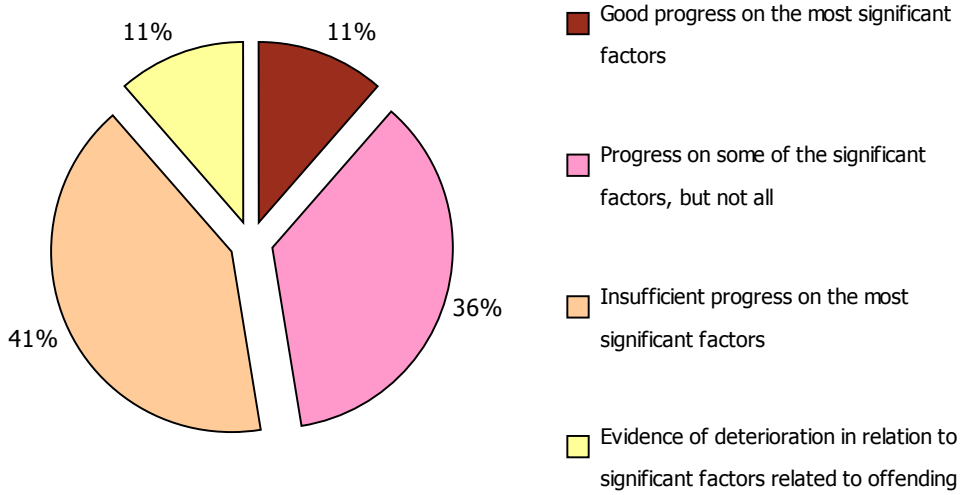
3.1. We had identified that the key factors linked to reoffending in our case assessment sample were (in descending order) thinking and behaviour, lifestyle and associates, alcohol misuse, relationships, drug misuse and attitudes to offending.

3.2. We were pleased to see that the availability of services and interventions provided by the Trust recognised this pattern and prioritised resources according to need. Generally, there were sufficient services and interventions available to meet the needs of individual cases. However, there was a requirement for greater provision in financial management, drug misuse, thinking and behaviour and lifestyle and associates.

3.3. We were disappointed to see the number of cases where services were available and not being used. A number of respondents to the NOMS Offender Survey expressed their wish for more help to meet their accommodation and education needs. About 25% would have like more assistance with their employment. We found that while services were available in these areas, they were not being used as often as they should have been, especially in relation to (ETE).

3.4. Positive change requires the willingness of individuals subject to supervision to make best use of the services provided. For many offenders, the factors contributing to their offending are complex, varied and deep rooted. Thus, we understand that, for some, positive and sustainable change will be a slow process. In this context, we were pleased to note the evidence, illustrated in the chart below, that showed that where relevant, just under half of individuals had made progress on the most significant factors linked to their offending. In around one in ten cases we judged there had been deterioration in these factors.

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



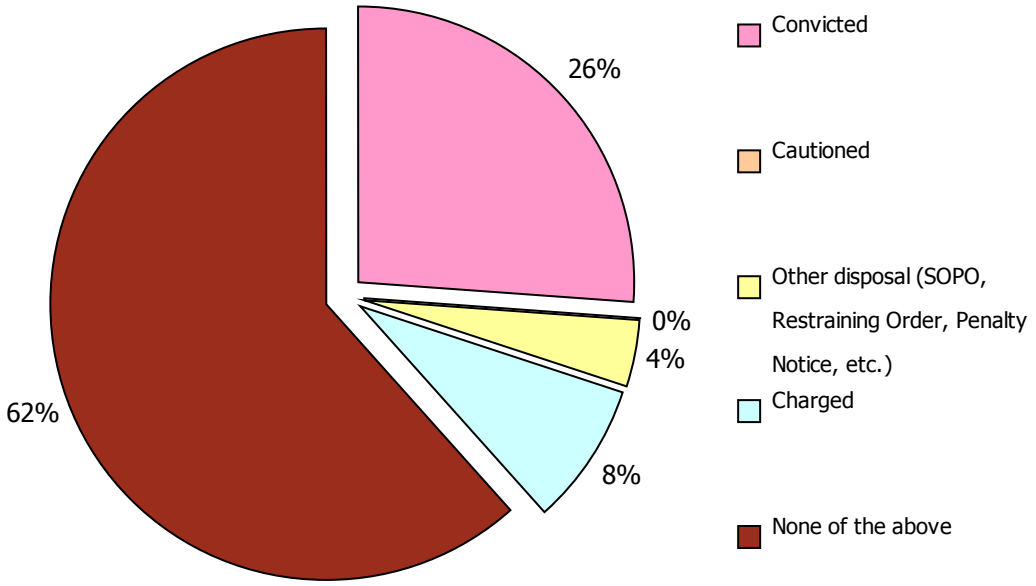
3.5. We identified the factors associated with offending that were most frequently found in our case sample (listed in order of prevalence from the 73 cases inspected), we found the following:

Offending-related factor (and number of cases identified by us where this applied):	Of those cases where the factor was identified, the % where sufficient interventions or services were delivered was:	Of those cases where the factor was identified, the % where sufficient progress was made:
Most prevalent factors:		
thinking and behaviour (59)	47%	29%
lifestyle and associates (33)	36%	36%
alcohol misuse (32)	50%	44%
difficulties handling relationships (31)	45%	23%
Other common factors		
drug misuse (30)	37%	33%
attitudes to offending (30)	40%	20%
accommodation (28)	61%	43%
emotional well-being (20)	60%	30%
education, training and employment (20)	45%	40%
issues related to financial management (15)	33%	20%

3.6. The above table also indicates that many individuals subject to supervision were making positive changes on factors that were associated with their offending by the time we conducted the inspection. Overall, we judged that resources had been used efficiently to assist the individual to achieve planned outcomes in three-quarters of all cases.

3.7. As illustrated in the chart below, about two-thirds of individuals had not been cautioned for, charged with, or convicted of a further offence during the period of supervision by the time of our inspection.

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



4. Leadership and management to reduce the likelihood of reoffending

4.1. While we would have liked to have seen better embedding of some services, we found examples of effective working relationships with partners in order to develop a range of well considered interventions. The strength of these relationships lay in sound strategic links, as well as active liaison at the operational level.

4.2. While a mental health nurse helps to support the assessment of need in Norfolk, (a legacy from before the merger), no such arrangements exist in Suffolk. Although we did not assess the impact of this discrepancy, offender managers in the North half of the Trust area welcomed and praised the input of the mental health worker, while mental health services in Suffolk were identified as an area where better resources were needed.

4.3. There is an evident commitment by senior management to obtain feedback from partners and service users and use this to strengthen relationships, understand issues and develop services. The Trust undertook an annual offender survey of service users and was able to provide examples of how they had improved services as a result.

4.4. Accredited programmes had been established to address a number of areas of offending behaviour, including thinking skills and domestic violence. While it was not within the scope of this inspection to review the programmes being offered, we noted that the latest NOMS audits found that the quality and integrity of delivery was inconsistent across programmes and some required better resourcing.

4.5. The Trust had also developed and introduced a range of SARs in order to retain services but provide them at a reduced cost. The Trust had worked hard to ensure they met assessed needs and were based on the evidence available about what works. The SARs were proposed in pre-sentence court reports and welcomed by sentencers. However, they did not appear to have a high profile among offender managers. These interventions were fairly new and yet to be fully evaluated by the Trust. There had, however, been an initial assessment of the women's emotional well-being SAR which had shown that there had been an increase in compliance in women attending this.

4.6. We would encourage the Trust to make greater use of its programmes and range of interventions available through external providers. We understand that there is a high attrition rate which could, in part, be due to the rural nature of the Trust area and difficulties some offenders have with travel. However, the Trust recognises that the rate of referrals could be higher. Our evidence suggests that there is scope for better joint working between offender managers and interventions managers to resolve this issue.

4.7. We were heartened by the Senior Management Team's welcome of the Criminal Justice Joint Inspection reports. The Trust has audited its services against these and planned action to address deficiencies where appropriate. Senior managers had noted and responded to the practice issues identified by the joint thematic inspection on Transitions[1] and we were pleased to learn of their work with Youth Offending Teams to try to help young people with their move from youth to adult services, and to agree a protocol for this.

