

# Inspection of Adult Offending Work in Kent

An inspection led by HMI Probation



# Foreword

The inspection of adult offending work in Kent 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 third 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 Kent Probation Trust. We were aware that, following a disappointing inspection in 2010, strategic leaders had become resolute in their determination to improve the quality of work across the Trust. The results of this effort were evident in some areas of practice, such as reports to court where work was of a high standard, and greatly appreciated by sentencers. However, there remained significant areas of work, particularly in relation to assessments and plans to manage risk of harm to others, where improvement efforts had not yet led to consistency in performance. Although strategic relationships with partner agencies were healthy, too often links at a practical level were less effective, leading to difficulties in gaining prompt access to information to enlighten assessments of risk of harm and child safeguarding. This impacted on the Trust's ability to deliver an effective service to protect the public.

We have made a number of recommendations designed to address the shortfalls identified in this inspection. We would encourage senior managers to prioritise the development and implementation of a robust action plan to deliver the necessary improvements.



**Paul McDowell**  
HM Chief Inspector of Probation  
March 2014

# Summary

Outcomes	The proportion of work judged to have been done well enough
Assisting sentencing	86%
Delivering the sentence of the court	74%
Reducing the likelihood of reoffending	63%
Protecting the public by minimising the risk of harm to others	58%
Delivering effective work for victims	64%

## Outcome 1: Assisting sentencing

*Overall, 86% of work to assist sentencing was done well enough.*

Most court reports, and all of those on individuals assessed as posing a high risk of harm to others, were of high quality. They generally gave relevant information about the individual's background and included an assessment of their likelihood of offending and of the risk of harm they posed to others. However, routine checks were not always made before sentence to identify any issues relating to the safety of children and young people.

Court reports usually assessed the individual's level of motivation and capacity to comply with the proposed sentence. Proposals within court reports were generally appropriate and most were followed by the courts. Sentencers were enthusiastic about the service they received from the Trust, although were fearful for future provision under the Government's Transforming Rehabilitation Strategy<sup>1</sup>.

## Outcome 2: Delivering the sentence of the court

*Overall, 74% of work to deliver the sentence of the court was done well enough.*

Individualised inductions took place at the start of sentences or on release on licence. In most cases, there was a sufficient assessment of barriers to engagement, with motivational work to encourage compliance continuing throughout sentences. Individuals were reasonably well involved in the initial sentence planning process, which echoed their views expressed in the most recent annual National Offender Management Service Offender Survey.

It was not always clear when work would be reviewed or what might prompt an unscheduled review. Too many sentence plans had either not been reviewed, or not reviewed to a satisfactory standard; as such, opportunities were missed to celebrate progress or to reallocate a different level of resource. Too few plans contained objectives focusing specifically on protecting children and young people, where required, or on meeting obligations from multi-agency risk management procedures.

Levels of contact with individuals were appropriate in most cases and enabled work to be delivered in line with court orders. Offender managers took a leading role in the management of most cases, monitoring attendance and investigating instances of non-compliance. However, there was some variation in the application of the local 'staying on track' letter, which was used as a means of motivating offenders to

<sup>1</sup> Under the Government's *Transforming Rehabilitation* Strategy, Probation Trusts are due to be replaced by the National Probation Service and 21 Community Rehabilitation Companies (CRCs). Recommendations addressed to Probation Trusts in this report must be followed up by whoever delivers probation services in the future, including both the National Probation Service and CRCs. The Strategy can be accessed at <http://www.justice.gov.uk/transforming-rehabilitation>.

comply with their court order. Sentence planning objectives were fully or partially achieved in the majority of cases and most individuals had not been charged with a new offence or reconvicted. Offenders were generally very positive about their experience of being on supervision with Kent Probation Trust.

Offender managers gave positive feedback about the skills of their managers to assess their work, although many felt that staff absences were not well managed or workloads fairly balanced. Offender managers and their seniors were dealing with sizeable workloads. The majority of staff felt that the culture within the Trust promoted learning and development.

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

*Overall, 63% of work to reduce reoffending was done well enough.*

In too many cases, the initial assessment of likelihood of reoffending was either delayed or inadequate and in four cases it had not been completed at all. This had an inevitable impact on the production of appropriate sentence plans. Similarly, only half of the reviews of these assessments were satisfactory, the remainder being either insufficient or not completed.

Constructive interventions encouraged and challenged the individual to take responsibility for their actions in too few cases. Offender managers struggled to maintain the focus within supervision on the changes offenders needed to make to their behaviour. However, approved premises offered constructive interventions in line with individuals' needs and sentence plan objectives. Similarly, specified activity requirements made a useful contribution to planned work. Planned accredited programmes were not always delivered in a timely fashion, with demand for these exceeding supply.

The Trust recognised that there were gaps in available interventions, such as in relation to acquisitive crime, which was a major strategic focus for police colleagues. In contrast, most offender managers thought that their choice of available interventions to enable the delivery of planned work was good. However, the quality and accessibility of some services varied across the area.

A countywide mentoring scheme was well-embedded and proved useful in supporting work with offenders. In particular, volunteer mentors gave much needed help in securing accommodation. Together with employment, accommodation was an area where one-quarter of offenders surveyed by the National Offender Management Service said they would have appreciated more support. In the cases in our sample we noted a degree of success in this area of work, despite the acute shortage across the county of suitable accommodation. Mentors also provided a helpful means of reintegrating female offenders into their community as they approached the end of the women's specified activity requirement.

There was a clear strategic steer emphasising the importance of good communication between interventions staff and offender managers. As a consequence, the flow of information was effective between these parties, enabling offender managers to review with the offender work in other parts of the order or licence. Almost three-quarters of individuals had not been cautioned for, charged with, or convicted of a further offence during the period of supervision we inspected, although there had been insufficient progress, or even deterioration, on some of the most significant factors relating to offending in nearly half of the cases in the sample.

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

*Overall, 58% of work to protect the public by minimising the risk of harm to others was done well enough.*

Analysis of the risk of harm posed by individuals was not consistent or thorough. A number of risk of harm screenings and analyses had not been completed, although those which were done were timely. Too few cases included an effective plan to manage the risk of harm posed by the individual. Too many plans were produced late or not at all; many were over-reliant on a template, which did little to enhance the offender's

involvement in the plan. Nonetheless, some progress had been made on risk management planning since the previous full inspection of the Trust and cases classified as posing a higher risk of harm included better quality plans than those posing only a low or medium risk of harm.

Greater attention needed to be paid to consulting multi-agency sources of information in order to inform reviews of work to manage risk of harm. Multi-agency procedures were used effectively in less than one-third of relevant cases, with some staff lacking confidence about working in the Child Protection arena. In contrast, the Trust's input into Multi-Agency Public Protection Arrangements was effective and strategic partnerships among those agencies focused on protecting the public were strong.

Home visits were not always carried out where needed in high risk cases or in response to concerns about Child Protection. There was insufficient evidence of effective management scrutiny of such cases.

The use of restrictive interventions, such as curfews and restraining orders, was proportionate to the risk of harm posed by the individual. In particular, the approved premises was valued by offender managers and contributed effectively to the management of risk of harm posed by its residents.

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

*Overall, 64% of work to deliver effective services to victims was done well enough.*

In all statutory victim contact cases, where the victim had so elected, the quality of contact with the victim was good. Victims responding to our survey were mostly positive about their experiences of the Trust and all felt that their circumstances and needs had been taken into account during their meetings with victim liaison officers. There was evidence of good liaison between victim liaison officers and offender managers.

Not all risk management plans addressed the risk to specific victims or potential victims and too few described how objectives would address risk of harm issues for victims. In a greater proportion of cases, victims' safety needed to be prioritised and the well-being of children and young people promoted.

The Trust had an appropriate strategic focus on the need to deliver effective work for victims and a small, but strong, team of victim liaison officers and women's safety workers who were well regarded by staff and managers.

# Recommendations

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

1. checks are made as a matter of routine with children's social care services and other relevant agencies to ensure that work with all individuals commences and progresses in the light of any Child Protection and safeguarding concerns
2. sentence planning pays sufficient attention to factors that may promote the individual's compliance; where relevant, plans of work contain objectives designed to protect children and young people and meet obligations from multi-agency risk management procedures
3. reviews of work are timely and thorough, particularly when the individual's circumstances change, and are used to celebrate progress and to reallocate a different level of service where required
4. a thorough assessment of risk of harm to others is carried out in all cases; where necessary, this assessment underpins planning to manage risk of harm to others, with assessments, plans and work aimed at protecting the public being reviewed appropriately
5. managers provide effective oversight in all cases where the individual poses a high or very high Risk of Serious Harm to others and/or where there are Child Protection concerns
6. planning to manage the risk of harm to others takes full and specific account of the safety of actual and potential victims.

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

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# Assisting sentencing

1



# 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 that include an assessment of the offender and, where appropriate, a clear proposal.

## Case assessment score

Overall 86% of work to assist sentencing was done well enough.

## Key strengths

1. Most court reports were of good quality. They were well written and contained sufficient relevant information to assist sentencing.
2. Report authors routinely assessed the individual's level of motivation and their capacity to comply with the proposed sentence.
3. Proposals within most court reports were appropriate, clarifying the objectives of the proposed sentence; these proposals were usually followed by the courts.

## Key area for improvement

1. In many cases, report authors failed to seek information from children's social care services or undertake other checks to support the protection of children and young people.

## Explanation of findings

### 1. Assessment and planning to inform sentencing

- 1.1. Our sample of community cases included 42 where a report had been prepared to assist sentencing. Sixteen of these reports had been presented orally on the day of sentencing with the remaining 26 being typed. All of the typed reports were clear and accessible to the reader.
- 1.2. All but one of the reports gave relevant information about the individual's background and most included an assessment of their likelihood of offending and of the risk of harm they posed to others. However, we read 18 reports that we felt required checks to be made with children's social care services or other agencies in order to identify risks to children and young people; these had been made in only four. We were pleased to note that checks had been made in both the higher risk cases where required. We understood that the Trust had struggled in the past to elicit routine information from children's social care services. In order to overcome this problem, they had seconded a probation officer (PO) on a part-time basis to the Central Referral Unit within Kent County Council; she was well placed to provide a useful conduit between offender managers and colleagues in children's social care services. However, the impact of her deployment was not felt within the cases examined, due to the recent timing of her taking up post. Nonetheless, this deployment augured well for the future.

- 1.3. The overall quality of typed reports was sufficient in the majority of cases. Quality was high in all the cases of individuals posing a high risk of harm to others; it was slightly lower for those assessed as low risk of harm, and much lower for those posing a medium risk of harm. The four typed reports on females were all of an exemplary standard.
- 1.4. The majority of typed reports contained a clear proposal for a community sentence. Most proposals followed logically from the main body of the document, were appropriate to the nature of the offending and were proportionate to the seriousness of the offence. As such, the vast majority of proposals were followed by the court.
- 1.5. All but one report outlined the intended outcomes for the proposed work and these were always relevant. Similarly, all but one report indicated the individual's motivation and capacity to comply with the proposed sentence, although just over one-quarter would have been improved by describing how barriers to compliance and engagement would be addressed.
- 1.6. All except one report had a proposal that included a punitive requirement, such as unpaid work or a curfew. It was clear from our discussions with sentencers that such proposals met with their favour.

## **2. Leadership and management to support sentencing**

- 2.1. During the second week of our inspection, we met with sentencers, including judges, magistrates and Bench Chairs. We also met with the senior manager responsible for liaison with the courts. It was obvious that a positive working relationship existed between the Trust and the courts they served, with both formal and informal liaison regularly taking place. There was an established system of meetings and forums, together with a regular newsletter to sentencers, supplemented by informal email and telephone communication as required.
- 2.2. Despite the Trust's best efforts to keep sentencers informed about significant developments, such as those linked to the Government's *Transforming Rehabilitation* Strategy, sentencers felt that they would have liked more detailed information about the forthcoming changes, given their high impact. However, they recognised that the Trust itself did not always have the answers to their questions. Sentencers expressed concerns about whether, under the new arrangements, financial considerations might unduly influence sentencing proposals and breach recommendations; in particular, they were concerned about how any conflicts of interest might be resolved.
- 2.3. Sentencers welcomed the changes in court staffing brought about by the Trust over the last two years, with the reintroduction of POs into court. They indicated that this had helped improve the quality of reports to court, as well as enabling speedier sentencing through increased use of oral reports. One of the judges we met noted that report authors had changed their approach, moving away from a former tendency to advocate for the defendant towards making a more balanced overall assessment of the case. This had led, in his view, to more appropriate proposals being made. Sentencers commented that reports produced in Kent were more detailed and useful than many seen by other Trusts' authors. Rather than containing 'off the shelf' objectives, reports included imaginative proposals that had been carefully tailored to the individual.
- 2.4. Punitive requirements were clearly popular with the magistrates we met. However, some expressed frustration with reports which indicated that the individual was unsuitable for unpaid work without a fuller explanation being given. Some sentencers felt that report authors were at times inconsistent about whether sex offenders in particular were suitable for unpaid work, with varying and contradictory approaches being taken to the issue of their vulnerability. We were encouraged to hear that the Trust monitored outcomes at court very closely, raising any seemingly unusual disposals with sentencers, such as where 'standalone' unpaid work was given without the support of supervision in higher risk cases.
- 2.5. Sentencers expressed confidence in the use of community sentences and valued what could be achieved in the community, rather than via the alternative of custody, where they deplored the lack of available interventions, particularly in specialist areas such as sexual offending via the internet.

- 2.6. Much use was made of video conferencing in Kent to speed up the court process, enhanced by the recent introduction of a 'virtual' remand court. This development had adversely affected the workload distribution for the Trust, but there appeared to have been limited consultation about the impact, from the Trust's point of view. This was surprising, given the quality of the strategic relationship with the courts.

#### **Comment from sentencers**

*"The uncertainty that probation staff are living with is deplorable and I am astonished at how well they have continued to provide the service we need; I have nothing but praise for them."*

#### **Summary**

*Overall, 86% of work to assist sentencing was done well enough.*

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

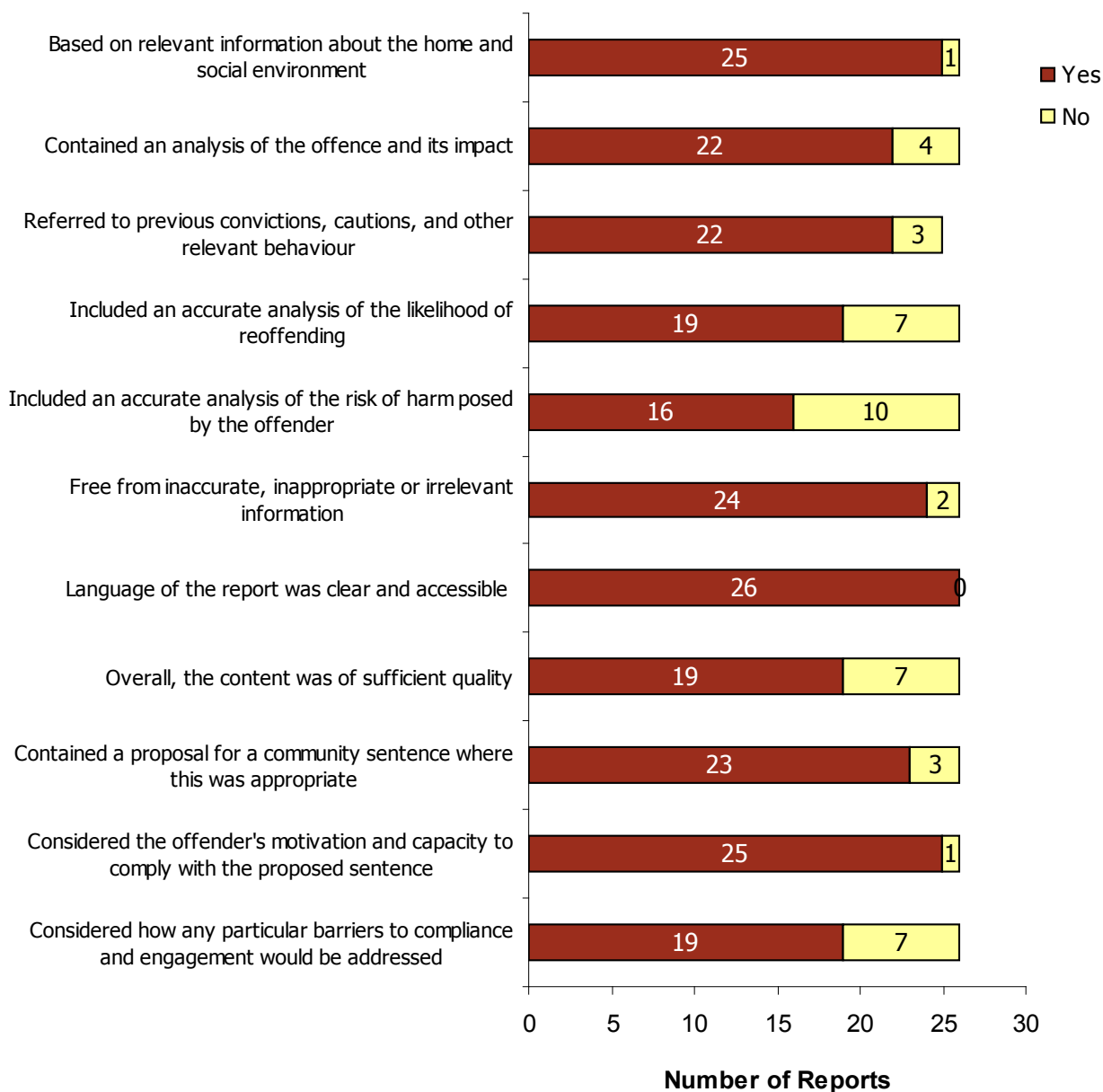
- checks are made as a matter of routine with children's social care services and other relevant agencies to ensure that work with all individuals commences and progresses in the light of any Child Protection and safeguarding concerns.

For a summary of our findings please see page 2

### Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 86 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]

#### Pre-Sentence Reports



# Delivering the sentence of the court

# 2

## Outcome 2: Delivering the sentence of the court

### What we expect to see

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

### Case assessment score

*Overall, 74% of work to deliver the sentence of the court was done well enough.*

### Key strengths

1. Offender managers met promptly with individuals sentenced to community orders or released on licence in most cases, with individualised inductions being tailored to meet specific needs. Motivational work to encourage compliance continued throughout most sentences, with sufficient work taking place to overcome any barriers to engagement.
2. Sentence plans were usually timely and either new or sufficiently revised from a previous one; they were generally informed by assessments of likelihood of reoffending and of risk of harm to others. Individuals were reasonably well involved with formulating their sentence plans; this was evident from both our reading of the cases and the results of the National Offender Management Service (NOMS) Offender Survey.
3. Planned levels of contact were largely appropriate. Offender managers played a central role in coordinating the work being delivered, monitoring attendance across all parts of the order or licence and generally taking a timely and investigative approach to instances of non-compliance.
4. Sentence plan objectives were achieved fully or partially in the majority of cases and were not usually disrupted with a change of offender manager.
5. Those who had offended were usually very positive about their experience of contact with the Trust. Offender managers were very complimentary about the skills of their managers to assess and develop the quality of their work and to support them. Most staff interviewed felt that the Trust promoted a culture of learning and development.

