HM Inspectorate of Probation
Arolygiaeth Prawf EM

Inspection of Adult Offending Work
Arolygiad o Waith Troseddu Oedolion

Inspection of Adult Offending Work in **Devon & Cornwall**

An inspection led by HMI Probation

independent inspection of adult offending work

September 2013

Foreword

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

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

The case sample for this inspection was drawn from those cases managed by Devon & Cornwall Probation Trust. Generally court reports were of good quality and provided sufficient information, including a clear and appropriate proposal for a community sentence which was broadly followed by the court. There was room for improvement in relation to sentence planning, but interventions were generally delivered according to the requirements of the sentence and in line with sentence plan objectives. Victim contact work was done well and, overall, the risk of harm to victims was sufficiently well managed and the safety of children and young people promoted.

The Trust worked with a range of partners in delivering offending-related work, and was an active and effective contributor to multi-agency public protection work across its area. Since the last inspection, senior managers had been working hard to address the recommendations; in-house research and quality assurance were providing them with useful information to help focus resources appropriately and improve performance. This inspection provides evidence of the effectiveness of that approach, albeit there remains a need for further improvement in risk of harm assessments and planning.

Liz Calderbank
HM Chief Inspector of Probation

September 2013

Summary

Outcomes	The proportion of work judged to have been done well enough
Assisting sentencing	**82%**
Delivering the sentence of the court	**78%**
Reducing the likelihood of reoffending	**69%**
Protecting the public by minimising risk of harm to others	**70%**
Delivering effective work for victims	**78%**

Outcome 1: Assisting sentencing

Overall, 82% of the work to assist sentencing was done well enough.

Generally, court reports were of good quality, provided sufficient information for the court appearance and contained a clear and appropriate proposal for a community sentence. The court broadly followed the proposal. More reports should have contained information about how particular barriers to compliance and engagement would be addressed.

Both the Trust and HMI Probation expect all reports to contain a risk of harm screening, but we found a number that did not. In addition, and bearing in mind that all the cases we inspected involved violent offending, it was concerning that a small number of sentences were imposed without the court having requested or received a report.

The Trust was working hard to develop and maintain its strategic and operational relationships with the courts, who were generally satisfied with the quality of reports they received and very positive about individual court probation staff and report writers. The accommodation and facilities provided for probation in the courts were sufficient, and enabled probation staff in the courts to do their jobs without impediment.

Outcome 2: Delivering the sentence of the court

Overall, 78% of the work to deliver the sentence of the court was done well enough.

Cases were usually allocated to the correct tier of service at the start of sentence or release on licence or transfer into the area, and initial appointments were arranged promptly. Most individuals were offered a full, timely and individualised induction, and informed of their rights and responsibilities. This included a sufficient assessment of their individual needs and potential barriers to them engaging with their sentence and completing it successfully.

The quality of initial sentence plans was not always sufficient. Some plans had not been completed in a timely manner, while others were not sufficiently informed by the assessments that had been carried out in regard to the individual's likelihood of reoffending or risk of harm. We inspected some cases where no initial sentence plan had been produced. In general, sentence planning paid attention to the individual's level of motivation and capacity to change. However, quite a few sentence plans failed to incorporate the individual's personal strengths and aptitudes or the methods that were most likely to be effective for them. Actions to minimise the potential barriers to engagement were not always included.

While most sentence plans set appropriate objectives pertinent to the individual case, there was room for improvement. We inspected cases where the individual had been convicted for a violent offence; alcohol misuse was a major contributory factor in a high percentage of their lives. Most sentence plans included objectives around alcohol. While sentence plans were generally clearly and simply framed, we found not all of the objectives were sufficiently outcome-focused. Where required, not all sentence plans incorporated objectives to manage Child Protection concerns or to address required actions from multi-agency risk management procedures.

Recorded levels of planned contact with the individual were generally appropriate, but it was not always clear when the sentence plan would be reviewed. In those cases where the review period was set out, we thought it was usually appropriate. However, it was not always clear what would require an unscheduled review.

Interventions were generally delivered according to the requirements of the sentence and in line with sentence plan objectives. While most individuals received help to improve their accommodation, employability and education situations, insufficient help was provided in relation to the individual's social networks and support within the family and local community. Motivational work was done with individuals to encourage them to engage fully and, in most instances where required, diversity factors were taken into account by the offender manager and others in the way interventions were delivered.

Appointments offered to individuals were enough to promote positive outcomes, and in most cases the offender manager took a lead role in managing the sentence and monitoring attendance. In nearly all cases the offender manager took a timely and investigative approach to non-compliance. Offender managers exercised appropriate professional judgements in determining whether absences were acceptable, with the reasons usually recorded.

We found that sentence plan reviews were not timely in many cases, while in some instances there had been no review completed. Where they were done, but to an insufficient standard, the reviews were not always used to increase the individual's commitment to their sentence or to celebrate and/or reinforce progress made. Where there had been a significant change in the individual's circumstances or completion of a requirement of the sentence, we expected to see a review undertaken; in many instances no such review had been done.

Case records were well maintained and normally shared with other workers involved in the case. Most of them reflected the work carried out with individuals.

Sentence requirements were generally carried out as intended, but sentence plan objectives were achieved in fewer cases than we would have liked. In most instances where individuals had not complied with the sentence, action was taken by the offender manager to promote compliance.

Results from the annual National Offender Management Service survey of offenders' views indicated that service users were generally positive about their experience of being on supervision with Devon & Cornwall Probation Trust.

Offender managers received regular formal supervision and most expressed positive views about the quality and support of line managers. Most thought that their training needs to undertake their current job was sufficient, but fewer thought that training prepared them sufficiently to meet their future development needs.

Outcome 3: Reducing the likelihood of reoffending

Overall, 69% of the work to reduce reoffending was done well enough.

Initial assessments of likelihood of reoffending were generally carried out to a sufficient standard. Most were timely and took account of the individual's previous relevant behaviour and home and social environment. While they usually identified the factors relating to the individual's offending, the person who had offended was not always actively and meaningfully involved in the assessment.

Alcohol misuse was a factor that made the individual more likely to reoffend in most of the cases we inspected, and it was usually sufficiently recognised in the initial assessment of likelihood of reoffending. However, interventions to address the problem should have been provided in more of the cases.

The provision of group and other structured interventions was improving and sufficiently resourced by the Trust. Many of the interventions were provided by other organisations. There was effective partnership working with the police in relation to Integrated Offender Management cases.

In most instances constructive interventions encouraged and challenged the individual to take responsibility for their actions and decisions related to offending, and the work kept a focus on the changes they needed to make to their behaviour. Most had been sufficiently prepared for interventions delivered throughout their community order or licence. However, offender managers had not always reviewed with individuals the work that had been done with them in other parts of their order or licence. More people could have been informed of local services that could have supported them in their rehabilitation, and referred as necessary.

In a majority of cases, there was a sufficient record of the progress made by the offender. However, we found that not enough individuals had made sufficient progress in addressing the most significant offending-related factors that might have led to a reduction in their likelihood of reoffending.

Offender managers had mixed views about the range of interventions available to them. Disaggregation of offender managers' views, about what resources were available, showed there were differential levels of resource provided within the different local delivery units.

Not enough individuals showed improved integration into the community or improved family relationships.

The Trust applied information and research findings proactively, and used them to improve services. They had well developed quality assurance arrangements that were used to drive up both organisational and individual offender manager performance.

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

Overall, 70% of the work to protect the public by minimising the risk of harm to others was done well enough.

Partner organisations spoke well of Devon & Cornwall Probation Trust, which was regarded as a major player at a strategic level in relation to multi-agency work designed to protect the public.

An initial Risk of Serious Harm screening was missing or not completed sufficiently well in a number of cases. An initial full risk of harm analysis was not always completed where required. When completed, the quality was not always good enough. Reasons for insufficiency were usually because the assessment was not suitably analytical or did not take account of all available information to inform the offender manager's judgement. However, offender managers usually assessed the Risk of Serious Harm classification (low, medium, high or very high Risk of Serious Harm to others) correctly.

We found too many risk management plans were either not completed or were completed to an insufficient quality. While most addressed factors identified in the risk of harm analysis, they did not always anticipate possible changes in risk of harm factors or events pertinent to the individual case that would prompt a review. They did not then state the consequential actions that would be required. Not all risk management plans accurately described how the objectives of the sentence plan and other activities would address risk of harm issues and protect actual and potential victims. Actions set out in risk management plans were generally carried out as required. Key risk of harm information had been passed between all relevant staff and other agencies involved in most cases.

The Multi-Agency Public Protection Arrangements cases we inspected were well managed, and the Trust had a robust and coherent approach to both the referral processes and Multi-Agency Public Protection Arrangements meetings. Nearly all of the Multi-Agency Public Protection Arrangements eligible cases we

inspected had been correctly identified and referrals were made in a timely manner, ensuring sufficient time for necessary measures to be put in place prior to release of the individual from prison. Decisions taken within Multi-Agency Public Protection Arrangements were generally clearly recorded, followed through and acted upon.

Offender managers had not always responded appropriately when there had been a change in an individual's risk of harm factors. In many cases changes had not been identified swiftly or acted upon by all relevant staff, or other agencies notified where needed.

Restrictive requirements or conditions were monitored fully in most cases, while approved premises had played a key part in helping to manage the individual's risk of harm to others in all of the cases that we inspected where the offender had resided there. Initial home visits were not always carried out and repeated as necessary in those cases where the individual posed a high risk of harm to others, or where there were Child Protection issues.

Risk of harm assessments and risk management plans were not always reviewed in a timely way or promptly after a significant change in circumstances or risk of harm factors. Some risk of harm assessment reviews contained an insufficient analysis of the risk of harm posed by the individual.

The Trust had sought to develop good strategic relationships with the three Children's Services Departments covered by the Trust area, but at an operational level there was room for improvement with the quality of joint work being variable and inconsistent. In a number of cases the use of multi-agency Child Protection procedures had been insufficiently effective and decisions had not been clearly recorded or communicated, or followed through, acted upon and reviewed.

There was insufficient evidence of effective management scrutiny in a sizable minority of the cases classified as posing a high risk of serious harm or where there were child protection issues. Senior managers were aware of the inconsistent management oversight deployed across the Trust area, and had initiated a quality audit of that aspect of work with a view to improving individual manager performance.

Outcome 5: Delivering effective work for victims

Overall, 78% of the work to deliver effective services to victims was done well enough.

Assessment and planning to minimise risk of harm to others paid sufficient attention to safeguarding children and young people. Most of the cases we inspected evidenced that prompt contact had been made with Children's Services at the start of the community order or licence to check whether there were any children and young people living in the same household as the offender. However, insufficient attention had been paid to the risk of harm the individual posed to actual and potential victims, with offender managers often failing to draw sufficiently on all available sources of information to inform their judgements and with many risk management plans being of an insufficient quality.

Generally, offender managers ensured appropriate priority was given to the safety of potential and actual victims in the ongoing work undertaken with the offender, with restrictive requirements in licences and community orders monitored.

Risk of harm to identifiable or potential victims was, in most cases, managed effectively and the safety of children and young people promoted.

We thought the quality of work where the victim had elected to participate in the victim contact scheme was good, with accurate and regular information sharing between the offender manager and victim liaison officer. Victims had been enabled to provide their views on licence conditions and informed of relevant conditions relating to the offender's release.

Recommendations

Post inspection improvement work should focus particularly on ensuring that:

1. risk of harm to others is assessed accurately and promptly, and is reviewed as appropriate, taking account of information from other organisations
2. planning to manage the risk of harm to others takes full account of the safety of actual and potential victims, and pays appropriate attention to the protection of children and young people
3. offenders are actively involved in their sentence planning, and timely reviews are used to reinforce objectives and commitment to the sentence, and to support progress
4. effective management oversight is clearly evidenced in the records of all cases involving the protection of children and young people and of those classified as posing a high/very high risk of serious harm to others.

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

Assisting sentencing

1

Outcome 1: Assisting sentencing

What we expect to see

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

Case assessment score

Overall, 82% of work to assist sentencing was done well enough.

Key Strengths

1. Court reports were generally based on sufficient information for the court appearance.
2. Reports contained an appropriate proposal for a community sentence, and the sentence imposed by the court broadly followed the proposal.
3. Sentencers were positive about the calibre and enthusiasm of court based probation staff, and were generally satisfied with the quality of PSRs.
4. Accommodation for probation staff in the courts enabled them to do their jobs.

Key Areas for Improvement

1. A sizable number of court reports lacked a sufficient risk of harm screening and/or assessment.
2. Many court reports failed to include information about how specific barriers to engagement and compliance would be addressed.

Explanation of findings

1. Assessment and planning to inform sentencing

1.1. We inspected 44 cases where a report had been prepared for the courts to assist them in passing an appropriate sentence; of these, 11 were oral reports. There was a hard copy record of the oral reports in the paper case file for all but two of them. The remainder of the reports were typed, of which 15 were full reports and the remainder shorter reports that were normally prepared within a shorter timeframe.

1.2. We found that nearly all of the typed reports were written in a clear and accessible style, and were free from typographical and/or grammatical errors. We found that nearly all the reports we read were suitably concise, but the resident Crown Court judge said some reports he had read could have been shorter.

1.3. Overall, we assessed that all but 5 out of the 33 typed reports of either the full or shorter variety provided sufficient information for the court appearance. Sources of information were indicated in all but one of the reports, and, in nearly all of them, the sources were verified where required.

1.4. Most of the reports included relevant information about the offender's home and social environment, but about one-fifth of written reports had not been based on the required assessment of likelihood of reoffending or incorporated a risk of harm screening or assessment, which was contrary to

the Trust's policy. Of the seven reports that had not incorporated the risk of harm screening or assessment, six were shorter format reports.

1.5. Just over three-quarters of the reports were judged to be of sufficient quality. Where they were deemed to be insufficient, the main reasons were that the reports did not: include an accurate analysis of the risk of harm posed by the offender (slightly more than one-third); contain an accurate assessment of the likelihood of reoffending (28%); and/or a sufficient analysis of the offence and its impact (just under one-quarter).

1.6. Of the 33 typed reports we read, all but three contained an appropriate proposal for a community order. Proposals always flowed logically from the main content of the report, were proportionate to the seriousness of the offence and appropriate to the nature of the offending. All but one of the reports included a proposal that was appropriate to the offender's circumstances, including their motivation and ability to complete the proposed sentence. Where required, all but one of the reports proposed a requirement that would have kept risk of harm to a minimum, and all but two contained an appropriate proposal for a punitive requirement.

1.7. Most of the reports stated intended outcomes or objectives appropriate to the proposed sentence. While over four-fifths of the reports advised of the offender's motivation and capacity to comply with the proposed sentence, less than half indicated how any barriers to compliance and engagement would be addressed. This was an omission that the magistrates mentioned when we met with them. They particularly wanted to know 'what would be different on this occasion' in those cases where the offender had had a previous community order and their response to supervision had been unsatisfactory.

1.8. We found that sentencers broadly followed the proposals of the report writer in all but three cases. In one of those reports there was a differing assessment of the seriousness of the offence.

1.9. In four cases, a community order was passed without evidence of any report having been prepared or other information having been made available to the court. One offender received a suspended sentence order, while the other three received community orders. One of the community order cases related to a 19 year old man who had committed a new offence whereby he had threatened to stab a security guard whilst on a community order for public order offences. He had an extensive criminal record, and was dealt with by the court without a report despite being managed as a Tier 4 'high Risk of Serious Harm (RoSH)' offender. Outcomes were particularly poor in that case.

2. Leadership and management to support sentencing

2.1. We met with three representatives of sentencers; a resident Crown Court judge and two magistrates, one of whom was a Bench Chairman.

2.2. Overall, the message from sentencers was that court facilities for probation staff were sufficient. That was a view to which probation managers concurred. Probation staff had access to private rooms, and were able to conduct interviews with offenders in confidential settings. The court staff were able to access the probation case management system and OASys from within the court buildings. The Trust was able to get relevant information in relation to court cases, such as prosecution papers, electronically as part of the criminal justice system's efficiency project.

2.3. The judge and magistrates were extremely positive about the calibre and responsivity of individual probation staff in court. They said that issues about individual reports could be addressed with the relevant probation court manager or staff member at the time they arose.

2.4. The Trust was carrying out minimal 'gatekeeping' of PSRs, but peer reviewing was being carried out in relation to reports on women and ethnic minority offenders. There was also some 'dip sampling'. That said, sentencers told us that PSRs were generally of a good quality. The magistrates said that, overall, they were happy with the risk of harm assessments within the PSRs, but occasionally they

felt the assessment was too narrow and, while taking account of the index offence, did not give sufficient weight to the individual's offending history.

2.5. While the overall comments from sentencers were positive, the Bench Chairman commented about the levels of resourcing in a specific court, which had occasionally led to some difficulties in getting an 'on the day' report produced. This was acknowledged by the Trust, which recognised that court staffing was a priority. They said there was a need to deliver consistency of service to the courts while recognising local differences across the Trust area. The national *'Transforming Rehabilitation Strategy'*[1] was not yet clear on the amount of resources that would be allocated for assessment services, which the Trust said made it difficult for them to do too much further work in that area because of the uncertainty.

2.6. Although we found proposals generally sufficient, senior management were aware that not all court writers were making the right proposals in relation to the interventions that delivered the best outcomes. As a consequence, they were monitoring reports, and where writers were not making proposals for structured interventions, for example in relation to an appropriate accredited programme or treatment requirement, then that was followed up with the relevant staff member.

2.7. There seemed to be an appropriate level of communication with sentencers, but it was not consistent across the Trust area. The judge said he would like to have known a bit more about some of the interventions, but had found a recent visit to a service provider very informative. Probation was contributing to the sentencers' newsletter and attending the justices' issues group, local liaison group meetings and, where feasible, lunchtime briefings although there was a problem with attendance of sentencers at those sessions. It was acknowledged by the magistrates that probation had made attempts to share information about the relevant interventions delivered in Devon & Cornwall. However, a combination of lack of magistrates attending training events and probation court staff not always being sufficiently informed about the interventions delivered by third parties, meant there was room for improvement.

2.8. As we only saw three sentencers, we did not have a complete picture of sentencer satisfaction across the whole Trust area. Overall, the sentencers we interviewed said they had confidence in the credibility of community sentences, although there were some difficulties in accessing appropriate interventions in parts of Devon & Cornwall. The main area where interventions were identified as a problem by the sentencers related to the provision of accommodation for vulnerable adult offenders and accessing appropriate help for offenders who had mental health problems.

Comments from sentencers:

"I respect the views of experienced probation officers."

"Personal contacts have helped to resolve problems, and the bench is happy to move to on the day reports and oral reports."