Summary

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

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

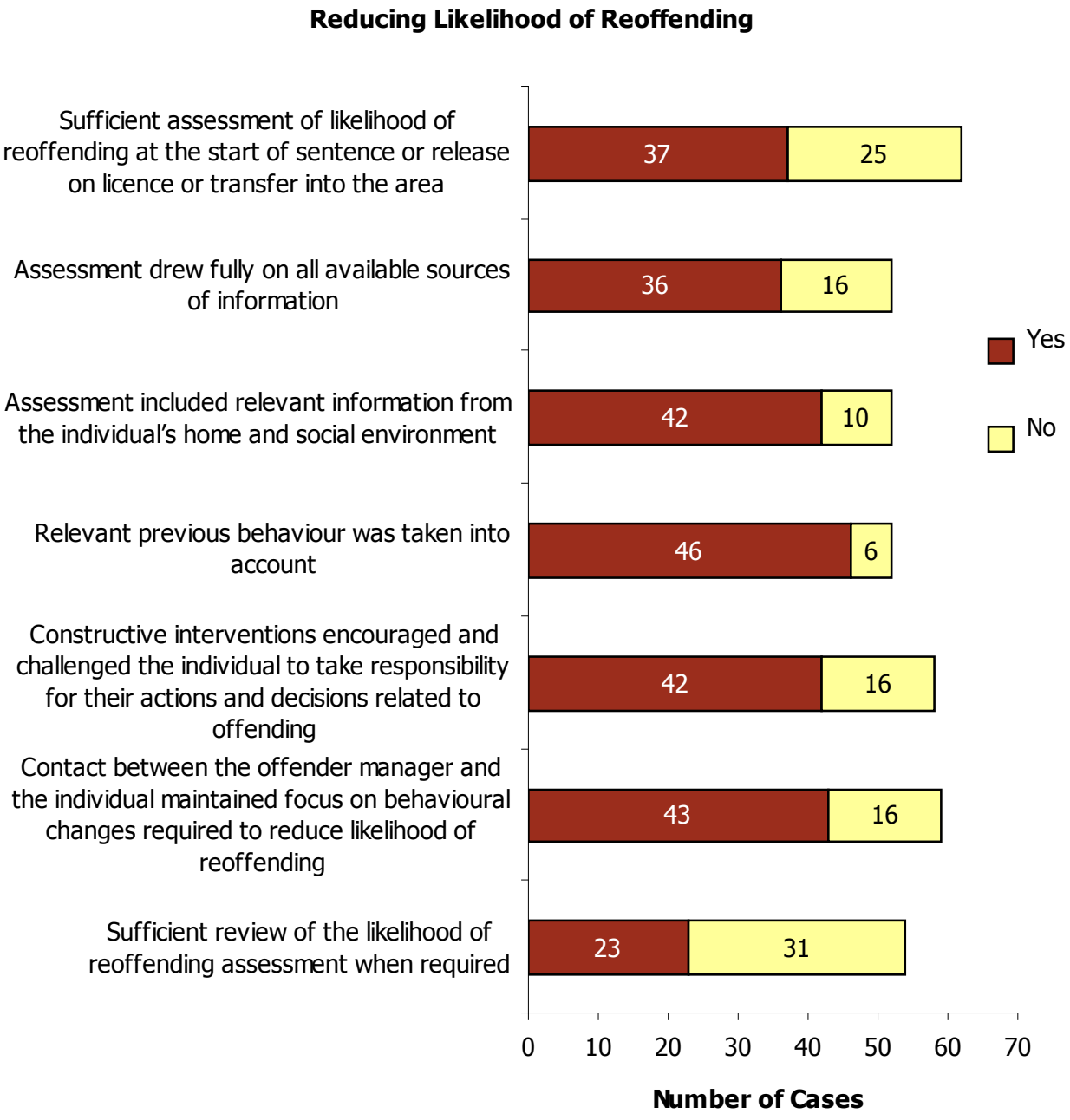
- assessments, plans and work are reviewed appropriately, and offender managers recognise events that should trigger this action.

For a summary of our findings see page 2

1 HMI Probation, (October 2012) *Transitions: An inspection of the transitions arrangements from youth to adult services in the criminal justice system.* HMI Probation, Manchester

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 73 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Protecting the public by minimising risk of harm to others

4

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

What we expect to see

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

Case assessment score

Overall, 67% of work to protect the public by minimising risk of harm to others was done well enough.

Key strengths

1. The Trust had a sound understanding of the quality of practice to manage risk of harm and had built constructive strategic and operational relationships with partner agencies to improve structures and processes to manage risk of harm.
2. MAPPA were operating effectively: identification of MAPPA cases and subsequent referral were good and, overall, the Trust was contributing well to this multi-agency partnership.
3. The level of resource, including use of approved premises, level of contact with the offender and mode of intervention, were suited to the level of harm posed to others in the majority of cases.
4. Enforcement proceedings or recall were used appropriately in response to an increase in the risk of harm.

Key areas for improvement

1. There were too few cases where the risk of harm posed to others had been analysed well enough. A sizeable number of risk of harm screenings and analyses were missing.
2. Plans to manage risk followed a similar pattern. Just over half set out all necessary actions. Many plans did not contain enough detail and there was a lack of contingency planning.
3. There was insufficient review of risk of harm assessments and risk management plans and many had not been completed, especially in response to a significant change.
4. There was evidence of effective management involvement in cases involving high/very high risk of harm issues in only a small percentage of cases.
5. There were a number of areas of work relating to protecting children and young people that needed improvement. Management oversight was not making enough positive difference to probation practice in relevant cases.

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

Explanation of findings

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

1.1. The initial Risk of Serious Harm (RoSH) screening was completed sufficiently well in less than two-thirds of cases. This judgement included the fact that nearly one-quarter had not been undertaken at all. Most of those that had been completed were timely and accurate.

1.2. We considered that there was a need to conduct a full initial analysis of risk of harm in 62 of the cases we looked at and found this had been done in 46.

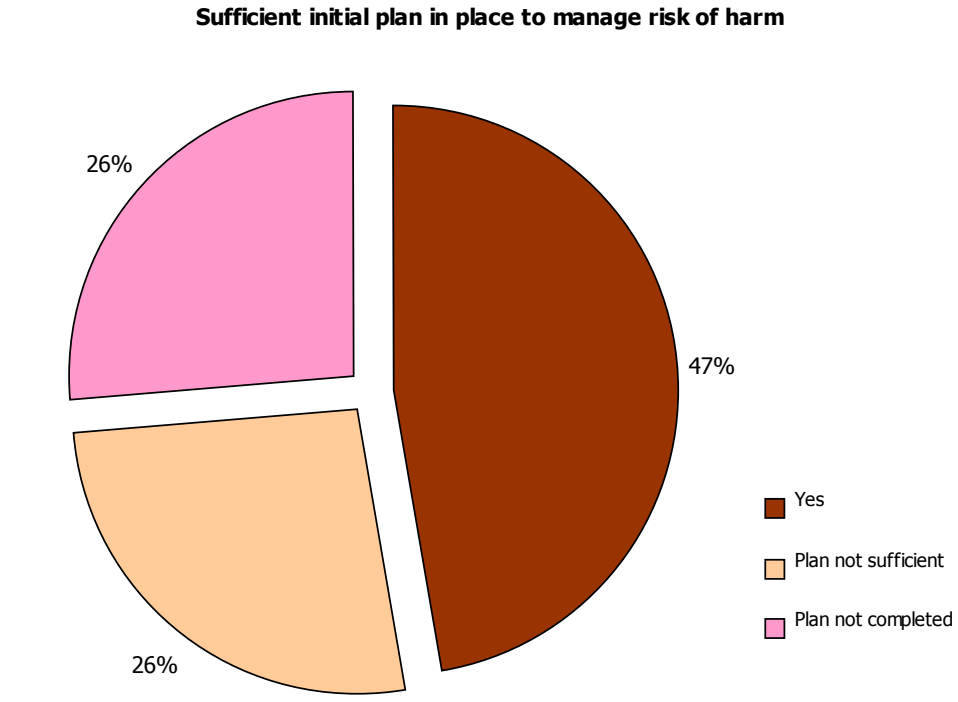
1.3. Where a full analysis of the risk of harm had been undertaken, we agreed with the risk categories allocated to the public, known adults and staff in the large majority of cases. However, in seven, we considered the overall RoSH classification to be incorrect. We judged that the level was too low in six of these. No classification was recorded in six cases.

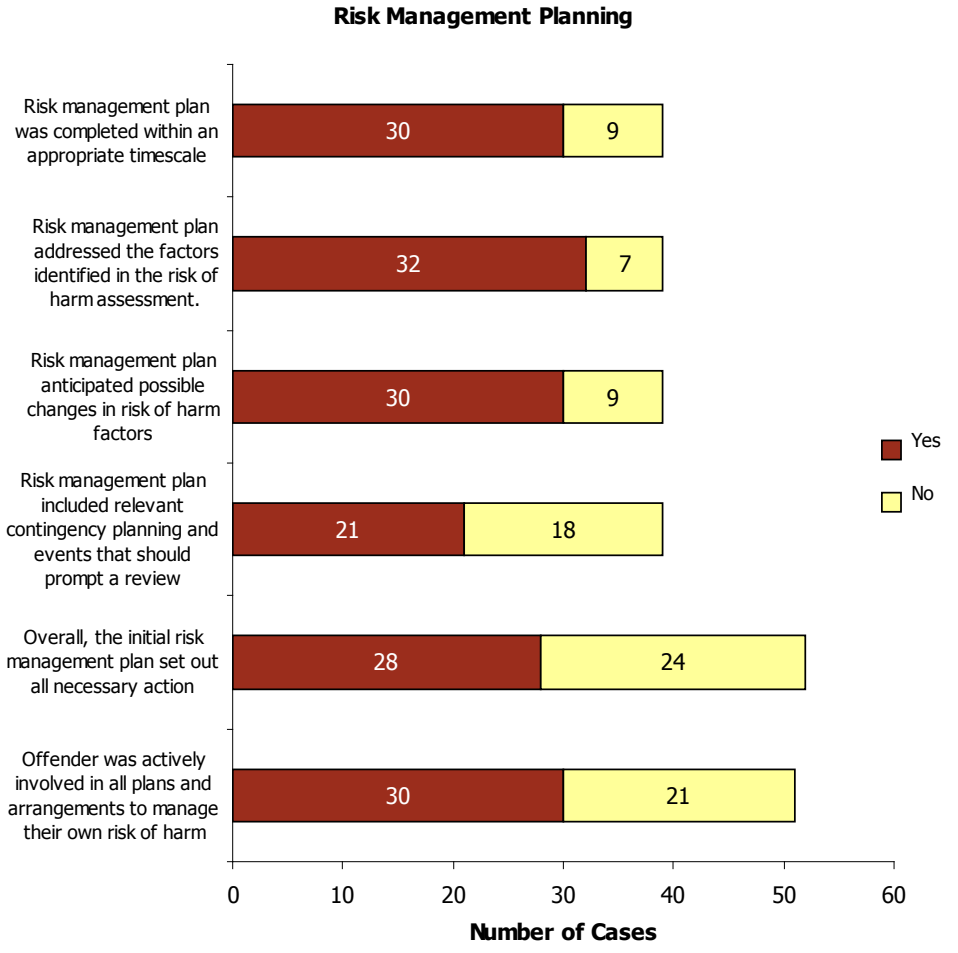
1.4. Nearly three-quarters of the analyses were new or sufficiently revised from a previous one. Most had been completed within an appropriate timescale and the large majority took account of relevant previous behaviour. Information had been actively sought from other relevant staff and agencies involved with the offender in only slightly more than half of the cases we looked at.