### Key areas for improvement

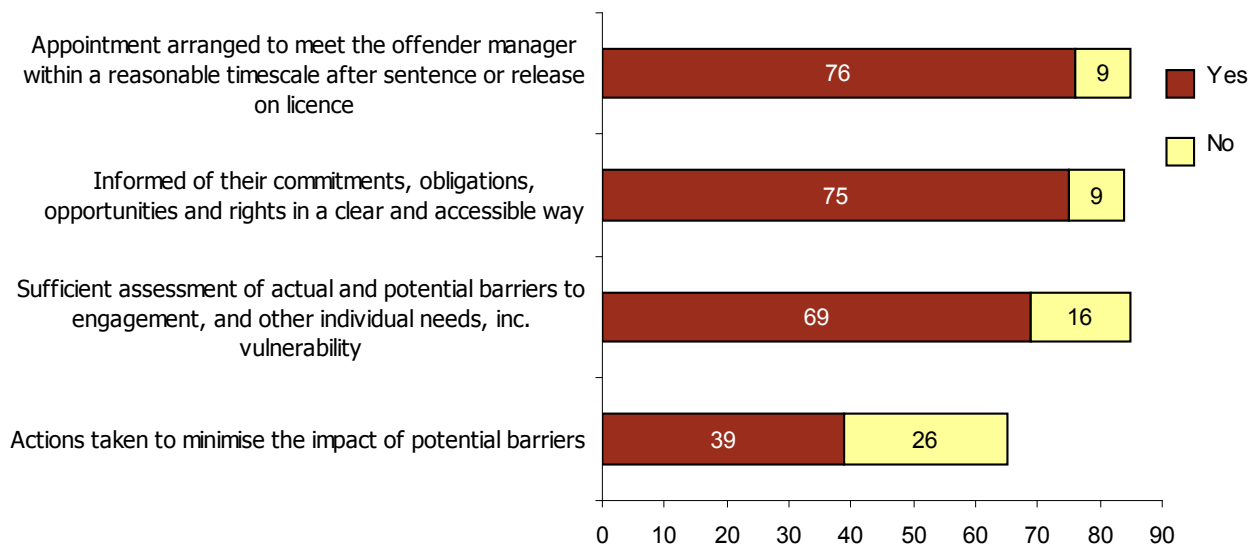
1. The overall quality of sentence planning left room for improvement. Many plans paid insufficient attention to the methods likely to be most effective with the individual, which was a missed opportunity, given the individualised nature of the induction programme. Objectives designed to protect children and young people or to meet obligations from multi-agency risk management procedures were not always specified within plans.
2. It was not always clear when a case would be reviewed or what might prompt an unscheduled review. Too often, the work was either not reviewed or not reviewed sufficiently well. Opportunities were often missed at the review stage to celebrate progress or to allocate a different level of service where needed.
3. Many offender managers and their managers were dealing with sizeable workloads. A number of offender managers felt workloads were not managed in a fair and transparent way and that staff absences, both planned and unplanned, were not effectively managed.

## Explanation of findings

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

- 1.1. We examined 86 cases during this inspection and found that most of these were allocated to the correct tier at the start of the sentence, on release on licence or on transfer into the Trust. However, where the indicative tier had not been followed (in 14 cases), the reason for departing from this was recorded in only three cases.
- 1.2. The Trust had made significant effort to promote the importance of engagement in order to encourage desistance from offending. The results of this effort were evident in a number of ways. Appointments were made promptly with individuals following their court appearance or release on licence and individualised inductions were generally the norm, other than in one office where a group arrangement prevailed. The chart below provides a breakdown of our findings of work related to engaging people at the start of supervision.

**Engaging people at the start of sentence**



- 1.3. Individualised induction enabled offender managers to assess the person’s needs, including in the crucial areas of education and employment, and whether there were diversity factors that needed to be taken into account. The following example illustrates the benefit of this individualised approach:

#### Practice illustration – personalised approach to induction

A high risk sex offender, Peter was particularly vulnerable due to his learning difficulties. On his release from custody, the offender manager met Peter at the prison gate, walking with him to the nearby approved premises. Peter’s licence was complex, with some ten additional conditions, so the offender manager had prepared an ‘easy read’ version of the licence to increase his understanding. When explaining the conditions, she asked him to provide an example of how he could abide by each one, in order to measure his understanding. She then asked approved premises staff to repeat the exercise at regular intervals to ensure he understood.

- 1.4. With sentence planning, we expect to see that individuals are actively and meaningfully involved in drawing up their plan. We saw evidence of this in nearly three-quarters of cases; feedback from offenders indicated that they were involved in more than three-quarters of cases (see the NOMS

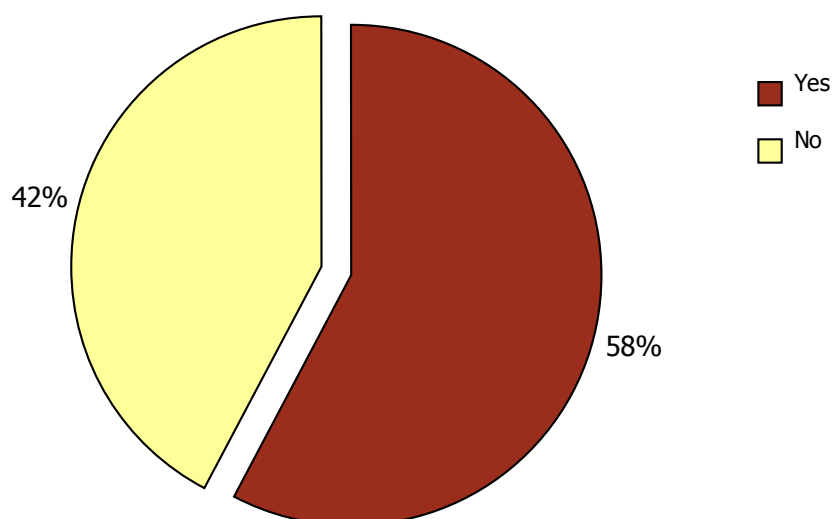
Offender Survey results for the Trust at paragraph 3.4 on page 21 below). The self-assessment questionnaire was used to good effect, as a means of engaging the individual with the planning process, as in the following example:

### Practice illustration – effective use of the self-assessment questionnaire

Stephen was a 35 year old man who had been ordered to complete a domestic abuse programme following an assault on his ex-partner. The case began well with a comprehensive assessment and sentence plan that targeted specific risks and issues pertinent to Stephen. The plan was succinct and easy to understand, with realistic and meaningful targets to effect change. The self-assessment questionnaire was used at each review to inform the sentence plan review. By this means, Stephen contributed to, and had ownership of, his own progress.

- 1.5. Although we found good examples of effective sentence planning, we, nonetheless, judged the overall quality of the initial sentence planning to be sufficient in only six out of every ten cases. This was in part because a number of cases either did not have a plan, had an inadequate plan or the plan had been completed so late as to be irrelevant. Those which had been done were well informed by an assessment of the individual's likelihood of reoffending, and, to a lesser extent, their risk of harm to others. Most plans were also either new or sufficiently revised from a previous plan, rather than simply being duplicated.
- 1.6. Most plans took account of the individual's level of motivation and their readiness to change, although fewer took the individual's *capacity* to change into account. As the chart below indicates, too few plans paid sufficient attention to factors that might promote compliance, including the methods most likely to be effective with the individual. Similarly, actions required to minimise potential barriers to engagement were omitted from four out of every ten plans.

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



- 1.7. The best sentence plans were those that contained objectives which were Specific, Measurable, Achievable, Realistic and Time-bounded (SMART) and focused on the desired outcome. Most sentence plan objectives were sufficiently clear about what the individual had to do to achieve them and objectives were usually clear and simply framed. However, fewer were outcome-focused or set out in achievable steps.



- 1.8. A prime focus of this inspection was how well the Trust contributed towards protecting children and young people. In 47 cases we believed that there should have been objectives to focus on protecting children and young people; disappointingly, such objectives were missing from the majority of these (28 cases). We attributed this oversight to the lack of focus on the protection of children and young people, given the absence of routine information from partner agencies. Similarly, in only 12 out of 33 relevant cases were objectives included that were designed to meet obligations from multi-agency risk management procedures.
- 1.9. We also expect sentence planning objectives to be focused on what will help the individual integrate, or reintegrate, into their community, since this is an important factor in them desisting from reoffending in the longer-term. In making a community integration plan, the offender manager must, of course, first assess the current degree of integration, including the individual's personal strengths, social networks and sources of support. We found such assessments in nearly three-quarters of cases, including some good examples in a number of female cases. This was particularly important, given the lack of a women's community resource centre in the county. The following case illustrates effective support to encourage community integration:

### Practice illustration – providing support for community integration

Sheila was a middle aged woman of previous good character, who had been convicted of driving with excess alcohol and given an alcohol treatment requirement. With a significant alcohol problem, Sheila was an extremely difficult character to engage, initially turning up for her appointments under the influence of alcohol. But the offender manager persisted with her, with a mixture of patience, flexibility and firmness. She recognised that social isolation was a key problem for Sheila, since she was new to the area and was largely alone with her young son, while her partner worked long hours away from home. The offender manager therefore elicited the help of the school's family liaison officer to support and develop Sheila's community integration. The introduction of a mentor also helped this process.

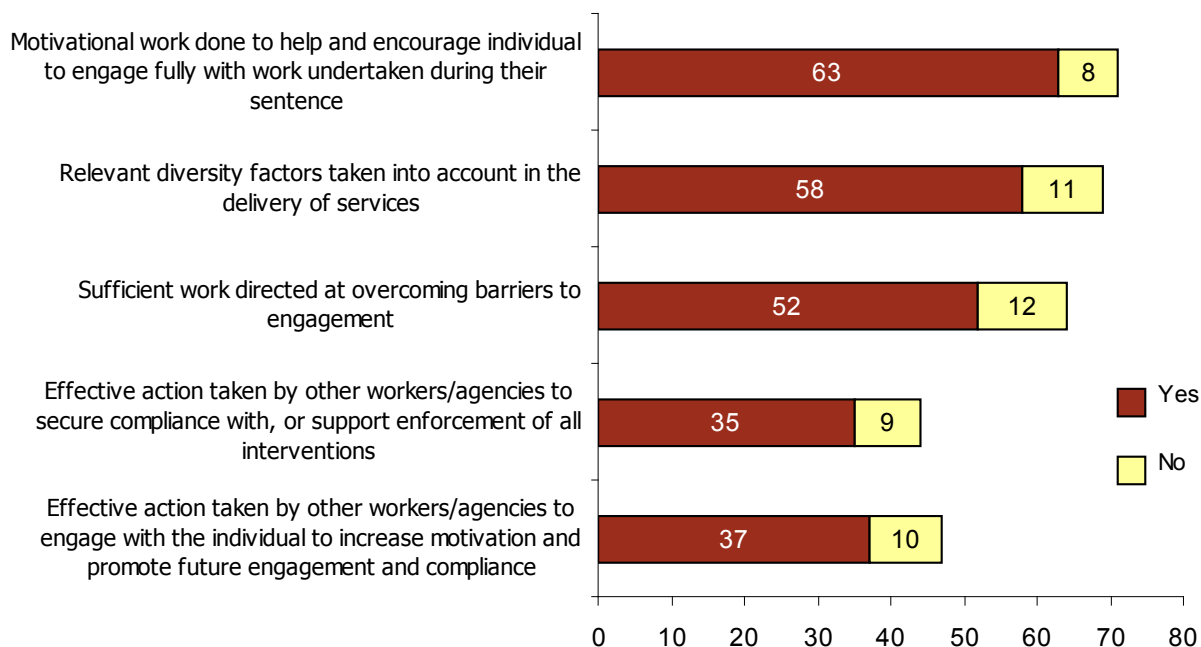
When Sheila had completed the alcohol treatment requirement, the offender manager reframed the sentence planning objectives so as to ensure that Sheila knew that the alcohol service provider could give ongoing assistance with relapse prevention. Although at the time of the inspection Sheila was still drinking, her consumption had reduced significantly and she had not reoffended.

- 1.10. Offender managers routinely assessed educational, employment and accommodation needs in most cases, together with the individual's access to primary health services. However, closer attention could have been paid to potential sources of support within the family or community in over one-third of cases. Where necessary, offender managers signposted individuals to other sources of support in most cases.
- 1.11. Planned levels of contact between offender managers and the individuals they were working with were mostly recorded and appropriate, although offender managers did not always record the rationale for their decisions when professional discretion was exercised.
- 1.12. We noted that in around four in ten cases there was little or no indication of when the work with the individual would be reviewed. Only one-third of cases clarified what might prompt an unscheduled review. Where the review period was indicated, it was appropriate in every case.
- 1.13. Where other workers were involved in the case, it was not always evident that relevant parts of the sentence plan had been clearly communicated to them; this was clear in less than half of the relevant cases.

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

2.1. In the majority of cases examined, interventions were delivered according to the requirements of the sentence, although less often in line with sentence plan objectives, perhaps due to the absence of plans in some cases.

### Increasing motivation and promoting compliance with the sentence



2.2. A number of individuals needed work to improve their motivation to engage; this was done in the vast majority of relevant cases, as the chart above shows, and done well in the following example:

#### Practice illustration – perseverance in the face of limited progress

The offender manager had established a positive working relationship with Andrew, a young man with mental health problems and learning difficulties (Attention Deficit Hyperactivity Disorder). Andrew routinely missed important appointments in the community even if it was in his interest to attend them. In an attempt to assist, the offender manager organised a series of volunteer mentors for Andrew, so that they could accompany him to appointments, but still he did not respond. She continued to encourage him throughout his sentence, eventually persuading him to attend a key interview with a psychiatrist. Despite Andrew's reluctance, the offender manager persevered, acknowledging that even small improvements over a long period of time represented a big achievement for him. At the time of the inspection, Andrew had not reoffended.

2.3. The level of contact offered by offender managers promoted positive outcomes in the majority of cases. Specifically, it was sufficient to facilitate the delivery of the sentence and of sentence planning objectives, to monitor any changes in dynamic risk factors, and to take full account of the individual's likelihood of reoffending and their assessed level of risk of harm. In most licence cases, an acceptable level of contact had been maintained while the individual was in custody. This contributed to effective post-release planning and case management. The following case demonstrates this:

### Practice illustration – effective release preparation

Michael was on licence following a conviction for repeated sexual offences against two young female relatives, offences which he denied. While in custody, his offender manager had maintained contact with Michael and taken responsibility for the completion of annual Offender Assessment System (OASys) assessments, given his high risk status.

On the day of his release from custody, a meeting took place involving Michael, the offender manager and the public protection officer, in order to give him a comprehensive induction into his licence period. As planned, Michael was released to approved premises which gave him effective support and control, with useful group and one-to-one work. In the first three weeks following release, support was provided in relation to benefits, banking, education, GP registration, housing referrals and engagement with the job centre.

In addition, the offender manager completed some useful victim awareness work with him, a remarkable achievement given his complete denial of the offences.

- 2.4. The level of resource allocated was also judged to be appropriate in most instances, although in seven cases we thought the level of resource allocated was too high.
- 2.5. An essential element of effective offender management is the coordination of work by all who are involved with an individual. In most of the cases inspected, the offender manager took a leading role in relation to other workers in managing the sentence. They monitored attendance at appointments for supervision, rehabilitation work or for unpaid work.
- 2.6. Offender managers also took an investigative approach to most instances of non-compliance, together with effective action to secure compliance, as the following example illustrates:

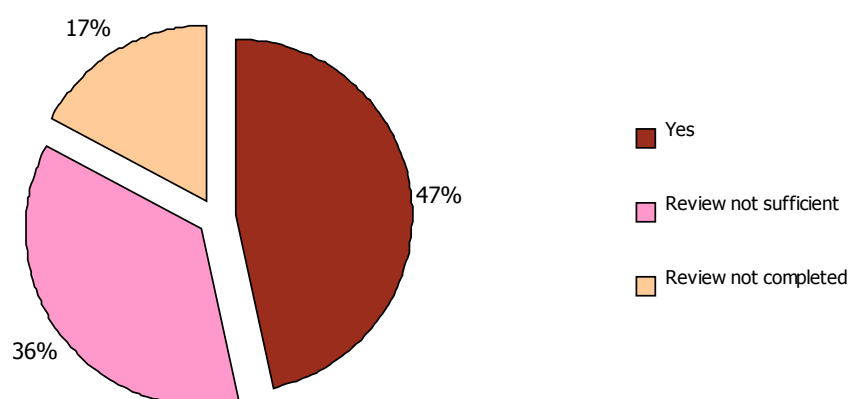
### Practice illustration – effective action to secure compliance

Joe was a middle aged man sentenced to 80 hours of unpaid work for assaulting a customs officer. The father of nine children and carer for his wife, Joe had a range of diversity factors to be taken into account, but a placement was identified with sufficient flexibility to allow him to complete his hours and provide care for his family. The manager of the warehouse was fully briefed about the issues and the offender manager worked hard to encourage Joe to complete his hours, using 'staying on track' letters designed to encourage compliance on two occasions and making several motivational telephone calls to him. Joe's pattern of attendance could have led to breach action but the offender manager's use of professional judgement achieved a satisfactory outcome, a completed order.

- 2.7. Clear and timely formal warnings were issued in most cases, as appropriate. However, we noted a high level of variation over the use of 'staying on track' letters, with some staff using these sparingly, while others used them on repeated occasions, rather than escalating the case. One sentencer commented to us that he had occasionally noted a rather relaxed approach to non-compliance in the early stages of some cases eventually brought to court for breach hearings. Among our selected cases, we found a number (eight in total) where we might have expected to see legal proceedings, but did not; we also found one case where we considered the use of legal proceedings to have been inappropriate. Where legal proceedings or recall were instigated, action was taken promptly in most cases. A clear explanation was given to the individual as to why the action was taken in all but one of those cases. Sufficient effort was then made to re-engage the individual with their sentence plan in most of the cases where breach or recall had taken place as a result of non-compliance.