Summary

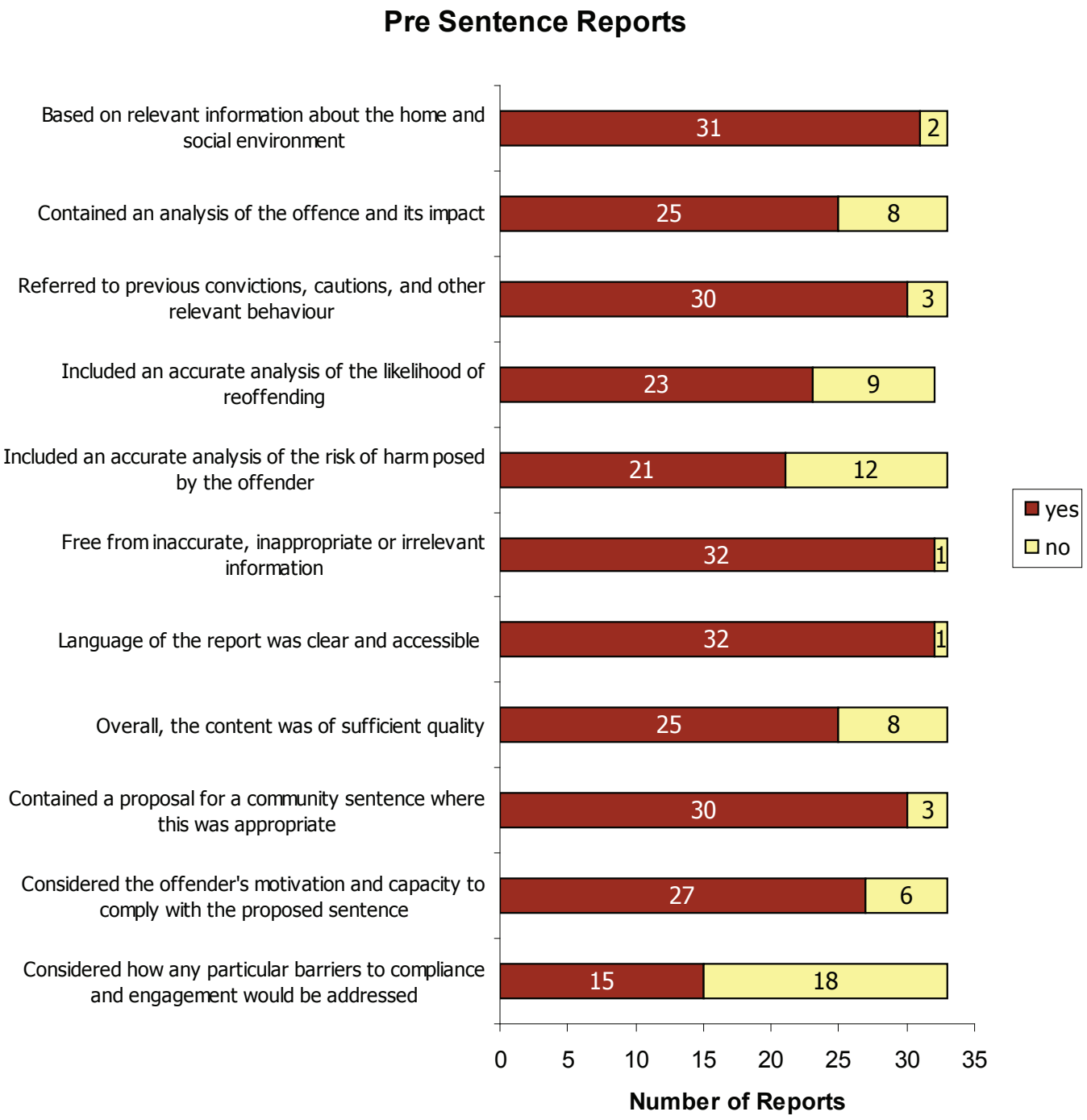
Overall, 82% of the work to assist sentencing was done well enough.

For a summary of our findings, please see page 2

1 Under the Government's *Transforming Rehabilitation Strategy*, Probation Trusts are due to be replaced by the National Probation Service. Recommendations addressed to Probation Trusts should be followed up by whoever delivers probation services in the future, including both the National Probation Service and private providers. The strategy can be accessed at http://www.justice.gov.uk/transforming-rehabilitation

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 72 cases were inspected. However the total answers may not equal this, since some questions may not have been applicable to every case]



Delivering the sentence of the court

2

Outcome 2: Delivering the sentence of the court

What we expect to see

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

Case assessment score

Overall, 78% of work to deliver the sentence of the court was done well enough.

Key Strengths

1. Contact with offenders generally started promptly following sentence or release. Individuals received a full, tailored induction, which included informing them of their commitments, obligations, responsibilities and rights.
2. There was sufficient assessment of most individuals' needs at the start of the community order or licence, including their ability to engage with the sentence. Planned levels of contact with the individual were recorded and appropriate.
3. Attendance was monitored and offender managers and others generally took appropriate action in relation to non-compliance. Where breach action or recall was instigated, it was usually done promptly with the individual advised of the reasons why action was taken. Most offenders were then appropriately re-engaged with their sentence plan.
4. Records were well organised, and offender managers and others captured information in a clear and timely way that generally reflected the work that had been carried out.
5. The requirements of the order or licence were delivered as intended in most cases, and reporting instructions were generally appropriate.
6. Offender managers said they had received sufficient training in relation to diversity issues, albeit some were less confident in working with individuals who had mental health needs.
7. People who had offended were largely positive about their experience of contact with the Trust.

Key Areas for Improvement

1. A greater number of offenders could have been actively and meaningfully engaged in drawing up their sentence plan. More consideration could have been paid to individuals' personal strengths and aptitudes. In a sizable number of cases insufficient attention was given to what needed to be done to minimise the impact of potential barriers to engagement.
2. While the link between alcohol and violent offending was recognised and incorporated into most sentence plans where required, objectives to manage Child Protection issues and/or obligations from multi-agency risk management procedures were not always included. In addition, sentence plan objectives could have been more outcome-focused.
3. Sentence plan review dates were not always clearly recorded, nor were the circumstances that might prompt an unscheduled review identified. Reviews were not always completed within the time frames stated or when required by a significant event. When done, the sentence plan reviews were not

always completed to the required standard, nor did they sufficiently focus on the further work to be undertaken with the individual.

4. There was recognition by most offender managers that workloads were actively monitored, but fewer staff thought that workloads were managed sufficiently well to minimise the impact of absences or the full range of work they were required to undertake.
5. Many offender managers said they had not received specific training in delivering interventions in relation to violent offending.

Explanation of findings

1. Assessment and planning to deliver the sentence

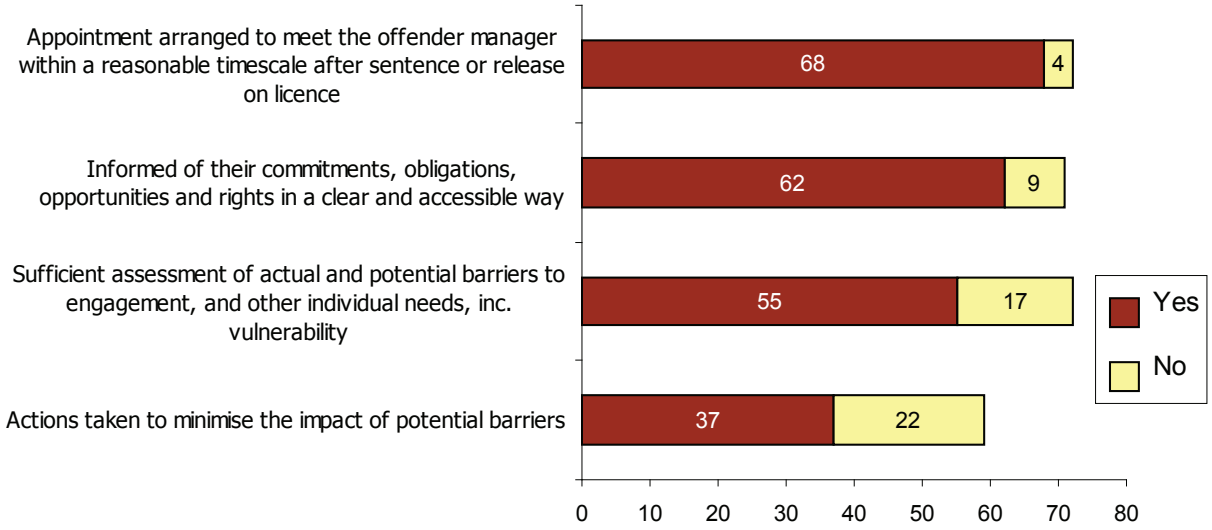
1.1. We assessed 72 cases as part of this inspection, of which 65 were clearly allocated to the correct tier of service at the start of sentence or release on licence or transfer into the area. In none of the seven cases where the case had been incorrectly tiered, was a valid reason for this recorded on the case file.

1.2. In all but four of the cases we assessed, an appointment had been arranged for the individual to meet their offender manager soon after sentence. Most individuals were offered a full and individualised induction at the start of their order or licence.

1.3. We found, in nearly all cases, that offenders were informed of their commitments, obligations, responsibilities and rights in relation to their order or licence in a clear and accessible way. In just over three-quarters of the cases, there had been a sufficient assessment of the offender's individual needs, including their vulnerability and ability to engage with their sentence.

1.4. In sentence planning, we expect to see that individuals are actively and meaningfully engaged in helping draw up their plan. In Devon & Cornwall we found that 31% of the cases we inspected did not demonstrate this (Chart 2.9), which was lower than the findings from the National Offender Management Service (NOMS) Offender Survey. A timely and informed sentence plan was completed in slightly more than two-third of cases, while one-fifth of the plans were insufficiently informed by an assessment of the likelihood of reoffending or risk of harm. There were six cases we inspected where no sentence plan had been completed.

Engaging people at the start of sentence



1.5. In more than three-quarters of relevant cases, there was a sufficient assessment of the factors relating to the offender's needs in relation to accommodation and employability. Around seven-tenths of required assessments were carried out in relation to primary health needs or the offender's main sources of support within the family or community. In almost one-quarter of the cases, there was no evidence of a current 'Skills for Life' screening or assessment having been carried out.

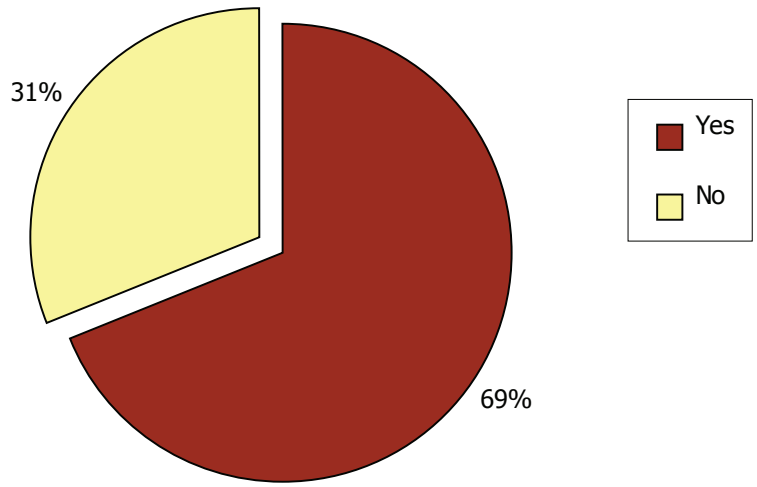
1.6. Disappointingly, in two-fifths of relevant cases, insufficient action had been taken or included in sentence planning to impact on those factors. In just over seven-tenths of relevant cases, offenders were signposted to an appropriate service.

Case illustration - signposting to appropriate services

William had been sentenced to a community order for an offence of common assault. He was signposted, initially and promptly, to a specialist alcohol service, as required by his Alcohol Treatment Requirement. However, following a review regarding its suitability to meet his chronic alcohol needs, he was returned to court and the court order amended. He was then referred to Addaction who worked with him on his Alcohol Specified Activity Requirement, which was deemed a more suitable intervention. There was lots of evidence of offending behaviour work having been undertaken in this case. William completed the required work in relation to his alcohol issues, complied with his curfew, secured independent accommodation and retained his employment. He did not reoffend.

1.7. Desistance research indicates that the quality of the supervisory relationship, attention to the offender's specific needs, and the use of strengths based approaches to enable their reintegration into the wider community are of critical importance to the longer term outcome of stopping offending. We expect to see that sentence planning ensures a sufficient assessment is made of the relevant factors that are likely to help the individual engage and comply with their order or licence. About four-fifths of the cases we inspected sufficiently addressed the individual's level of motivation/readiness and their capacity to change. However, in approximately two-fifths of the cases, insufficient attention was given to the individual's personal strengths and aptitudes or the methods likely to be most effective. As a consequence, we found that in over one-third of relevant cases actions required to minimise the impact of potential barriers to engagement were not included in relevant planning documents.

Sentence planning paid sufficient attention to factors which may promote compliance



1.8. In over two-thirds of cases, sentence planning set appropriate objectives. Most of the objectives within the sentence plan were appropriate to the purposes of sentencing; three-quarters addressed the likelihood of reoffending; and just over two-thirds addressed the risk of harm to others. However, slightly less than three-fifths incorporated objectives to manage Child Protection issues and/or relevant obligations from multi-agency risk management procedures.

1.9. The cases we assessed in this inspection were all ones of violence. Bearing in mind the high correlation between alcohol and violent offending, we wanted to find out if the contribution of alcohol to the offence was sufficiently addressed in the sentence plan. Of 54 cases where alcohol needed addressing, we found it was sufficiently included in almost four-fifths of them.

1.10. We expect to see sentence planning objectives that are clearly and simply worded, outcome-focused and which set out in achievable steps what needs to be done. Almost four-fifths of the plans were clearly and simply framed, but around one-third were either not outcome-focused and/or set out in achievable steps.

1.11. In most instances, the planned levels of contact with the individual were recorded and/or appropriate to the requirements of the individual case.

1.12. In over two-thirds of cases, there was a clear record of the contribution to be made by all workers involved in the case to achieve sentence planning objectives. In a similar proportion of cases, the relevant parts of the sentence plan were communicated to other people involved in working with the offender.

1.13. In over two-thirds of the cases there was a clearly recorded date for when a review would be carried out of the offender's progress with their sentence planning objectives; we found in over four-fifths of those instances that the planned review date was appropriate. However in three-fifths of the cases we were not able to evidence what changes might prompt an unscheduled review.

Case illustration - signposting to appropriate services

The offender manager was very aware of the pro-criminal attitudes of Graham, who had been released on licence following a custodial sentence for an offence of malicious wounding. The sentence plan was, therefore, drawn up with motivational work and the development of a rapport with Graham being prioritised before the structured offence focused work was addressed. Despite the offender manager having developed the relationship and undertaken appropriate offending-related work with Graham, he subsequently failed to comply. The offender manager instigated recall procedures promptly, and then sought to re-establish contact with Graham, with a view to putting in place appropriate plans for when he was next released.

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

2.1. Interventions were delivered according to the requirements of the sentence and in line with sentence plan objectives in over four-fifths of the cases.

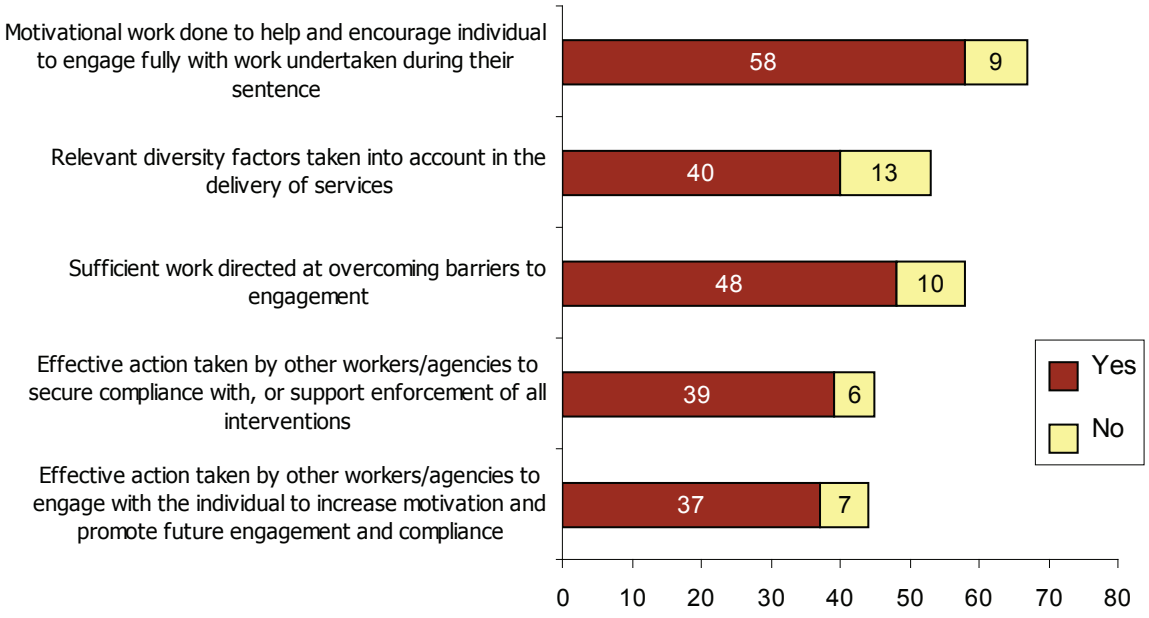
2.2. In over three-quarters of cases, the delivery of interventions took account of the risk of harm posed by the offender to others. In breaking down those results, we found that the figure for female offenders was markedly better than for male offenders; it was also better for those who had alcohol issues rather than those who did not have problems around alcohol.

2.3. Most individuals received sufficient help to enable them to improve their education, employability or accommodation situation. However, help was less forthcoming in relation to factors relating to the individual's social networks and support within the family and local community. In over one-third of relevant cases help for the offender to access primary health services was not forthcoming, although in the Plymouth local delivery unit (LDU) where a GP had a weekly surgery, in every case where

there was a health requirement it was delivered; in Cornwall and Devon & Torbay LDUs, help with health issues was forthcoming in less than half of the required cases.

2.4. Motivational work was done with individuals to encourage them to engage fully with their sentence in most cases. Where required, in three-quarters of the relevant cases, diversity factors were taken into account in the delivery of services.

Increasing motivation and promoting compliance with the sentence



2.5. Overall, the level of contact offered by the Trust to the offender was sufficient in most cases to promote positive outcomes. Specifically, it was sufficient to facilitate the delivery of the sentence and deliver the 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, the level of contact that had been maintained with the offender while they were in custody was assessed as having been sufficient to contribute to good post-release planning and case management.

2.6. As part of the inspection, we determined whether the level of resources allocated in individual cases was appropriate in relation to the offender's likelihood of reoffending, the risk of harm they posed, the purpose of the sentence and any relevant diversity needs the offender may have had. In a high percentage of cases, we determined that the level of resources was appropriate in relation to each of those factors. We judged that the level of resources allocated was too high in just seven of the cases we inspected.

2.7. Offender managers are required to take a lead role in the management of the sentence, including the parts of the sentence that may be delivered by others. We assessed that they took such a lead role in over four-fifths of the cases.

2.8. In all but four of the cases, the offender manager monitored the offender's attendance across all aspects of the order and, in 85% of those cases where the offender did not comply, the offender manager took a timely and investigative approach to non-compliance. In most cases, we also found that other workers took action to increase motivation and encourage future engagement and compliance where such an approach was required.

2.9. In over four-fifths of the cases we inspected, the individual had not attended when required or there were instances of unacceptable behaviour. In most of those cases, the professional judgements

made by the offender manager about the acceptability, or otherwise, of the absence were appropriate. When required, a clear and timely formal warning was given to the offender in nearly all of the cases.

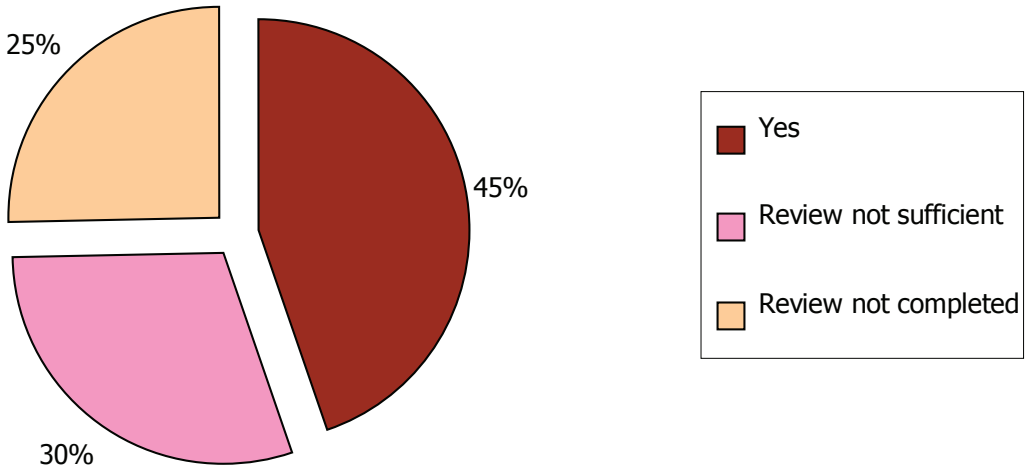
2.10. We found that enforcement proceedings or recall were used appropriately in response to absence or other offender behaviour in 71% of cases when required. In four cases breach or recall was used inappropriately. Breach or recall was required, but not instigated, in a different four cases. Where legal proceedings or recall were instigated, it was promptly actioned in three-quarters of the instances. A clear explanation was given to the individual as to why the action was taken in all but three of those cases. Sufficient effort was made to engage the offender with their sentence plan, and get their commitment to continued engagement, in three-quarters of those cases where breach or recall had taken place.