1.5. We paid particular attention to how well the Trust assessed the need to protect children and young people throughout the sentence. We found that where a full analysis of risk of harm had been completed, offender managers had attributed the correct level of risk to children and young people in almost all cases. However, it was unclear how they had achieved this; we found evidence that checks had been made with Children's Services in 67% of cases and sufficient analysis of risk of harm to children and young people had been undertaken in 69%. Details of children that were at risk from the offender were included in the assessment in 73% of cases. Overall, we judged that sufficient attention had been paid to the protection of children and young people in relation to the offender's contact with children and young people in 64% of cases. There was less evidence that checks had been made and details of relevant children and young people included in cases held by PSOs.

1.6. A restrictive requirement (such as a curfew) had been imposed in 19 cases and we considered this was appropriate in every one. These requirements were considered proportionate to the offender's risk of harm and their likelihood of reoffending in every case but did not always help to minimise any risk of harm to actual or potential victims. In both cases involving a curfew, this provided a significant punishment and helped to protect the public from risk of harm or further offending by the individual.

1.7. Risk management plans are required in cases where the risk of serious harm classification is medium or higher. The charts below present our findings in respect of this work. It is worth noting that just under half of relevant cases contained a sufficient plan. In 14 cases there was no initial plan and in another 14 the plans had not been completed well enough. The key factors that would have improved planning were: addressing all of the factors identified in the full risk of harm analysis, accurately describing how the objectives in the sentence plan and other activities would address risk of harm issues and protect victims; and to include relevant contingency planning and events that would prompt a review. Many contingency plans were a standardised 'breach if does not comply'.


Sufficient initial plan in place to manage risk of harm
26%
47%
26%
Yes
Plan not sufficient
Plan not completed


Risk Management Planning
Risk management plan was completed within an appropriate timescale
30
9
Risk management plan addressed the factors identified in the risk of harm assessment.
32
7
Risk management plan anticipated possible changes in risk of harm factors
30
9
Risk management plan included relevant contingency planning and events that should prompt a review
21
18
Overall, the initial risk management plan set out all necessary action
28
24
Offender was actively involved in all plans and arrangements to manage their own risk of harm
30
21
Yes
No
0
10
20
30
40
50
60
Number of Cases

1.8. We judged that, overall, only just over half of the initial risk management plans set out all necessary action. Many plans failed to clarify joint working arrangements and the roles and details of others working in the case (for example, who would do what and when) and processes for sharing relevant information.

1.9. There was not enough evidence of joint working to form plans to manage risk of harm. The offender was actively involved in the planning process, and key risk of harm information was communicated with other staff and agencies in less than two-thirds of cases where it was necessary to do so.

1.10. We were disappointed to find that in the cases where the offender manager had identified a need to take action to keep children and young people safe, relevant objectives were included in sentence plans in only 45% of these.

1.11. We found a considerable difference in the quality of planning for male and female offenders. We judged that objectives to protect children and young people were included in half of the relevant 32 cases involving men and only one of the six cases involving women. There was a similar disparity for objectives to manage risk of harm; objectives were included in about three-quarters of the cases involving men and in only two of the seven cases involving women.

1.12. The Trust had taken positive steps to review and strengthen processes relating to MAPPA. There was evidence that these had led to improvement and we found that of the 14 cases that met the criteria for MAPPA, 13 had been correctly identified. Of these, the initial MAPPA level of management was appropriate in 12 and effective referral processes were evident in most.

1.13. Offender managers were not good at recognising the need to include, in planning documents, their obligations relating to multi-agency risk management procedures, such as MAPPA and Child Protection. Although actions agreed by MAPPA were communicated to all relevant agencies in the great majority of cases, they were incorporated into all relevant planning documents in less than two-thirds, with the Trust's specific role being included in just over half of plans.

1.14. We recognise the value of the Violent and Sexual Offender Register (ViSOR, a computer based information system managed by the police) in helping to share information in relevant MAPPA cases (where there has been sexual or serious violent offending or potentially dangerous or terrorist activity). Of the nine cases that should have been recorded on ViSOR, we found that five had been. We acknowledge that the ViSOR business model limits access and that the IT system itself can impede its use. However, the Trust will wish to address this issue. Managers within the Trust monitored ViSOR recording and partner agencies, such as the police, felt this system was working well.

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

2.1. Actions set out in risk management plans were carried out as required in over two-thirds of cases.

2.2. We were pleased to see that in most cases the delivery of interventions took account of the risk of harm the offender posed to others. Resources were allocated appropriately and the level of contact was high enough to take full account of the assessed level of risk.

2.3. There was a change in risk of harm in 20 cases. The Trust responded effectively in two-thirds of these. In the majority of cases offender managers identified the changes swiftly but were less good at taking action or advising other agencies of relevant information.

2.4. Where there were restrictive requirements or conditions in community orders or licences, they were monitored fully in the great majority of cases. Where approved premises were used as a restrictive intervention to manage risk of harm, they were used effectively in every case.

2.5. In cases classified as high RoSH or involving issues relating to protecting children and young people, we expect to see a purposeful home visit carried out and repeated as necessary. We judged there were 25 cases that merited an initial home visit. This had been undertaken in 16. There were 27

cases where either a repeat visit or a visit due to a change in risk was required. Again, we found that these had been completed in only 16 cases. We understand the current resource constraints have impelled the Trust to restrict home visits to high or very high risk of harm cases. We are concerned that this policy will negatively impact on the effective management of cases involving a need to protect children and young people, many of which may not meet this criterion.

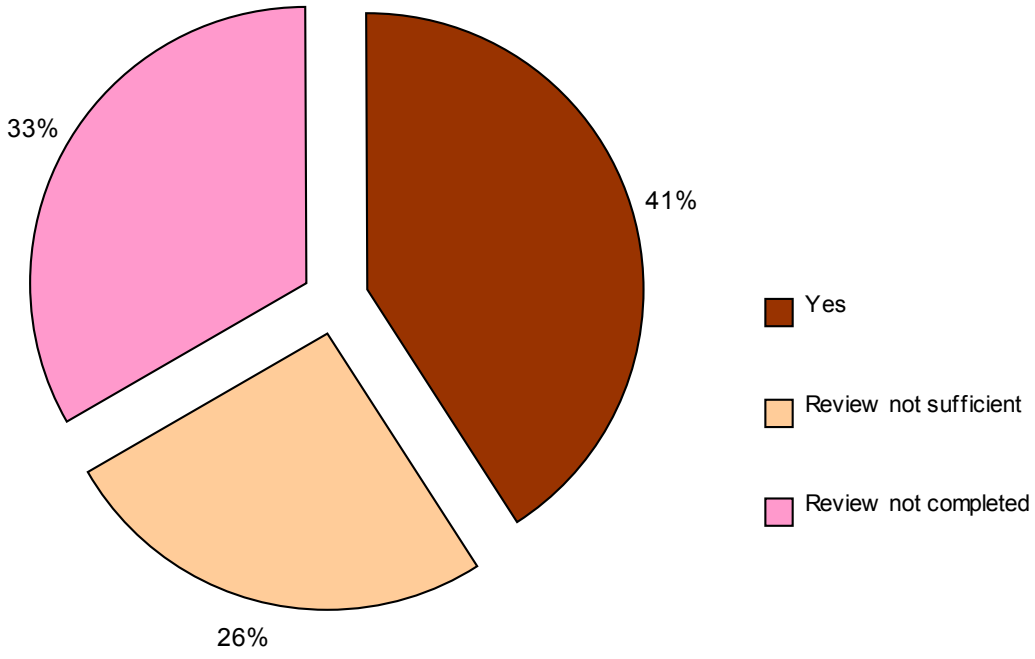
2.6. There were 20 cases in the sample where enforcement proceedings or recall to prison were needed as an appropriate response to an increase in the risk of harm posed by the individual. We were pleased to find that this action had been taken in every case. In all but one case this had been taken promptly and in all but two, the offender was given clear reasons. The Trust's focus was evidently on putting formal proceedings in place and we found that the offender manager had made sufficient effort, subsequently, to re-engage the individual and motivate them to continue with the work that needed to be undertaken in 12 of these cases.