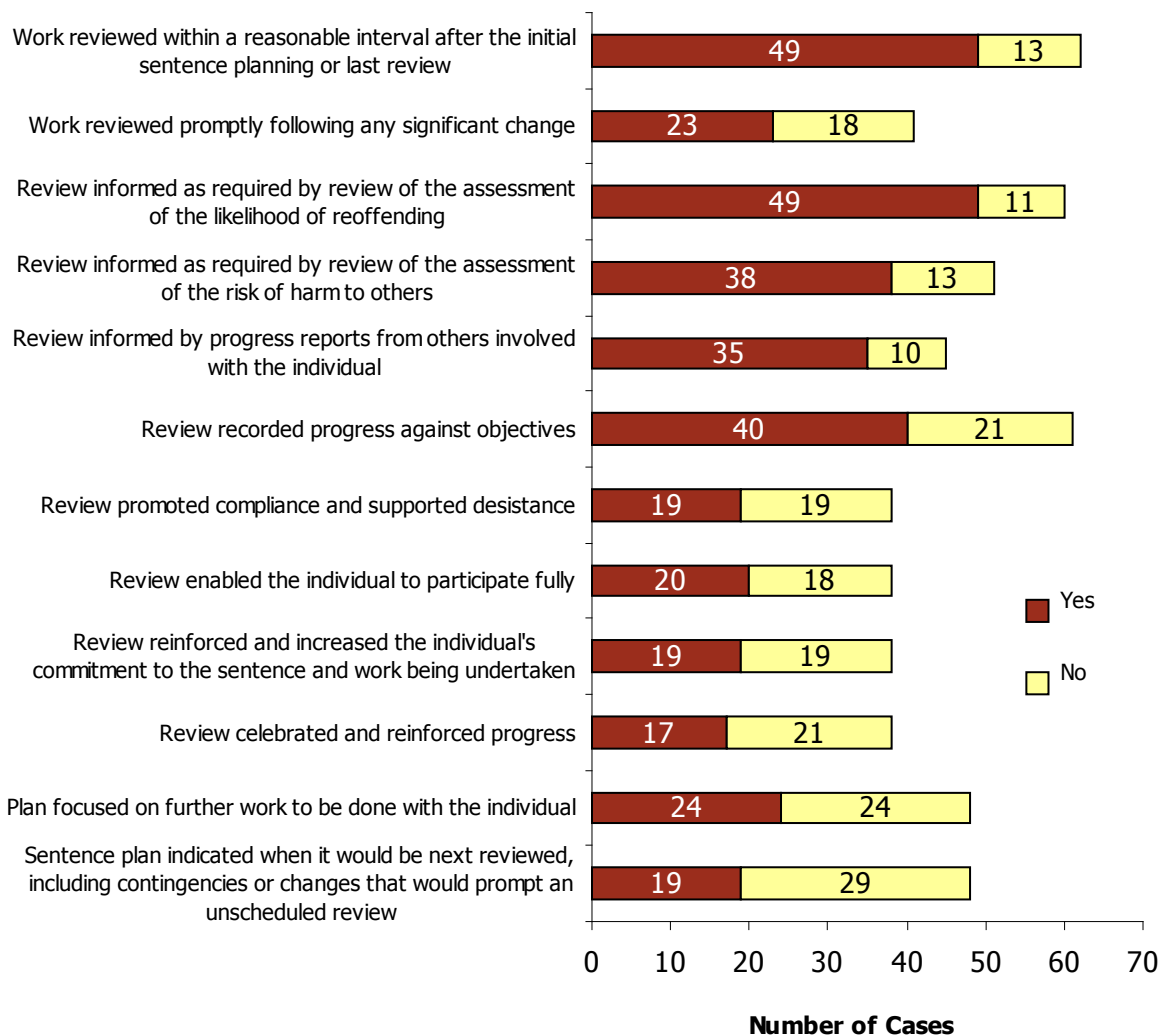
- 2.8. Professional judgements about acceptability, or otherwise, of absences or other behaviour were mostly reasonable, consistently applied and clearly recorded.
- 2.9. We expect to see work with individuals reviewed within the timescale stated in the initial plan or within a reasonable period. In addition, we expect to see work reviewed in response to a significant change, such as the completion of an offending behaviour programme or altered circumstances which might affect the level of risk of harm to others. As mentioned above, initial plans did not always note when such reviews were due or what might prompt an unscheduled review. Furthermore, many reviews were either done late or not sufficiently thoroughly. Over one-third of reviews (27 in total) were of insufficient quality, and a further 13 had not been undertaken at all.

**Sufficient review of work with the offender**



- 2.10. In a little over half of relevant cases where a significant change had occurred were reviews conducted. Reviews, whether routine or ad hoc, presented important opportunities to celebrate progress, reflect changes in the case and allocate a different level of service where needed. Offender managers failed to maximise these opportunities in around half of all cases.
- 2.11. Among the 86 cases inspected, two had been transferred into the Trust as a result of individuals moving to Kent and two were transferred out. Only one of the incoming and one of the outgoing transfers were handled appropriately; in the other cases there was a degree of confusion about who was managing the case during the transfer process and management of the two incoming cases would have been enhanced by a home visit.
- 2.12. Case files were well organised and recording of information was mostly clear and timely. Most case records contained sufficient information to support offender management tasks.

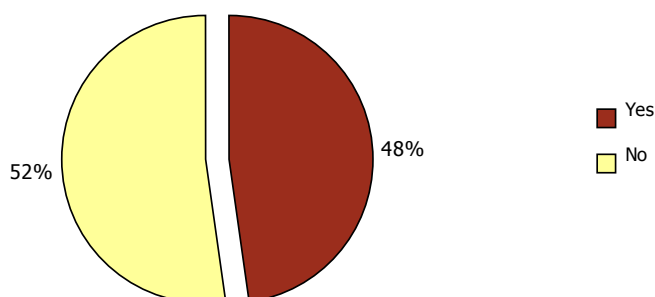
### Reviewing sentence plans and reinforcing progress



### 3. Initial outcomes are achieved

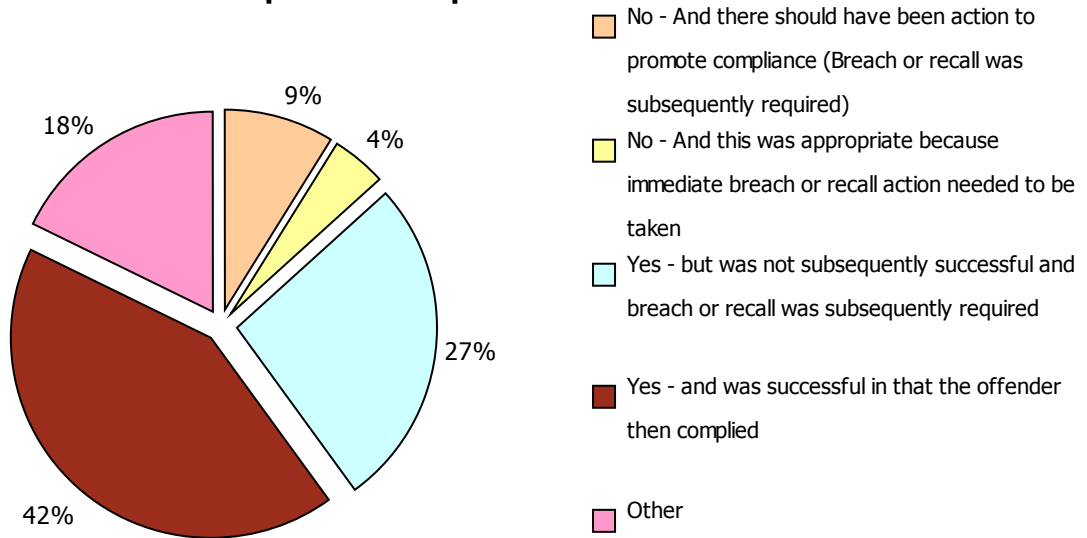
3.1. Reporting instructions were sufficient for the purpose of carrying out the sentence of the court in the majority of cases. The charts below show that the requirements of the order or licence were delivered in most cases. In just under half of the cases the individual complied with the sentence without the need for additional action by the offender manager. Women were marginally more compliant than men and, when challenged about any non-compliance, responded more positively than men.

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



3.2. There were only four cases where we thought action to promote compliance should have been taken but was not, although in a number of cases we considered that breach action or recall had not always been used when required.

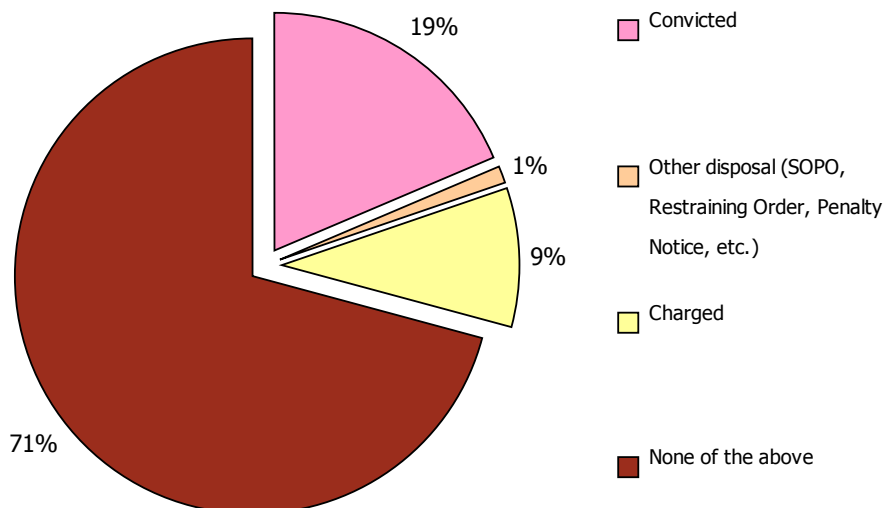
**Action taken to promote compliance**



3.3. Sentence planning objectives had been either fully or partially achieved in almost three-quarters of cases. A similar proportion of cases had been managed by more than one offender manager; 19 cases had been managed by three or more. However, in just over three-quarters of relevant cases, we found that a change of offender manager caused little or no disruption to the delivery of planned objectives.

3.4. As illustrated in the chart below, almost three-quarters of individuals had not been cautioned for, charged with, or convicted of a further offence during the period of supervision we inspected.

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



**What people who had offended thought of their experience:**

NOMS conducts an annual survey of the offenders in contact with Probation Trusts. For 2012, Kent received 597 responses, the data from which is given below.

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

The survey found, as we did, that offender managers were good at motivating and supporting individuals to undertake the work needed to fulfil objectives. However, some respondents identified that they would have appreciated more support in relation to their search for employment and housing. Others complained about the distance they had to travel for appointments or having had several changes of offender manager.

**Comments from individuals:**

*"I feel it has gone well; it is down to the individual, if he/she wants help then it is available, you just need to be motivated and ask for it".*

*"I would not change a thing. I feel I have been treated very fairly. I have been given the best possible support by my probation officer".*

*"Everyone and everything is better than I expected".*

**Less positive comments:**

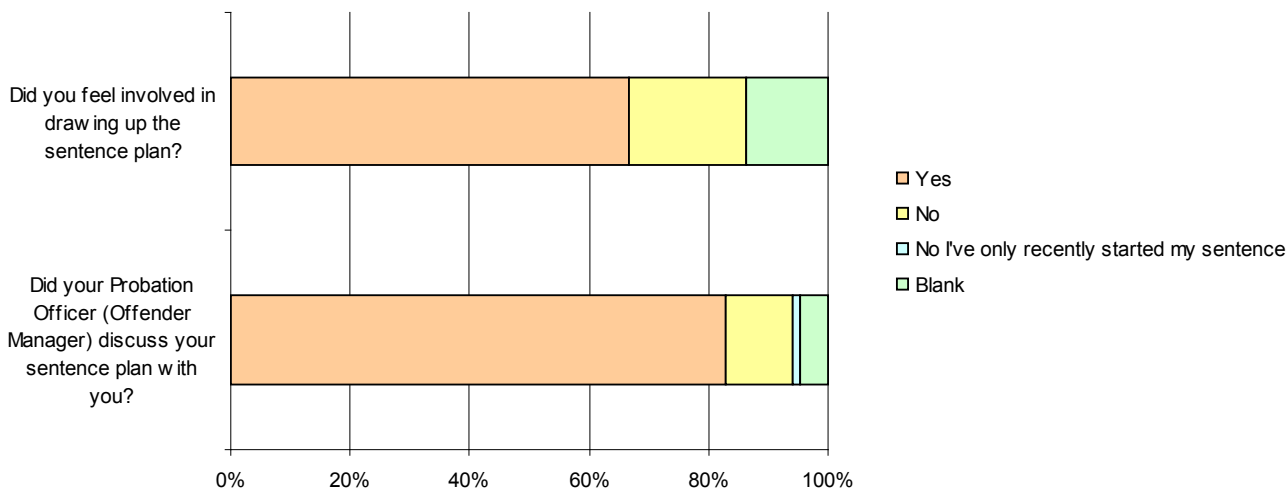
*"[I would like] to see the same probation officer all the time to be able to build a relationship. Seeing a different person all the time does not help build trust with offender and officer"*

*"If possible I would have liked more help with housing and getting a job"*

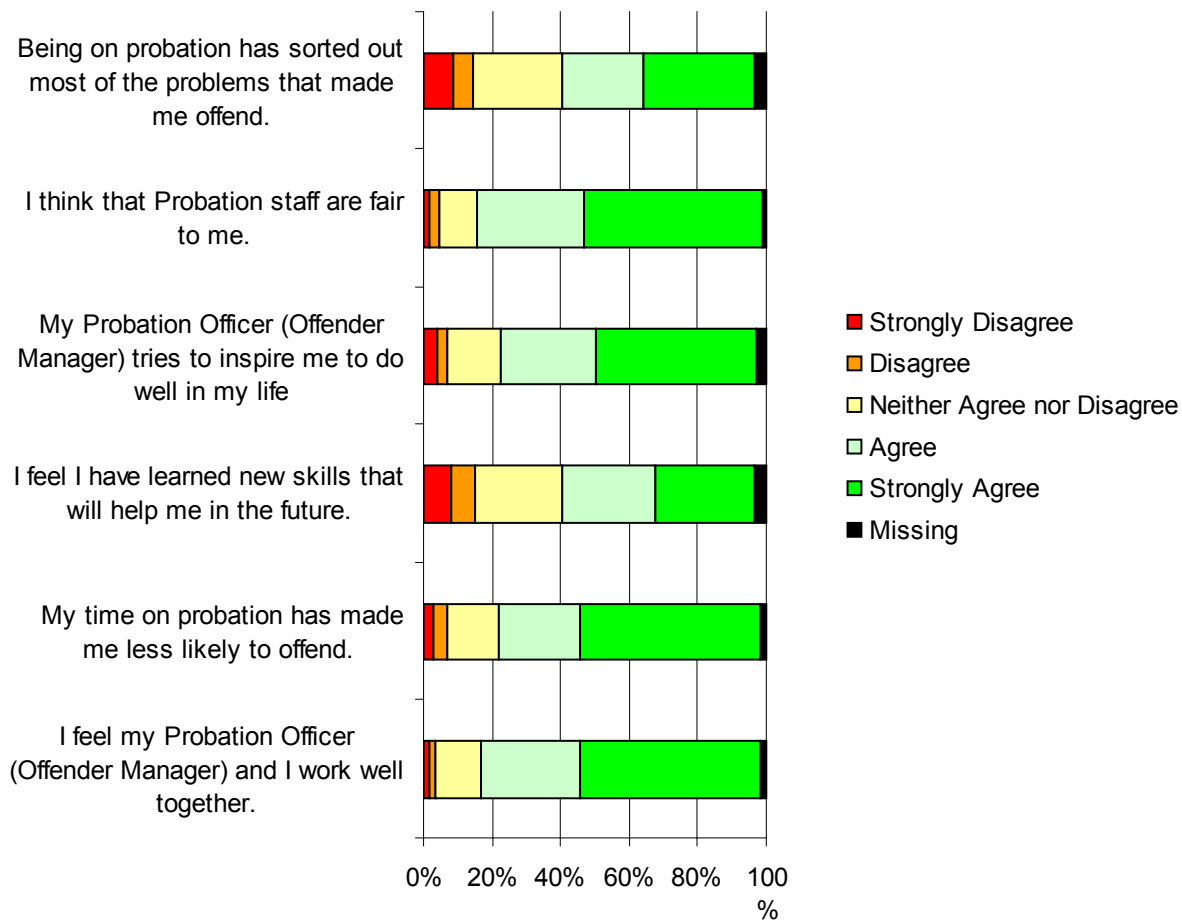
*"[I would have liked] being seen at the time of my appointment. I appreciate that it may not always be possible but I don't think it has ever happened during the four months I have been reporting to this office".*

The charts below show some of the responses from the survey

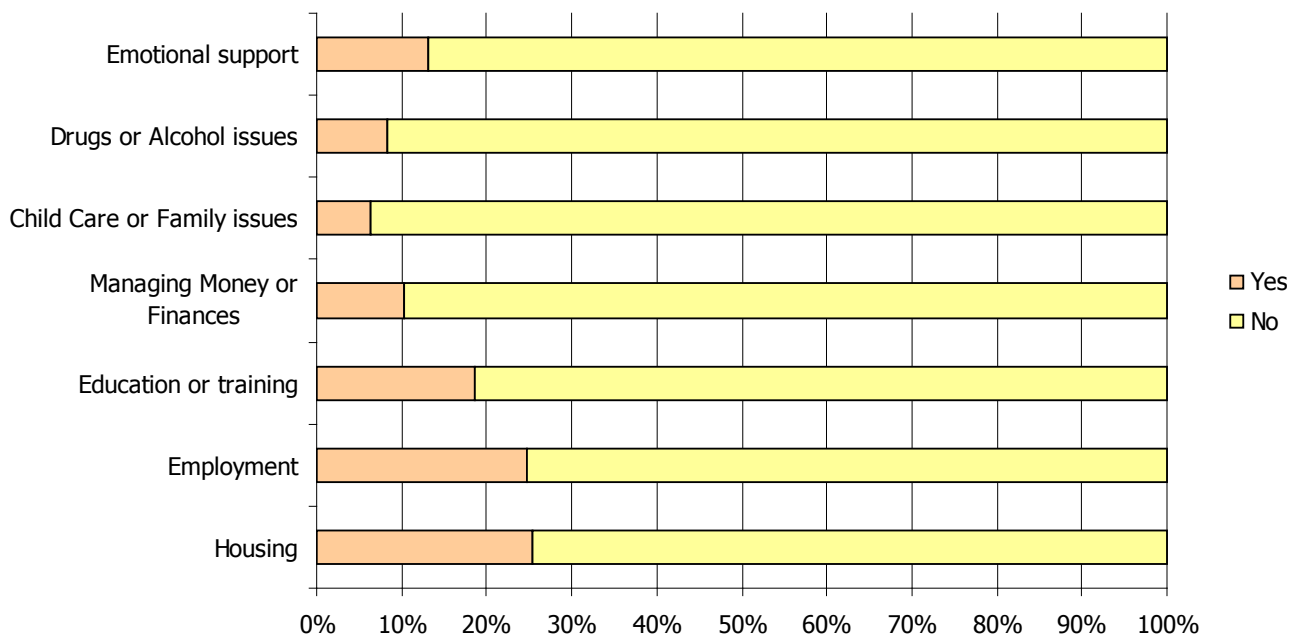
**Section 1 - About Current Order / Sentence**



