HM Inspectorate of Probation
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Transforming Rehabilitation

Early Implementation 3

'An independent inspection of the arrangements for offender supervision'

November 2015

HM Inspectorate of Probation

Transforming Rehabilitation **– Early Implementation 3**

‘An independent inspection of the arrangements for offender supervision’

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Foreword

This is our third report in a series looking at early implementation of the *Transforming Rehabilitation* programme.

Our findings are broadly similar to our last report published in May 2015, and such is the scale of changes this is no great surprise. Our concerns are clearly documented and reflected in our recommendations.

Within the National Probation Service we have found inconsistent application of the Risk of Serious Recidivism tool which is leading to mistakes in allocation. The variable quality of risk of harm assessments is a continuing concern. Within Community Rehabilitation Companies we have found inconsistent standards in relation to risk of harm assessment, likelihood of reoffending assessment and recording of escalation and breach processes.

On the positive side, use of Multi-Agency Public Protection Arrangements and restrictive requirements is good and risk escalation processes between Community Rehabilitation Companies and the National Probation Service have improved.

Staff in Community Rehabilitation Companies and the National Probation Service feel under workload pressures but the offenders we spoke to have noticed little change and are generally happy with the service they received.

We will continue to monitor the implementation of *Transforming Rehabilitation* until March 2016. With the passage of time we do expect to see evidence that our recommendations have been progressed by the National Offender Management Service, the National Probation Service and Community Rehabilitation Companies.

In April 2016 we will introduce the new Quality & Impact inspection programme. By combining assessment of quality of work with evaluation of impact on offenders we will provide better evidence through which delivery organisations can be held to account for their performance, and HMI Probation will be better able to highlight specific ‘enablers’ or ‘barriers’ to the goal of reducing reoffending rates and protecting the public from harm.

Paul Wilson CBE
HM Chief Inspector of Probation

November 2015

Contextual Information

The National Probation Service and Community Rehabilitation Companies came into existence on 01 June 2014, as part of the Ministry of Justice Transforming Rehabilitation programme. This was the first step in a series of changes designed to open up the probation market to new providers, reduce reoffending rates and allow the National Probation Service to focus on managing high risk of harm offenders, those eligible under Multi-Agency Public Protection Arrangements and foreign national offenders subject to deportation. Community Rehabilitation Companies were transferred from public to private ownership on 01 February 2015. The table below shows the main responsibilities and interface between the two agencies.

<table>
<tr><th>COURTS, REPORTS AND ALLOCATION</th><th>INTERFACE</th><th>DELIVERY</th></tr>
<tr><td>National Probation Service</td><td>Community Rehabilitation Companies and National Probation Service</td><td>National Probation Service</td></tr>
<tr><td rowspan="3">Prepare reports for court

Decide on case allocation</td><td rowspan="3">Communicate and promote sentencing options

Commence orders promptly

Exchange information

Ensure swift enforcement

Ensure risk escalation promotes effective risk management</td><td>Manages cases that are Multi-Agency Public Protection Arrangement eligible, foreign nationals who are subject to deportation, public interest cases and all others who are assessed as presenting a high risk of serious harm. Also delivers sex offender treatment programmes.</td></tr>
<tr><td>Community Rehabilitation Company</td></tr>
<tr><td>Manages cases presenting low and medium risk of serious harm. Delivers interventions on low medium and some high risk cases</td></tr>
</table>

All court work is delivered by the National Probation Service. Over recent years there has been a drive to speed up the justice system and produce reports more quickly for court. Before the new arrangements, Probation Trusts were measured on the proportion of reports they were able to complete within five working days or less. These shorter reports could be written or verbal, but were normally not based on an Offender Assessment System full analysis of the risk of serious harm. In Probation Trusts, these were expected to be completed in the first few weeks of an order, but following Transforming Rehabilitation there is now an expectation that, where indicated as necessary, they will be completed by the National Probation Service within two working days of sentence.

Community Rehabilitation Companies are not involved in preparing reports for court, and many of their new cases are assigned to offender managers who have no previous knowledge of the offender. Good communication between the Community Rehabilitation Company and the National Probation Service is crucial in ensuring the smooth allocation of cases, full transfer of information, and also to ensure proper breach and escalation.

This inspection can be seen as a continuation of HMI Probation's work to understand and report on the developing Transforming Rehabilitation landscape. Our last report and its recommendations can be found by using the following link:

www.justiceinspectorates.gov.uk/hmiprobation/inspections/transformingrehabilitation2/#.VdbrHaPsqQA.