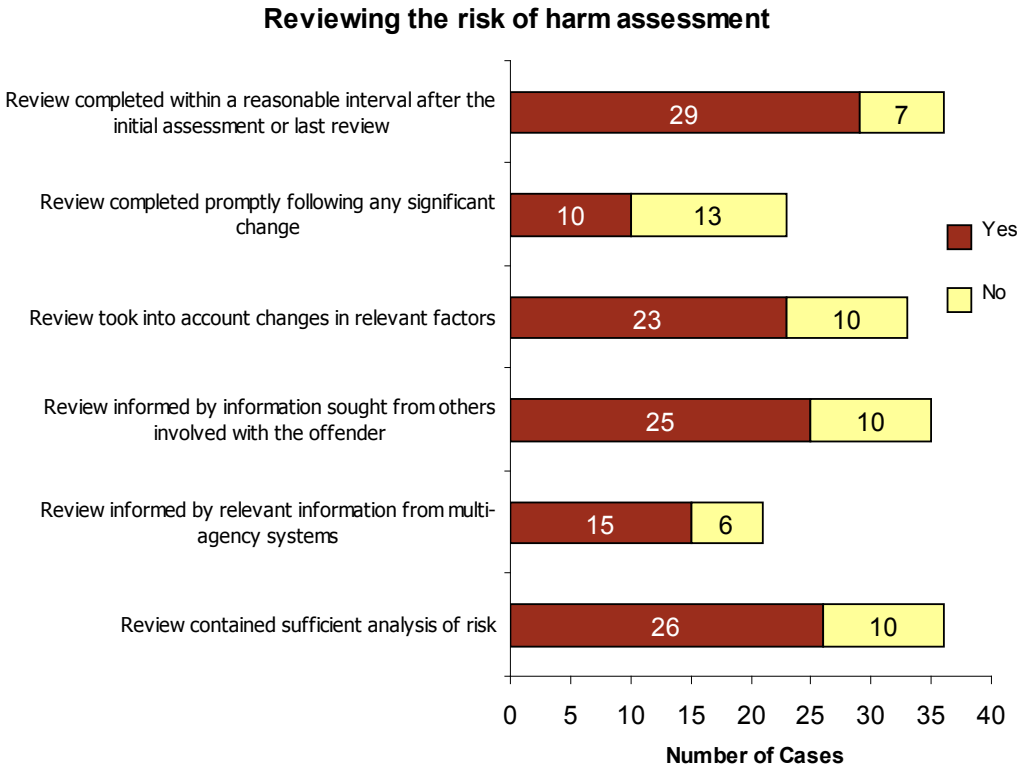
2.7. Multi-agency Child Protection procedures were used effectively in 13 of the 17 relevant cases. The Trust's strengths in this work were to communicate, follow through and act on decisions made in the context of Child Protection procedures. However, it needed to focus more on reviewing decisions that affected Trust work, and ensuring all members of its staff working with the offender contributed effectively to relevant multi-agency procedures.

2.8. Issues relating to an individual's risk of harm to others do not remain static. We expect to find an assessment of risk of harm reviewed to reflect this. Following the pattern that we identified with sentence planning and work being completed in a case, we found that the Trust had not reviewed risk of harm issues well enough or often enough. The charts below present our findings, that there had been a sufficient review of risk of harm in 41% of the cases that needed one (22 out of 54). Similarly, there had been a prompt review after a significant change in circumstances of the individual in 43%. There had been no review in 33% of the cases that required one.

2.9. Reviews of risk management plans also reflected this pattern. These were not sufficiently reviewed in 40% of relevant cases. There had been no review in 35%, and in 43% a review had not been completed promptly after a significant change.

Sufficient review of the risk of harm assessment





2.10. Where cases are assessed as posing a high or very high RoSH to others, or where there are concerns relating to children, we expect to see structured management involvement in the case. We found evidence of effective management oversight in 7 out of 28 relevant cases. In 17, there was no evidence of structured management oversight and in four there was evidence that oversight had taken place but not that it had made a positive difference to the management of the case.

3. Risk of harm is minimised

3.1. All reasonable action had been taken to keep to a minimum the offender's risk of harm in just over two-thirds of cases.

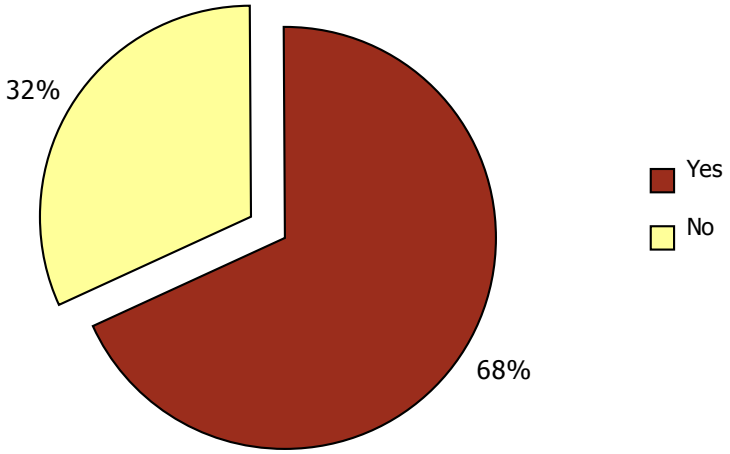
3.2. Overall, we judged that the safety of children and young people had been promoted in just under two-thirds of cases (27 of the 42 cases involving issues or potential issues relating to protecting children and young people).

3.3. The second chart below, 'Working with other agencies', represents our finding that multi-agency work contributed to the management of risk of harm issues in 69% (22 of a relevant 32) of cases. We specifically looked at how often the Trust was making appropriate checks to identify issues relating to domestic abuse or the need to protect a child or young person. We found that appropriate checks had been made with the police about domestic abuse callouts in 65% (26 of a relevant 40) of cases and with Children's Services in 67% (30 of a relevant 45).

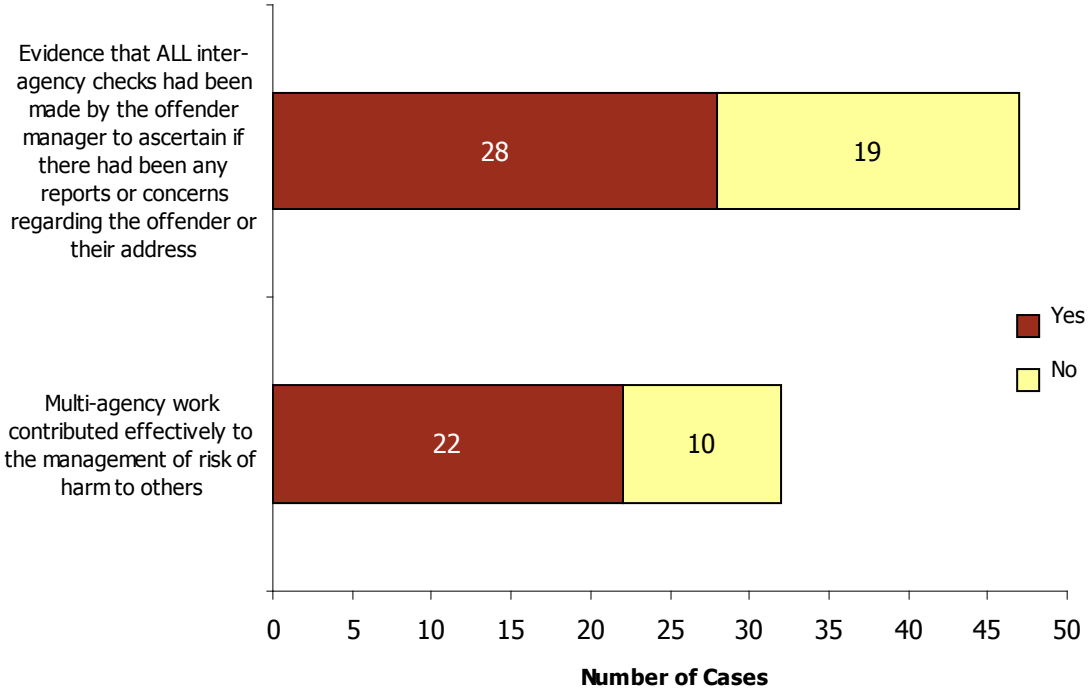
3.4. Where a risk of harm was identified to children and young people or their main carer, a referral was made to children's social care services, in line with local protocol, in nearly two-thirds of these cases. Referrals were monitored and followed up where necessary in nearly three-quarters.

3.5. Despite the Trust's policy, cases involving concerns about the safety of children and young people were included in the caseload of PSOs, who were sometimes managing them with little management support. Perhaps as a consequence of this, we found potential or actual risks relating to domestic abuse or Child Protection were more likely to be identified in cases held by POs. There was evidence that checks had been made with Children's Services in 81% of cases held by POs and 47% by PSOs. Similarly, a referral was made as appropriate to children's social care services in 83% of cases held by a PO and in only 38% held by PSOs.

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



Working with other agencies



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

4.1. The Trust has taken steps, including the innovative undertaking of a staff survey, to gain a better understanding of its strengths and weaknesses in relation to its management of risk of harm issues.

4.2. Although it recognised there was still scope for improvement, the Trust was working well with partner organisations in a number of key areas and we received positive feedback about the contribution made by the Trust to multi-agency work to protect the public at both strategic and operational levels. Examples of this included the Trust's commitment to MAPPA and the area's

Integrated Offender Management (IOM). The Trust had taken steps to ensure that it was an effective partner in MAPPA. A probation MAPP manager convened a MAPPA eligibility forum to make sure relevant cases and information were captured. IOM was a joint venture at every level with police staff working closely with probation staff to manage relevant cases.

4.3. The Trust was also involved in smaller projects with the police to improve outcomes for the public, such as improving the timeliness of the Building Better Relationships programme.

4.4. Offender managers advised that they were content with their relationships with the police and praised the role of approved premises in supporting restrictive requirements. However, the Trust had more to do to improve communication with Serco, which provided electronic monitoring services for curfews at the time of this inspection. Offender managers reported that they were frustrated by the reliability and timeliness of information provided about violations, which they considered obstructed their ability to address issues appropriately.

4.5. The Trust managers acknowledge that they do not have the capacity to attend as many meetings as they would like. However partners on both Norfolk and Suffolk Local Safeguarding Children Boards (LSCBs) considered the Trust to be appropriately engaged at executive board level and a valued and responsive partner. Their lead on bringing together the counties to undertake Section 11 audits[2] was appreciated by both boards.

4.6. The LSCBs also acknowledged the contribution made at sub-group level. However, in Norfolk, attendance at local boards was considered to be inconsistent and there was concern that attendance at meetings is at PO or first line manager level only.