### Section 2 - About Experience on Probation



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





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

- 4.1. We interviewed 64 offender managers (as part of the inspection of the 86 cases in the sample) to gain their views about their experience of working for the Trust. Just over half of these staff were probation services officers (PSOs), the others were qualified POs. Of these staff, nine felt that their diversity needs had not been well handled by the Trust, while many others had much more positive experiences.
- 4.2. Two-thirds of staff thought that workloads were actively monitored. However only one-third thought felt sure this was in a clear and transparent way. Responses from PSOs were noticeably more positive than those of POs in this respect. A user group comprising practitioners of various roles and grades had overseen the introduction of a workload management tool and senior leaders were confident that the tool enabled fair distribution of work. However, many individuals described being overwhelmed by the volume of work, using expressions such as "*we are on our knees*". Staff routinely discussed their concerns about workloads with their seniors, but felt that managers were powerless to provide relief, given the level of staff shortages and constant supply of new work.
- 4.3. It followed logically, that only a little over half of all those interviewed felt that planned absences, such as annual leave or long-term sick absence, were managed effectively so as to minimise any disruption to the continuity of offender management. In relation to unplanned absences, such as that caused by ad hoc sickness, this figure dropped to a little over one-third. Senior leaders were grappling with sick absence running at its highest level for the last six years and with a higher than normal departure rate, due, in their perception, to staff fears over the impending implementation of the *Transforming Rehabilitation* Strategy. They reported that these circumstances were impacting on the Trust's capacity to drive forward improvements in the quality of practice.
- 4.4. The vast majority of offender managers held positive views about the skills of their line managers, indicating that they had the ability to assess the quality of their work, assist their development and support them. Most also thought that routine countersigning of their work and management oversight was an active process, either sometimes or always.
- 4.5. Of the offender managers we interviewed, around eight out of ten had regular, professional supervision with their manager, at least at six-weekly intervals, with almost half having such meetings monthly. PSOs tended to have supervision more frequently than POs. Case discussion featured strongly in supervision, as well as feedback about performance, training and development issues and discussion about personal well-being.
- 4.6. A little over two-thirds of offender managers reported that their practice had been observed, with the opportunity for reflection, more often with a colleague than with a manager. Most thought that this and other methods used in supervision had promoted improvements in their practice. The Trust was on the verge of rolling out Skills for Effective Engagement, Development and Supervision training across the area.
- 4.7. In order to drive up standards of practice, the Trust had implemented a comprehensive quality development strategy since the time of the last inspection. At the heart of this strategy were Quality Development Officers, who were allocated one per office, while also holding cases or having other responsibilities (such as those of the safeguarding officer seconded to Kent County Council's Central Referral Unit). Their role was to support the local senior probation officer (SPO) by coaching staff in best practice, both individually and in group settings. It was clear that the SPOs, to whom we spoke, welcomed this initiative, since it extended their ability to provide support to their busy teams. However, we had some concerns that, ironically, the sharing of responsibility for quality assurance and development in this way had diluted rather than strengthened its impact, with attention to some key issues falling between the two parties.
- 4.8. Most staff said they thought formal opportunities to discuss practice issues with colleagues were sufficient, while also making use of informal opportunities. The Quality Development Officers took

the lead in organising many regular formal sessions, although one offender manager commented that the somewhat unstructured nature of these sessions led to inconsistency about what was delivered across the Trust. Almost two-thirds thought the process for disseminating the findings from serious further offences or serious case reviews was sufficient. However, some staff felt that dissemination of information relied too heavily on the use of the local intranet, which they did not always find the time to access.

- 4.9. In relation to learning and development opportunities, just over three-quarters of offender managers thought that arrangements for ongoing training and development were, at least, sufficient to equip them to do their current job, but they were slightly less positive about the extent to which their future development needs were met. A small number of staff questioned the relevance of some training and felt that there was an overemphasis on OASys quality at the expense of other areas of importance or interest.
- 4.10. All but four staff described feeling confident in identifying and working with Child Protection and safeguarding issues. There had clearly been a drive on this type of training, with most staff having received some over the last two years, many within the last year.
- 4.11. A high proportion of staff considered that the Trust promoted a culture of learning and development.

## Summary

*Overall, 74% 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:

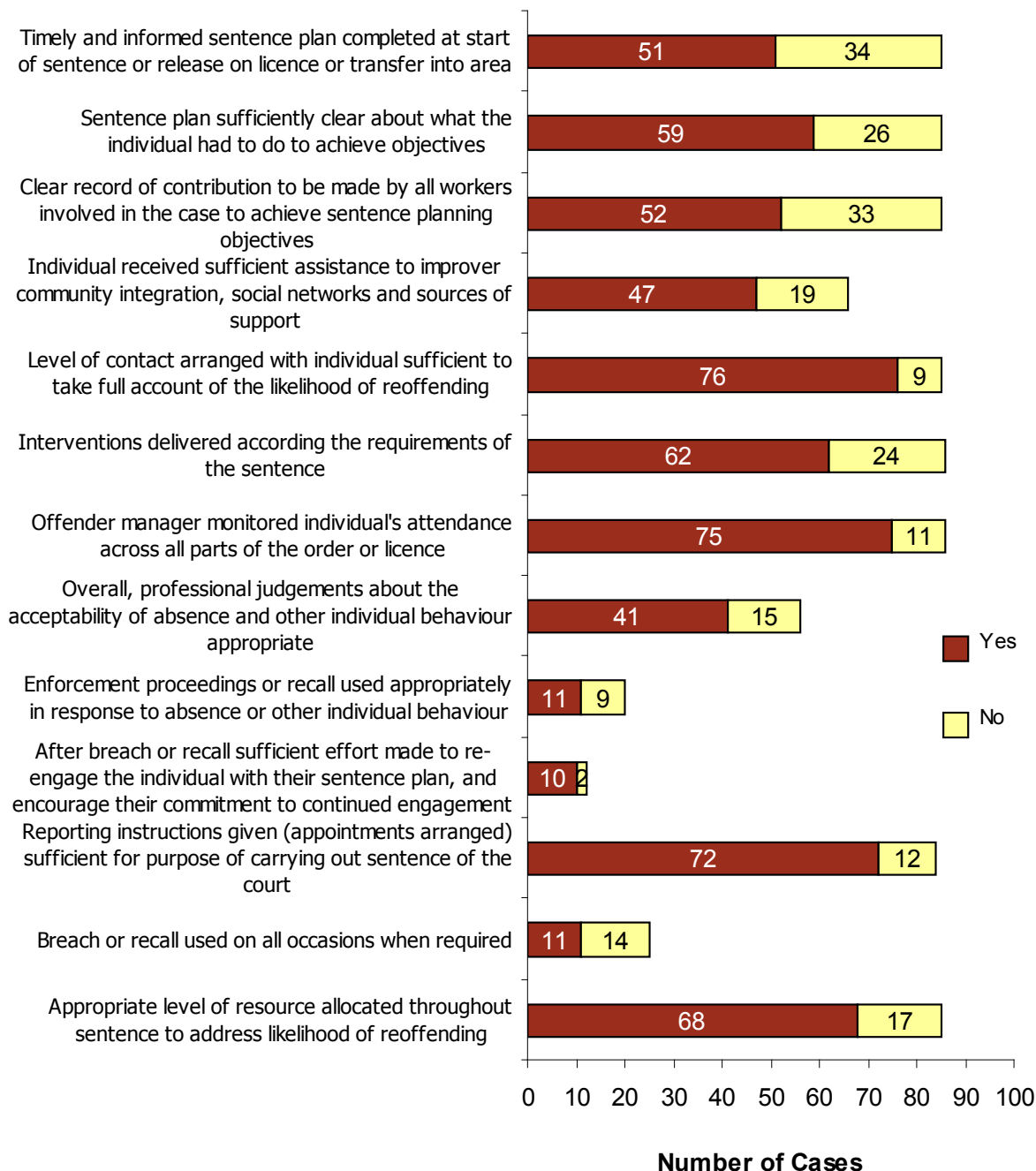
- sentence planning pays sufficient attention to factors which may promote the individual's compliance; where relevant, plans of work contain objectives designed to protect children and young people and meet obligations from multi-agency risk management procedures
- reviews of work are timely and thorough, particularly when the individual's circumstances change, and are used to celebrate progress and to reallocate a different level of service where required.

For a summary of our findings please see page 2

## Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 86 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]

### Delivering the Sentence



# Reducing the likelihood of reoffending

3

## Outcome 3: Reducing the likelihood of reoffending

### What we expect to see

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

### Case assessment score

*Overall, 63% of work to reduce the likelihood of reoffending was done well enough.*

### Key strengths

1. Approved premises offered constructive interventions in line with individuals' needs and sentence plan objectives in most relevant cases. Similarly, specified activity requirements (SARs) made a useful contribution to planned work in the majority of relevant cases.
2. There was a clear strategic steer emphasising the importance of good communication between interventions staff and offender managers; as a consequence, feedback from intervention providers was regularly provided, enabling offender managers to review with the offender work in other parts of the order or licence.
3. Most offender managers described the range of interventions available to them as either sufficient or excellent, although the quality and accessibility of some services varied across the county. A county-wide mentor scheme was well embedded and proved useful in supporting the work of offender managers and others.

### Key areas for improvement

1. One in five initial assessments of likelihood of reoffending was not completed, or was so late as to be largely irrelevant, although, of those that were done, seven in every ten were sufficient. Similarly, only half of the reviews of these assessments were sufficient; the remainder being either inadequate or not completed.
2. Work with offenders did not always consist of constructive interventions designed to encourage them to take responsibility for their actions; more could have been done to maintain a focus on the individual's offending behaviour.
3. Delivering accredited programmes within planned timescales was challenging for the Trust; in almost half of the relevant cases, such programmes should have been delivered, but had not been.
4. There had been insufficient progress, or even deterioration, on some or most of the significant factors relating to offending, in nearly half the cases examined. There was not always evidence of improved family relationships or improved community integration.

### Explanation of findings

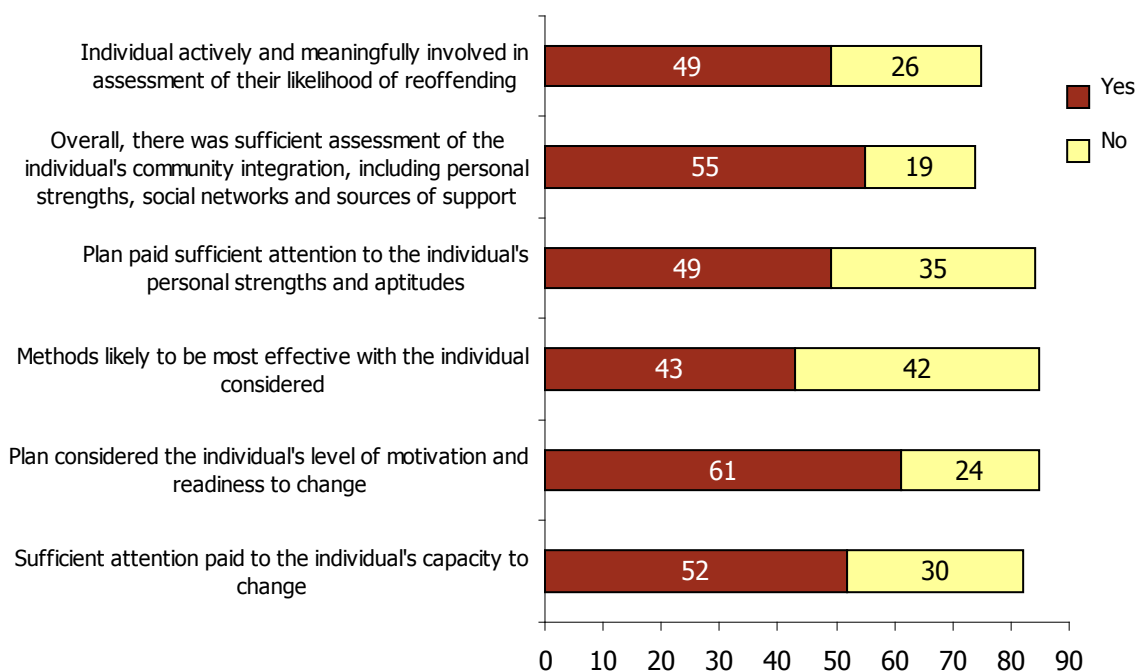
#### 1. Assessment to reduce the likelihood of reoffending

- 1.1. At the start of sentence, an assessment of the factors that may have contributed to the likelihood of offending was required in 75 of the cases in our sample. In four instances no such assessment

was completed, while in a further 11 it was completed so late as to be of little value. In a further 18 cases, the assessment was considered insufficient. On this basis, more than four in every ten assessments were inadequate. This had an inevitable impact on the production of appropriate sentence plans.

1.2. The process of assessing the likelihood of reoffending can be complex. The chart below illustrates how well the various aspects of this task were completed. Where assessments had been completed, they were usually either new or had been sufficiently revised from a previous one. The majority included relevant information from the offender’s home and social environment and identified the factors that related to the individual’s offending, taking relevant previous behaviour into account. In cases where assessments had been completed, we found evidence that the offender had been actively and meaningfully involved in this process in almost two-thirds of these. There was a marked difference in the quality of the assessments of likelihood of reoffending in women’s cases, compared with men; nearly all of the assessments on women were of a good standard, while only half those on men were. Assessments of likelihood of reoffending in those cases where the individual posed a high risk of harm to others were better than those in medium or low risk of harm cases.

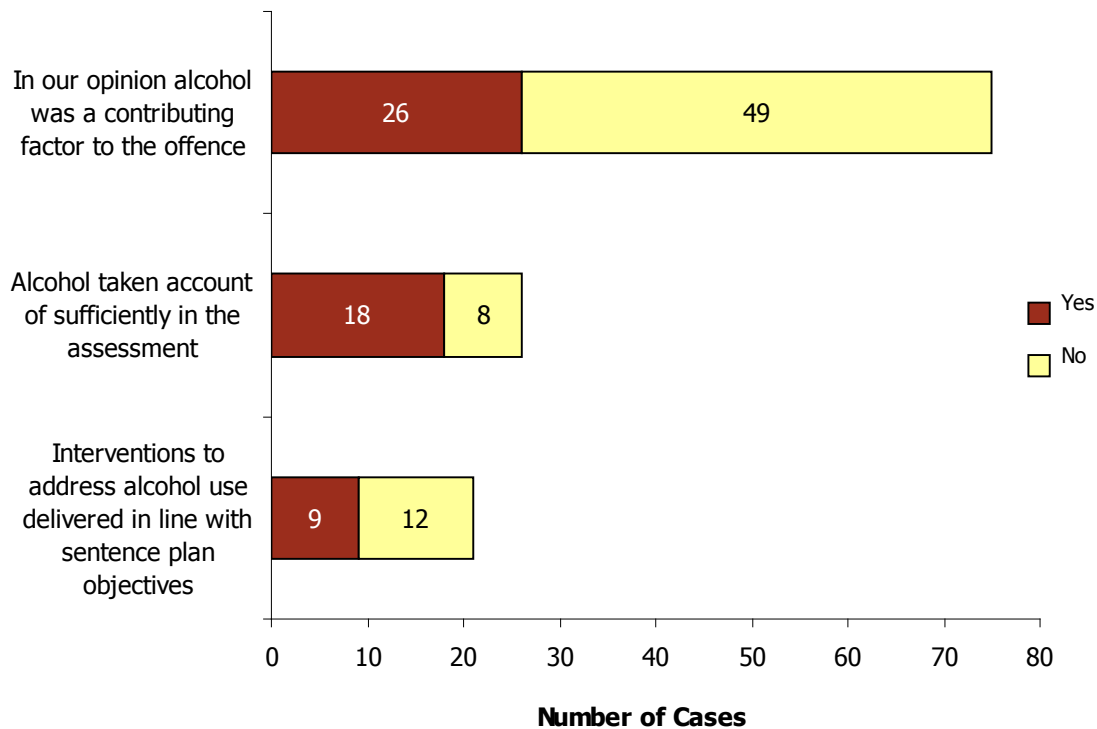
### Involving people in assessing the likelihood of them reoffending



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 cases we looked at were: thinking and behaviour (in 73 cases), followed by relationships (44), attitudes to offending (38), emotional well-being (35), lifestyle and associates (33), drug misuse (32), accommodation issues (29) and alcohol misuse (26).

1.4. Nearly one-third of the cases we looked at had involved violent offending. In almost half of the cases, the subject was, or had been, a perpetrator of domestic abuse. Given that the focus of this inspection was on protecting children and young people, we were pleased to find that alcohol had been addressed sufficiently in assessments in a high proportion of cases, where there were obvious Child Protection or domestic abuse concerns.

### Alcohol and offending



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

- 2.1. We were disappointed to note that constructive interventions encouraged and challenged the individual to take responsibility for their actions, and decisions related to offending, in only just over half of the cases. With many individuals experiencing crises in their lives, such as in relation to housing, it was difficult for offender managers to maintain the focus within supervision sessions on the changes individuals needed to make to their behaviour; they achieved this in less than two-thirds of cases. The availability of accredited offending behaviour programmes did little to help in this respect, as demand exceeded supply in several areas of work, particularly in relation to programmes for sexual offenders and domestic abusers.
- 2.2. Fifteen cases in our sample included plans for delivering accredited programmes, many to address domestic abuse. In seven of these cases a programme had not yet been delivered at the point of inspection, when we thought it should have been. There were a range of reasons for this, including a lack of cooperation on the part of the offender. In one case, the offender manager interviewed, who had a background in accredited programme delivery, was struggling to persuade the court that an inappropriate programme had been ordered, having been proposed by her predecessor. We were nonetheless pleased with her persistence in seeking variation of the order.
- 2.3. Senior leaders recognised that there were gaps in available interventions, such as in relation to acquisitive crime; this type of offending was a major strategic focus for local police colleagues. In contrast, most offender managers thought that their choice of available interventions, to enable the delivery of planned work, was either excellent or sufficient.
- 2.4. The Trust had a variety of SARs on offer and these made a useful contribution in the majority of cases where used. Similarly, the choice of available unpaid work placements was wide ranging, allowing for individuals to be matched to positions to suit their diverse needs and skills. Arrangements for Integrated Offender Management (IOM) were sound, with those subject to this scheme benefiting from a high level of support and intervention, as the following example illustrates:

### Practice illustration – effective multi-agency working via IOM

With a long history of mainly acquisitive offending linked to her drug use, Paula had been released on licence following a custodial sentence for supplying drugs. Subject to IOM arrangements for her licence period, Paula had regular joint meetings with her supported housing keyworker, her IOM police officer, her drug intervention programme worker and her offender manager. The offender manager took the lead in liaising with other agencies to acquire all necessary support for Paula, both in relation to her immediate practical needs, such as accommodation, and her more deep-rooted problems relating to mental health. There was well documented evidence throughout the case of effective multi-agency working. The offender manager succeeded in maintaining a focus on the factors likely to cause Paula to reoffend, while simultaneously addressing Paula's welfare needs. As a consequence, Paula was making good progress on all her objectives and had not reoffended at the time of the inspection.