2.11. We expect to see sentence plans reviewed within the timescale stated in the initial plan or within a reasonable period. However, in Devon & Cornwall we found reviews had not been done sufficiently well in over half of the cases, where required. Of the 37 cases that had not had a sufficient review, 17 had had no review at all.

2.12. In relation to timeliness, 29% of sentence plans had not been reviewed within a reasonable interval after the initial sentence plan or last review (given the specific nature of each case); two-fifths had not been reviewed in line with the timescale stated in the initial plan. Despite the introduction of professional judgement within National Standards, we were somewhat surprised to see how many cases still had 16 week review periods set out in the sentence plans. While such a review period was not necessarily inappropriate, we did then expect to see the review carried out within that timeframe; yet we found many that were not.

2.13. NOMS standards require that reviews are undertaken where there has been significant change, for example completion of a requirement of the sentence, or changes in the individual's circumstances which might affect classification of risk of harm to others. However, reviews had not been done promptly following any significant change in more than three-fifths of the relevant cases, nor used to prioritise objectives appropriately (one-third of cases), and/or not used to allocate additional resources if required (almost half of those instances where required).

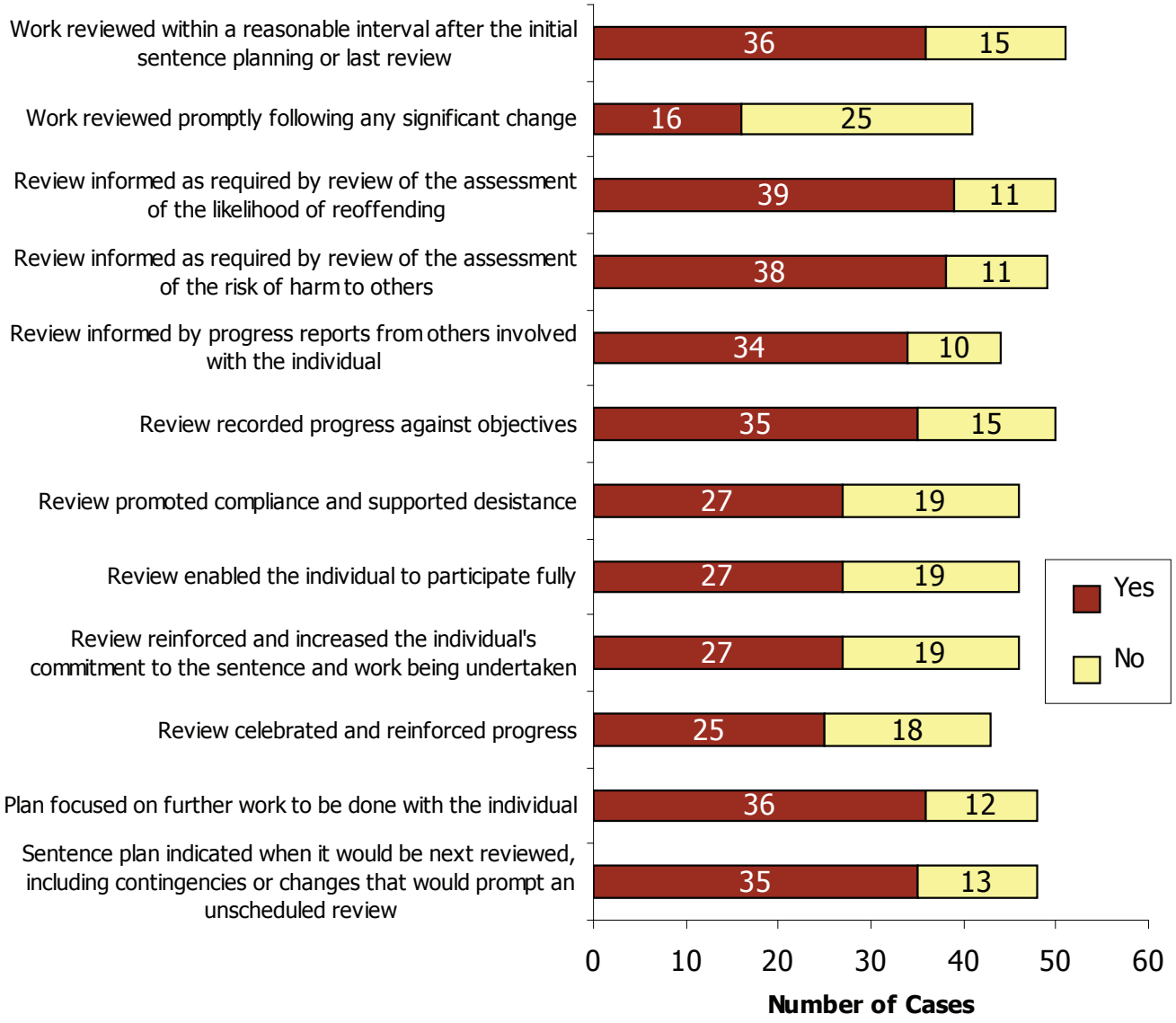
Sufficient review of the sentence plan



2.14. In two-fifths of relevant cases, the review of work was not used as an opportunity to enable the offender to participate fully, reinforce and increase their commitment to the sentence and/or celebrate and reinforce any progress made. In the context of promoting compliance and supporting desistance from offending, these were definitely missed opportunities.

2.15. In one-quarter of cases, the review did not focus on further work to be done with the offender. Almost one-third did not set out the ongoing level and pattern of future contact or say when the sentence plan would next be reviewed, including setting out what might prompt an unscheduled review. Half of the cases (seven) had not been reallocated to a different level of service where the review had indicated this was necessary.

Reviewing sentence plans and reinforcing progress



2.16. Five cases in our sample had been transferred between Trusts or other organisations. All had taken place because the offender had moved following a change of geographical area. Three of the transfers had been in to Devon & Cornwall, and two from Devon & Cornwall. Two of the transfers had been well managed (one in and one out), while the other three (one out and two in) were less well managed. The reasons for the transfers were always appropriate, but there were delays in sharing the likelihood of reoffending assessment and sentence plan and/or risk of harm assessment and risk management plan in three of the cases (two in and one out). In four of the five

cases, there was clarity about who was managing the case. In all three cases where the individual transferred in to Devon & Cornwall, an appointment was made with them as soon as possible upon their arrival while, in both cases where required, a prompt home visit was made to the offender's new address.

2.17. In most instances, the case records (both electronic and paper) contained sufficient information to support the management of the order or licence and had been shared with other workers involved in the case. Records were well organised and the recording of information was clear, timely and generally reflected the work carried out, although almost one-quarter of case files lacked relevant documents. We were told by offender managers that, for a number of cases that had already terminated, the case files had been 'pruned' of some of the core documents that we would normally have expected to have seen.

3. Initial outcomes are achieved

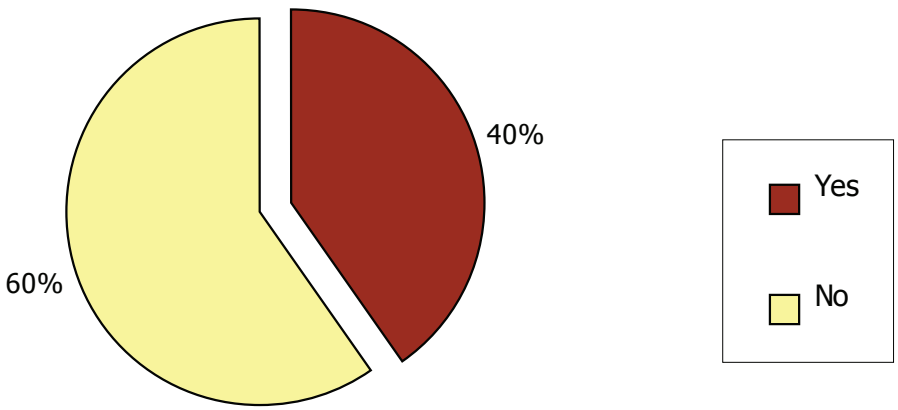
3.1. The requirements of the order or licence were delivered as intended in over four-fifths of the cases in the sample. Reporting instructions given were sufficient for the purpose of carrying out the sentence of the court in 90% of the cases.

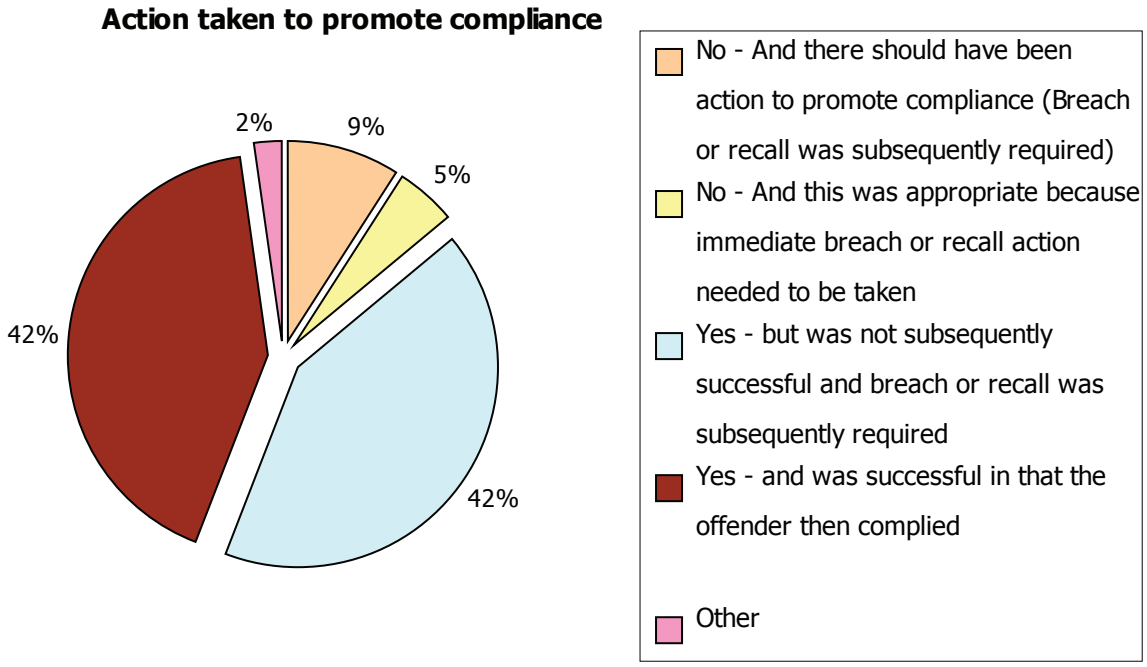
3.2. In two-fifths of the cases inspected, the individual complied with the sentence without the need for any additional action by the offender manager. Of the remainder, in most instances action was taken to promote compliance. However, in a small number of cases action that was required was not taken. In 29% of relevant cases, breach or recall was not used on all occasions where it should have been.

3.3. Sentencers were positive about the quality of Drug Rehabilitation Requirement reports and reviews. It was clear that in Devon & Cornwall, the benefit of getting the same person to hear the monthly reviews in court was seen to be important and provided an opportunity to give positive, motivating messages to the offender when they were doing well.

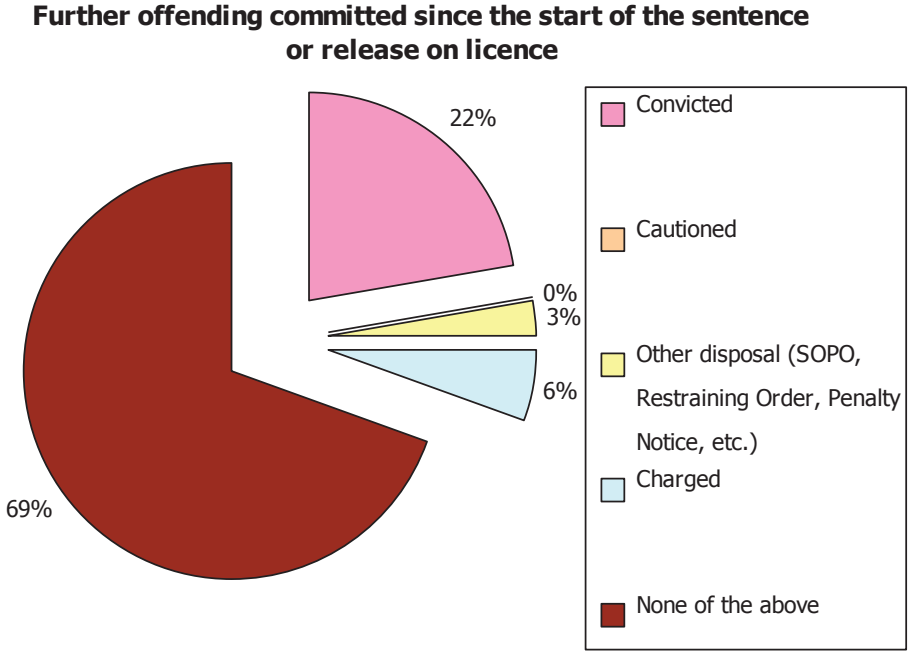
3.4. Magistrates were less positive about the quality of some of the breach reports they received, saying it was not always clear what had gone wrong with the original order and, if the proposal was for the order to continue, what was going to be done differently to now get a better outcome.

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





3.5. In the case sample, over two-thirds of the individuals had not been cautioned for, charged with, or convicted of a further offence during the period of supervision we inspected.



3.6. Sentence planning objectives had been achieved fully in more than one-fifth, and partly in one-half, of the cases. In a high percentage of cases where there had been a change in offender manager, delivery of the sentence plan had been maintained.

3.7. One case in the sample had been terminated early for good progress, and we considered that to have been appropriate.

This is what people who had offended thought of their experience

What people who had offended thought of their experience:

NOMS conducts an annual survey of the views of people in contact with victims. For 2012, Devon & Cornwall received 245 responses, the data from which is given below.

The findings were largely positive. The survey found a higher level of individuals' involvement in their sentence planning than we evidenced in the 72 cases we inspected. Their experiences of being on supervision were generally favourable.

A large majority indicated they felt they had received sufficient help, albeit one-quarter would have liked more assistance with employment issues and almost one-quarter with accommodation problems.

Most of the offenders who responded to the survey made no comments about improvements.

Comments from individuals:

"As this is my first time on Probation I was unsure what to expect; I have been surprised by all the help given to me."

"For me the shame of having a conviction is enough to stop me offending again; my Probation Officer has been very supportive."

"My Probation Officer is experienced and obviously knows what she is doing."

"My Probation Officer has made such a difference to my life and I am gutted that I won't be seeing her again."

"In the early stages I saw six different officers due to ill health. Now I have [name provided], and he has been a huge help and inspiration."

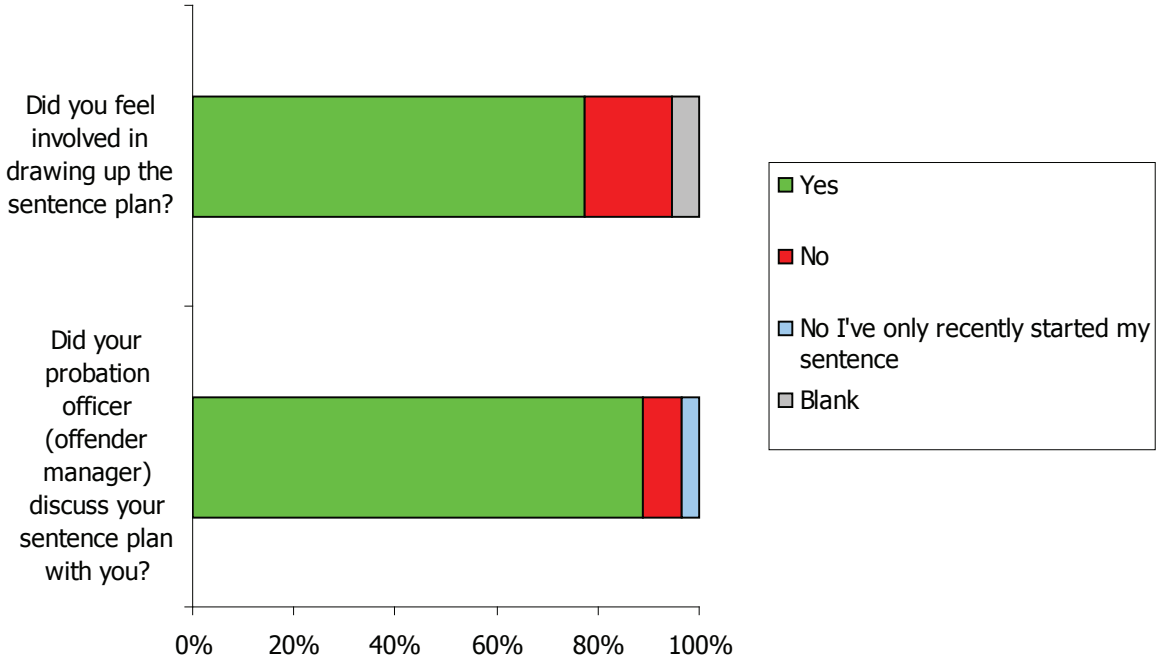
Less positive comments:

"Programmes should run on time and dates shouldn't change. If I miss a session or am late I get into trouble, but it's OK for programme tutors to change dates and arrive late!"

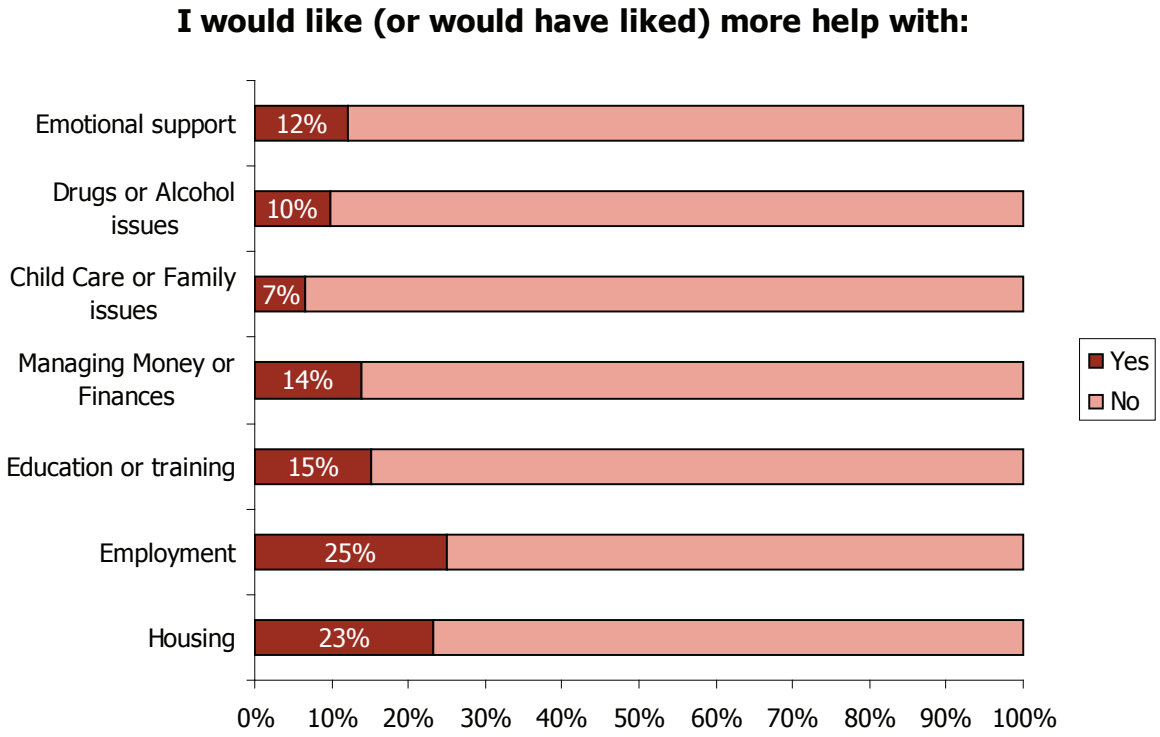
"More funding and opportunities should be made available for training and education."