4.7. The Trust was considered to be active, well engaged and providing a valued contribution to the work of the Suffolk LSCB. Probation were seen as core panel partners for MAPPA and multi-agency risk assessment conferences (MARAC), attending meetings regularly and being engaged in all cases. Suffolk is about to set up its Multi-Agency Service Hub (MASH) in early 2014 and it has been agreed that the Trust will make a regular part-week contribution to this to aid the flow of information.

4.8. In Norfolk, the Trust was considered to be open to learning and good at responding to challenges. However, while there was a recognition that probation was not alone in this, the LSCB would have benefited from the more proactive provision of information from the Trust.

4.9. At an operational level, the Trust was deemed to work well with Suffolk children's care services, with offender managers making prompt formal contacts and referrals. The Trust was also praised for providing good information relating to release dates and risk information about prisoners, and for notifying the allocated social worker about concerns about children and young people as they arose, or about important changes in an offender's circumstances. It was noted that offender managers tried to attend initial Child Protection conferences where they were involved with the offender, particularly where they provided intensive supervision.

4.10. In Norfolk, the level of operational engagement by the Trust in protecting children and young people was seen as inconsistent and of concern. This related to the incidence and quality of referrals, and to attendance and contributions to Child Protection conferences and groups. (It should be noted that there is no agreed system in place to ensure that offender managers are informed by Norfolk children's social care services in a timely way about these meetings). There was a lack of confidence in the focus offender managers gave to, and their understanding and recognition of, child abuse or safeguarding risks: *"they don't see the child and are focused on the offender"*. There were also concerns that offender managers did not have a good enough understanding about the thresholds for referral, Child Protection processes and the role of social workers. There have been issues around the flow of information into and out of the Norfolk MASH and the Trust's plan to dedicate a part-time PO to help ease these was welcomed.

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2 These audits help to monitor and evaluate the local authority and its partner agencies' compliance with their specific and general duties in respect of safeguarding as defined in Section 11 of the Children Act 2004 to safeguard and promote the welfare of children and young people.

4.11. Effective management oversight plays an essential role in ensuring that actual or potential victims of the offenders, and children and young people known to them, are sufficiently protected from harm in individual cases. A skilled manager, taking a fresh look at a case and with a degree of 'healthy scepticism', can help practitioners take a more balanced and informed view of a case, and identify more appropriate interventions and responses than if working in isolation. We expect to see that a Trust has a system in place for identifying relevant cases, clearly recording outcomes of oversight on the case record, and ensuring remedial actions are taken.

4.12. Norfolk & Suffolk Probation Trust has a range of quality assurance (QA) systems in place including an OASys QA process that has been recognised and adopted nationally. However, the Trust places an overreliance on this to ensure that cases are being managed effectively and there is a need for a trust wide system to enable managers to take account of all the information available in a case when assessing how well it is being managed. Middle managers acknowledged their role in discussing all high risk, MAPPA and MARAC cases during supervision, but some voiced their concern that urgent issues often overtook this. Additionally, rather than add to the caseloads of their already busy offender managers, some are managing cases themselves, leaving them with less time to oversee practice.

4.13. We were alarmed by the lack of oversight in a number of the cases managed by PSOs. While some were experienced practitioners, others presented as less confident during interview and were managing issues, for instance, relating to domestic abuse or Child Protection, with little support. We learned that once a PSO had gained their vocational qualification and had a number of consecutive positive OASys QA feedbacks, their work was no longer checked and countersigned.

4.14. We acknowledge that there may have been more oversight than was evidenced in case records. We learned that this was hampered by lingering confusion around the use of nDelius, which had been implemented only a short time before this inspection, and that there was no consistent practice or guidance relating to how management oversight should be recorded.

Summary

Overall, 67% work to ensure the protection of the public was done well enough.

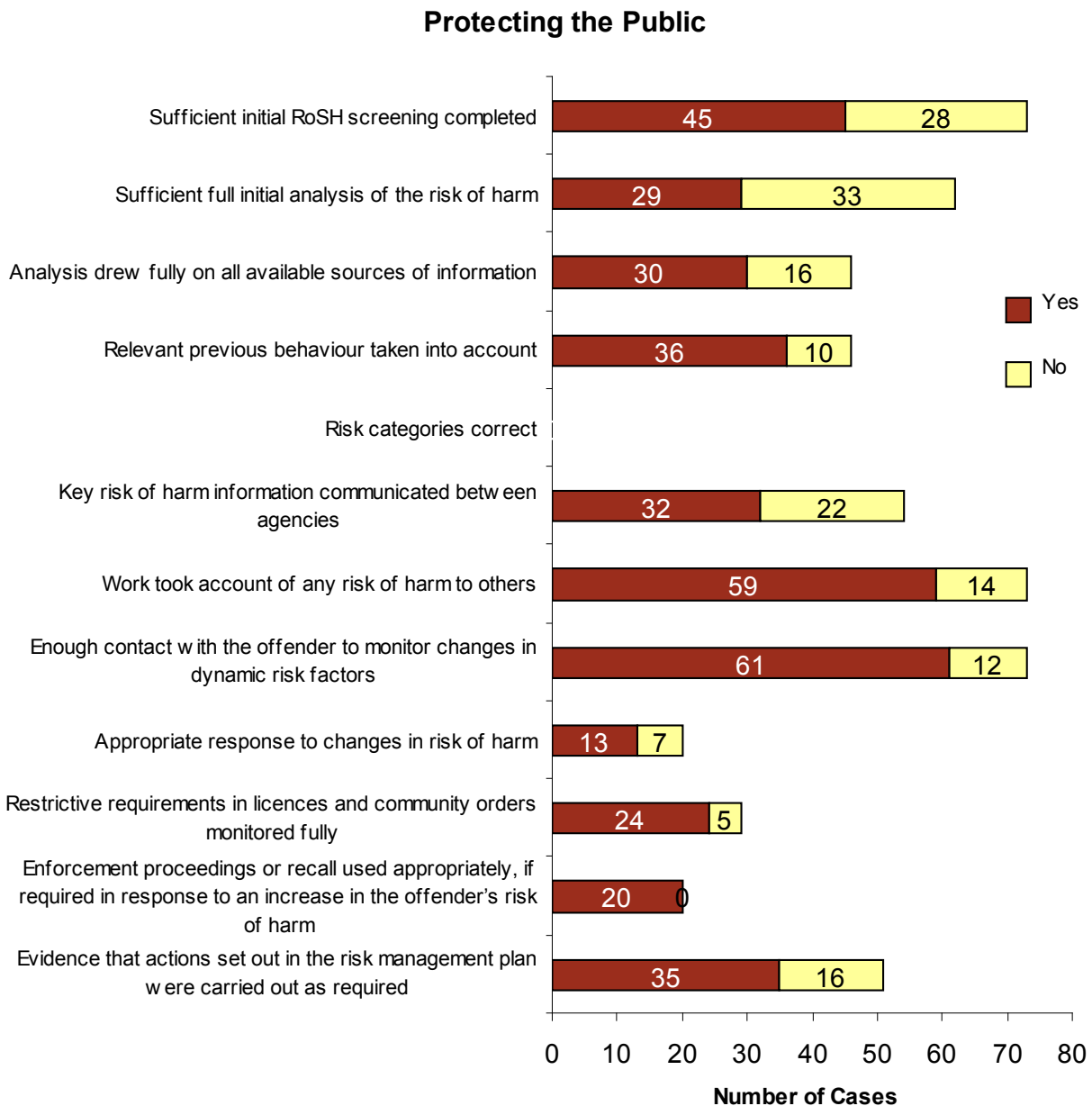
We have recommended that post-inspection improvement work focuses on ensuring that:

- risk of harm to others is assessed accurately and takes account of information actively sought from relevant staff and other agencies
- a plan to manage risk of harm factors is in place where appropriate and this addresses all factors identified in the assessment and includes appropriate contingency planning
- additional attention is given to work to protect children and young people
- assessments, plans and work are reviewed appropriately, and offender managers recognise events that should trigger this action
- effective management oversight is clearly evidenced in the records of all cases involving the protection of children and young people and of those classified as posing a high/very high risk of serious harm to others.

For a summary of our findings see page 2

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 73 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Delivering effective work for victims

5

Outcome 5: Delivering effective work for victims

What we expect to see

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

Case assessment score

Overall, 70% of work to deliver effective services for victims was done well enough.

Key strength

1. In almost all relevant statutory victim contact cases, the quality of the contact with victims was satisfactory. Victims who responded to our questionnaire were mostly positive about their experiences of the Trust; they reported that they felt safer as a result of their contact.

Key areas for improvement

1. Planning to manage risks to actual and potential victims did not provide enough detail, for instance, about how activities would address risks and protect victims.
2. Despite some notable examples of good practice, not enough attention was given, overall, to the safety of victims during the delivery of interventions.

Explanation of findings

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

1.1. We expect to see offender managers and others giving appropriate attention to the risk of harm to both actual and potential victims. We identified 32 cases that involved risks to specific victims and were pleased to find that these were addressed in the large majority of plans. However, there was enough detail about how the objectives of the sentence plan and other activities would address risk of harm issues and protect actual and potential victims in less than two-thirds of relevant cases.

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

2.1. Offender managers and others need to give appropriate priority to the safety of existing and potential victims throughout the sentence. Of the 45 cases where there was a risk to victims, this need had been met in 30. The offender manager had taken full account of concerns expressed by, and the likely impact of the individual's behaviour on, the victim in nearly three-quarters of relevant cases.

2.2. We learned of some good practices in the delivery of interventions. For instance, IDAP workers worked closely with offender managers to identify possible changes or new information relating to risk of harm. In recognition that risk can escalate at the beginning of the IDAP course, they circulated details to children's social care teams when an offender joined the programme.