- 2.5. The Trust had just one approved premises, Fleming House in Maidstone, which was for men. In all but one relevant case, we considered that the regime at the approved premises offered constructive interventions in line with the needs of residents and their sentence plan objectives. Many offender managers, to whom we spoke, were enthusiastic about the quality of work delivered at the approved premises and the effective way in which keyworkers there communicated with them.
- 2.6. Over two-thirds of individuals were well prepared for the interventions delivered throughout their community order or licence. In a similar proportion of cases, the offender manager reviewed, with the individual, the work they had done in other parts of their order or licence so as to reinforce the learning.
- 2.7. In order to support and sustain their desistance from offending, almost three-quarters of individuals had been informed of relevant local services that could assist them; a slightly lower proportion were then referred to these services where relevant. The Trust made good use of volunteer mentors, with these being available throughout the area. In particular, mentors provided much needed help in trying to secure affordable accommodation, of which there was an acute shortage across the county.
- 2.8. We expect to see the assessment of the likelihood of reoffending reviewed thoroughly when required, but in only half of the cases had there had been a sufficient review. Where reviews were done, changes in relevant factors were taken into account in most cases, with information being sought from others involved with the individual. In 13 cases the review had not taken place at all and in a further 25 cases it was insufficient. Assessments were not always reviewed promptly following a significant change; this occurred in only six out of every ten relevant cases. This echoed our findings regarding the review of sentence plans.

### 3. Likelihood of reoffending is reduced

- 3.1. In the NOMS Offender Survey, one-quarter of respondents said that they would have liked more help with accommodation and employment. Accommodation and employment were less prominent factors in the cases examined compared, for example, with thinking and behaviour and relationship difficulties. However, given the shortage of available affordable housing in Kent, the level of progress in solving accommodation problems in our sampled cases was both surprising and pleasing. Employment was less of an issue within the case sample, but progress in this area of work was less impressive by comparison. In relation to the factors associated with offending, that were most frequently found in our case sample (listed in order of prevalence from the 86 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:	sufficient progress was made:
<b>Most prevalent factors:</b>		
thinking and behaviour (73)	42%	36%
difficulties handling relationships (44)	45%	39%
attitudes to offending (38)	34%	24%
emotional well-being (35)	31%	31%
lifestyle and associates (33)	21%	30%
drug misuse (32)	53%	44%
<b>Other common factors</b>		
accommodation (29)	52%	41%
alcohol misuse (26)	23%	23%
financial management (22)	27%	36%
education, training and employment (19)	32%	21%

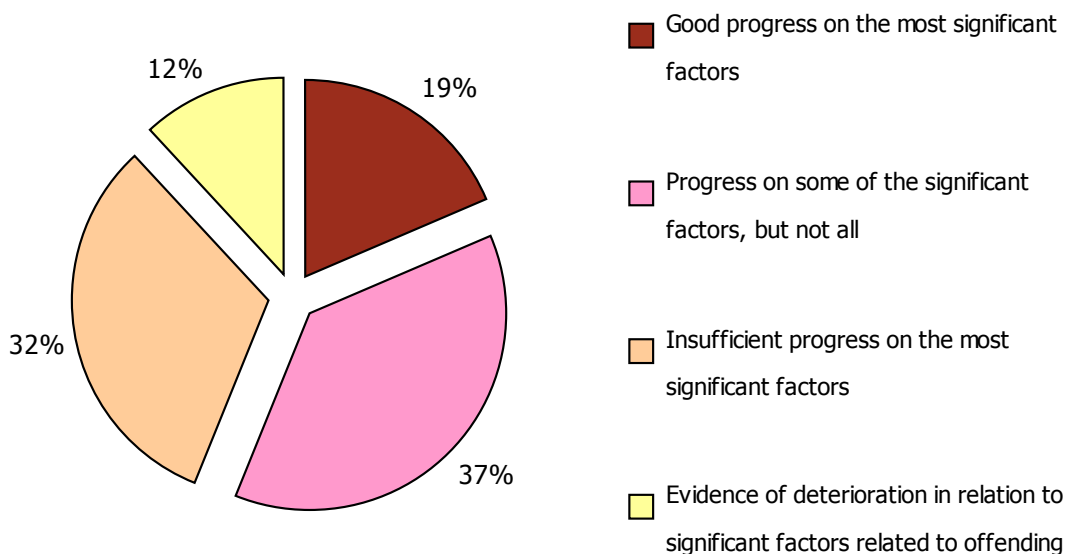
- 3.2. There was a sufficient record of progress made by the offender in less than two-thirds of cases. We inspected community orders or licences that commenced some nine months prior to the inspection; this provided an opportunity for the individual to have shown improvement in factors related to their offending if the planned work had been delivered. However, we recognise that positive and sustainable progress can be a slow process for many offenders, given the complex and entrenched nature of the factors contributing to their offending.

### Practice illustration – focused interventions contributing to successful outcomes

Sandra had a good level of support throughout her community order, particularly in relation to her alcohol problems. The offender manager had correctly identified that Sandra's relationship difficulties, mental health issues and alcohol misuse were all linked. Therefore, while initiating the work to deliver the alcohol treatment requirement (ATR) imposed by the court, she also arranged counselling for Sandra, as she had struggled to access this via her GP. Communication was good throughout the order, between the offender manager, the ATR key worker and the counsellor. While maintaining client confidentiality, the counsellor kept the offender manager fully informed so that she could ensure the work delivered in supervision complemented the counsellor's work. Sandra made impressive progress, such that her 12 month order was revoked for good progress after only seven months.

- 3.3. In 14 cases we found individuals had made good progress, with a further 28 showing some progress on the most significant factors. However, in 24 cases we thought there had been insufficient progress on the most significant factors for that individual, and in nine cases there had been deterioration.
- 3.4. As illustrated in the chart below, almost three-quarters of individuals had not been cautioned for, charged with, or convicted of a further offence during the period of supervision we inspected.

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



3.5. Resources were used efficiently to help the individual achieve planned outcomes in two-thirds of cases, but only half showed improved integration in the community or improved family relationships.

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

- 4.1. It was clear that the Trust valued its partner agencies and, particularly at the strategic level, worked hard to develop a range of interventions to meet the diverse needs of their offender population. Representatives we met from partner agencies were very complimentary about the Trust’s commitment to joint working.
- 4.2. An appropriate range of interventions were available, including alcohol and drug treatment interventions and other resettlement services, such as those provided by Health Trainers who encouraged offenders to sign on with GPs. However, the quality, ease of access and communication links in relation to most services inevitably varied across the county; this was unsurprising given its size. Mental health services were particularly inconsistent across the county; in some parts of the area, such services were difficult to access due to lengthy waiting lists, although the introduction into all the Kent courts of community psychiatric nurses had had a positive impact. Recent changes in providers, such as for accommodation services, had led to some confusion over referral processes. Many offender managers also cited a deterioration in the provision of education, training and employment over the preceding months.
- 4.3. We were pleased to note that the Trust had responded positively to the recommendations in our joint thematic inspection on women offenders<sup>2</sup>. Despite the lack of a women’s community resource centre, they had focused appropriately on the distinct needs of women offenders, developing a SAR for this group which also incorporated parenting skills. One of the local Youth Offending Team (YOT) Managers indicated that the approach shown by the Trust had, in turn, influenced them to redesign YOT services with a focus on the distinct needs of girls and young women.
- 4.4. Mentors were used effectively to support women approaching the end of the women’s SAR, through encouragement to engage in other mainstream community services. Perhaps as a consequence of this approach, we found that outcomes for women were generally better than those for men within our selected case sample. In relation to our five ‘outcome measures’, it was interesting to

<sup>2</sup> HMI Probation (October 2011) *Equal but Different: An inspection of the use of alternatives to custody for women offenders*, HMI Probation, Manchester

note that the female cases inspected scored significantly better than their male equivalents in three out of the five overall measures ('Delivering the Sentence of the Court', 'Reducing the Likelihood of Reoffending' and 'Protecting the Public'). They scored marginally worse than men in relation to 'Assisting Sentencing' and 'Delivering Effective Work for Victims'. However, these findings should be treated with caution, given that only 13 out of the 86 cases sampled were female.

- 4.5. The Trust had also provided a welcome focus on improving the transition from Youth Justice to adult services for offenders, in line with the local Police and Crime Commissioner's priority to provide better opportunities for children and young people. Responding to our joint thematic inspection on Transitions<sup>3</sup>, a pilot project had been introduced enabling cases to be jointly managed by local YOTs and probation staff for three months prior to, and three months after, the offender turned 18 years of age. This was a welcome initiative, given the difficulties that young offenders often experience as they move from youth to adult services. Unpaid work placements for younger offenders ensured that those who had educational needs were provided with help and support as part of their order; for example, those without a driving licence, who had been convicted of driving offences, were often assisted in completing their driving licence theory test as part of their unpaid work commitment.

## Summary

*Overall, 63% of work to reduce the likelihood of reoffending was done well enough.*

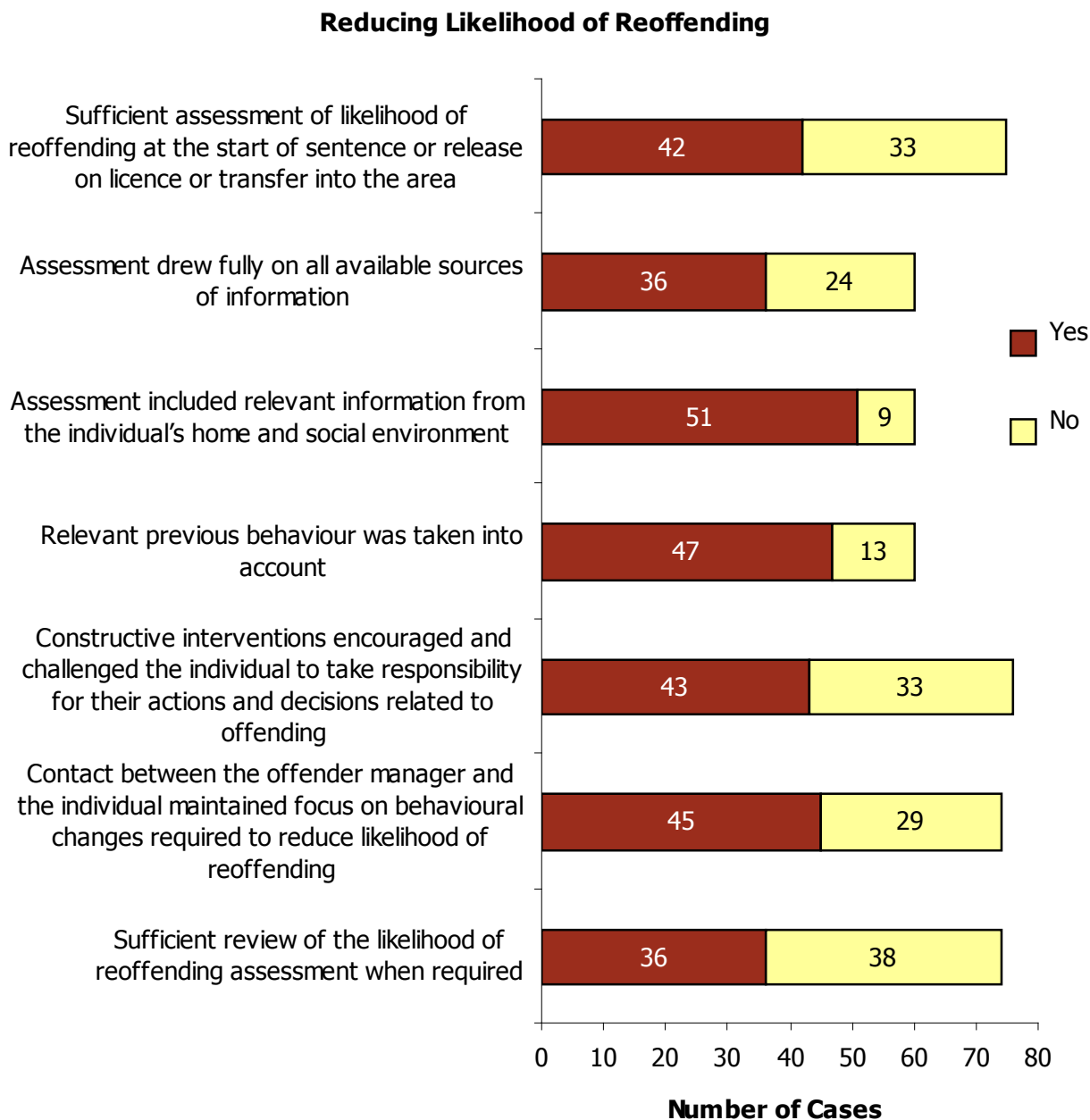
For a summary of our findings please see page 2

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<sup>3</sup> 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: 86 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<sup>4</sup>.

### Case assessment score

*Overall, 58% of work to ensure the protection of the public was done well enough.*

### Key strengths

1. Those Risk of Serious Harm (RoSH) screenings that were completed were generally on time and accurate. Similarly, where RoSH analyses were completed, these were usually new or sufficiently revised from a previous assessment.
2. The use of restrictive interventions, such as curfews, approved premises and restraining orders, was always proportionate to the risk of harm posed by the individual.
3. Most cases meeting the criteria for Multi-Agency Public Protection Arrangements (MAPPA) were identified correctly. Those cases requiring a higher level of MAPPA involvement were all managed efficiently. The Violent and Sexual Offender Register (ViSOR) was used effectively in most cases and ViSOR police officers were valued by staff.
4. Strategic relationships with partner agencies were strong, particularly with the prisons in the county and in relation to IOM and MAPPA.

### Key areas for improvement

1. There were too few cases where the risk of harm posed to others had been well analysed. A number of risk of harm screenings and analyses had not been completed.
2. Similarly, too few cases included an effective plan to manage the risk of harm posed by the individual; too many were either not completed in a timely manner, or relied on a template that did little to enhance the offender's involvement in the plan.
3. There was insufficient response to changes in risk of harm factors, with too few reviews of work taking place and information being sought infrequently from multi-agency systems. Overall, multi-agency procedures were used effectively in less than one-third of relevant cases.
4. Initial home visits were not always carried out where needed (in high risk cases or in response to Child Protection concerns), nor were they repeated as appropriate to the case.
5. There was insufficient evidence of effective management scrutiny in cases classified as posing a high RoSH or where there were Child Protection issues.

<sup>4</sup> 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.