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

Section 1 - About Current Order/Sentence



Section 2 - About Experience on Probation



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

4.1. We interviewed 50 offender managers during the inspection to gain their views about their experience of working for Devon & Cornwall. We asked them about workloads. Three-quarters of offender managers interviewed said they thought that workloads were actively monitored. However when we asked if workloads were managed in a fair and transparent way, only one-third of offender managers responded positively. Some offender managers said they did not think the workload measurement tool used by the Trust reflected of all the work undertaken, for example parole reports. Senior managers acknowledged workloads may not have been managed as actively as they might.

4.2. With regard to staff absences, three-fifths of offender managers thought planned absences were managed in an effective way to minimise any disruption to the continuity of offender management. In relation to unplanned absences, such as last minute sickness, that figure dropped to two-fifths responding 'yes'. These were disappointing findings, particularly in the context of a Trust that had actively sought to manage staff sick leave. In that regard they had had some success, with the average number of days off having reduced in the past 30 months from ten and a half days average then to eight days now. Managers commented this was in the context of an organisation that had seen a sizable reduction in staffing over the same period. They said they had tried to manage resources flexibly, but aspects of the geography of the Trust's area, with many small teams, did mean that it was difficult to build in sufficient resilience everywhere.

4.3. Most of the offender managers we interviewed were positive about the skills of their line manager. In particular, they thought their manager had the skills to assess the quality of their work, to assist them to develop their work and to support them in their work. However, when we asked the offender managers if their line manager was actively involved in helping them to improve the quality of their work, under three-fifths of them said 'yes'. This is an interesting finding. Senior managers said middle managers had been trained in the reflective supervision model and were now providing resources to improve the quality of middle management practice, including countersigning practice.

That is a welcome initiative in the light of our findings, whereby about one-quarter of the offender managers said routine countersigning management oversight of their work was never an active process, and less than one-half of them commented that it was always an active process.

4.4. Of the 50 offender managers we interviewed, two-thirds had received formal supervision over the past 12 months at a frequency of no less than every six weeks. A further one-quarter of the offender managers had received quarterly supervision, while six offender managers said they had received supervision at a frequency of half yearly or less. The most frequently discussed subjects in formal supervision were the offender manager's personal well-being, training & development, performance targets & feedback, and discussion of actual cases. Career development and the dissemination of information also featured in at least half of the offender managers' formal supervision sessions with their line manager.

4.5. Two-thirds of the offender managers we interviewed had had their practice observed, and this was mainly done by their line manager. Sixteen of the offender managers had received mentoring or coaching, and this had been delivered by managers, senior practitioners and others. The same number of offender managers had also been involved in action learning sets or similar structured learning experiences. As part of the roll out of the Skills for Effective Engagement and Development (SEED) pilot during 2012-2013, all managers were trained in the Reflective Supervision Model which uses observation of practice as a key method of assessing offender management practice. As part of the Trust's 2013-2014 performance and development planning, all managers are to have their own practice observed with a view to ensuring their adherence to the SEEDS approach.

4.6. About four-fifths of the offender managers we interviewed thought that the particular methods that had been used in supervision with them had promoted improvements in their practice. We asked offender managers if they had any diversity needs and to what extent they had been addressed by the Trust. Of the 50 offender managers we interviewed, 26 said they had no specific diversity needs that could be reasonably addressed. Of the other 24, three-quarters said their needs had been reasonably addressed by the organisation.

4.7. We asked offender managers about their learning and development. Of the 50 offender managers we interviewed, 20 were Probation Service Officers (PSOs). Some had attained the NVQ Diploma in Probation Practice at Level 3 or the NVQ Community/Criminal Justice award also at Level 3. Three PSOs were currently undertaking the former award, while a further three were undertaking the Probation Qualifications Framework Community Justice Honours Degree and Level 5 Diploma in Probation Practice. The Trust had set itself the demanding target of having all of its PSOs qualified to Vocational Qualification Level 3 by April 2014. Senior managers admitted it was an aspirational target, but the Trust had its own accredited Vocational Qualification Centre and was committed to enabling staff to be as well prepared as possible for when the *'Transforming Rehabilitation'* agenda was implemented.

4.8. Most offender managers thought that ongoing training and development equipped them to do their current job, but fewer thought it helped them meet any future development needs. PSO offender managers answered this question less positively than probation officers (POs). Almost twice as many people who answered those questions negatively said the reason was to do with a lack of availability of relevant training/development opportunities, rather than the fact they did not have sufficient time to take advantage of the opportunities.

4.9. Less than two-fifths of the offender managers said they had received specific training in practice methods/interventions in relation to violent offending, the thematic topic of this particular inspection. Most felt they had received sufficient training in relation to diversity issues. The diversity factors that offender managers felt least confident in identifying, and forwarding on for specialist assessment if required, were mental health (13 offender managers) and culture and ethnicity (seven offender managers).

4.10. All but one of the offender managers said they felt able to identify and work with Child Protection and safeguarding issues. Despite some good practice having been identified, in relation to sharing of information with Children's Services, practice in relation to Child Protection and safeguarding was not always sufficient. That may indicate a need for more targeted training in relation to this area of practice.

4.11. A sizable minority of offender managers said they thought formal opportunities to discuss practice issues with colleagues were insufficient. Just over two-thirds thought the process for disseminating the findings from serious further offences or serious case reviews was sufficient; with a slightly higher percentage considering the organisation promoted a culture of learning and development. In relation to each of those three questions, PSOs answered more positively than POs. Within the LDUs, the responses from staff in Plymouth were considerably less positive than that from the other two LDUs, which was an interesting finding considering that Plymouth's performance across most of the outcome measures was higher than that from elsewhere.

Summary

Overall, 78% of work to deliver the sentence of the court was done well enough.

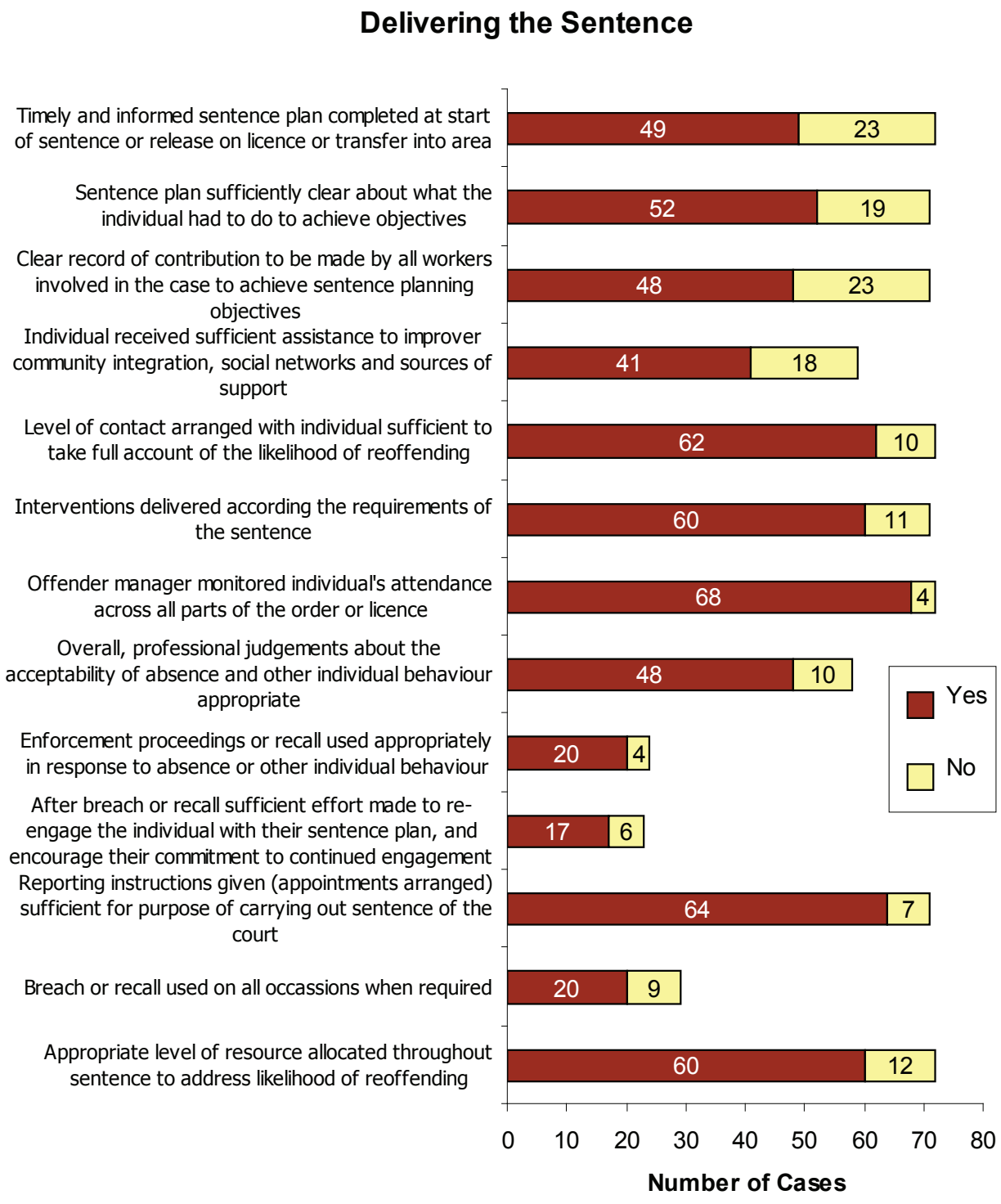
We have recommended that post-inspection improvement work focuses on ensuring that:

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

For a summary of our findings, please see page 2

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 72 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



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, 69% of work to reduce the likelihood of reoffending was done well enough.

Key Strengths

1. Assessments of the likelihood of reoffending were generally sufficient, taking into account relevant previous behaviour and information from the individual's home and social environment and the factors which had contributed to offending. Although, individuals could have been more actively and meaningfully involved in the assessment.
2. Alcohol misuse was a factor which made the individual more likely to reoffend in many cases in this inspection. It was nearly always sufficiently included in the assessments, albeit interventions to address the problems were not always delivered.
3. Individuals were generally sufficiently prepared for the interventions delivered throughout their community order or licence, although some partnership providers considered more could have been done to provide them with realistic expectations of what would be expected of them. A range of group and other interventions were provided by the Trust, often in partnership with other organisations.
4. The Trust used research information well, and its quality assurance work was focused on driving up performance where required.

Key Areas for Improvement

1. Assessments of the likelihood of reoffending were not always reviewed in a timely way, or reviewed when significant change had taken place. Reviews were not generally used to celebrate progress or acknowledge the changes individuals had made in their lives.
2. There was insufficient progress in addressing the most significant factors associated with individuals' likelihood of reoffending in a minority of the cases we inspected. In many cases there was insufficient integration into the community or improved family circumstances.
3. Where the need for programmes had been identified in sentence plans, they had not always been delivered. Where they had been provided, some of them had been delivered late. Not all interventions to address alcohol misuse had been delivered.

Explanation of findings

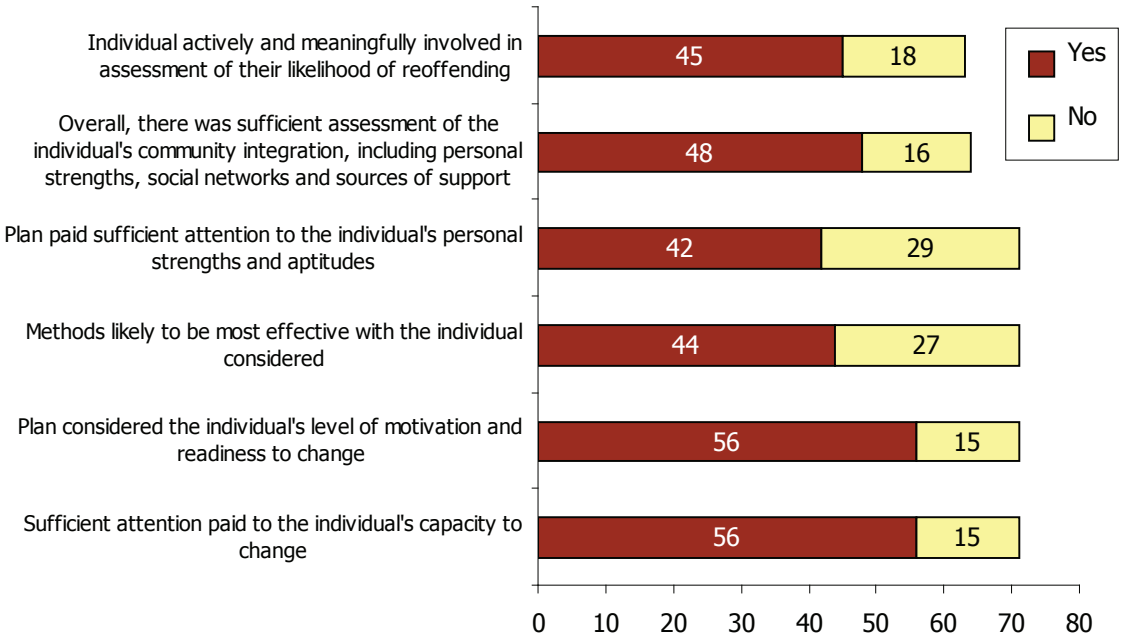
1. Assessment to reduce the likelihood of reoffending

1.1. At the start of sentence, release on licence or transfer into the area an assessment of the factors which may have contributed to the likelihood of further offending was required to be carried out in 65 of the cases in our sample. In four instances no assessment was completed while, in a further 16, the assessment was judged to be insufficient.

1.2. Generally, completed assessments were timely and were either new or sufficiently revised from a previous assessment. Over four-fifths of the initial assessments drew fully on all available sources of information and/or included relevant information from the offender's home and social environment and/or identified the factors that related to the individual's offending and/or took relevant previous behaviour into account.

1.3. We expect individuals to be actively and meaningfully involved in the assessment of the factors that are related to their offending and what will help them to desist from reoffending. Evidence of this was lacking in 29% of the cases.

Involving people in assessing the likelihood of them reoffending



1.4. An initial assessment needs to be comprehensive so that it identifies the offending-related factors in the individual's life and helps the offender manager provide the right interventions to reduce their likelihood of reoffending. From assessing the cases, we determined that thinking & behaviour (65 individuals); alcohol (61 individuals); and difficulties managing relationships (43 individuals) were the factors that made the offenders in our case sample most likely to reoffend.

1.5. In view of the links between alcohol use and violent offending, we were particularly interested, in this inspection, to see what role alcohol had played in the main offence, and to what extent it was recognised in the likelihood of reoffending assessment. We found that alcohol was a contributing factor in 57 of the offences, where an initial assessment had been required. We thought that the initial assessment in relation to the alcohol factor took it into account sufficiently in the assessment in all but eight of those cases (86%).

1.6. In addition to the factors listed above, many offenders in our sample had problems relating to attitudes to offending (40 individuals); lifestyle & associates (39 individuals); and emotional well-being (33 individuals).

1.7. The individuals in our sample had been convicted of a range of offences, counting the 'principal' (most serious) of the offences for which the current sentence had been passed. A detailed breakdown of the principal offences is shown in Appendix 2.

1.8. In six cases, the principal offence related to possession of a weapon. However, in a further eight cases the offence had involved the use, carrying or possession of a weapon alongside more serious

offences. This meant 14 of the 72 cases we inspected had involved the possession, use or carrying of a weapon.

1.9. In almost two-thirds of the cases (46), the offence had involved physical violence. A further 31 were likely to have resulted in psychological harm, while 20 cases had involved domestic violence. Racial, religious or other hate appeared to have been a motivating factor in just two of the cases we inspected.

2. Delivery of interventions to reduce the likelihood of reoffending

2.1. Constructive interventions encouraged and challenged the individual to take responsibility for their actions and decisions related to offending in almost four-fifths of the cases. Three-quarters demonstrated that work with the individual had focused on the changes they needed to make to their behaviour.

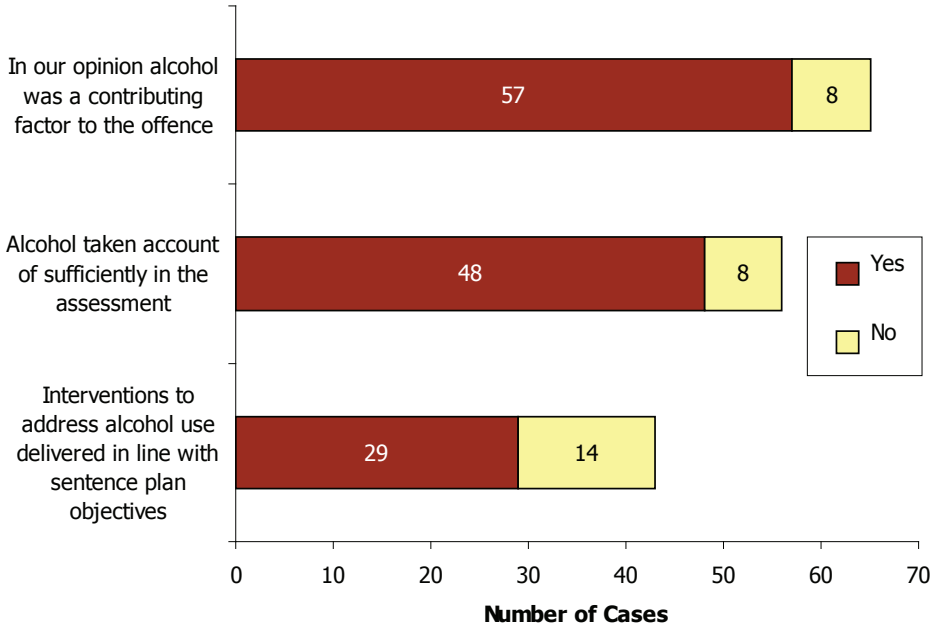
2.2. Almost one-third of the cases in the sample included the planned delivery of an accredited programme. These included Building Better Relationships (BRR) (nine cases) and Thinking Skills (four cases). Seven cases included a substance misuse programme.

2.3. In three-fifths of the relevant cases in the sample, delivery of the programme was consistent with the sentence plan, in so much as it had either been completed by the time of the inspection or there were plans to deliver it at an appropriate time in the future. In two cases, the programme was delivered late, while in a further seven cases a programme had not been delivered that should have been. There were a variety of reasons for this including insufficient evening or weekend provision or the programme not being run frequently enough. In addition, some offenders had difficulty committing to the scheduled start date as a consequence of work commitments or for other reasons.

2.4. There were two approved premises in Devon & Cornwall, providing accommodation for offenders under supervision. In the sample we inspected, six of the cases involved individuals who had been resident in approved premises. Constructive interventions had been delivered to all of them.

2.5. In 18 cases the offender's sentence contained a specified activity requirement, for example in relation to tackling alcohol use or addressing issues around the individual's education, training and employment (ETE). In 13 of those cases, the delivery of the specified activity made the intended contribution to the planned work with the person who had offended.

Alcohol and offending



2.6. The Trust was offering an alcohol specified activity requirement across the whole of the Trust area for offenders with a chronic alcohol problem. However, despite being delivered by the same provider, the contracts were different across the LDUs, and the Trust was planning to conduct a review to ensure the best level of service was provided for all individuals who were given a sentence that included the requirement.

2.7. Of 43 cases where an intervention to address alcohol misuse was identified in the sentence plan, it had not been delivered in one-third.

2.8. In almost four-fifths of the cases, the individual was prepared sufficiently for the interventions delivered through their community order or licence. That included preparatory work that was required to be delivered by the offender manager prior to the individual commencing the group work element of an accredited programme.