3. Risk of harm to victims is minimised

3.1. Overall, we judged that in cases where there was an identifiable or potential victim, the risk of harm to them had been managed effectively in two-thirds of cases. In almost three-quarters of relevant

cases, the safety of children and young people had been promoted. There was a considerable difference in performance in this area between cases held by POs and those held by PSOs. We judged that the safety of children and young people had been promoted in 83% of cases managed by POs and in only 35% of those handled by PSOs.

Practice illustration – Work to safeguard victims

James was serving a suspended sentence order for assault against his partner and criminal damage to her property. James attended an induction for IDAP in the first week of his order and his offender manager continued to meet with him while he attended the programme to reinforce the work covered and monitor any emerging risk factors. Post-sentence, James moved back in with his partner and her child. The offender manager made a referral to children's social care services the following day and spoke with the partner about the risks to her child and herself.

4. Victim contact and restorative justice

4.1. Probation Trusts have responsibility for running victim contact schemes. There were 12 licence cases in our sample where victim contact work was required. In 11 of these, an offer of a face-to-face meeting with the victim contact worker was made, ten of these within the appropriate eight weeks of the person being sentenced to custody.

4.2. Victims took up the offer of contact in nine cases. The quality of the work undertaken with them was sufficient in eight. There was regular and accurate information exchange between offender managers and victim contact workers, and between offender managers and prison staff in most cases.

4.3. Where relevant, all of the victims were given the opportunity to express their views on proposed licence conditions. They were offered the opportunity to see the relevant part of any appropriate report and were informed of pertinent events during the individual's sentence, together with relevant conditions of their release.

Comments from victims

Twenty-one victims of crime, who were in touch with the victim contact scheme, responded to our questionnaire.

Responses to the questionnaire were as follows:

- Twenty confirmed that the initial letter about the scheme was easy to understand and 19 that this made it clear that they had a choice about whether to become involved.
- Twenty said that their individual circumstances and needs had been taken into account and that victim contact staff had a full understanding of the impact of the offence on them.
- All but two of the victims said that they were kept informed about key points in the individual's sentence.
- Twenty responded that they had the chance to say what conditions they thought should be included in the licence for their release; 17 said that extra licence conditions had been added to help keep them safer when the individual was released.
- Most respondents said they had reported concerns to the Trust and were satisfied with the Trust's response.
- Eighteen said they felt safer as a result of the work undertaken via the victim contact scheme. Three said it had made no difference.
- Every respondent reported being partially or completely satisfied with the service provided by probation.

Comments from victims

Several victims provided additional comments; some of which are reproduced below:

"I am extremely relieved to have ease of communication via email or a telephone call away. All questions have been answered and assistance has been exceptional. If I feel I have a problem then I email and a response has always been quick. The people are very knowledgeable and I feel that I have somewhere to turn".

Another commented that *"The Victim Liaison officer was very compassionate and friendly and sympathetic when discussing the crime, and the service offered".*

Another added, *"I felt that I would have liked to meet the offender but he did not want to meet which I feel is unfair of the system".*

4.4. We identified 19 cases in the sample where a restorative justice intervention might have been appropriate. The opportunity to participate in such a process was offered to victims in two of these but was not taken up.

5. Leadership and management to deliver effective work for victims

5.1. We found that while statutory victim contact had worked well in the cases we inspected, the Trust acknowledged that there were improvements to be made to the systems relating to referral and the exchange of relevant information.

5.2. The Trust considers that communication with the police is working well. However, it has responsibility for victim contact on behalf of Youth Offending Teams (YOTs) and, here, the flow of information is less well developed. The Trust is frustrated by a lack of referrals from the YOTs, yet the YOTs, who have specialist victim work staff, advised that systems are working and were unaware of the Trust's concerns.

5.3. There are also some internal issues relating to referral. The victim liaison officer (VLO) team does not always receive information from colleagues in a timely fashion about court results and custody releases. Although a range of methods have been used to try and address this, these have had little long-term impact.

5.4. The Trust's senior management acknowledges that the VLO/Women's Safety Officer team is currently short of staff and is proud of its continued commitment in what it considers to be difficult circumstances. The team continues to support the case management process by providing offender managers with relevant reports to help inform assessments, and by attending MAPPA and MARAC meetings.

5.5. We heard about examples of good operational work. The Trust extends its contact with victims to discretionary cases such as those involving vulnerable victims. Some Women's Safety Officers become involved with female offenders who are also victims of domestic abuse. Offender managers are aware of the need to refer these cases to the VLO.

5.6. We were advised that VLOs are aware of the need to notice potential issues relating to the protection of children and young people. We were told of a case where the mother of a victim, who was a child, advised a VLO that her daughter was not coping well. In response, the VLO signposted the mother to appropriate resources in the community and referred the case to children's social care services.

5.7. The Trust is yet to embed restorative justice either culturally or operationally. Although it has been available for some time it has only recently been introduced for community cases, through a pilot running in Waveney and Yare. The Trust would like all offenders to be offered the opportunity to participate but it has been difficult to encourage referrals to this scheme and, by the time of the inspection, there was yet to be a referral.

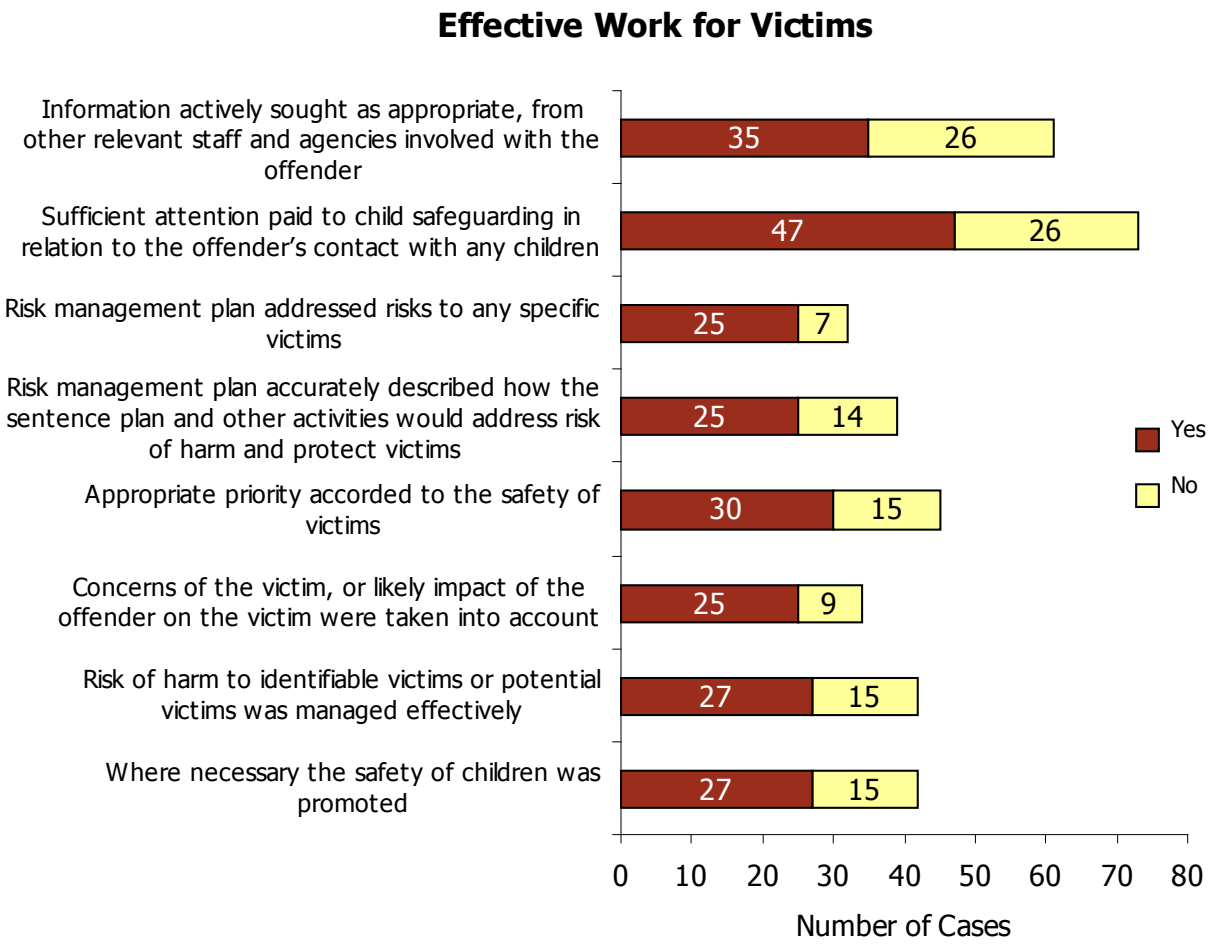
Summary

Overall, 70% work to ensure the protection of the public was done well enough.