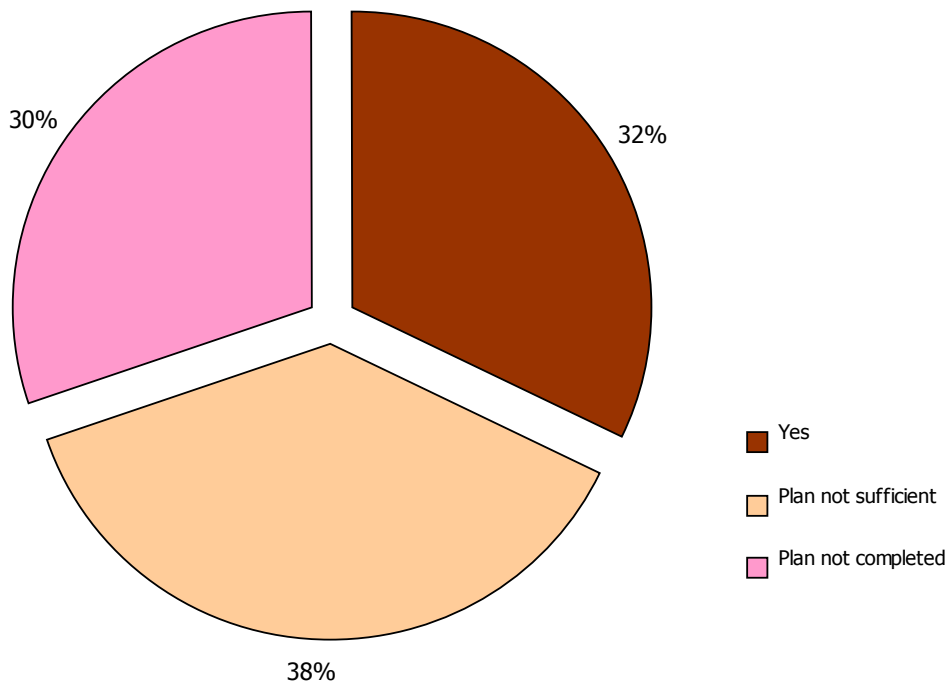
## Explanation of findings

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

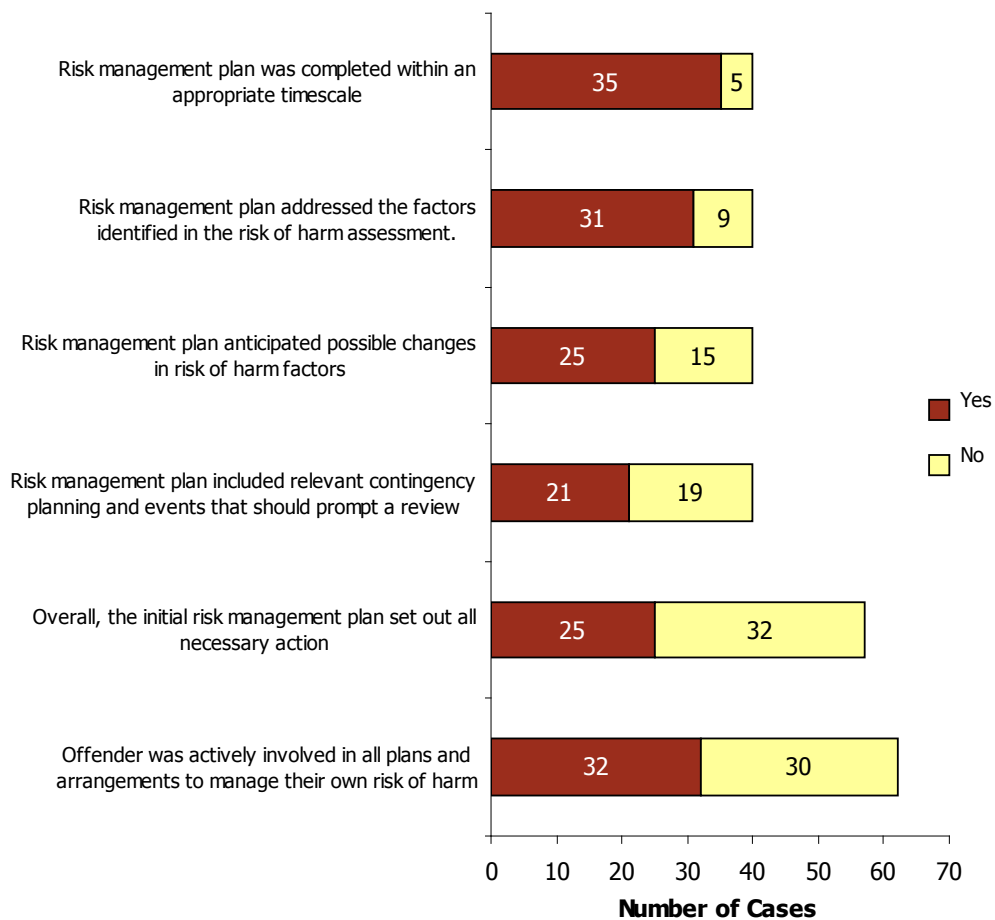
- 1.1. In all but five cases where the OASys RoSH classification was recorded, we considered that it was correct; where we took a different view from the offender manager, we thought that the RoSH had been classified too low.
- 1.2. Of the initial RoSH screenings that had been completed, most were on time and accurate. However, as with initial assessments of the likelihood of reoffending, some had not been completed, were so late as to be largely irrelevant or were otherwise insufficient, for example, overlooking historic domestic abuse or potential risks to children and young people.
- 1.3. We found a similar picture in relation to analyses of the risk of harm posed by the individual. In one-third of cases, an analysis had not yet been completed, with offender managers sometimes taking great pains to explain within the OASys assessment why a full analysis was not required; this was inappropriate in several cases. Of the analyses that were completed, more than half were satisfactory, with most being done on time and the majority analysing and classifying risk appropriately. However, information was not always sought from other agencies in order to inform the assessment and to ensure the protection of children and young people; this echoed the problems highlighted above in relation to court reports.
- 1.4. Restrictive requirements, such as curfews or restraining orders, were imposed in 31 cases and we considered these to have been appropriate in all but two cases. Such requirements were proportionate to the individual's risk of harm in every case, but in two we did not consider that these restrictions assisted in minimising the risk to actual or potential victims. Where curfews were imposed, they generally provided a significant punishment to the offender, but it was not always evident that they helped to protect the public.
- 1.5. Risk management plans are required in cases where the RoSH classification is medium or higher; planning to manage risk of harm can be one of the most challenging pieces of work for offender managers to perfect. Only one-third of relevant cases in the sample contained a sufficient risk management plan. Comparing this with our findings during the last offender management inspection of the Trust in 2010<sup>5</sup> (when three-quarters of risk management plans had been found wanting), this particular aspect of work had improved, but remained in need of further development.
- 1.6. It was clear that a good deal of work had gone into trying to improve the quality of risk management planning over the past three years. As part of this drive towards quality improvement, a template had been introduced, with dropdown lists of items to consider for inclusion within the plan. This enabled offender managers to ensure that all the necessary sections of the plan were covered, but had the unintended consequence of 'de-personalising' plans. Several plans included inappropriate actions or contingencies, such as '*refer to Level 2 MAPPA if the need arises*' for cases that were clearly outside of the MAPPA remit.
- 1.7. The following two charts provide a detailed breakdown of our findings in relation to risk management planning. Most plans that were completed were timely and addressed most, if not all, factors identified in the risk of harm assessment. But, too many failed to set out all required actions, to include relevant contingencies or to integrate with sentence plans. Furthermore, it was not always clear who would deliver what and by when; nor was it always evident that the plan had been communicated to all relevant staff and agencies or that the offender had been actively involved in its design.
- 1.8. We were pleased to note that the quality of screening, analysis and risk management planning was significantly better in those cases posing the highest risk of harm.

<sup>5</sup> HMI Probation (August 2010): *A report on Offender Management in: Kent*, HMI Probation, Manchester.

**Sufficient initial plan in place to manage risk of harm**



**Risk Management Planning**





- 1.9. Twenty-one of the cases we inspected should have been recorded on the ViSOR, the information system managed by the police to share information in relevant MAPPA cases where there has been sexual or serious violent offending or potentially dangerous or terrorist activity. In all but five cases, an appropriate record had been made on ViSOR. Overall, we judged that effective use had been made of ViSOR in seven out of every ten cases, although it was clear from our discussions with offender managers that they also valued their informal links with police colleagues working within the ViSOR arena. These were often used as an alternative and more accessible source of information, when more formal channels proved problematic.
- 1.10. One-quarter of the sampled cases met the criteria for management under MAPPA, most via Level 1 arrangements, that is, with the Trust managing the case as a single agency. Eighteen cases had been identified and referred into MAPPA, of which three were being managed at Level 2 and none at Level 3; we agreed that this was the correct level of management in all cases. Those cases requiring the higher level of MAPPA involvement were all found to be effectively managed, with MAPPA decisions being clearly recorded, acted upon and reviewed appropriately. It was evident, from our discussions with partner agencies, that the Trust was well respected for their work in this arena. The following exemplifies a well managed MAPPA case:

### Practice illustration – effective risk management via MAPPA

Brian was a convicted sex offender, recently released on licence and due to attend the sex offender treatment programme in the community. Due to his level of risk of harm, his case was being managed at MAPPA Level 2, with the approved premises initially being used as a means of controlling his risk. When it was identified that a niece of Brian's fell into the age range of his previous victims, the Trust and other agencies involved took prompt action to ensure that the niece was sufficiently protected through careful monitoring of the strict licence conditions. Throughout the case, the victim liaison officer (VLO) maintained regular contact with the offender manager and, through this means, contributed to the management of his risk of harm.

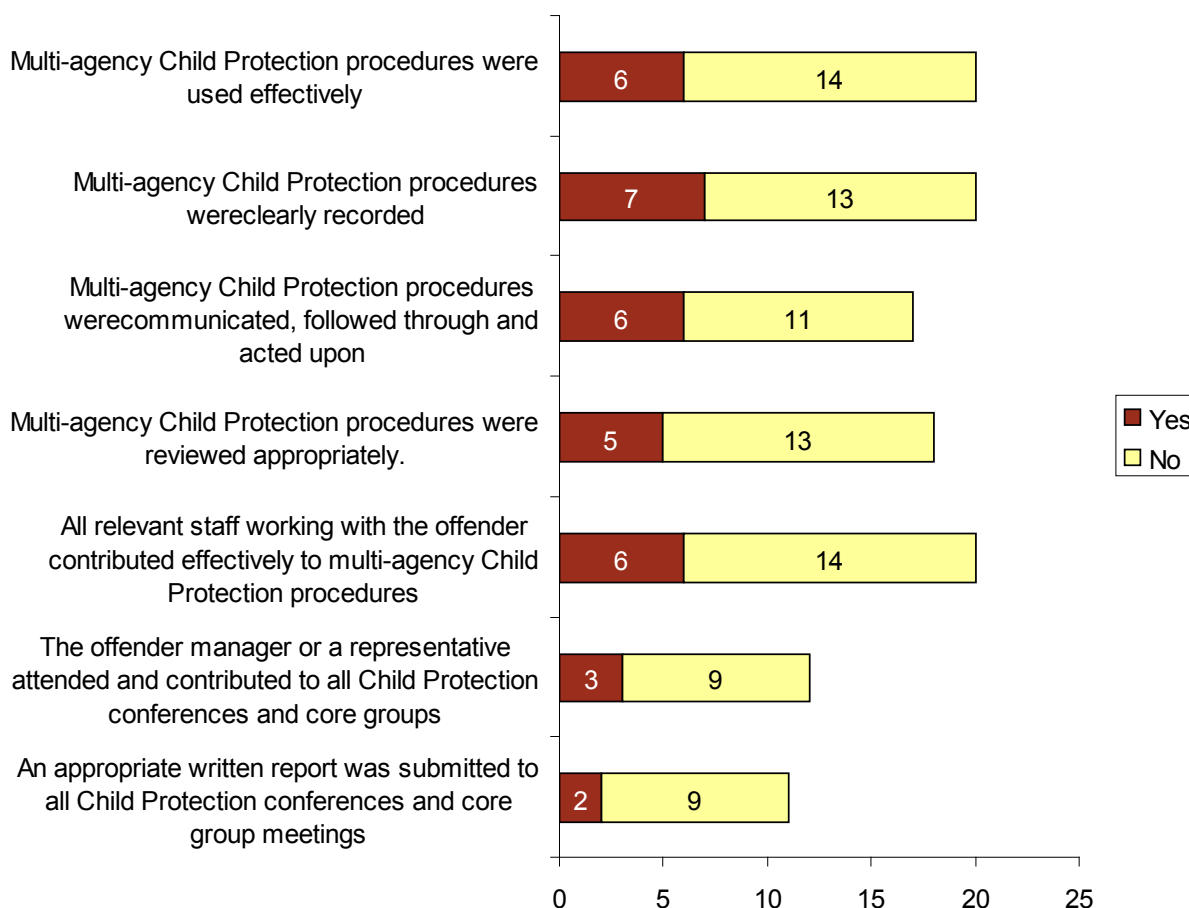
## 2. Delivery of interventions to minimise risk of harm to others

- 2.1. The response by the offender manager to changes in the risk of harm posed to others was inappropriate in almost one-half of relevant cases. Although changes were generally identified swiftly, offender managers did not always act on them promptly nor notify other agencies where the risk of harm had increased. Where there were restrictive requirements or conditions in community orders or licences, they were monitored fully in almost three-quarters of cases. For those resident in approved premises, the requirement to reside there and other restrictions on their behaviour were used effectively to manage risk of harm to others in all relevant cases. The effective contribution of the approved premises in helping to protect the public was clearly valued by staff working within the Trust.
- 2.2. Where the offender poses a high risk of harm to others or where there are concerns in relation to protecting children and young people, we expect to see a purposeful home visit carried out and repeated as necessary. Initial home visits took place in less than one-third of cases where we felt they were needed. Similarly, in two-thirds of relevant cases, a repeat visit was required, but not done, or not done in a purposeful way. Although the Trust encouraged home visits and had recently issued guidance to staff about how to conduct these effectively, they were perceived as time-consuming, and this limited the number undertaken. However, we were encouraged to learn that the Trust was planning to provide training for staff on making the most of the opportunities presented by home visiting.
- 2.3. There were 14 cases in our sample where we felt that enforcement proceedings or recall to custody were needed in response to an increase in the risk of harm posed by the individual. In five of those

cases no action had been taken. Where breach or recall *did* occur, for reasons of increased risk of harm, this was instigated promptly in all cases, with an explanation given to the individual in all but one case. Sufficient efforts were later made to re-engage the individual with their sentence plan in two-thirds of cases following breach or recall.

2.4. Multi-agency Child Protection procedures were used effectively in less than one-third of relevant cases (see the chart below). Decisions taken in the context of Child Protection procedures had been clearly recorded, communicated to others, and acted upon in a similar proportion of relevant cases. Although senior staff in children’s social care services indicated that they were satisfied with probation staff’s input to Child Protection conferences, some offender managers interviewed told us that they were not entirely comfortable with their role in Child Protection forums. They also indicated that they were often not given sufficient notice of Child Protection meetings, which seriously hampered their ability to attend. Senior leaders in the Trust indicated that the expectation of staff was that they should attend such meetings, as well as providing a written report to the meeting. Some staff interviewed indicated that they would have welcomed more guidance about what to include in such reports. In our sampled cases, we found evidence of written reports being supplied in only two cases and of the offender manager attending in only three.

**Multi-agency Child Protection procedures**



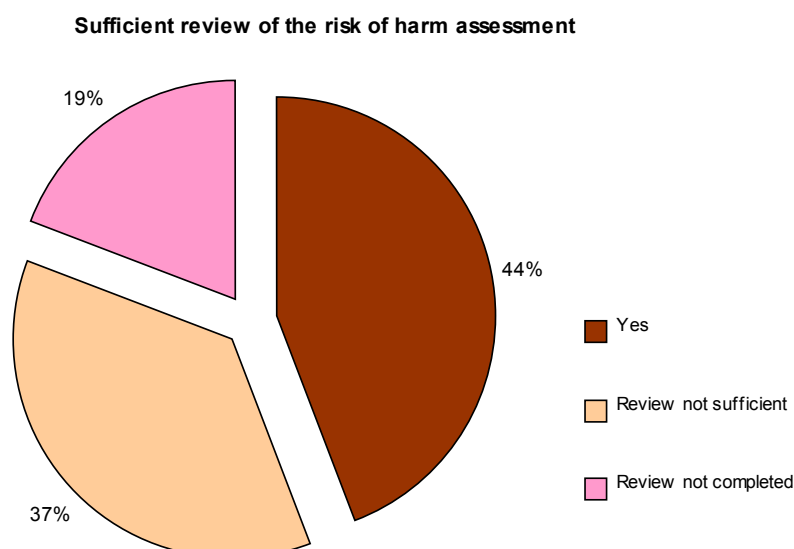
2.5. Issues relating to an individual’s risk of harm to others do not remain static, but can, and do, change over time; we expect to find that the assessment of risk of harm is reviewed to reflect this. However, the review was sufficient in less than half of the relevant cases (30 out of 68), with many lacking detail from multi-agency systems. No review had taken place in 13 of these 68 cases. However, we were pleased to note that, where significant changes in circumstances had occurred, the risk of harm assessment had been reviewed in around two-thirds of cases. This was better than we normally find.

- 2.6. Risk management plans were sufficiently reviewed in only one-third of relevant cases. In 14 cases there had been no review at all, and in a further 28 the review was inadequate. We found evidence that actions set out in risk management plans had been carried out in a little over half of relevant cases. This proportion rose to over three-quarters in cases where the individual posed a higher risk of harm.
- 2.7. Where there are Child Protection concerns or in higher risk of harm cases, we expect to see structured management involvement in the case. We found evidence of management oversight in only 19 out of 43 relevant cases and judged this to have been effective in only 11 of these cases. In some cases, for example, work had been countersigned by a manager when there were clear deficiencies in quality; in other cases, managers had failed to intervene when reviews were overdue. However, the following illustrates the impact of effective management oversight:

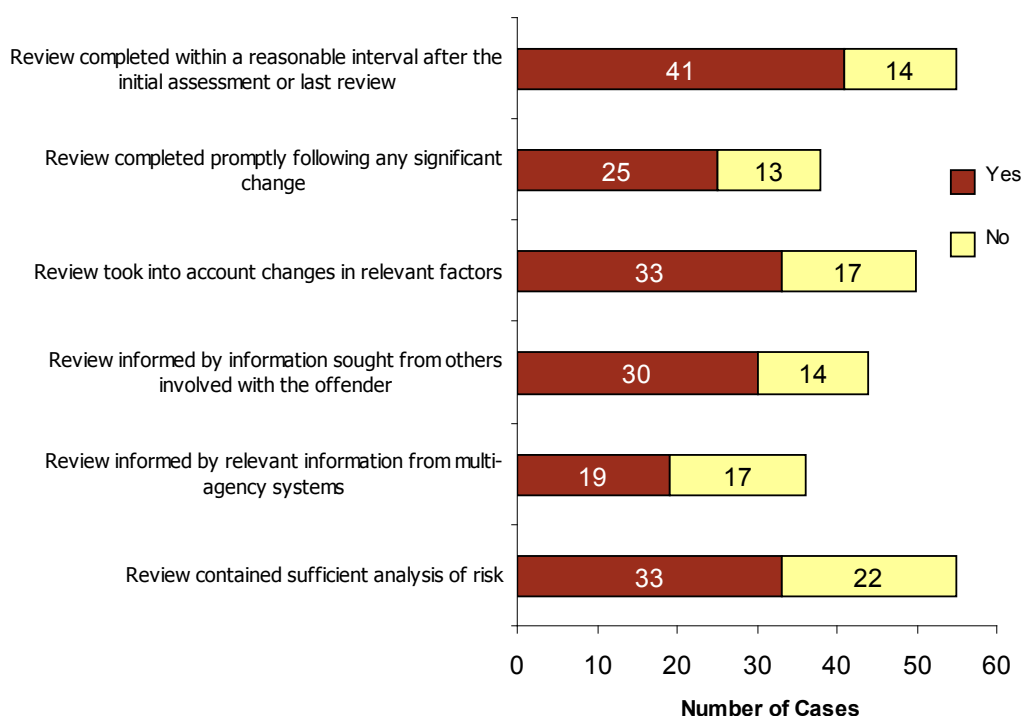
### Practice illustration – effective management oversight

There was strong and regular management oversight in Derek's case, particularly in relation to work with MAPPA. The offender manager recognised the serious nature of Derek's offending, which included a long history of violence against previous partners and offences against children and young people. She ensured that the work prescribed within the suspended sentence order (SSO) started promptly, arranging for the ATR and the one-to-one domestic violence SAR to run alongside each other. She carefully monitored the work done by the ATR provider so as to ensure it complemented her work with Derek and kept her line manager informed at regular intervals, as to progress on the case. Unfortunately, despite good assessment and planning, frequent management oversight and robust multi-agency partnership working, Derek maintained his negative attitude towards his victim and breached his restraining order. He was further charged, which led to the SSO being activated by the sentencing court and him going to prison. Throughout the case, the victim's safety was prioritised and the safety of children and young people promoted. We judged that nothing more could have been done to prevent the outcome, by either the offender manager or the organisation.

- 2.8. One of the issues that impacted on managers' ability to provide effective oversight lay in their reliance, or over-reliance, on staff having correctly identified Child Protection concerns and 'flagging' these within case records. While managers were able to identify 'flagged' Child Protection cases via both OASys and National Delius, neither they, nor the Quality Development Officers who supported them, could readily identify concerns of this nature if the offender manager had failed to highlight them. Given the wide span of control of the SPOs, with some reported to have 20 or more staff to manage, it was hardly surprising that management oversight was lacking in many cases.



### Reviewing the risk of harm assessment



### 3. Risk of harm is minimised

3.1. Notwithstanding the earlier criticism regarding reviews of risk of harm assessments and plans, we found that all reasonable action had been taken to keep to a minimum the individual’s risk of harm to others in nearly two-thirds of cases. However, the safety of children and young people was promoted in too few cases, with too little evidence of routine checks being made throughout the order or licence with the police (in relation to domestic abuse callouts) or with children’s social care services about their involvement with the case. Where the information from children’s social care services or the police indicated something needed to be done, appropriate action was taken by the offender manager in all eight of the relevant cases. The following illustrates this being done well:

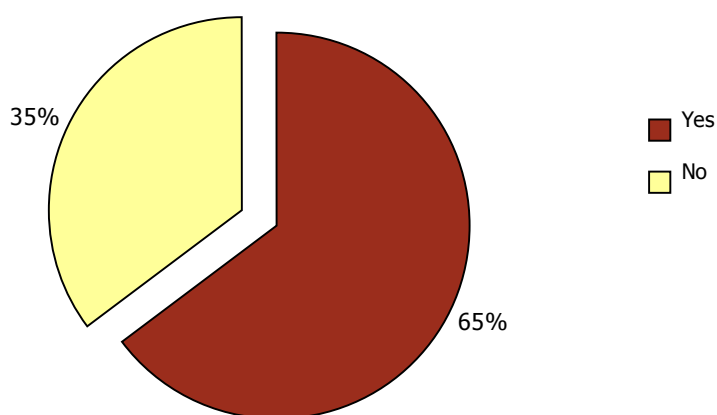
#### Practice illustration – balancing risk management and Child Protection

The assessment of Cliff’s risk of harm to others was re-evaluated promptly when a social worker observed him behaving aggressively at home in front of his younger disabled sister. Both the risk of harm assessment and the risk management plan were reviewed in the light of this and other information coming from the Child Protection case conference. The offender manager demonstrated a thorough awareness of the risk and safeguarding issues in this case and was working closely with the other involved agencies to address these. There was a clear planned response that struck an appropriate balance between risk management and safeguarding.