2.9. In almost one-third of cases, the offender manager did not routinely review the work done by the individual in other parts of their order or licence.

2.10. We interviewed a number of individuals who delivered interventions to individuals referred by offender managers. Some of them worked for external partnership organisations, while others were employed by the Trust. We were told that not all individuals were appropriately prepared for the work that would be done with them, with some turning up with unrealistic expectations. Three way appointments were the exception rather than the rule, although intervention providers were positive about the benefits that such meetings offered.

2.11. To support and sustain their desistance from reoffending, over two-thirds of the individuals were informed of relevant local services that could assist them. Where relevant, they were referred in 71% of cases.

2.12. The likelihood of reoffending assessment should be reviewed thoroughly when required, but disappointingly we found that this happened in only half of the cases. No review had been completed in over one-quarter of the cases, while in just under one-quarter the review completed was of insufficient quality. While most reviews took account of changes in the individual's offending-related factors, slightly more than one-quarter had not been reviewed within a reasonable interval following completion of the initial sentence plan or previous review.

2.13. In 39 cases, a review was required as a consequence of a significant change occurring, for example completion of an important aspect of the individual's order or licence or the committing of a new offence. However, more than half of those cases did not receive a prompt review at that time.

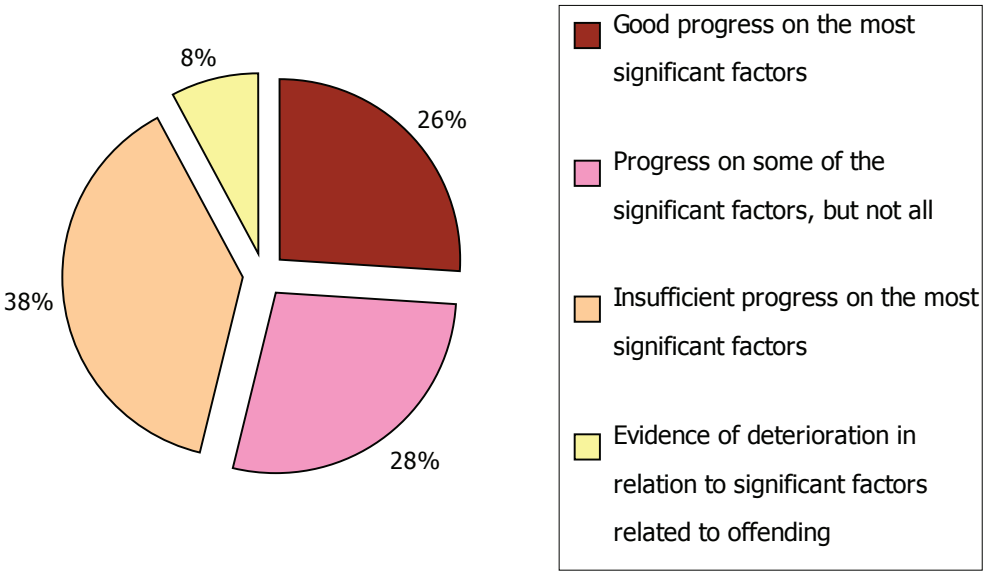
3. Likelihood of reoffending is reduced

3.1. There was a sufficient record of the degree of progress or change made by the offender in two-thirds of the cases. We inspected community orders or licences that commenced some nine months previously, which provided opportunity for the individual to have shown improvement in factors related to their offending if the planned work had been delivered.

3.2. We found just over one-quarter of offenders had made good progress, with a slightly higher proportion showing some progress on the most significant factors. In almost two-fifths of the cases we thought that there had been insufficient progress in respect of the most significant factors for that individual, while in five cases we inspected there had been deterioration. We found that the best outcomes, in relation to progress against the most significant factors that contributed to the individual offending, were in the Devon & Torbay LDU.

3.3. Generally, we found that services and interventions were available to address identified offending-related factors across all the different factors, although when we asked offender managers if they had access to sufficient resources almost one-third said 'no'. Offender managers in Devon & Torbay LDU responded more positively to that question than those from the Plymouth and Cornwall LDUs.

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



3.4. In relation to the factors associated with offending that were most frequently found in our case sample (the factors are listed below in the order of prevalence from the 72 cases we inspected), we found the following:

	Of those cases where the factor was identified, the % where	
Prevalent offending related factor (and number of cases identified by us where this applied):	**Sufficient interventions or services were delivered was:**	**Sufficient progress was made:**
Most prevalent factors:		
thinking and behaviour (65)	60%	38%
alcohol misuse (61)	57%	42%
difficulties handling relationships (43)	49%	40%
attitudes to offending (40)	48%	33%
Other common factors		
emotional well-being (39)	31%	21%
lifestyle and associates (33)	52%	48%
accommodation (25)	60%	28%
drug misuse (23)	78%	30%

In 23 of the cases we inspected, we found that there had been insufficient progress made against any of the relevant factors.

3.5. Resources had been used efficiently to help the offender achieve the planned outcomes in three-quarters of the cases, but less than one-half showed improved integration into the community or improved family relationships.

4. Leadership and management to reduce the likelihood of reoffending

4.1. The Trust had a strong focus on the delivery of interventions, on developing new provision and piloting new ways of working. The delivery of high quality offender management, assessment, planning and review is identified as the first priority in the Trust's Annual Delivery Plan that runs up to April 2015.

4.2. At the beginning of the 2012-2013 financial year the Trust had restructured its operational delivery structure and established an East and West programmes team. The Trust realised that completions of offending behaviour programmes were not meeting the set target. They found it was because of a low level of referrals due to report writers not proposing and offender managers not referring. As a consequence, the Trust was now doing detailed monitoring in order to identify which report writers and/or offender managers were not contributing appropriately. Programme managers also attended local team meetings to raise the profile of programmes and that had had a positive impact on completions, which in June 2013 were running ahead of the target. The Trust said there was sufficient capacity to deliver programmes to meet demand, but the one area where there remained a problem related to the BBR programme. BBR is for men convicted of a serious domestic violence offence, and the goal of the programme is to help them develop practical and sustainable strategies for maintaining change once they completed the programme and promote better lives for all those who were affected by the men's violent and aggressive behaviour. Devon & Cornwall Probation Trust had the capacity to deliver BBR, but advised that a delay in the provision of national training slots meant cases were stacking up. They acknowledged a problem in delivering the foundation block sufficiently frequently, which may have led to the situation whereby some individuals were not getting onto the programme promptly enough. The Trust was seeking to redress that.

4.3. The Trust also offered a 'Safer Drinking Choices' programme that had delivered some good outcomes in relation to violent offenders. The 'Thinking Skills' offending behaviour programme offered some 150 places a year, but programme tutors said there had been some historical difficulty in getting sufficient appropriate referrals - a situation referred to in paragraph 4.2 and one that the Trust was actively seeking to resolve.

4.4. With regards to unpaid work, we were told about difficulties in identifying suitable placements in some parts of the Trust area; in Cornwall, some individuals may have to travel quite long distances, even when the distance on a map may not have looked very far, because of the patterns of public transport and the number of estuaries. It was acknowledged there could also be a problem in finding suitable placements for some women offenders who were usually placed in agency placements but, on occasion, had been asked to help identify their own placement. Wherever feasible, the Trust's strategy was to try to link an individual in with their local community. In Devon, the Trust had linked in with Community Volunteers, an organisation offering 30,000 hours of unpaid work in local villages. Devon & Cornwall was also one of three Trusts that had been accepted for a pilot in relation to green reparation, for example recycling projects using mentors.

4.5. Female offenders on a community order or licences were supervised outside of probation offices, and it was interesting to note that outcomes in relation to:

- delivering the sentence of the court
- reducing the likelihood of reoffending
- protecting the public by minimising the risk of harm to others

were all higher for the female cases we inspected than for the male cases. We should, however, say that we only inspected the cases of nine women and therefore caution should be heeded in inferring too much statistical significance to that finding.

4.6. The Trust had a specified activity requirement for women offenders that addressed offending behaviour within a supportive environment for those in Plymouth LDU.

4.7. There were six Turnaround (Integrated Offender Management (IOM)) teams operating across the counties of Devon & Cornwall. The joint probation/police staff teams operated out of non-probation accommodation, and half the cohort of individuals with whom they worked comprised non-statutory cases. The Turnaround teams operated using an intelligence led approach with daily reports on the cohort. Cases were colour rated, with 'red ragged' getting priority. Unlike in some parts of the country, Turnaround did not restrict their intake to just prolific offenders and we saw cases where

the offender was subject to Multi-Agency Public Protection Arrangements (MAPPA) or had violence in their offending history. However, the Joint Scheme was careful about what violent offenders they took into the scheme.

4.8. SEEDS had been rolled out by the time the inspection took place, but not fully across the Trust area at the time most of the community cases or licences in this sample started. Therefore the impact of the initiative was not fully demonstrated, albeit offender managers and most middle managers expressed enthusiasm about it.

4.9. We interviewed a number of representatives from the Voluntary and Community Sector (VCS). Overall, comments were positive. One ETE provider working with Tier 2 individuals commented that offender managers were not always clear what it was they wanted the provider to achieve. Many offender managers were co-located with VCS staff in non-probation premises. External providers all said they had information sharing agreements in place that seemed to operate well.

4.10. The Trust had a well developed and committed research section that used information appropriately to identify where the organisation had issues. Senior managers then commissioned the Quality Development Managers to carry out a series of 'audits' on specific aspects of work (using the HMI Probation benchmark). This included some 'thematic audits' on specific aspects of work such as reports and management oversight. Results arising from that work indicated there had been an improvement from the Offender Management Inspection 2 (OMI 2) levels, which we considered was also reflected in the results from this inspection. The results from the audits were reported at a variety of different levels, but the work as a whole was overseen by a 'Quality Assurance in Offender Management' sub-group of the Trust Board. Managers acknowledged this was work in progress.

4.11. The Trust was monitoring numerous aspects of its work, including achievement of outcomes at termination, for example employment and accommodation; programmes completed successfully; orders completed successfully; and timeliness of the termination assessment. The research department produced a quarterly performance outcomes report showing comparisons between all Trusts, and identifying where Devon & Cornwall rated against all Trusts and where it rated against its comparator Trusts.

4.12. A 2013 evaluation of the success of the Trust's partnership work with 'Shekinah', a Tier 2 ETE provider, showed that those individuals who completed the intervention noticeably reduced their likelihood of reoffending.

4.13. During the financial year 2013-2014 the Trust was intending to improve delivery and outcomes through the introduction of 'The Engage Programme', which was to be delivered on a one-to-one basis with individuals. It had been developed using desistance research that showed the importance of social inclusion and strengthening offenders' community links to help reduce their likelihood of reoffending. The Trust was planning to offer it either through a 'Supervision Requirement' or as a standalone 'Engage Programme' Specified Activity Requirement depending on the level of assessed risk and need.

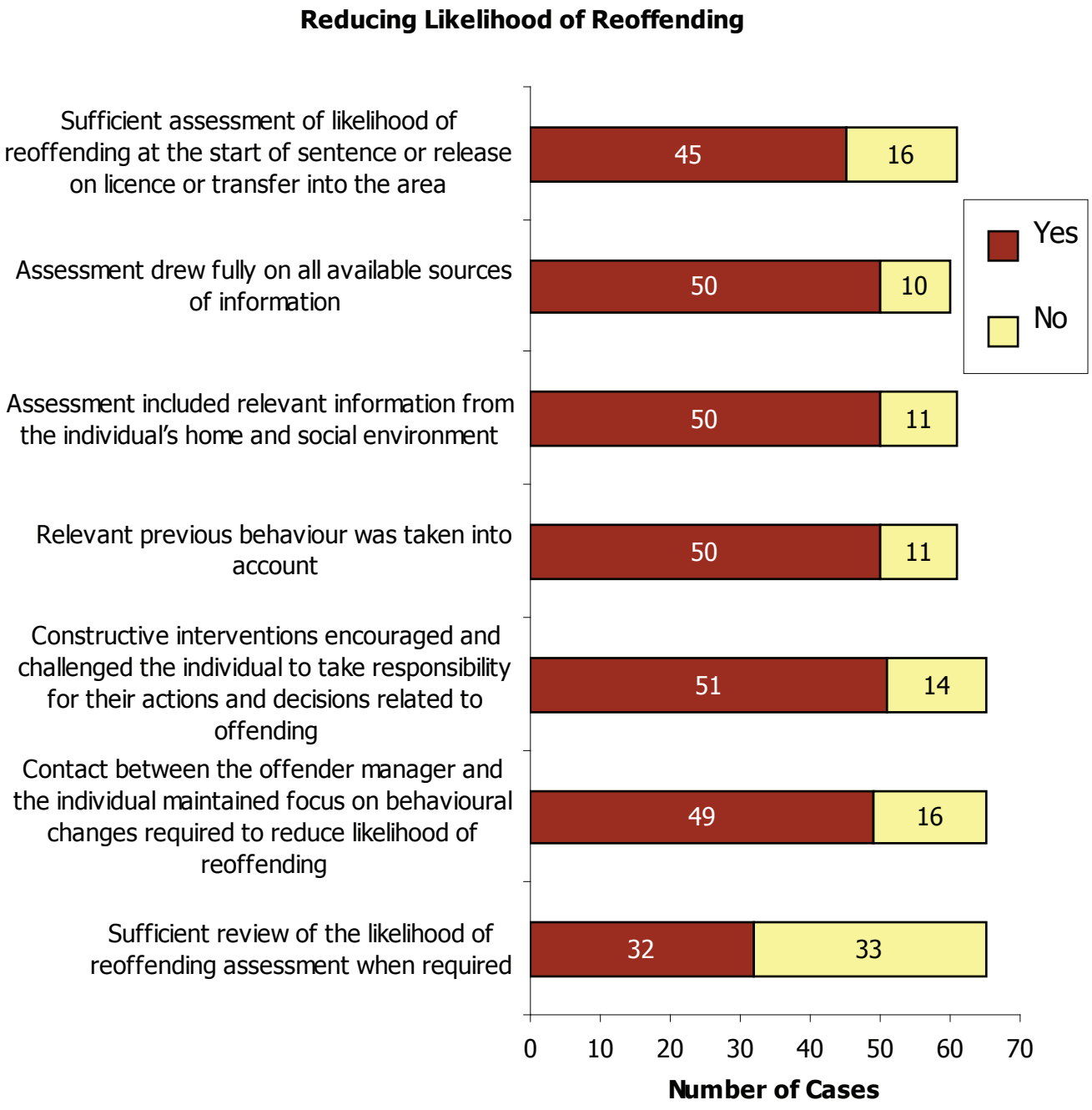
Summary

Overall 69% of the work to reduce the likelihood of reoffending was done well enough.

For a summary of our findings, please see page 2

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 72 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Protecting the public by minimising the risk of harm to others

4

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

What we expect to see

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

Case assessment score

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

Key Strengths

1. In the initial risk of harm assessment, sufficient attention was nearly always paid to child safeguarding in relation to the individual's contact with any children and young people.
2. Most cases that met the criteria for MAPPA had been correctly identified. Referrals were done in a timely way in those instances where the case needed to be managed at a higher level within MAPPA. Decisions taken within MAPPA were clearly recorded, followed through and acted upon.
3. Violent and Sexual Offenders Register (ViSOR) was embedded into the organisation's culture for sharing information about sexual and serious violent offenders within the Trust and with the police. We saw good use made of ViSOR within this inspection, with access to the system sufficient across the Trust area and with relevant staff appropriately trained.
4. Restrictive requirements or conditions were monitored fully in most cases and approved premises were always used effectively to manage risk of harm to others.
5. The Trust made a strong and leading contribution at a strategic level to multi-agency work to protect the public. Contributions by probation staff to MAPPA were effective.
6. In most cases, key risk of harm information had been shared between relevant staff and other agencies involved in the case.

Key Areas for Improvement

1. Initial RoSH screenings were missing or not completed sufficiently well in a number of cases. Where required an initial full risk of harm analysis was not always done or not done well enough. Account was not always taken of all available information to form the judgement, and the assessments were often insufficiently analytical.
2. Many risk management plans were either not done or completed to an insufficient quality. They did not anticipate possible changes in risk of harm factors or set out the actions needed. Others did not accurately describe how the objectives of the sentence plan would address risk of harm issues and protect actual and potential victims.
3. Use of multi-agency Child Protection procedures was not always effective. Decisions taken were not clearly recorded, communicated, acted upon or reviewed appropriately in a sizable minority of relevant cases.

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

4. Where there had been changes in risk of harm factors, offender managers had not always responded. Changes had not always been identified swiftly or acted upon by all relevant staff.
5. Home visits were not always carried out at the start of sentence or release on licence in those instances where required because of the RoSH that the individual posed or because there were Child Protection concerns. Home visits were not always repeated when required.
6. Many risk of harm assessments and risk management plans were not reviewed in a timely way or promptly after a significant change in circumstances or risk of harm factors.
7. There was insufficient evidence of effective management scrutiny in cases classified as posing a high RoSH or where there were Child Protection issues.

Explanation of findings

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

1.1. The initial RoSH screening was completed sufficiently well in three-quarters of the cases we inspected. We found that 15% of the screenings were of insufficient quality, of which two-fifths were late and three-fifths inaccurate. In seven cases, there was no record of an initial screening having been completed, which was contrary to the Trust's practice standard in relation to the assessment and management of risk of harm which sits alongside its risk of harm policy. The practice standard states:

'All offenders managed by Devon & Cornwall must have an up-to-date Risk of Harm Screening. This should be done at Court report stage and/ or commencement of sentence or release into the community on licence. A 'yes' response to any questions in the screening indicates a Full Risk of Harm Analysis should be undertaken. If there are indicators of harm at the screening stage but a full analysis is not completed, clear reasons should be given in the screening document and the judgement countersigned by an appropriate person.'

We know that the Trust was particularly disappointed when we told them about this finding, as it was an area they had worked hard on.

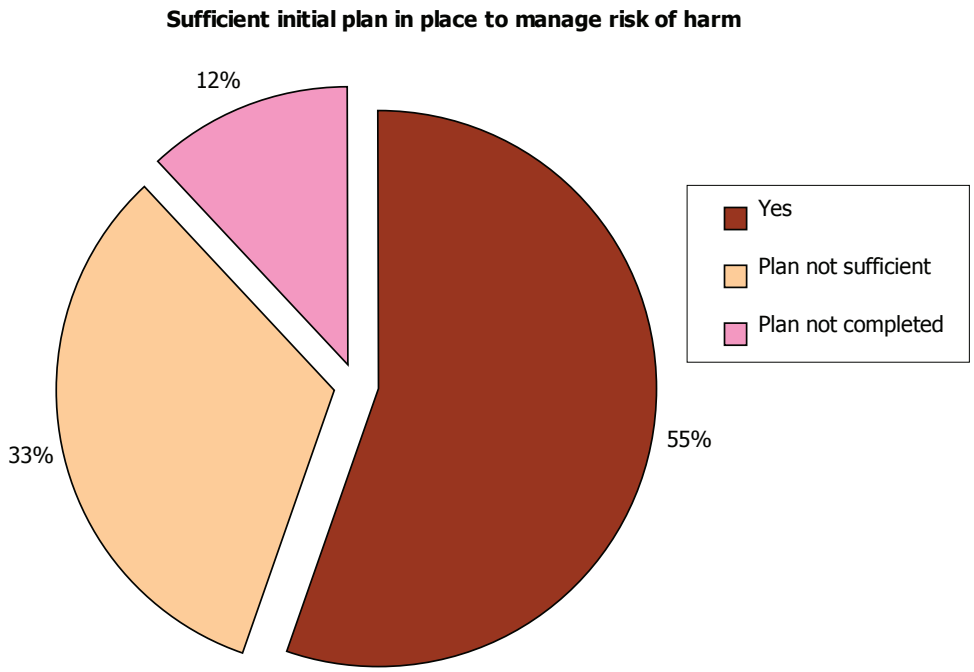
1.2. In all but two cases where the OASys RoSH classification was recorded, we considered that it was correct. No classification was recorded in five cases.