For a summary of our findings see page 2

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 73 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Appendices

Appendix 1
Contextual information about the area inspected

Norfolk and Suffolk demographic data

Local Authority	Unemployment[1]	Population[2]	Black and minority ethnic population[3]
Norfolk	6.9%	857,900	3.5%
Breckland	6.4%	130,500	2.7%
Broadland	4.6%	124,700	2.2%
Great Yarmouth	9.8%	97,300	3.2%
King's Lynn and West Norfolk	7.9%	147,500	2.9%
North Norfolk	5.6%	101,500	1.4%
Norwich	9.1%	132,500	9.3%
South Norfolk	4.9%	124,000	2.4%
Suffolk	**6.6%**	**728,200**	**4.6%**
Babergh	5.8%	87,700	2.0%
Forest Heath	5.1%	59,700	8.1%
Ipswich	9.8%	133,400	11.2%
Mid Suffolk	5.2%	96,700	2.1%
St Edmundsbury	5.7%	111,000	4.0%
Suffolk Coastal	4.3%	124,300	3.5%
Waveney	9.8%	115,300	2.4%
England and Wales	**8.0%**	**56,075,900**	**14.1%**

[1] Office for National Statistics Local Labour Market Indicators - October to September 2012

[2] Office for National Statistics 2011 Census

[3] Office for National Statistics 2011 Census

Probation Caseload Data

Total by gender/ethnicity (Analytical Services, Ministry of Justice October 2012)

Norfolk and Suffolk	Supervised in community and pre-release	National average
Total caseload	4,162	n/a
% White	87.2 %	76.4%
% Minority ethnic	6.5 %	19.9%
% Male	88.6 %	90.0%
% Female	11.4 %	10.0%

Appendix 2
Contextual information about the inspected case sample

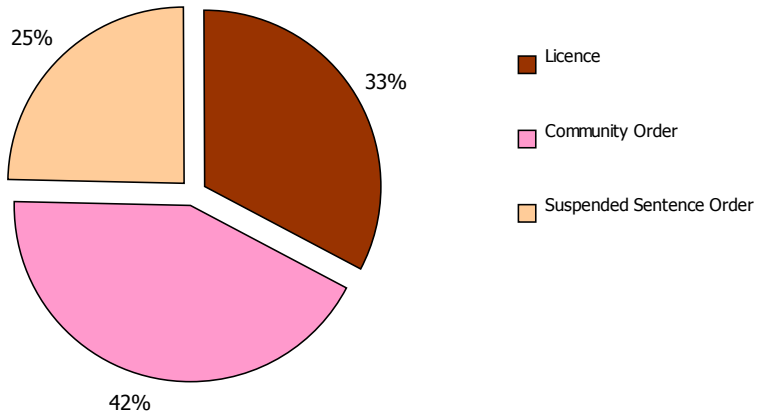
In the first fieldwork week we look at a representative sample of between 50 and 90 individual cases (depending on the size of the area), which have been supervised for around nine months. These are community orders, suspended sentence orders and post-custody licences.

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

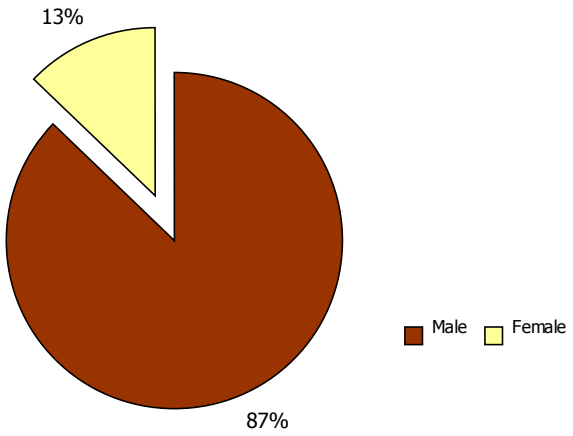
Between October 2013 and March 2014, we will pay increased attention to the work of the Probation Trust to protect children.

In Norfolk and Suffolk we inspected a total of 73 cases.

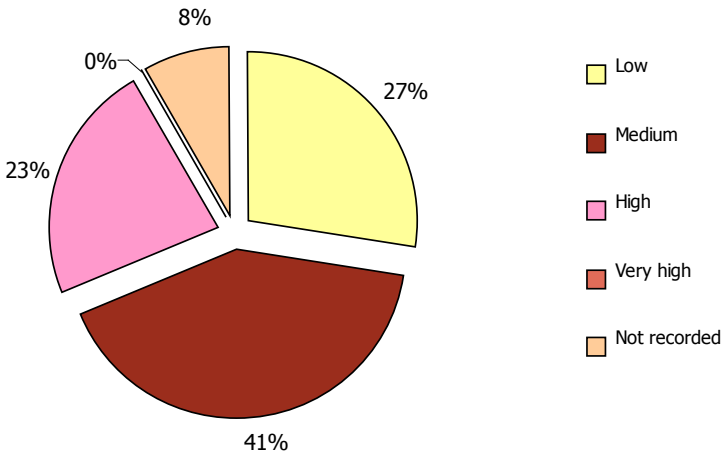
Type of Case



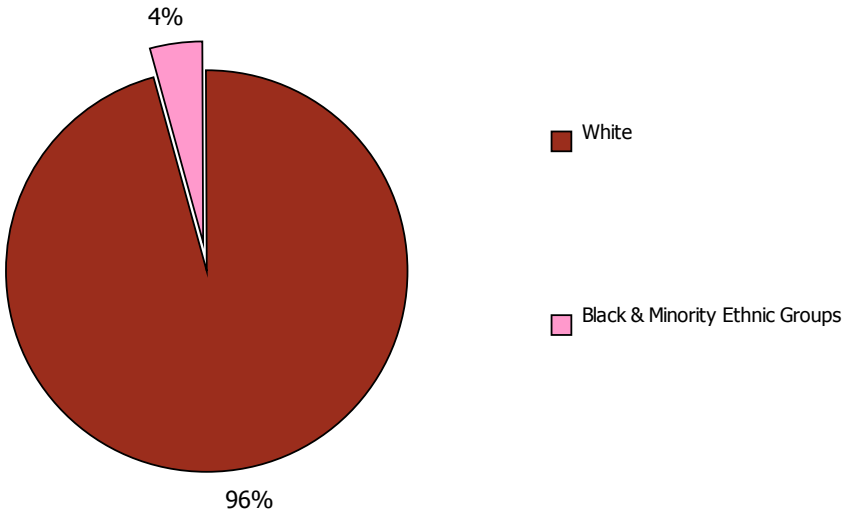
Gender



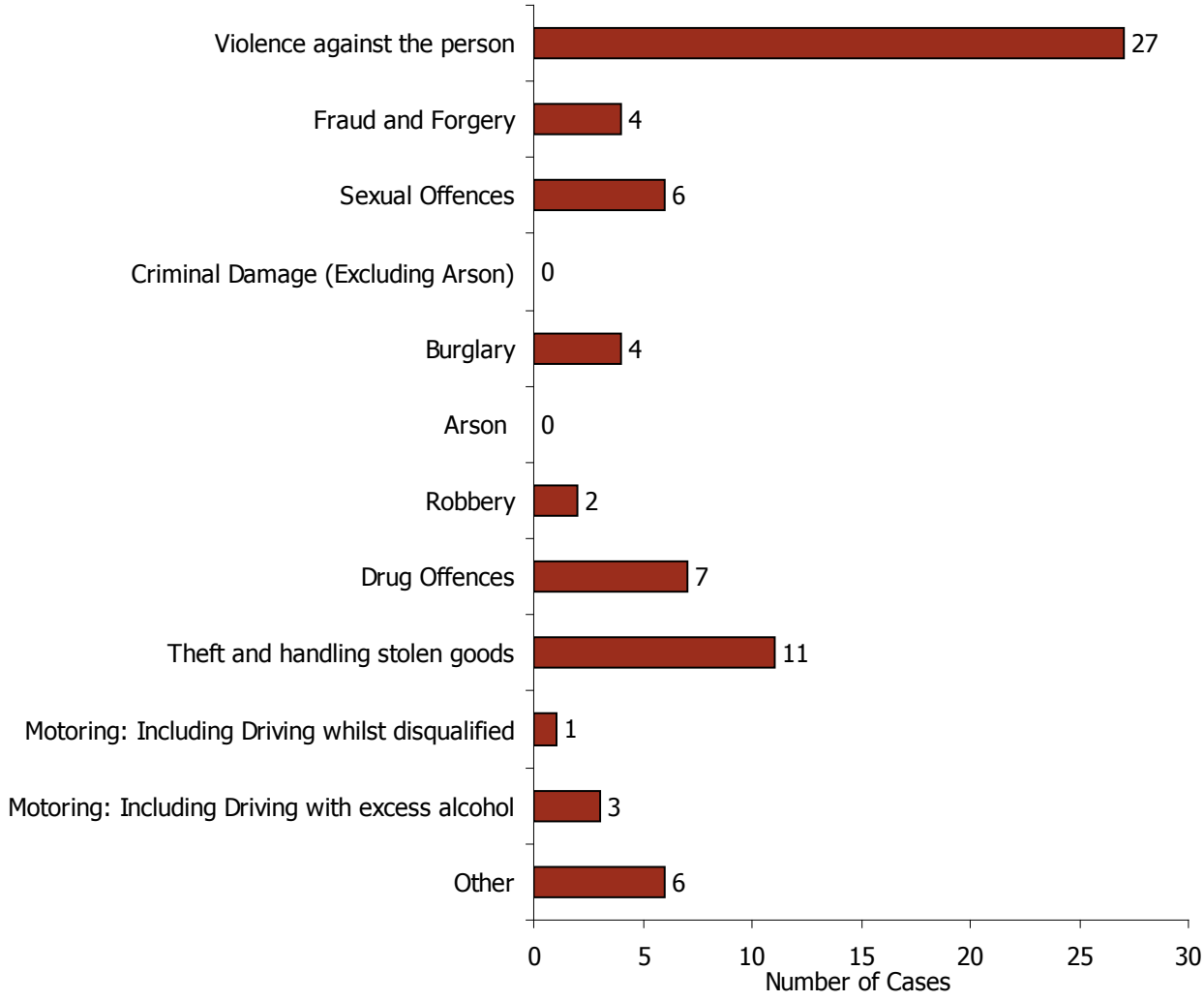
OASys RoSH classification as recorded at the start of sentence or release on licence or transfer into this area



Race and Ethnicity



Principal Offence



Appendix 3
Acknowledgements

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

Lead Inspector	Vivienne Clarke, *HMI Probation*
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	Christopher Reeves, *Proof Reader*
	Jane Regan, *Support Services Officer*
	Rob Turner, *Support Services Manager*
Assistant Chief Inspector	Sally Lester, *HMI Probation*

Appendix 4
Inspection arrangements

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

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

Inspection focus

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

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

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

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

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

Methodology

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

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

Formal meetings with managers, sentencers and service providers are held two weeks after the case inspection. Preliminary analysis of the data from the case inspections allows us to explore, in greater detail,

the themes that are emerging. We also consider specific local characteristics and needs; the ways in which gaps in provision are identified and filled; and work that has been done to improve the quality of service delivery. In particular, issues relating to leadership, management and partnership are explored to help us understand their contribution, or otherwise, to the quality of the work delivered.