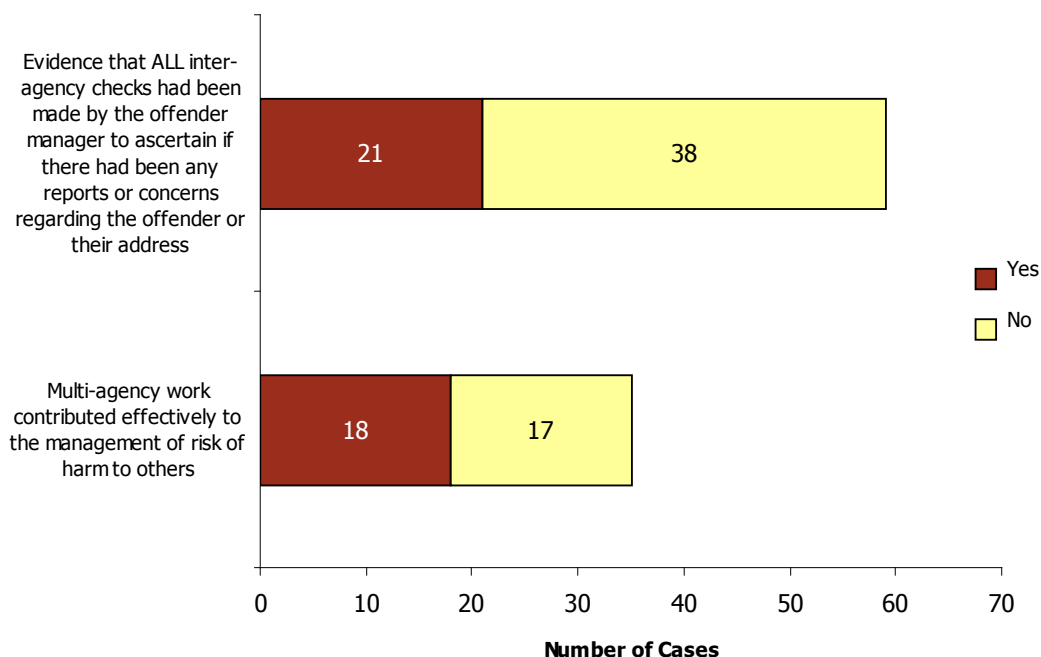
3.2. The ease with which Trust staff could make checks with the police was said to have worsened following a police reorganisation in 2012, when their domestic violence units had been replaced by safeguarding teams. The effect of this change had been to destabilise local links, a problem that was exacerbated by the police introducing more formal means of supplying information, in line with data protection protocols. Offender managers complained to us that eliciting information from the police was much slower than previously, although senior leaders’ commented that the situation was now beginning to improve.

- 3.3. 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 nearly half of relevant cases. Cases managed by POs were almost twice as likely to involve making a referral as those held by their PSO colleagues. The quality of referrals made by Trust staff was said, by the relevant director of Kent County Council, to be satisfactory, although they also noted that the rate of referral by the Trust was low in comparison to those from police, health and education.
- 3.4. The Trust was aware that some of their staff remained unclear about the thresholds that children’s social care services employed in relation to referrals. Staff commented to us that it was easier to interest social workers in cases involving drug misuse, when compared with domestic abuse cases, even though the welfare needs of the child or young person could be just as important, if not more so, with the latter. The deployment of a PO to the Central Referral Unit presented the opportunity for Trust staff to seek advice from a peer about when and how to make referrals; this was a welcome development. When made, referrals were monitored and followed up where necessary in over two-thirds of cases.

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



**Working with other agencies**



- 3.5. One of the recommendations in our joint criminal justice thematic inspection on MAPPA<sup>6</sup> was that strategies should be drawn up to minimise the risk of harm posed by the individual in the longer-term when no longer subject to MAPPA (at Levels 2 and 3). We were pleased to find evidence of such planning for the future post-MAPPA in both cases where it was relevant.

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

- 4.1. Strategic relationships with partner agencies involved in protecting the public were strong and effective. Partners acknowledged the high level of uncertainty for the Trust associated with the Government's *Transforming Rehabilitation* Strategy and considered that their continuing commitment, such as to MAPPA and IOM, was particularly impressive in light of this.
- 4.2. There were a large number of prisons within the county, as well as two YOTs, and Trust staff worked well, both at the strategic and operational level, to ensure that effective joint working was the norm. One YOT Manager expressed some concern about the sustainability of arrangements for secondments into the Youth Justice field, with the onset of impending changes.
- 4.3. At an operational level, a number of offender managers expressed frustration about the length of time it sometimes took to install electronic monitoring equipment; others complained about delays in being notified of curfew violations.
- 4.4. The Trust made a sound contribution to the work of the two Local Safeguarding Children Boards (LSCBs) within the county, that is, both the larger Kent board and the smaller board within the unitary authority of Medway. Trust staff of varying grades attended LSCB meetings, chaired subgroups, assisted with the training of LSCB members and contributed to the local Domestic Abuse Strategy group. In particular, the Trust's contribution to the Serious Case Review subgroup of the Kent Safeguarding Children Board was appreciated by the board.
- 4.5. The Trust's participation in the Medway Safeguarding Children Board was said to have improved considerably over the last two years, with Trust staff having developed a wider focus on safeguarding, rather than simply considering the offender's perspective, as previously. Nonetheless, the Medway Safeguarding Children Board felt that the Trust missed valuable training opportunities at times, although they did acknowledge that staff had availed themselves of specialised training in child or young person sexual exploitation and honour-based violence.
- 4.6. In relation to their work with children's social care services, the recent initiative of deploying a PO to the Central Referral Unit showed great promise in terms of resolving the problems of access to information from Kent County Council's database. However, the equivalent 'triage' arrangement within Medway was less well developed, so it was much harder to access information on Medway cases by comparison with Kent cases. While strategic leaders of the Trust and the two Councils were focused on joint working, there was an obvious lack of contact or collaboration at middle manager level, which hindered progress in this area of work.
- 4.7. The Trust had provided a high volume of training in protecting children and young people, with most staff having had some within the last two years, many more recently than that. Multi-agency training in this field was regarded as much more useful than the e-learning alternative. All but four of the offender managers interviewed reported feeling confident in this area of work.

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<sup>6</sup> HMI Probation, (November 2011), *Putting the pieces together: an inspection of Multi-Agency Public Protection Arrangements*, HMI Probation, Manchester

## Summary

Overall, 58% work to ensure the protection of the public was done well enough.

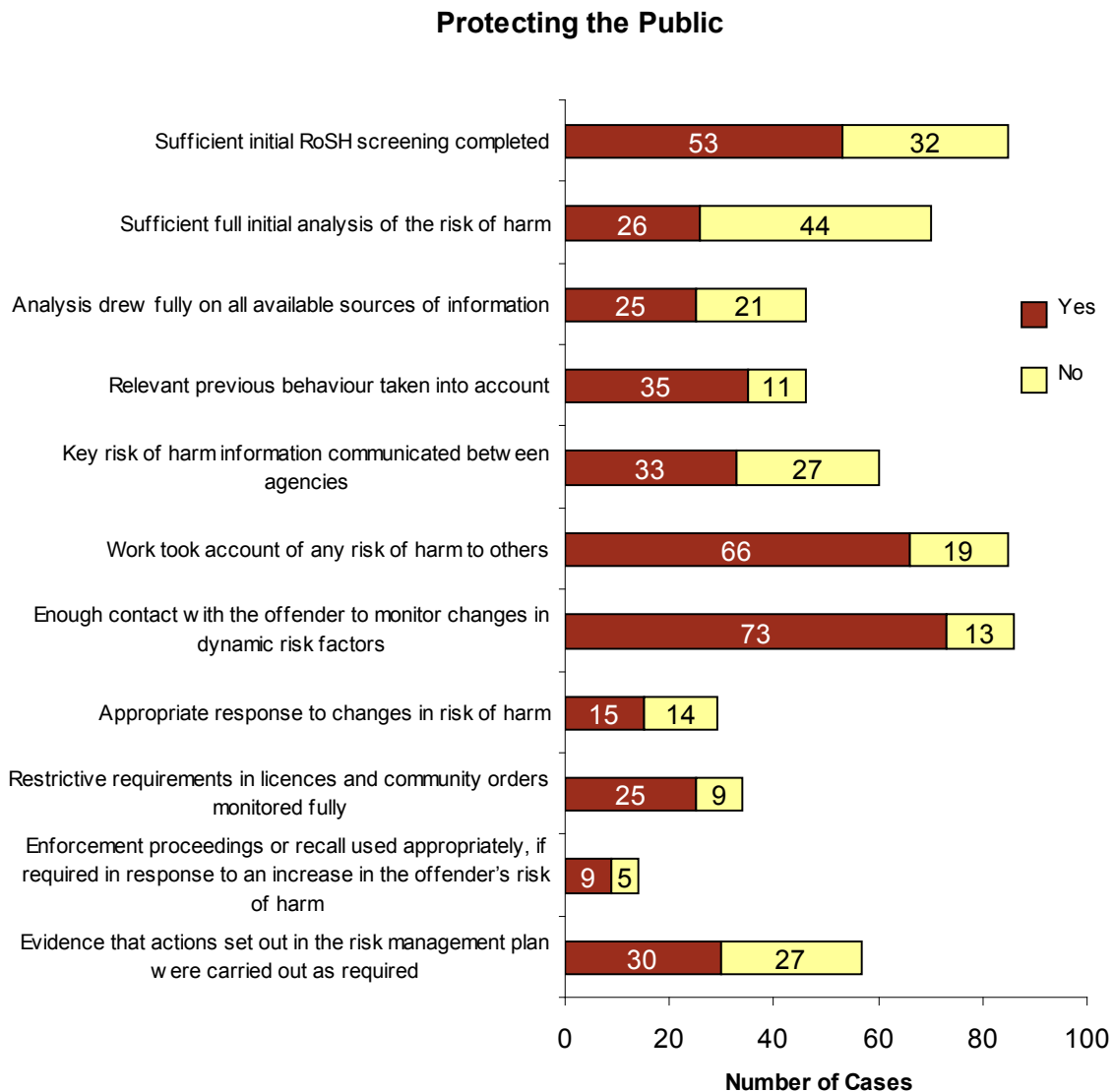
We have recommended that post-inspection improvement work focuses on ensuring that:

- a thorough assessment of risk of harm to others is carried out in all cases; where necessary, this assessment underpins planning to manage risk of harm to others, with assessments, plans and work aimed at protecting the public being reviewed appropriately
- managers provide effective oversight in all cases where the individual poses a high or very high risk of serious harm to others and/or where there are Child Protection concerns.

For a summary of our findings please see page 2

## Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 86 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, 64% of work to deliver effective services for victims was done well enough.*

## Key strengths

1. In all statutory victim contact cases, where the victim had so elected, the quality of contact with victims was good. Victims who responded to our survey were mostly positive about their experiences of the Trust; all felt that VLOs had a full understanding of the impact the offence had had on them.
2. Offender managers took into account concerns expressed by the victim in the majority of relevant cases.

## Key areas for improvement

1. In a greater proportion of cases, victims' safety needed to be prioritised and the well-being of children and young people promoted.
2. Not all risk management plans addressed the risk to specific victims or potential victims; too few accurately described how the sentence plan objectives and other activities would address risk of harm issues and protect actual and potential victims.

## Explanation of findings

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

- 1.1. Given the imperative of protecting the public, we expect to see offender managers and others paying appropriate attention to risk of harm to actual and potential victims within their assessments and plans. While almost two-thirds of risk management plans addressed the risks to specific victims, including potential victims, less than half of these plans were clear about how sentence plan objectives and other planned work would protect victims. Offender managers needed to keep a specific focus within plans on the victim perspective, in addition to taking a more general, non-specific, stance on protecting the public.

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

- 2.1. In ongoing work with individuals, offender managers and others need to give appropriate priority to the safety of existing and potential victims. This was done sufficiently well in six out of every ten cases, which left some room for improvement. By way of contrast, offender managers had taken into account concerns expressed by victims, together with the likely impact of the offender's behaviour on the victim, in a much higher proportion of cases. This finding concurs with the views expressed by victims in our survey; all those who responded had been given an opportunity to raise

any worries about the offender's eventual release from prison and to influence licence conditions. We found several examples of offender managers 'doing the right thing' to protect victims, as the following illustrates:

### Practice illustration – protecting the victim and potential victims

Leonard was released unexpectedly from prison following an appeal court hearing. A convicted sex offender, he had been assessed as posing a high risk of harm to children and young people. Leonard was initially homeless so the offender manager had to find emergency accommodation for him, first in a hotel, then in the approved premises until more permanent accommodation could be found. These arrangements were made with a specific focus on minimising his risk of harm to children and young people in general and to his victim in particular. A number of Trust staff took sound, carefully considered, decisions over this very intensive period; this undoubtedly assisted with his initial reintegration into the community and the successful management of his risk of harm. Following further carefully targeted work, Leonard complied well and his risk of harm classification was subsequently reduced to medium.

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

- 3.1. Overall, we considered that in two-thirds of those cases where there was an identifiable or potential victim, the risk of harm to them had been managed effectively. However, we judged that the safety of children and young people was promoted in fewer cases, probably linked to the difficulties identified earlier with accessing information from multi-agency systems.
- 3.2. Given this inspection's particular focus on protecting children and young people, we decided to meet with a number of staff involved in accredited programmes aimed at reducing incidence of domestic abuse. These included programme tutors and women's safety workers (WSWs) whose role was to support the victims and partners of offenders undertaking work to address abusive behaviour within relationships. These staff impressed as being remarkably committed to their roles. Evidence of their effectiveness was also noted within some of the cases examined, as in the following illustration:

### Practice illustration – valuable support provided by WSWs

Trevor received a suspended sentence of imprisonment for an assault on his partner and began the Integrated Domestic Abuse Programme shortly thereafter. In line with normal practice, a WSW was appointed; she made contact with Trevor's partner at an early stage and had some real concerns about her vulnerability. Not only did she share these concerns with Trevor's offender manager, she also provided practical help in relation to alternative housing provision. The supportive contact between the WSW and Trevor's partner, coupled with regular and effective liaison between the WSW and the offender manager, ensured that the victim was given priority throughout the case.

- 3.3. The following example also shows another offender manager being proactive in relation to the victim's welfare:

### Practice illustration – attention to the victim's welfare

There were concerns that Paul, who had served a prison sentence for breaching a restraining order, would seek to harass his victim immediately upon his release. When he failed to report to probation on the day of release, as directed in his licence, the offender manager took prompt action, including telephoning his family members to check on his whereabouts and checking on the precise time of his release from prison. Once she had confirmed that he had been released too late to comply with his appointment time, the offender manager briefed both her SPO and the VLO. Paul reported later that day, after which the offender manager again liaised with the VLO so that they could update the victim.

#### 4. Victim contact and restorative justice

- 4.1. Probation Trusts have responsibility for running victim contact schemes. They provide victims of certain crimes with information about the key points in a prisoner's sentence, such as their move to open conditions and their release; they also give victims the chance to say what conditions they think should be included in the individual's licence when they are released.
- 4.2. There were ten licence cases, in our sample, where the Trust offered the victim face-to-face contact with a VLO; in all of these cases, the offer was made within eight weeks of the offender being sentenced to custody. In a further four cases, we considered that an offer of a meeting should have been made, but it was not. Eight victims took up the offer of contact and the quality of the work undertaken with them was sufficient in all cases, with regular information exchange occurring between the offender manager and the VLO. Communication between the offender manager and prison staff was marginally weaker, although was sufficient in six of the eight cases.
- 4.3. Where relevant, all victims were given the opportunity to express their views on proposed licence conditions; they were also informed of pertinent events during the individual's sentence, together with relevant conditions of their release.

#### Responses from victim questionnaire

Ten victims of crime who were in touch with the victim contact scheme responded to our questionnaire:

- All confirmed that the initial letter about the scheme was easy to understand and made it clear that they had a choice about whether to become involved.
- All respondents said that their individual circumstances and needs had been taken into account and all thought that victim contact staff had a full understanding of the impact of the offence on them.
- Six out of nine people who answered the particular question said that they had been kept informed about key points in the individual's sentence.
- Each respondent had been given the chance to discuss concerns about the offender's eventual release and to express what conditions they thought should be included in the licence; extra licence conditions had been added in eight out of nine relevant cases to keep them safer when the individual was released.
- Nine respondents said they had reported concerns to the Trust; six of the nine were satisfied with the Trust's response, the other three were not.
- Five people said they felt safer as a result of the work undertaken via the victim contact scheme; two said it had not made them feel safer and a further two said it had not made any difference.
- On average, respondents were mainly satisfied with the service provided, with three being completely satisfied.

#### Comments from victims

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

*"Our VLO supplied us with information as they received it. Unfortunately the current system between the offender manager and the VLO clearly does not work. The offender was released for the first period of home visits two days before we even knew and the only reason we knew was because someone had posted it on Facebook. Our VLO had also not been made aware...the VLO has done her best to inform us of any changes, but as this information is not given to her she is facing an impossible task".*

*"If staff go on holiday they should leave a message on their voicemail advising the victim of another person to call in their absence".*

*"Our VLO has been very helpful and understanding".*

4.4. We identified 16 cases in the sample where an offer of a restorative justice intervention might have been appropriate. In one of these cases, the VLO had initiated a referral into the newly-established system for delivering restorative justice. However, although this offer was welcomed by the victim and an assessment of the offender's suitability to engage in the process was carried out, it was unclear whether the referral had been taken forward. The Trust was keen to develop restorative justice interventions, in conjunction with their criminal justice partners, including the police, YOTs and prisons in the county. With this in mind, a number of staff had been appropriately trained. However, restorative justice was at an embryonic stage.

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

- 5.1. The Trust had an appropriate strategic focus on the need to deliver effective work for victims. Our survey of victims indicated they were having some success in this respect. VLOs and WSWs were well regarded by staff and managers; contributions from Trust staff to the multi-agency arenas of multi-agency risk assessment conferences (MARAC) and MAPPA were clearly appreciated by their partner agencies.
- 5.2. However, it was unfortunate that difficulties in accessing information from multi-agency systems hampered offender managers' efforts in relation to assessing, planning and reviewing work with offenders, which in turn impacted on the Trust's ability to protect the public and provide a fully effective service to victims. The decision to deploy a PO to Kent County Council's Central Referral Unit was an attempt by the Trust to overcome this difficulty.
- 5.3. It was evident that the Trust was keen to learn from past inspections and from the results of reviews into Serious Further Offences, implementing findings from these whenever practicable, particularly where they related to public protection. They had developed a comprehensive quality improvement strategy and routinely conducted local quality inspections using HMIP benchmarks. Clearly, they remained on an ongoing 'journey' towards quality improvement, with the pressure of workload on individual offender managers impeding the speed of the Trust's progress to a significant extent.