1.3. Where the RoSH screening indicated that there was a need for a fuller analysis of the RoSH posed by the offender (and the nature of the offences in this inspection meant this would normally have been the requirement), then we expected to see one carried out. In this inspection, we found that in nine cases, where required, a full analysis was not completed, while in three cases the RoSH was correctly assessed as low and there was no need for a fuller assessment.

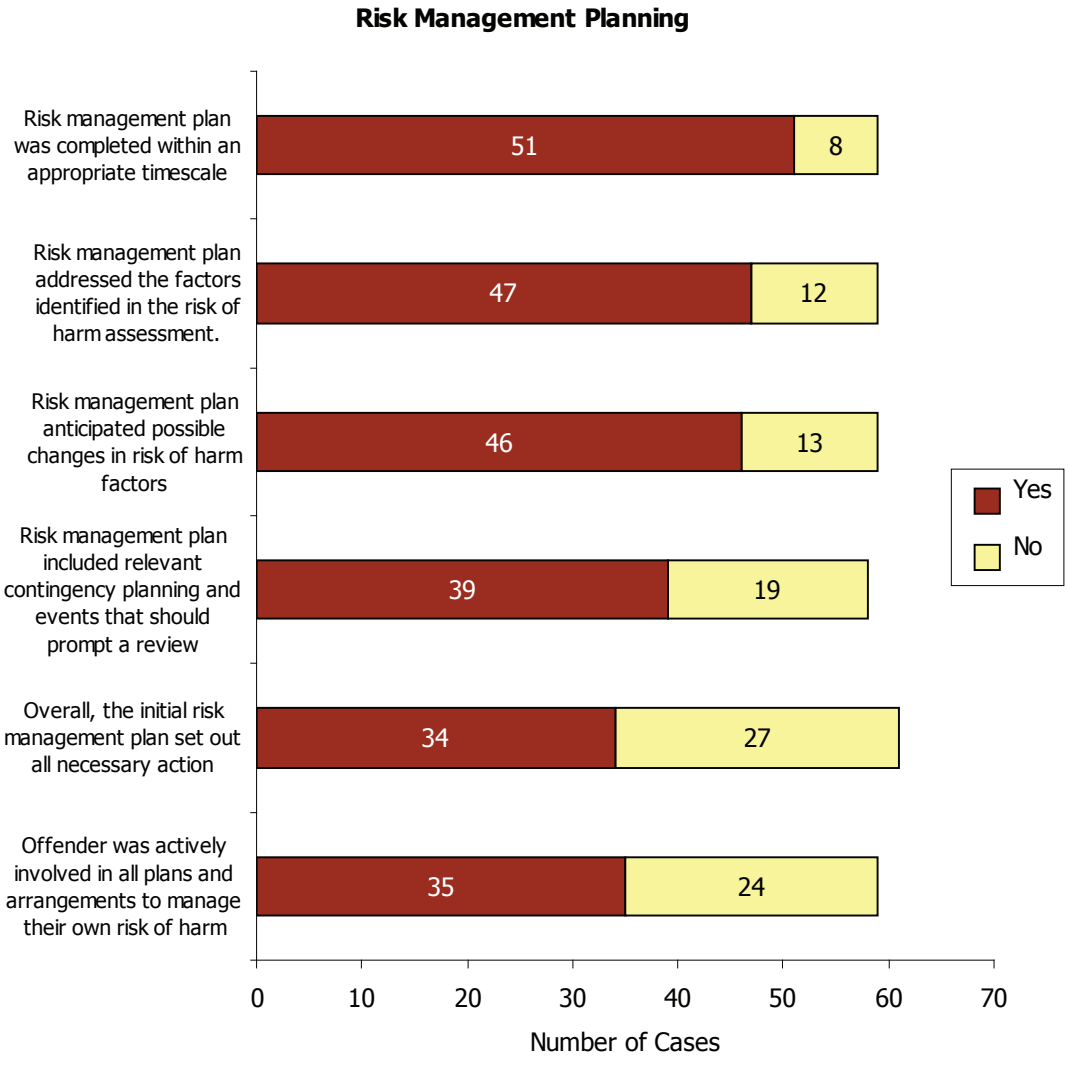
1.4. In the 60 cases where the full analysis of RoSH was completed, we found most were completed within an appropriate timescale, correctly categorised the RoSH to different groups of actual or potential victim, and were either new or sufficiently updated from a previous assessment. We found, however, that slightly more than one-quarter of the assessments were insufficiently analytical. In one-quarter the offender manager did not take account of all available information to form the judgement. However, in most cases (87%) sufficient attention was paid to child safeguarding in relation to the offender's contact with any children and young people.

1.5. In each of the 33 cases where a restrictive requirement was used, for example a curfew or electronic monitoring or restraining order, it was appropriate. The use of restrictive requirements was also proportionate to the risk of harm and likelihood of reoffending posed by the offender, and in all but one of the cases minimised the risk to actual or potential victims.

1.6. Five of the cases had a curfew, and all but one provided a significant punishment for the individual and/or protected the public from risk of harm or further offending.



1.7. The offender manager needed to complete a risk management plan in all cases where the RoSH classification was assessed as medium or higher. In eight instances where a plan was required, none was completed. Of the 59 cases where a plan was produced, 22 of them were insufficient; the main reasons for insufficiency were that the plan failed to accurately describe how the objectives of the sentence plan and other activities would address risk of harm issues and protect actual and potential victims (two-fifths of risk management plans); failed to address all relevant factors and/or the risk



to specific victims (almost two-fifths of plans); did not include relevant contingency planning and events that should prompt a review (one-third of plans); and/or failed to anticipate possible changes in risk of harm factors (one-fifth of plans).

1.8. Overall, over two-fifths of risk management plans did not set out all necessary action. A sizable minority of plans were not clear about who would do what and when, and could have set out more clearly how information would be shared. We found that key risk of harm information was, however, communicated to all relevant agencies in three-quarter of the cases. There was evidence in three-fifths of the cases that the individual was actively involved in all plans and arrangements to manage their own risk of harm, including constructive and restrictive interventions.

1.9. ViSOR is the information system managed by the police that enables police and probation to share information about offenders in cases where there has been sexual or serious violent offending. We found 11 cases in our case sample that should have been recorded on ViSOR, and in seven we were able to evidence it had been recorded. Information sharing between police and probation was one of the strengths in Devon & Cornwall, and there was plenty of access to ViSOR terminals across the area with key probation staff trained and vetted to use the system.

1.10. We found 23 cases met the criteria for MAPPA at any time during the order or licence, and all but three were identified as eligible MAPPA cases. Fourteen of the cases were appropriately managed at Level 1 by the Trust. The other six identified cases were being managed at Level 2, which involved wider multi-agency management by probation, the police, prison service and other agencies in the community. Those six cases were being appropriately managed at Level 2, and the referral processes in relation to those cases had generally been effective. All but one of the six Level 2 cases had been referred to MAPPA in a timely way, all details, including categorisation, were correct, and the actions that emerged from the MAPPA meetings were communicated to all relevant bodies. In two of the six cases we found that actions agreed by MAPPA had not been incorporated into all relevant planning documents, for example the risk management plan.

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

2.1. The offender manager's response to changes in the risk of harm posed to others by the individual was inappropriate in slightly more than two-fifths of relevant cases.

2.2. In a sizable minority of cases, changes were not identified swiftly while, in a higher proportion of cases, they were not acted upon by all relevant staff and other agencies were not notified of any increase in the offender's risk of harm.

2.3. Restrictive requirements or conditions were included in the community orders or licences in 34 of the cases we inspected. They were monitored fully in all but five of those cases. Six individuals resided in an approved premise for at least six weeks, and in all of those cases the approved premises were used appropriately to manage their behaviour and the risk of harm they posed.

Case illustration - intelligent risk management

George had been released on licence to approved premises. His offence was malicious wounding, but he had a history of serious domestic violence and controlling behaviour. The risk management plan included the need for hostel staff to be aware of 'offence paralleling behaviour', which meant they would be alert for behaviour such as grooming, targeting or bullying. The approved premises monitored his behaviour and gave detailed feedback to the offender manager, which led to his eventual recall to prison. The approved premises agreed to take George back on re-release which reinforced the offender manager's message that probation staff would not give up on him, even though at times his behaviour towards them had been rude and aggressive.

2.4. In those cases classified as posing a high RoSH to others or where there were Child Protection concerns, we expected to see an initial home visit carried out and repeated as necessary. An initial home visit was not done in half of the cases where required. It was not repeated in two-fifths of the cases where we thought it should have been. In those instances where home visits were required, we found fewer were carried out in Devon & Torbay than in the other two LDUs.

2.5. We identified 15 cases in the sample where enforcement proceedings or recall to prison were required in response to an increase in the risk of harm posed by the offender. We found in three of those cases, no action was taken. In a further three cases where action was taken, we considered it to have been inappropriate. In the other nine cases the action taken was appropriate.

2.6. In the 12 cases where breach action was taken or the offender was recalled to prison as a consequence of an increase in their risk of harm, we found a clear explanation was provided to them in two-thirds of the cases. The enforcement action was instigated promptly and efforts made to re-engage the individual with their sentence plan in three-quarters of the cases.

2.7. There was ongoing management at MAPPA Level 2 for six cases in our sample, and MAPPA operated effectively in all of those instances. We found decisions taken in the MAPPA meetings were clearly recorded, followed through and acted upon and reviewed appropriately. All staff working with the offender contributed effectively to MAPPA in each of the six instances.

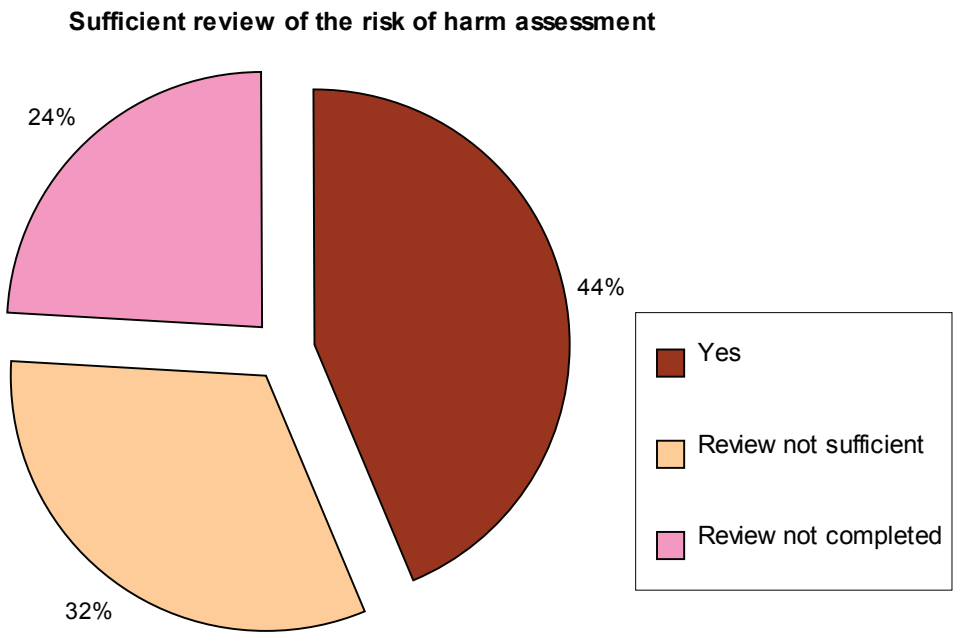
2.8. ViSOR was used effectively in all seven of the cases where information was recorded on the system. In one case we inspected, the offender manager had ensured a ViSOR entry was made in relation to contact from a previous victim who had concerns about the release arrangements for the offender.

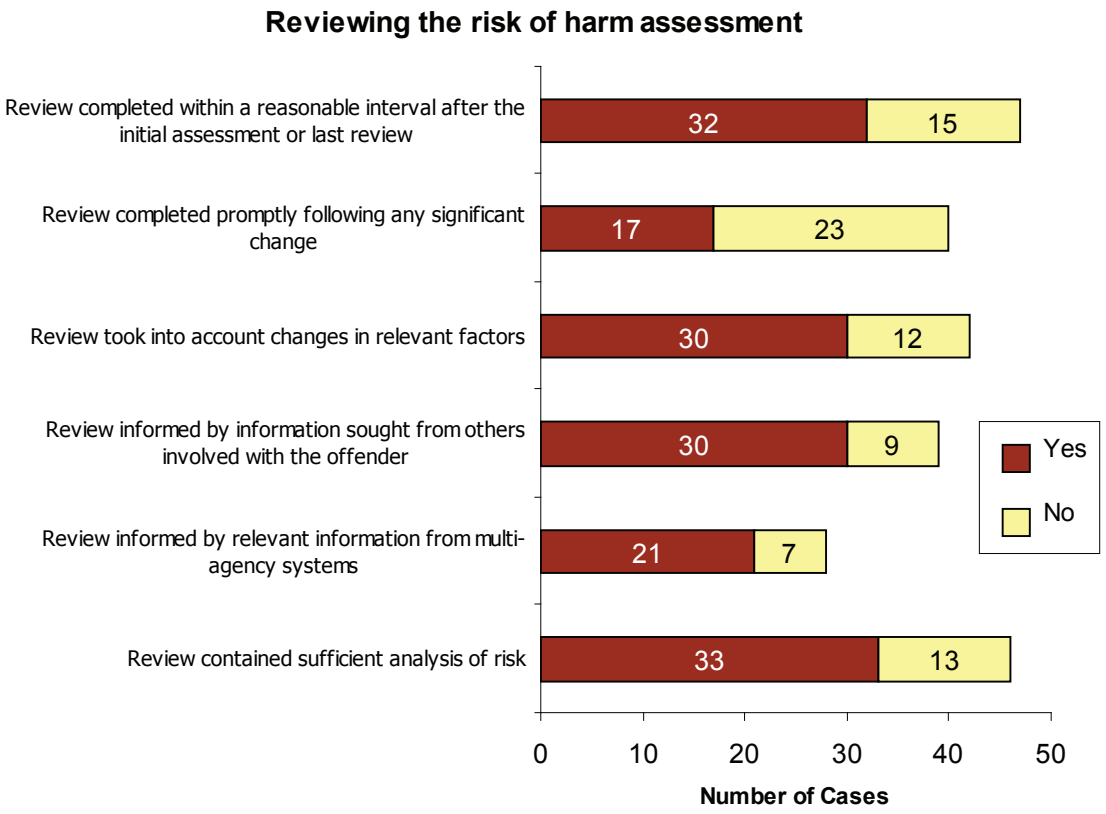
2.9. Despite a culture of awareness of Child Protection issues, and offender managers proclaiming that they felt confident in working with Child Protection cases, multi-agency Child Protection issues were not used effectively in almost half of the relevant cases. In about two-fifths of the cases, decisions taken within the Trust's Child Protection procedures were not clearly recorded and/or communicated, followed through and acted upon and/or reviewed appropriately. In a similar proportion of the cases, all relevant staff working with the offender had not contributed effectively to multi-agency Child Protection procedures. In some instances we found Child Protection cases were not accurately recorded, or relevant documentation in relation to Child Protection meetings were not held on file. We did, however, see examples where child safeguarding concerns were fed into the Multi-Agency Safeguarding Hub (MASH) which then led social services to commence core assessments.

2.10. Sufficient priority was given to the safety of current and potential victims by the offender manager and other workers in slightly less than three-quarters of the relevant cases we inspected. In more than three-quarters of the cases where there was an actual victim, there was evidence the offender manager took into account any concerns expressed including the likely consequence of the offender's behaviour on them.

2.11. We know that risk of harm issues change over time for many individuals and we expected to find that the assessment was reviewed to reflect that. However, there was a sufficient review in less than one-half of the relevant cases (44%). In one-quarter of the cases where a review was required, it was not carried out.

2.12. In 20 cases, the review was completed but was of insufficient quality. In general, one-third of reviews completed were not timely, while more than half (57%) were not carried out following a significant change. Around one-quarter of reviews did not take into account changes in relevant factors and/or information from others involved with the offender and/or information from multi-agency arrangements. More than one-quarter (28%) did not contain a sufficient analysis of the risk of harm posed by the offender.





2.13. The risk management plan identified what needed to be done to manage the risk of harm posed by the offender. In three-quarters of the cases, we found that the actions were carried out as required. However, there was a sufficient review of the risk management plan in less than half of the relevant cases, while in one-quarter there was no review at all. Findings in relation to the risk management plan reviews were, not surprisingly, congruent with those in relation to the reviews of the risk of harm assessments. Where required, the planned review period was not appropriate to the risks posed by the offender in 13 of the 45 cases.

2.14. We expected to see evidence of effective management oversight in relation to those cases where the offender posed a high or very high RoSH to others, or in those cases where there were Child Protection concerns. Structured management oversight was not evident in two-fifths of those cases we inspected, while in a further five cases the oversight provided was not effective. We saw evidence of countersigning having taken place of work that was of insufficient quality. Senior management were aware of the need to improve the quality of management oversight, and had commissioned the Quality Development Managers to do a piece of work on that subject. One operational middle manager told us that he thought that initiative would help him focus his attention on that aspect of his role as he did not want to be identified as a manager who countersigned poor quality work.

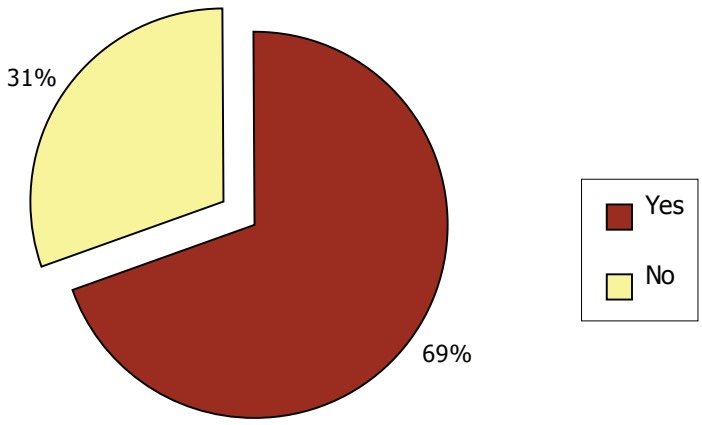
3. Risk of harm is minimised

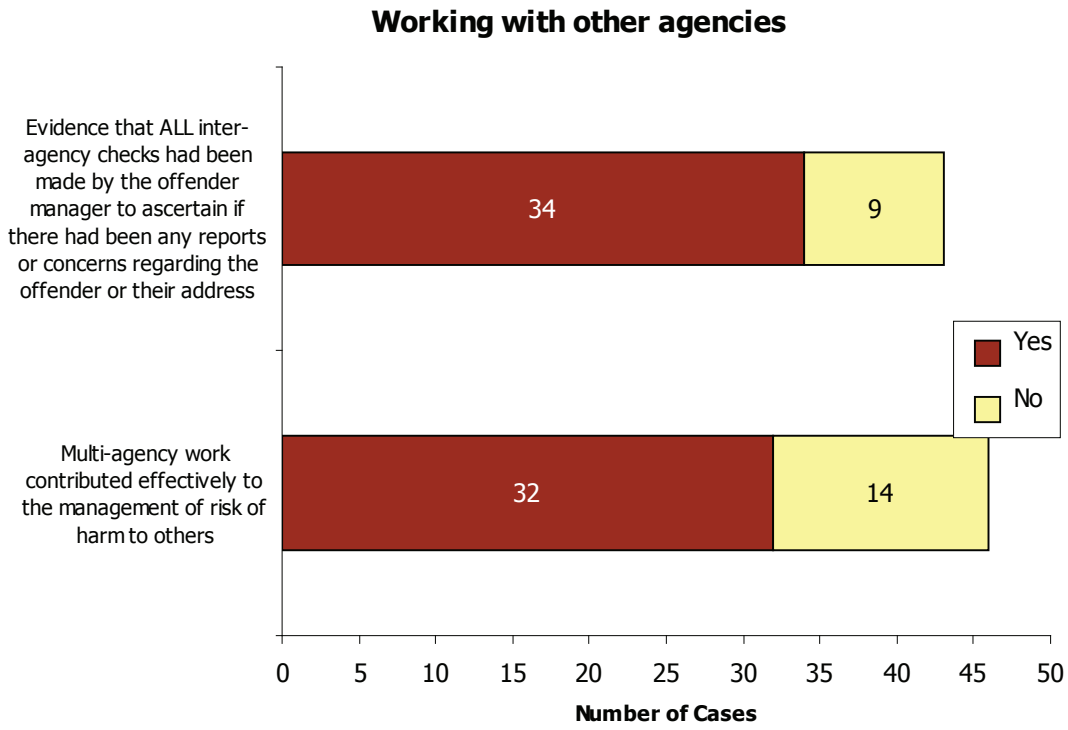
3.1. All reasonable action had not been taken to keep to a minimum the offender's risk of harm to others in almost one-third of the cases.