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

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

Publication arrangements

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

Appendix 5
Scoring approach

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

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

1. ASSESSMENT AND PLANNING

    1.1 Assessment and planning to inform sentencing

    2.1 Assessment and planning to deliver the sentence

    3.1 Assessment to reduce the likelihood of reoffending

    4.1 Assessment and planning to minimise risk of harm to others

    5.1 Assessment and planning to minimise risk of harm to victims

2. DELIVERY AND REVIEW

    2.2 Delivery and review of the sentence plan and maximising offender engagement

    3.2 Delivery of interventions to reduce the likelihood of reoffending

    4.2 Delivery of interventions to minimise risk of harm to others

    5.2 Delivery of interventions to minimise risk of harm to victims

3. CASE OUTCOMES

    2.3 Initial outcomes are achieved

    3.3 Likelihood of reoffending is reduced

    4.3 Risk of harm to others is minimised

    5.3 Risk of harm to victims is minimised

4. LEADERSHIP AND MANAGEMENT

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

    1.4 Leadership and management to support sentencing

    2.4 Leadership and management to deliver the sentence and achieve initial outcomes

    3.4 Leadership and management to reduce the likelihood of reoffending

    4.4 Leadership and management to minimise risk of harm to others

    5.4 Leadership and management to deliver effective work for victims

5. VICTIM WORK

    5.5 Victim contact and restorative justice.

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

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

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

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

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

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

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

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

Development of the inspection criteria

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

Appendix 6
Criteria

CRITERIA for the INSPECTION of ADULT OFFENDING WORK											
		PROCESS									
Headline CRITERIA OUTCOMES		1	ASSESSMENT AND PLANNING	2	DELIVERY AND REVIEW	3	CASE OUTCOMES	4	LEADERSHIP AND MANAGEMENT	5	VICTIM WORK
1	ASSISTING SENTENCING	1.1	Assessment and planning to inform sentencing					1.4	Leadership and management to support sentencing		
2	DELIVERING THE SENTENCE OF THE COURT	2.1	Assessment and planning to deliver the sentence	2.2	Delivery and review of the sentence plan and maximising offender engagement	2.3	Initial outcomes are achieved	2.4	Leadership and management to deliver the sentence and achieve initial outcomes		
3	REDUCING THE LIKELIHOOD OF REOFFENDING	3.1	Assessment to reduce the likelihood of reoffending	3.2	Delivery of interventions to reduce the likelihood of reoffending	3.3	Likelihood of reoffending is reduced	3.4	Leadership and management to reduce the likelihood of reoffending		
4	PROTECTING THE PUBLIC by minimising the risk of harm to others	4.1	Assessment and planning to minimise risk of harm to others	4.2	Delivery of interventions to minimise risk of harm to others	4.3	Risk of harm to others is minimised	4.4	Leadership and management to minimise risk of harm to others		
5	DELIVERING EFFECTIVE WORK FOR VICTIMS	5.1	Assessment and planning to minimise risk of harm to victims	5.2	Delivery of interventions to minimise risk of harm to victims	5.3	Risk of harm to victims is minimised	5.4	Leadership and management to deliver effective work for victims	5.5	Victim contact and restorative justice

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

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

Appendix 7
Glossary

Accredited programme	Structured courses for offenders which are designed to identify and reduce the factors related to their offending behaviour. Following evaluation, the design of the programmes has been accredited by a panel of experts
Approved premises	Approved premises provide controlled accommodation for offenders under supervision
CEO	Chief Executive Officer of a Probation Trust
Child protection	Work to ensure that that all reasonable action has been taken to keep to a minimum the risk of a child or young person coming to harm
Desistance	The process by which people stop offending and build a new, crime-free identity
Dynamic factors	As distinct from static factors. Dynamic factors are the factors in someone's circumstances and behaviour that can change over time
ETE	Education, training and employment: work to improve an individual's learning, and to increase their employment prospects
HMI Probation	Her Majesty's Inspectorate of Probation
IDAP	Integrated Domestic Abuse Programme
Interventions; constructive and restrictive interventions	A *constructive* intervention is where the primary purpose is to reduce likelihood of reoffending. A *restrictive* intervention is where the primary purpose is to keep to a minimum the individual's risk of harm to others. Example: with a sex offender, a constructive intervention might be to put them through an accredited sex offender programme; a *restrictive intervention* (to minimise their risk of harm) might be to monitor regularly and meticulously their accommodation, their employment and the places they frequent, imposing and enforcing clear restrictions as appropriate to each case. NB: Both types of intervention are important
IOM	Integrated Offender Management
LDU	Local delivery unit: an operation unit comprising of a probation office or offices. LDUs are generally coterminous with police basic command units and local authority structures
LSCB	Local Safeguarding Children Board: set up in each local authority (as a result of the Children Act 2004) to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children in that locality
MARAC	Multi-agency risk assessment conference: part of a coordinated community response to domestic abuse, incorporating representatives from statutory, community and voluntary agencies working with victims/survivors, children and the alleged perpetrator
MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher risk of harm to others

nDelius	National Delius: the national probation case management system which was completed in 2012, based on the earlier Delius system used by some Probation Trusts. The system is being rolled out through 2013
NOMS	National Offender Management Service: the single agency responsible for both Prisons and Probation Trusts
OASys/ eOASys	Offender Assessment System/electronic Offender Assessment System: the nationally designed and prescribed framework for both Probation and Prisons to assess offenders, implemented in stages from April 2003. It makes use of both static and dynamic factors
Offender management	A core principle of offender management is that a single offender manager takes responsibility for managing an offender through the period of time they are serving their sentence, whether in custody or the community. Offenders are managed differently depending on their risk of harm to others and what constructive and restrictive interventions are required. Individual intervention programmes are designed and supported by the wider 'offender management team or network', which can be made up of the offender manager, offender supervisor, key workers and case administrators
Offender manager	In the language of offender management, this is the term for the officer with lead responsibility for managing a specific case from 'end to end'
OGRS	Offender Group Reconviction Score: a predictor of reoffending based only on static risks such as age, gender and criminal history
OMI 2	Offender Management Inspection 2: HMI Probation's inspection programme which ran from 2009 to 2012
PCMS	Probation Case Management System
PO	Probation Officer: This is the term for a 'qualified' offender manager who has undertaken a higher education based course for two years. The name of the qualification and content of the training varies depending on when it was undertaken. They manage offenders posing the highest risk of harm to the public and other more complex cases
PPO	Prolific and other priority offender
PSO	Probation Service Officer: This is the term for an offender manager who was originally recruited with no qualification. From 2010 they may access locally determined training to 'qualify' as a probation services officer or to build on this to qualify as a probation officer. They may manage all but the most complex cases or those posing the highest risk of harm to the public depending on their level of training and experience
PSR	Pre-sentence report: this refers to any report prepared for a court, whether delivered orally or in a written format
QA	Quality assurance
'Risk of harm work'	This is the term generally used by HMI Probation to describe work to protect the public, primarily using restrictive interventions, to keep to a minimum the individual's opportunity to behave in a way that is a risk of harm to others

RoSH	Risk of Serious Harm: a term used in OASys. All cases are classified as presenting a low/medium/high/very high Risk of Serious Harm to others. HMI Probation uses this term when referring to the classification system, but uses the broader term risk of harm when referring to the analysis which has to take place in order to determine the classification level. This helps to clarify the distinction between the probability of an event occurring and the impact/severity of the event. The term Risk of Serious Harm only incorporates 'serious' impact, whereas using 'Risk of Harm' enables the necessary attention to be given to those offenders for whom lower impact/severity harmful behaviour is probable
SAR	Specified activity requirement: the court can include a specified activity requirement as part of a sentence. This can cover a range of activities to assist with compliance and address factors linked to offending behaviour
Safeguarding	The ability to demonstrate that a child or young person's well-being has been 'safeguarded'. This includes – but can be broader than – child protection
SEEDS	Skills for Effective Engagement and Development and Supervision: an initiative in place across many Probation Trusts which emphasises the importance of the practitioners' skills in relationship building to ensure effective work with individuals. The development of these skills is supported by the observation of practice and reflective feedback by managers or others.
SFO	Serious Further Offence: when an offender is charged with an offence classified as an SFO (serious sexual or violent offences), the Probation Trust conducts an investigation and review of the management of the case
SMB	Strategic Management Board: the duties and responsibilities of the Multi-Agency Public Protection Arrangements 'Responsible Authority' (police, probation and prison service) are discharged through the Strategic Management Board. This consists of senior representatives of the agencies involved in Multi-Agency Public Protection Arrangements and lay advisors
Static factors	As distinct from dynamic factors. Static factors are elements of someone's history that by definition can subsequently never change (i.e. the age at which they committed their first offence)
ViSOR	The Violent Offender and Sex Offender Register is a national computer based information system managed by the police and designed to enable probation, police and prison services to share information, risk assessments and intelligence about high risk offenders
VLO	Victim liaison officer: responsible for delivering services to victims in accordance with the Trust's statutory responsibilities
YOS/YOT/YJS	Youth Offending Service/Youth Offending Team/Youth Justice Service: these are common titles for the bodies commonly referred to as YOTs

Appendix 8
Role of HMI Probation and Code of Practice

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

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

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

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