## **Summary**

*Overall, 64% work to deliver effective services for victims was done well enough.*

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

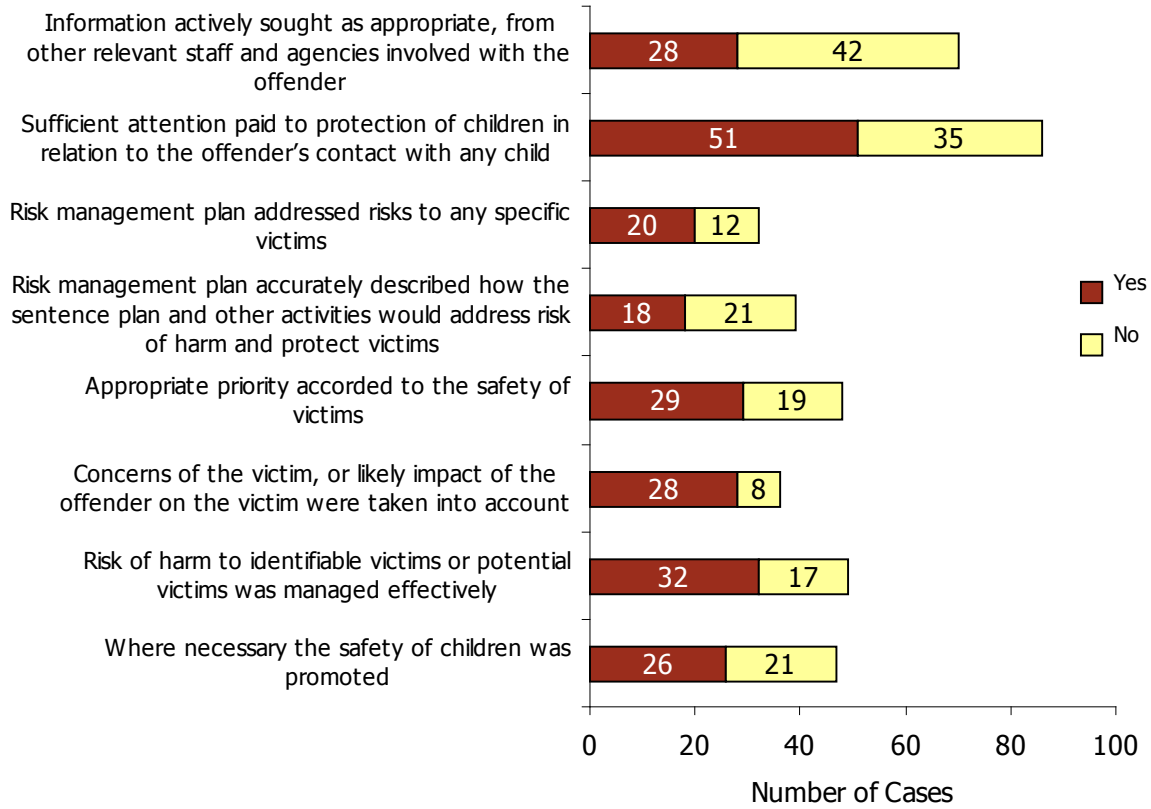
- planning to manage the risk of harm to others takes full and specific account of the safety of actual and potential victims.

For a summary of our findings please see page 2

**Data Summary**

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 86 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]

**Effective Work for Victims**



# Appendices

# Appendix 1

## Contextual information about the area inspected

### Kent demographic data

Local Authority	Unemployment <sup>1</sup>	Population <sup>2</sup>	Black and minority ethnic population <sup>3</sup>
Ashford	6.2%	118,000	6.4%
Canterbury	7.4%	151,200	7.0%
Dartford	6.9%	97,400	12.6%
Dover	7.7%	111,700	3.2%
Gravesham	9.3%	101,700	17.2%
Maidstone	5.9%	155,200	5.8%
Medway (Unitary Authority)	8.8%	263,900	10.4%
Sevenoaks	4.6%	114,900	4.2%
Shepway	7.2%	108,000	5.4%
Swale	8.0%	135,800	3.5%
Thanet	10.8%	134,200	4.2%
Tonbridge and Malling	6.1%	120,800	4.0%
Tunbridge Wells	4.3%	115,000	5.1%
<b>England &amp; Wales</b>	<b>8.0%</b>	<b>56,075,900</b>	<b>14.1%</b>

<sup>1</sup> Office for National Statistics Local Labour Market Indicators - October to September 2012

<sup>2</sup> Office for National Statistics 2011 Census

<sup>3</sup> Office for National Statistics 2011 Census

### Probation Caseload Data

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

Kent	Supervised in community and pre-release	National average
Total caseload	5,993	n/a
% White	88.6%	76.4%
% Minority ethnic	7.9%	19.9%
% Male	90.1%	90.0%
% Female	9.9%	10.0%

## Appendix 2

# Contextual information about the inspected case sample

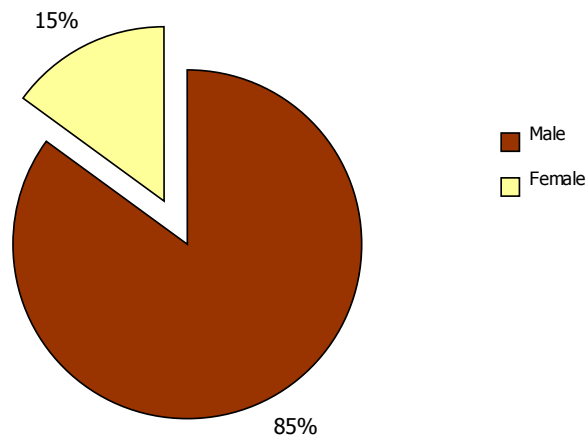
In the first fieldwork week we look at a representative sample of between 50 and 90 individual cases (depending on the size of the area), which have been supervised for around nine months. These are community orders, suspended sentence orders and post-custody licences.

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.

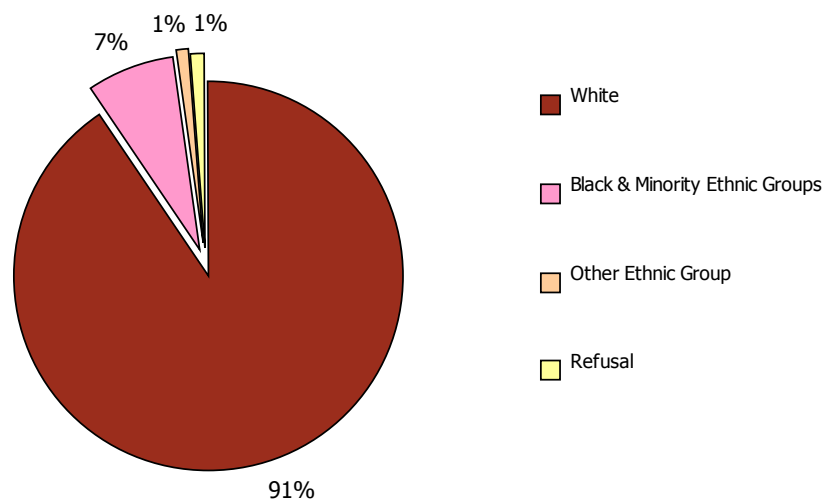
Between October 2013 and March 2014, we will pay increased attention to the work of the Probation Trust to protect children and young people.

In Kent Probation Trust we inspected a total of 86 cases.

**Gender**

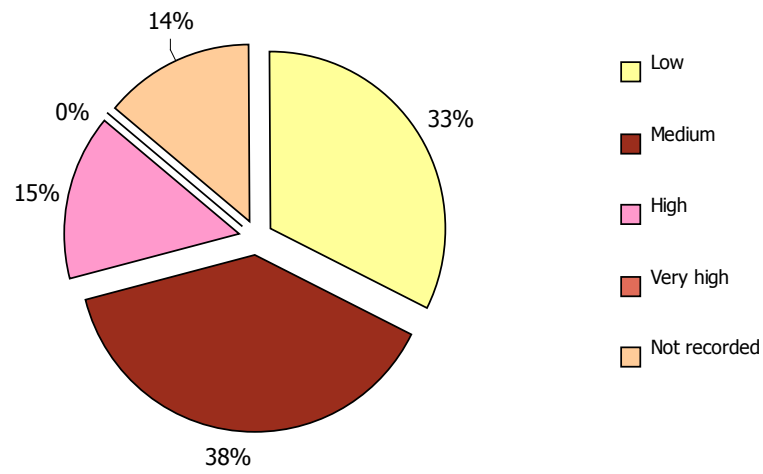


**Race and Ethnicity**

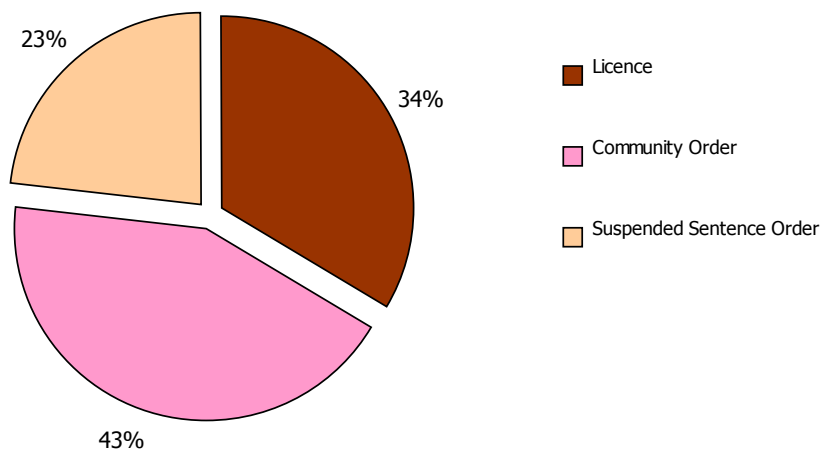




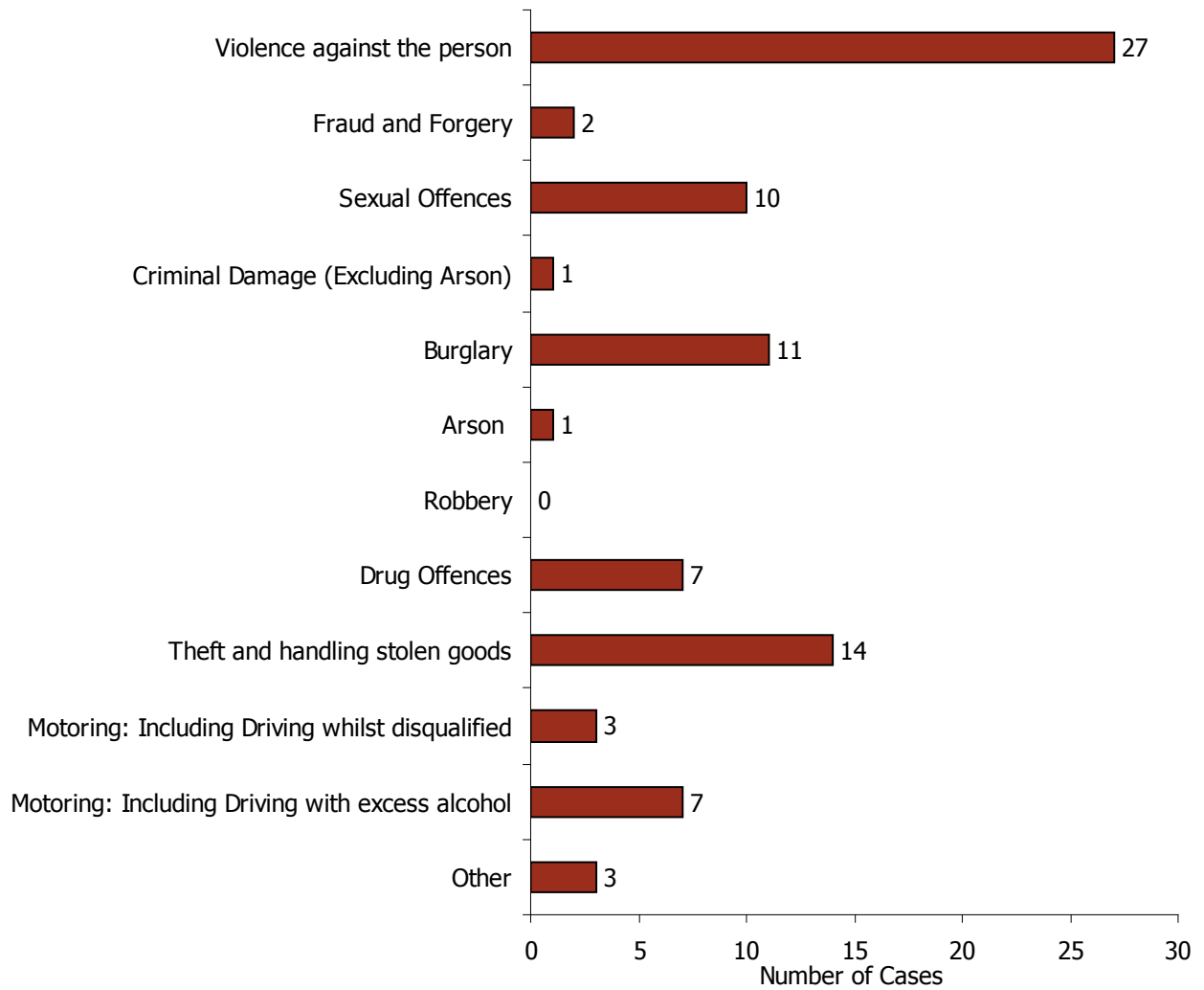
**OASys RoSH classification as recorded at the start of sentence or release on licence or transfer into this area**



**Type of Case**



## Principal Offence



## Appendix 3

### Acknowledgements

We would like to thank all the staff from Kent 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.

<b>Lead Inspector</b>	Helen Rinaldi, <i>HMI Probation</i>
<b>Deputy Lead Inspector</b>	Nigel Scarff, <i>HMI Probation</i>
<b>Inspection Team</b>	Lisa Clarke, <i>HMI Probation</i>
	Mike Lane, <i>HMI Probation</i>
	Greg Maguire, <i>HMI Probation</i>
	Beverley Reid, <i>HMI Probation</i>
	Gary Smallman, <i>HMI Probation</i>
	Liz Smith, <i>HMI Probation</i>
	James McParland, <i>Ofsted</i>
	David Ashley, <i>Local Assessor (reserve)</i>
	Rachel Harris, <i>Local Assessor</i>
	Claire Jones, <i>Local Assessor</i>
	James Morris, <i>Local Assessor</i>
	Jessica Willans, <i>Local Assessor</i>
	Sue Willis, <i>Local Assessor</i>
<b>HMI Probation Support Services</b>	Pippa Bennett, <i>Support Services Manager</i>
	Oliver Kenton, <i>Assistant Research</i>
	Lynne Osborn, <i>Support Services Officer</i>
	Alex Pentecost, <i>Publications Manager</i>
	Christopher Reeves, <i>Proof Reader</i>
<b>Assistant Chief Inspector</b>	Sally Lester, <i>HMI Probation</i>

## 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.

From April to September 2013 we selected cases where the index offence was one of violence; results from the six inspections involved will form the basis of an aggregate report. From October 2013 – March 2014, we are enhancing our focus on the work of Probation Trusts to protect children. In each case inspected we expect to see an assessment of whether the individual presents a risk of harm to a child or children, and appropriate action taken where required. We are selecting a broad case sample of individuals who are subject to a community order or post-custody licence. In some cases there will be no issues regarding the protection of children; in other cases concerns may have led to referral to other agencies, or multi-agency work.

### 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

<i>Accredited programme</i>	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
<i>Approved premises</i>	Approved premises provide controlled accommodation for offenders under supervision
<i>ATR</i>	Alcohol treatment requirement
<i>Child protection</i>	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
<i>CJS</i>	Criminal justice system: Involves any or all of the agencies involved in upholding and implementing the law – Police, courts, youth offending teams, probation and prisons
<i>Desistance</i>	The process by which people stop offending and build a new, crime-free identity
<i>ETE</i>	Education, training and employment: work to improve an individual's learning, and to increase their employment prospects
<i>HMI Probation</i>	Her Majesty's Inspectorate of Probation
<i>Interventions; constructive and restrictive interventions</i>	<p>A <i>constructive</i> intervention is where the primary purpose is to reduce likelihood of reoffending.</p> <p>A <i>restrictive</i> intervention is where the primary purpose is to keep to a minimum the individual's risk of harm to others.</p> <p>Example: with a sex offender, a constructive intervention might be to put them through an accredited sex offender programme; a <i>restrictive intervention</i> (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.</p> <p>NB: Both types of intervention are important</p>
<i>IOM</i>	Integrated Offender Management
<i>LSCB</i>	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
<i>MARAC</i>	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
<i>MAPPA</i>	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
<i>nDelius</i>	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
<i>NOMS</i>	National Offender Management Service: the single agency responsible for both Prisons and Probation Trusts

<i>OASys/ eOASys</i>	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
<i>Offender management</i>	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
<i>PO</i>	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
<i>PSO</i>	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
<i>PSR</i>	Pre-sentence report: this refers to any report prepared for a court, whether delivered orally or in a written format
<i>'Risk of harm work'</i>	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
<i>RoSH</i>	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
<i>SAR</i>	Specified Activity Requirement: a requirement of a Community Order, which involves activities to help the individual to deal with their offending or problems, or to make amends for their behaviour
<i>Safeguarding</i>	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
<i>SEEDS (Skills for Effective Engagement and Development and Supervision)</i>	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

<i>Serious Further Offence</i>	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
<i>SPO</i>	Senior probation officer: a manager who, typically, oversees the work of probation officers and probation services officers, or takes on other management functions
<i>SSO</i>	Suspended sentence order
<i>Transforming Rehabilitation Strategy</i>	Launched in 2013, <i>Transforming Rehabilitation: a Strategy for Reform</i> sets out the Government's radical plans for changing the way in which offenders are managed in the community with a view to reducing rates of reoffending. The strategy enables private and voluntary sector providers to deliver services to offenders and sets up a new National Probation Service to manage those posing a high risk of harm to the public
<i>ViSOR</i>	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
<i>VLO</i>	Victim liaison officer: responsible for delivering services to victims in accordance with the Trust's statutory responsibilities
<i>WSW</i>	Women's safety worker: appointed to support the partner of those undertaking the integrated domestic abuse programme
<i>YOS/YOT/YJS</i>	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](http://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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