3.2. Where multi-agency work had taken place, it had contributed effectively to the management of the risk of harm to others posed by the offender in more than two-thirds of the cases. Overall, we found staff were well aware of the need to make appropriate checks to see if there had been any reports or concerns registered in relation to the offender or addresses they were connected with. In that regard, checks had been made with Children's Services in all but four of the relevant cases and with the police domestic violence unit in almost four-fifths (nine checks were not done). Where the information from Children's Services or the police domestic violence unit indicated something needed to be done, appropriate action was taken by the offender manager in 13 of the 16 relevant cases.

3.3. For all four cases managed at MAPPA Level 2 where we expected to see plans put in place to minimise the risk of harm presented by the individual once they were no longer subject to MAPPA arrangements, there was evidence of this having been done.

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





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

4.1. Partnership organisations commented very positively on the role of the Trust in inter-agency work to support public protection. We saw evidence of effective partnership working.

4.2. We found MAPPA operated well in Devon & Cornwall, and this was evidenced in the cases we inspected. There were excellent partnership arrangements with the police, and coherence around the arrangements for managing Level 2 and 3 meetings. Referral processes were sound and involved both police and probation joint decision making, with a well defined escalation process. There was an intention to move towards co-located teams in the future.

4.3. We liked the simple approach adopted by MAPPA, which was 'what will MAPPA add?'. That important question focused the minds of those making referrals for Level 2 meetings, although offender managers needed to be more focused in identifying who needed to be at the MAPPA meeting. The coordinator illustrated that by saying a referral may fail to indicate that health needed to be represented, even though it was an unmet need and a factor in the individual's offending. We were told that attendance from some of the duty to cooperate agencies could be variable, although that was not something we identified from the cases we inspected.

4.4. The Trust had been inspected by NOMS as part of a national audit of ViSOR some six months prior to this inspection. The auditor said that the use of ViSOR was impressive and he had seen evidence of clear management commitment. He said that staff he interviewed were aware of their responsibilities in passing information to the ViSOR administrator for entering onto ViSOR. We found a similar picture, with good access to the system and staff appropriately trained. The Trust was monitoring usage of ViSOR by individual managers to ensure they were logging on and using information appropriately.

4.5. Probation enjoyed particularly good operational and strategic relationships with the police across Devon & Cornwall, including through MAPPA and Turnaround. These relationships had been enabled by half the salary of the Trust's Assistant Chief Officer with the public protection lead responsibility being paid by the police and that officer attending the Senior Management Group meetings of both probation and police. He had been able to introduce a new data sharing agreement, and a recent innovation arising from that had been the weekly distillation of information to probation by the

police from their national computer system regarding police intelligence relating to any individual being supervised by probation. This was powerful knowledge, and potentially provided excellent information for offender managers in helping them manage the risk of harm and likelihood of reoffending of the individuals they supervised.

4.6. There were effective information sharing agreements in place with other partner agencies that generally seemed to operate well in practice. Partnership organisations were overwhelmingly positive about the Trust's contributions in supporting public protection.

4.7. The Trust had worked with Children's Services and the Local Safeguarding Children Boards (LSCBs) around raising the levels of awareness of Child Protection/need issues and sharing of information. The MASH had been set up in recognition of the fact that different agencies often had access to different bits of information, but those individual pieces of information were never assembled to give a better informed picture of the risk of harm the individual may pose to a child or young person. We saw this as work in progress, but staff were confident about working with Child Protection cases and were making routine and timely checks with social care in relation to children and young people with whom the offender was in contact.

4.8. Strategically, across the Trust area, the four LSCBs were working together, and the Chair of one of those Boards was positive about the contribution of the Trust, which he said was *"not just about attending meetings, but asking 'what can my organisation do about safeguarding'."* He was also positive about the attendance of relevant probation staff in Child Protection meetings, and said offender managers were proactive in checking out information regarding the nature of offending/ children and young people in the family groups/other relationships but that they needed to ensure continuing good engagement with Children's Services. We picked up different messages from staff about the responsiveness of Children's Services to issues raised with them, but disappointingly saw some cases where information had not been shared with probation to the frustration of the individual offender manager.

4.9. The Trust's *'Practice Standard for the Assessment and Management of Risk of Harm'* was clear in its expectation that all offenders must have an up to date screening for risk of harm, which should be completed at the court report stage and/or commencement of sentence or release into the community on licence. These are our expectations as well. However, in this inspection, we found many RoSH screenings and/or assessments and/or risk management plans either not completed or completed to an insufficient quality. Countersigning by managers had not proved effective in those instances. However, taking account of the fact that this inspection sample and the methodology were different from our previous inspection programme, OMI 2, we did think there had been a marked improvement in relation to risk of harm assessment and planning since the last time we came to Devon & Cornwall some two and a half years previously. In particular, the focus of management in using the Trust's Quality Development Managers to assess practice in a range of different areas, for example into examining practice in relation to management oversight/ countersigning, was a positive acknowledgement that management were committed to driving up performance.

4.10. While the Trust was providing an appropriate range of interventions to tackle violent offending, almost three-fifths of the offender managers said they had not received specific training in practice methods/interventions in respect of violent offending. Those that said they had, referred to having received training in using the Spousal Assault Risk Assessment tool for domestic abuse cases, or had received general training in working with domestic violence perpetrators. Some of the offender managers had worked as Integrated Domestic Abuse Programme tutors, while others had been involved in Controlling Anger and Learning to Manage It or Aggression Replacement Training accredited programmes.

Summary

Overall 70% of the work to protect the public by minimising the risk of harm to others was done well enough.

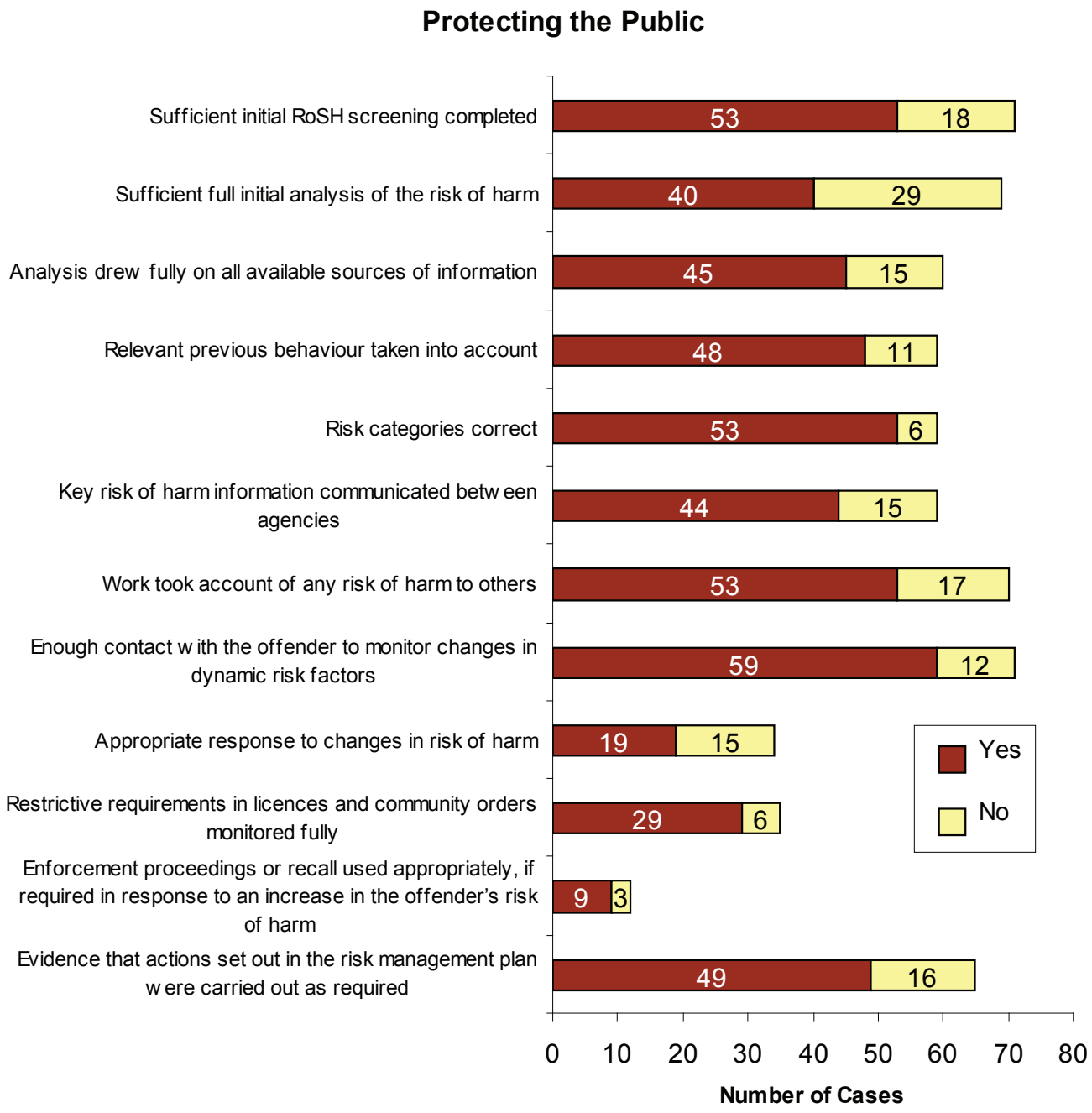
We have recommended that post-inspection improvement work focuses on ensuring that:

1. risk of harm to others is assessed accurately and promptly, and is reviewed as appropriate, taking account of information from other organisations
2. effective management oversight is clearly evidenced in the records of all cases involving the protection of children and young people and of those classified as posing a high/very high risk of serious harm to others.

For a summary of our findings, please see page 2

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 72 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Delivering 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, 78% of work to deliver effective services for victims was done well enough.

Key Strengths

1. Offender managers paid sufficient attention to child safeguarding.
2. In most instances where there were restrictive requirements in licences or community orders, they were monitored well.
3. Victim contact work was carried out well and to a high quality. Victims who responded to our questionnaire were positive about their experience of the work that was undertaken with them, and most felt safer as a consequence.
4. There were strong partnership relationships in place at both a strategic and operational level that supported the Trust's work in public probation.

Key Area for Improvement

1. Offender managers paid insufficient attention to planning how to manage the safety of victims and potential victims and in ensuring there were appropriate objectives included in sentence plans to protect victims.

Explanation of findings

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

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

1.2. We assessed whether the assessment of risk of harm drew fully on all available sources of information. We found that one-quarter of the cases did not. However, there was a culture of checking with Children's Services on a routine basis at the start of every order in relation to any child or young person living in the same household as the offender. We found that in 87% of cases there was sufficient attention paid to child safeguarding in relation to the offender's contact with children and young people.

1.3. Just over one-third of risk management plans did not address the risk of harm posed to any specific victims, while two-fifths of them failed to describe accurately how the objectives in the sentence plan would protect either actual or potential victims.

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

2.1. In ongoing work with offenders, appropriate priority was accorded to the safety of current and potential victims by the offender manager in almost three-quarters of the cases. In a higher percentage of cases, the offender manager took into account concerns expressed by the victim and/or the likely impact of the offender's behaviour on the victim.

2.2. In over four-fifths of relevant cases, restrictive requirements in licences and community orders were monitored fully.

3. Risk of harm to victims is minimised

3.1. We judged that in almost three-quarters of cases where there was an identifiable or potential victim, the risk of harm to them had been managed effectively. However, in relation to that question, the score for Cornwall LDU was considerably worse than for the other two LDUs.

3.2. In almost four-fifths of relevant cases, the safety of children and young people had been promoted.

4. Victim contact and restorative justice

4.1. Trusts have the responsibility for running victim contact schemes. They provide victims of certain offences with information about key points in an offender's custodial sentence, and afford them the opportunity to say what conditions they would like included in the offender's sentence when that person is released.

4.2. There were 21 licence cases in our sample where victim contact work was required. In 19 of them we found that an offer of face-to-face contact with the victim liaison officer (VLO) had been made, and that in all of those instances the offer was made within eight weeks of sentence.

4.3. In ten cases, the victim accepted the offer of statutory victim contact and it proceeded. Overall, the quality of statutory victim contact work was sufficient in all of those cases.

4.4. We found that there was regular and accurate information exchange between the offender manager and the VLO and between the offender manager and prison staff in nine of the ten cases.

4.5. In all of the cases where statutory victim contact proceeded, the victim had been enabled to give their views on proposed licence conditions and in all but one of the cases they were also given the opportunity to see the relevant part of any appropriate report.

4.6. In all these cases, the victim was informed of any conditions relating to the offender's release. In all but one of the cases, they were also informed of any relevant events that occurred during the offender's sentence.

Comments from victims:

Nine victims of crime who were in touch with the victim contact scheme responded to our questionnaire. Overall, the comments were positive. Comments included:

"My liaison officer was really helpful. Knowing he was on my side really helped."

"We discussed safety measures for the future. It was helpful to know and be kept up to date with issues concerning my safety and welfare".

Slightly less positively, one victim said that she was visited by a replacement victim liaison officer on one occasion and had had to repeat everything about her case which she had found upsetting. She said it would have been helpful if the replacement victim liaison officer had read her case notes before visiting.

Responses to the questionnaire were as follows:

- All the victims who responded said that the initial letter about the victim contact scheme had been easy to understand and had made it clear that they had a choice about whether to become involved in the scheme or not.
- They also said that their individual circumstances and needs had been taken into account, and that victim contact staff had a full understanding of the impact of the offence on them.
- All nine victims said they were kept informed about key points in the offender's sentence; in the eight instances where the offender was being considered for release, the victims said they had been provided with the opportunity to say what conditions they thought should be included in the licence.
- In the seven cases where the offender had been released, the victims said that extra licence conditions had been added to keep them safer.
- In all six instances where victims said they had reported concerns about the offender to the Probation Trust, they were satisfied with the response.
- Seven victims thought that the work of the victim contact scheme had made them feel safer, while the other two felt it had made no particular difference.
- Six were completely satisfied with the service provided, while the remaining three victims expressed neither satisfaction nor dissatisfaction.

4.7. With regard to restorative justice, we identified 23 cases in the sample where an offer of a restorative justice intervention might have been appropriate. However, an intervention was offered to the victim in just one case. The offer was accepted and the victim participated in the intervention. In that case, there was evidence of the offender's suitability to participate, having been assessed and the victim's safety fully considered. The intervention delivered was a face-to-face meeting, and there was a positive outcome in that particular case.

5. Leadership and management to deliver effective work for victims

5.1. The Trust had a well managed and supported Victim Contact Scheme. The statutory victim contact aspects of the relevant cases we inspected in this inspection were undertaken well.

5.2. Many individual offender managers spoke positively about the quality of individual VLOs.

5.3. We found that we scored victim contact cases better than other cases in the sample, in relation to the questions relating to 'sharing of key risk of harm between all relevant staff and agencies', 'appropriate priority having been accorded to the safety of current and potential victims by the offender manager and other workers', and 'evidence of the offender manager taking into account any concerns expressed by the victim and/or the likely impact of the offender's behaviour on the victim'. However, in response to the question as to whether the risk management plan accurately described how the objectives of the sentence plan and other activities would address risk of harm issues and protect actual and potential victims, we found that we scored the statutory victim contact cases less well. This indicated that many offender managers were not taking sufficient account of the actual victim's safety when drawing up the risk management plan when that person was in contact with the victim liaison service.

5.4. The Trust had invested, over the previous nine months, in a new victims' database that provided better caseload information. The victim liaison officers were managed by the MAPPA Coordinator and were embedded in the offender management teams. A new protocol was launched from the

summer of 2013, which provided direct access to victim information, which was another example of the close working between probation and the police. Another recent innovation was the introduction of a web based digital mapping system that was scalable and provided accurate maps for exclusion zones. This, apart from relieving the VLOs of a thankless task in drawing exclusion zones by hand onto maps, made them clearer and more accurate and reduced the likelihood of an offender being unclear where they were or were not allowed to go, thus reducing the likelihood of inadvertent contact with the victim.

5.5. PreView, the NOMS information system that costs a range of activities, indicates that the Devon & Cornwall victims' contact scheme is more expensive than others in England & Wales. However, the Trust had made a decision to reflect the special nature and skills required of the VLO role and to pay them at the same rate as POs.

5.6. Restorative justice was at an embryonic stage at the time of the inspection, and awareness of local initiatives was not yet fully understood by all partner organisations. However, the Trust had trained up Turnaround (IOM) staff and VLOs. The Trust's approach was that restorative justice had to be appropriate for both the offender and the victim, and was planning to use outside facilitators rather than its own staff in relation to restorative justice conferencing.

Summary

Overall, 78% of the work to deliver effective services to victims was done well enough.

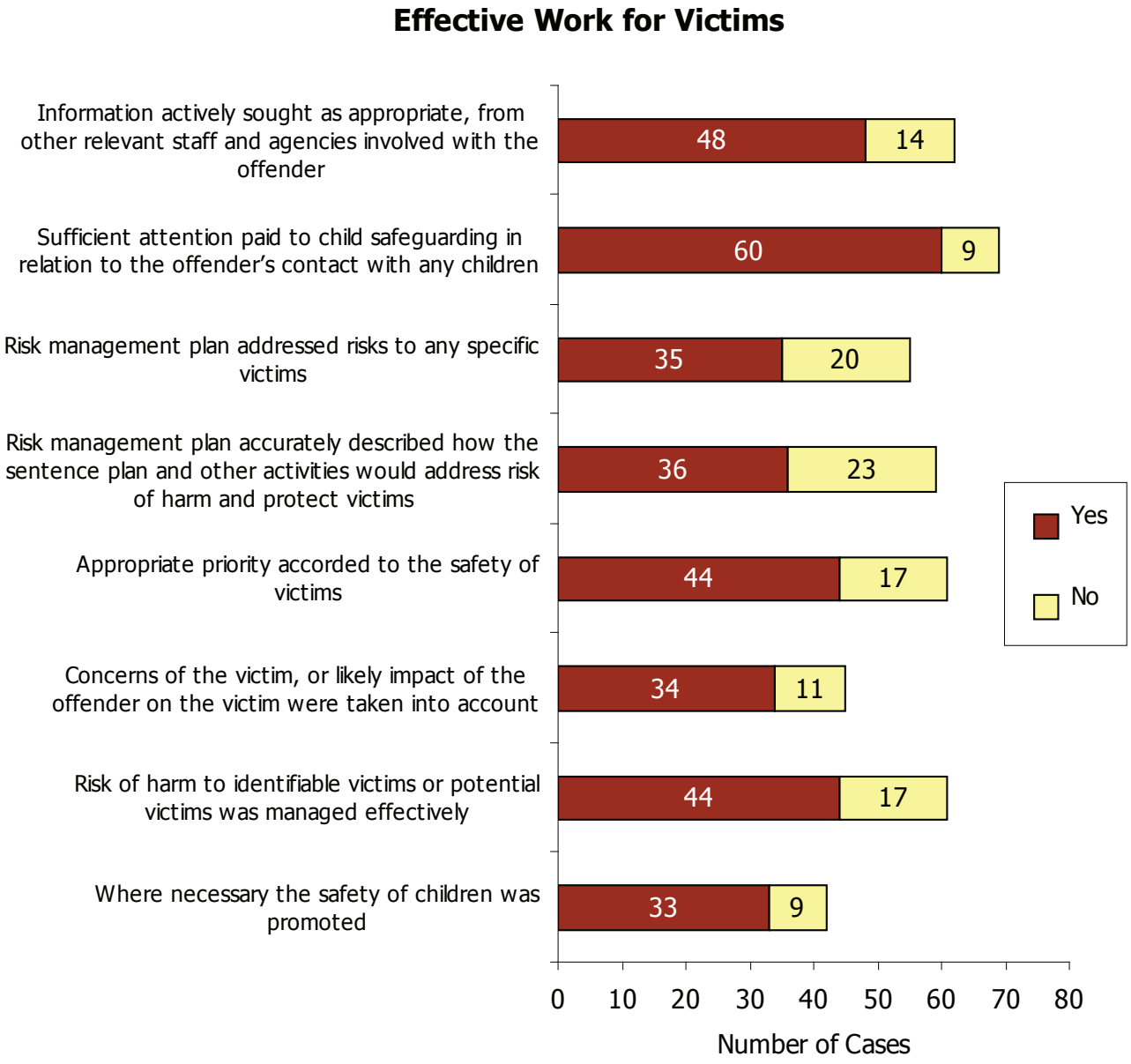
We have recommended that post-inspection improvement work focuses on ensuring that:

1. planning to manage the risk of harm to others takes full account of the safety of actual and potential victims, and pays appropriate attention to the protection of children and young people

For a summary of our findings, please see page 2

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 72 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Appendices

Appendix 1

Contextual information about the area inspected

Devon & Cornwall demographic data

Local Authority	Unemployment[1]	Population[2]	Black and minority ethnic population[3]
East Devon	4.6%	132,500	1.8%
Exeter	6.0%	117,800	6.9%
Mid Devon	5.4%	77,800	1.3%
North Devon	5.1%	93,700	2.1%
South Hams	4.1%	83,100	1.6%
Teignbridge	5.1%	124,200	1.6%
Torridge	6.8%	63,800	1.3%
West Devon	5.0%	53,500	1.4%
Cornwall UA	6.4%	532,300	1.8%
Plymouth UA	8.2%	256,400	3.8%
Torbay UA	7.9%	131,000	2.5%
Devon CC	5.2%	746,400	2.4%
England and Wales	**8.0%**	**56,075,900**	**14.1%**

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

Crime Survey for England and Wales, 2011/2012

Offences per 1000	Devon & Cornwall	England and Wales
Violence against the person offences (rate per 1000 adults)	13	14

Probation Caseload Data

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

Devon & Cornwall	Supervised in community and Pre-release	National average
Total caseload	4058	n/a
% white	92.8%	77.1%
% black and minority ethnic	2.8%	19.7%
% male	89.7%	89.9%
% female	10.3%	10.1%

Appendix 2

Contextual information about the inspected case sample

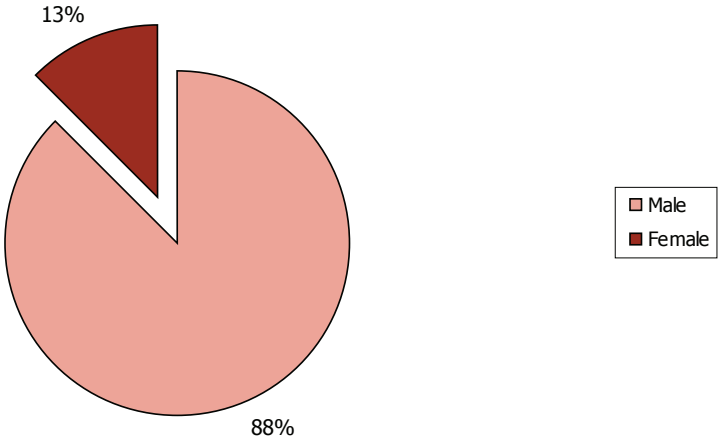
In the first fieldwork week we look at a representative sample of between 50 and 90 individual cases (depending on the size of the area), which have been supervised for around nine months. These are community orders, suspended sentence orders and post-custody licences.

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.

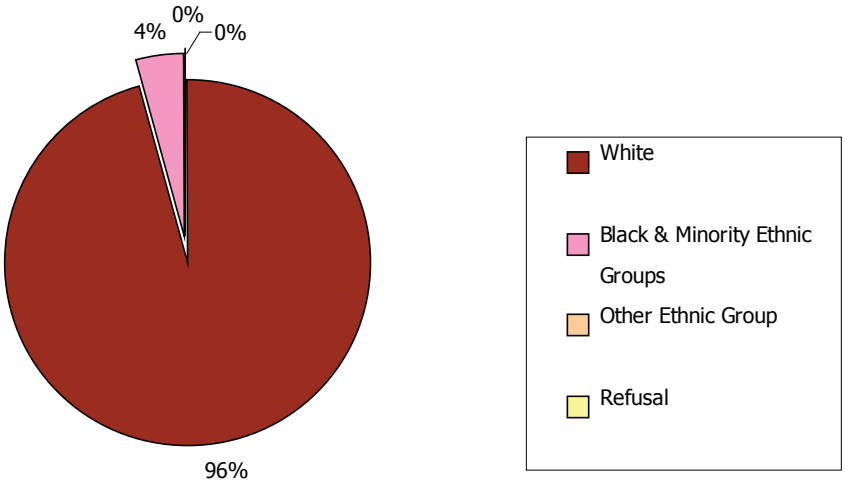
Between April and September 2013, the focus of the inspections is work with those who have committed violent offences.

In Devon & Cornwall we inspected a total of 72 cases.

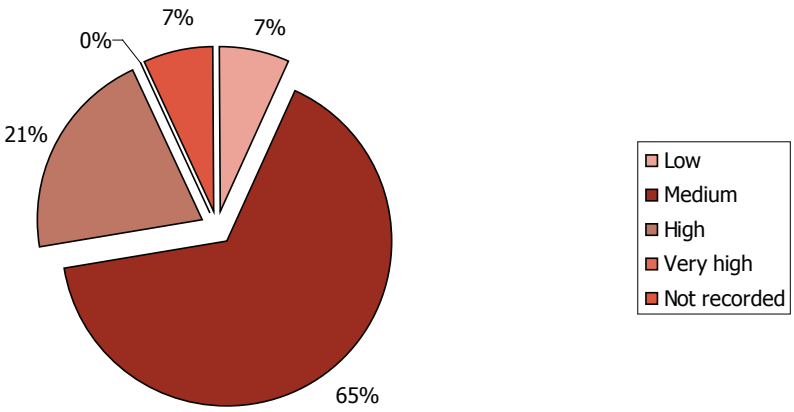
Gender



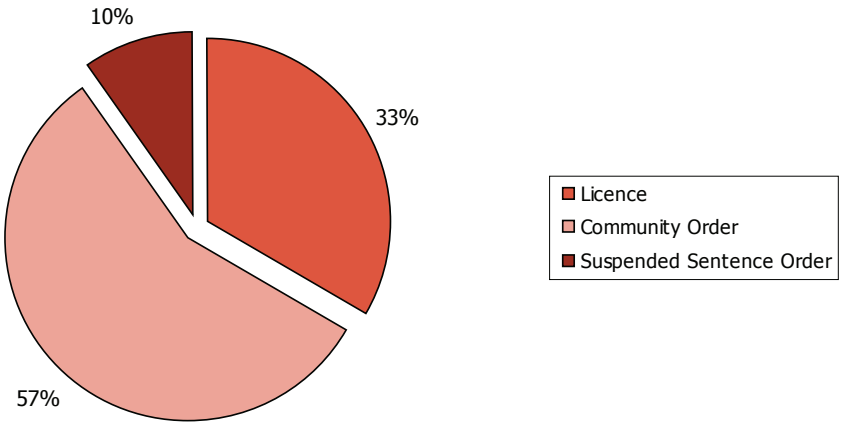
Race and Ethnicity



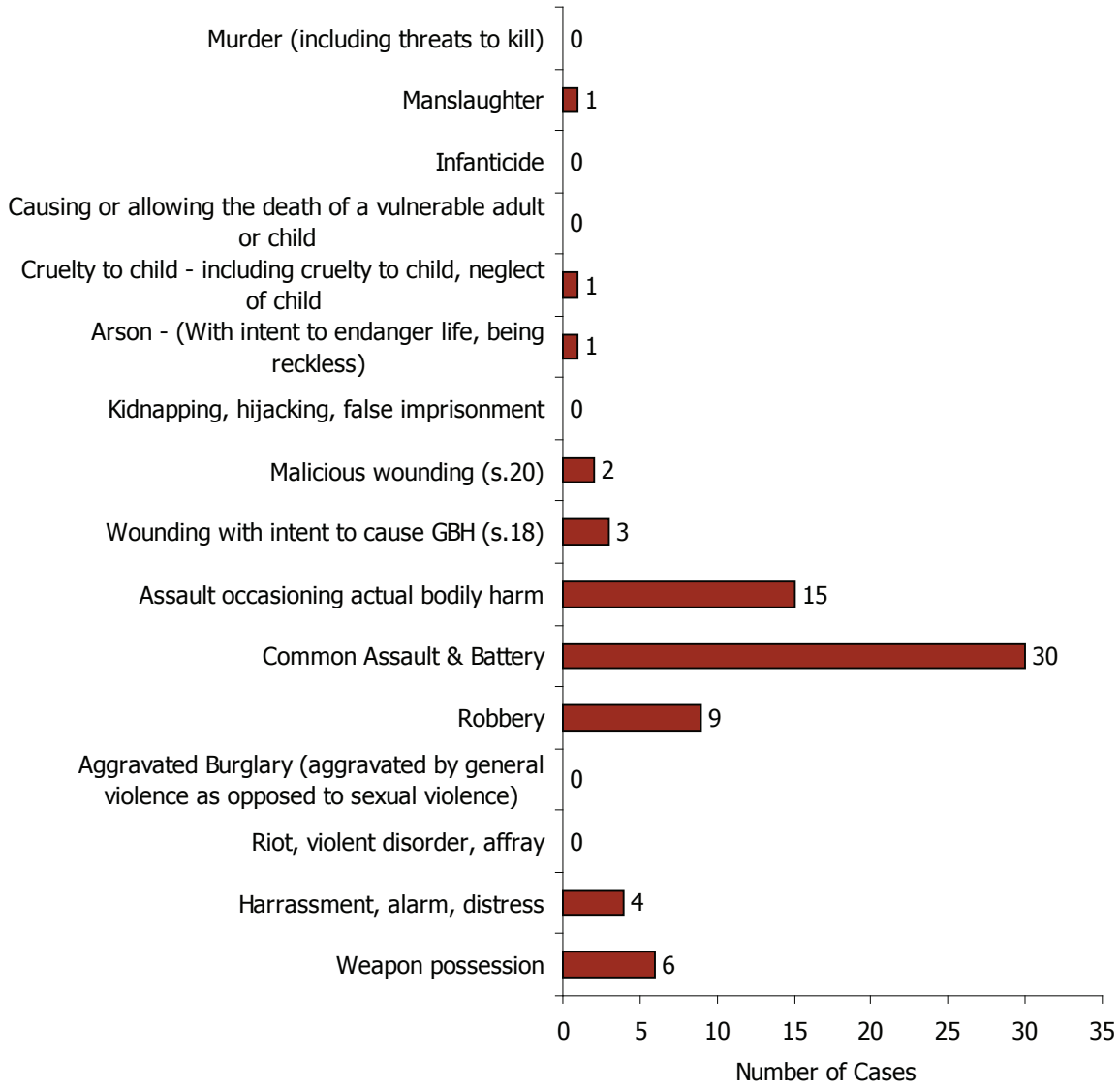
OASys RoSH classification as recorded at the start of sentence or release on licence or transfer into this area



Type of Case



Principal Offence



Appendix 3

Acknowledgements

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

Lead Inspector	Tony Rolley, *HMI Probation*
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	Greg Maguire, *HMI Probation*
	Jo Cann, *Local Assessor*
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	Leah Murdock, *Local Assessor*
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HMI Probation Support Services	Pippa Bennett, *Support Services Manager*
	Joanna Hewitt, *Support Services Officer*
	Oliver Kenton, *Assistant Research Officer*
	Alex Pentecost, *Publications Manager*
	Christopher Reeves, *Proof Reader*
Assistant Chief Inspector	Sally Lester, *HMI Probation*

Appendix 4

Inspection arrangements

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

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

Inspection focus

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

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

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

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

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

Methodology

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

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

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

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

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

Publication arrangements

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

Appendix 5

Scoring approach

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

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

1. ASSESSMENT AND PLANNING

   1.1 Assessment and planning to inform sentencing

   2.1 Assessment and planning to deliver the sentence

   3.1 Assessment to reduce the likelihood of reoffending

   4.1 Assessment and planning to minimise risk of harm to others

   5.1 Assessment and planning to minimise risk of harm to victims

2. DELIVERY AND REVIEW

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

   3.2 Delivery of interventions to reduce the likelihood of reoffending

   4.2 Delivery of interventions to minimise risk of harm to others

   5.2 Delivery of interventions to minimise risk of harm to victims

3. CASE OUTCOMES

   2.3 Initial outcomes are achieved

   3.3 Likelihood of reoffending is reduced

   4.3 Risk of harm to others is minimised

   5.3 Risk of harm to victims is minimised

4. LEADERSHIP AND MANAGEMENT

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

   1.4 Leadership and management to support sentencing

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

   3.4 Leadership and management to reduce the likelihood of reoffending

   4.4 Leadership and management to minimise risk of harm to others

   5.4 Leadership and management to deliver effective work for victims

5. VICTIM WORK

   5.5 Victim contact and restorative justice.

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

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

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

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

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

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

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

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

Development of the inspection criteria

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

Appendix 6

Criteria

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

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

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

Appendix 7

Glossary

Accredited programme	Structured courses for offenders which are designed to identify and reduce the factors related to their offending behaviour. Following evaluation, the design of the programmes has been accredited by a panel of experts
Approved premises	Approved premises provide controlled accommodation for offenders under supervision
BBR	Building Better Relationships: Nationally accredited group work programme designed to reduce reoffending by adult male perpetrators of intimate partner violence
CEO	Chief Executive Officer of a Probation Trust
Child protection	Work to ensure that that all reasonable action has been taken to keep to a minimum the risk of a child or young person coming to harm
CJS	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
Desistance	The process by which people stop offending and build a new, crime-free identity
DID	Drink Impaired Drivers programme: Nationally accredited group programme for offenders convicted of driving with excess alcohol.
Dynamic factors	As distinct from static factors. Dynamic factors are the factors in someone's circumstances and behaviour that can change over time
EPIC	Electronic Probation Information System: Official website for the national Probation Service
ETE	Education, training and employment: work to improve an individual's learning, and to increase their employment prospects
HDC	Home Detention Curfew: Arrangement whereby a prisoner is released on licence earlier than would otherwise have been the case, and is subject to an electronically monitored curfew to the release address up to the time the licence would have ordinarily started
HMI Probation	Her Majesty's Inspectorate of Probation
Interventions; constructive and restrictive interventions	A *constructive* intervention is where the primary purpose is to reduce likelihood of reoffending. A *restrictive* intervention is where the primary purpose is to keep to a minimum the individual's risk of harm to others. Example: with a sex offender, a constructive intervention might be to put them through an accredited sex offender programme; a *restrictive intervention* (to minimise their risk of harm) might be to monitor regularly and meticulously their accommodation, their employment and the places they frequent, imposing and enforcing clear restrictions as appropriate to each case. NB: Both types of intervention are important
IOM	Integrated Offender Management
LDU	Local delivery unit: an operation unit comprising of a probation office or offices. LDUs are generally coterminous with police basic command units and local authority structures

LSCB	Local Safeguarding Children Board: set up in each local authority (as a result of the Children Act 2004) to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children in that locality
MARAC	Multi-agency risk assessment conference: part of a coordinated community response to domestic abuse, incorporating representatives from statutory, community and voluntary agencies working with victims/survivors, children and the alleged perpetrator
MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher risk of harm to others
nDelius	National Delius: the national probation case management system which was completed in 2012, based on the earlier Delius system used by some probation trusts. The system is being rolled out through 2013
NOMS	National Offender Management Service: the single agency responsible for both Prisons and Probation Trusts
OASys/ eOASys	Offender Assessment System/electronic Offender Assessment System: the nationally designed and prescribed framework for both Probation and Prisons to assess offenders, implemented in stages from April 2003. It makes use of both static and dynamic factors
Offender management	A core principle of offender management is that a single offender manager takes responsibility for managing an offender through the period of time they are serving their sentence, whether in custody or the community. Offenders are managed differently depending on their risk of harm to others and what constructive and restrictive interventions are required. Individual intervention programmes are designed and supported by the wider 'offender management team or network', which can be made up of the offender manager, offender supervisor, key workers and case administrators
Offender manager	In the language of offender management, this is the term for the officer with lead responsibility for managing a specific case from 'end to end'
OGRS	Offender Group Reconviction Score: a predictor of reoffending based only on static risks such as age, gender and criminal history
OMI 2	Offender Management Inspection 2: HMI Probation's inspection programme which ran from 2009 to 2012
PCMS	Probation Case Management System
PO	Probation officer: this is the term for a 'qualified' offender manager who has undertaken a higher education based course for two years. The name of the qualification and content of the training varies depending on when it was undertaken. They manage offenders posing the highest risk of harm to the public and other more complex cases
PPO	Prolific and other priority offender
PSO	Probation services officer: this is the term for an offender manager who was originally recruited with no qualification. From 2010 they may access locally determined training to 'qualify' as a PSO or to build on this to qualify as a Probation Officer. They may manage all but the most complex cases or those posing the highest risk of harm to the public depending on their level of training and experience
PSR	Pre-sentence report: this refers to any report prepared for a court, whether delivered orally or in a written format

REM	Race and ethnic monitoring
'Risk of harm work'	This is the term generally used by HMI Probation to describe work to protect the public, primarily using restrictive interventions, to keep to a minimum the individual's opportunity to behave in a way that is a risk of harm to others
RoSH	Risk of Serious Harm: a term used in OASys. All cases are classified as presenting a low/ medium/ high/ very high Risk of Serious Harm to others. HMI Probation uses this term when referring to the classification system, but uses the broader term risk of harm when referring to the analysis which has to take place in order to determine the classification level. This helps to clarify the distinction between the probability of an event occurring and the impact/severity of the event. The term Risk of Serious Harm only incorporates 'serious' impact, whereas using 'Risk of Harm' enables the necessary attention to be given to those offenders for whom lower impact/severity harmful behaviour is probable
Safeguarding	The ability to demonstrate that a child or young person's well-being has been 'safeguarded'. This includes – but can be broader than – child protection
SEEDS	Skills for Effective Engagement and Development and Supervision: an initiative in place across many Probation Trusts which emphasises the importance of the practitioners' skills in relationship building to ensure effective work with individuals. The development of these skills is supported by the observation of practice and reflective feedback by managers or others.
SFO	Serious Further Offence: when an offender is charged with an offence classified as an SFO (serious sexual or violent offences), the Probation Trust conducts an investigation and review of the management of the case
SMB	Strategic Management Board: the duties and responsibilities of the Multi-Agency Public Protection Arrangements 'Responsible Authority' (police, probation and prison service) are discharged through the Strategic Management Board. This consists of senior representatives of the agencies involved in Multi-Agency Public Protection Arrangements and lay advisors
Static factors	As distinct from *dynamic* factors. *Static* factors are elements of someone's history that by definition can subsequently never change (i.e. the age at which they committed their first offence)
ViSOR	Violent and Sexual Offender Register: the information system managed by the police to share information in some cases where there has been sexual or serious violent offending
VLO	Victim liaison officer: responsible for delivering services to victims in accordance with the Trust's statutory responsibilities
YOI	Young Offenders Institution: a Prison Service institution for children and young people remanded in custody or sentenced to custody
YOS/YOT/YJS	Youth Offending Service/Youth Offending Team/Youth Justice Service: these are common titles for the bodies commonly referred to as YOTs

Appendix 8

Role of HMI Probation and Code of Practice

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

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

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

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