Summary and Key Issues

Assisting sentence and the assignment of cases

Communication between the National Probation Service and the Community Rehabilitation Companies was improving. There appeared to be better liaison concerning the flow of information relating to pre-sentence work. Several of the Local Delivery Units inspected had established effective systems to check whether cases were known to a Community Rehabilitation Company before sentence. There was, however, little discussion between the National Probation Service and Community Rehabilitation Companies over appropriate proposals for reports. Further, there were still too many cases without a sufficient Risk of Serious Harm screening, and where necessary a full analysis of the risk of serious harm, in place before allocation.

A Risk of Serious Recidivism score had been calculated in almost all cases. Based on the information on the case management system, the case was with the right organisation. Further investigation of Risk of Serious Recidivism scores, however, showed that a number were inaccurate, when compared with our inspector's calculation, and that a few cases were being allocated incorrectly. Some had misinterpreted the guidance and either ignored relevant information or placed it in the wrong section of the tool. This led to some cases being allocated to the Community Rehabilitation Companies when they should have been with the National Probation Service. There were no quality assurance processes in place to improve the completion of the Risk of Serious Recidivism tool.

The Case Allocation System had been completed in less than two-thirds of cases. Where it was done, it was completed on time and we also saw an improvement in the quality of the information it contained, with fewer sections marked 'not known'. The timescale for completing the Case Allocation System, however, was often too short for external agencies such as children's services or police domestic abuse units to return information.

Due to the demands to see offenders quickly, there was a shift towards group induction, particularly within the Community Rehabilitation Companies. This was unpopular with a number of offender managers who felt that individual inductions resulted in better engagement. We found no evidence, however, to suggest that individual induction was more effective than group induction.

Early Work in the Community Rehabilitation Companies

Most cases were assigned to an identified offender manager within one working day of sentence. Fewer than half of the cases we inspected, however, had their first appointments with their offender managers within five working days of sentence. Full information on new cases was often not available at, or immediately following, allocation. In many instances this information followed on after the case had gone to a Community Rehabilitation Company.

The Offender Assessment System likelihood of reoffending assessment was sufficient in just over half of cases. Sentence plans were not always completed in good time and did not always address the factors relating to offending, or wider diversity issues and barriers to engagement.

Many of the offenders supervised by a Community Rehabilitation Company had committed violent offences, or had been involved in domestic abuse. There were concerns about protecting children in a number of cases. Only two-thirds of Risk of Serious Harm screenings and half of full risk of harm analyses were sufficient. An effective risk management plan was in place in fewer than half of all relevant cases. Failure to assess accurately the risk of harm and then implement a plan to reduce it can lead to a focus on inappropriate work and to an increase in the harm an offender may pose.

Overall, appointments were offered in line with the requirements of the sentence and staff had made efforts to motivate offenders to comply. Non-compliance was addressed quickly by Community Rehabilitation Company staff who issued warnings appropriately and sought to re-engage offenders and promote compliance with the sentence.

Early Work in the National Probation Service

Almost all sampled cases were allocated within one working day and seen by their offender managers within two working days. Diversity issues and barriers to engagement were identified in the majority of cases; however, plans to address these issues were only developed in two-thirds of relevant cases. Most cases had a sufficient assessment of the likelihood of reoffending but timeliness was an issue. Sentence plans were sufficient in two-thirds of cases and where completed generally did contain appropriate objectives.

Most cases had a Risk of Serious Harm screening in place but some staff had taken too long to complete them. Full risk of harm assessments were sufficient in just over half of the cases we inspected. Assessments did not always draw on all available sources of information and the analysis of the risk to children was not good enough in too many cases. Poor quality assessments led almost inevitably to poor quality risk management plans, less than two-thirds of which were sufficient. Where there were concerns over the safety of children, we found that the use of Child Protection procedures by National Probation Service staff needed to improve. Management oversight had not been effective enough to address these shortfalls.

The frequency and type of contact was good in most cases, and in the majority interventions had been delivered as planned. Where offenders failed to comply we saw a robust response and appropriate use of the enforcement process. More home visits should have been made, however, where offenders posed a risk of serious harm to the public and in Child Protection cases.

Enforcement

Overall, the enforcement process was variable, with some Local Delivery Units still experiencing high rejection rates for breach packs. Many had been returned for spelling and grammatical errors or to question proposals. The best examples were found in Local Delivery Units that had established good quality assurance processes and positive relationships between Community Rehabilitation Company staff and National Probation Service prosecution staff, making swift enforcement more likely.

Swift enforcement is more likely to secure engagement with planned work and future compliance. To breach a case, the Community Rehabilitation Companies must produce a breach pack and pass the case to the National Probation Service for prosecution. There are a number of timescales which have to be met and these should be recorded clearly on nDelius. Recording was not clear in half of the breach cases we inspected and this made it difficult to determine if the required timescales had been met.

The small number of licence cases in the sample were enforced correctly by the Community Rehabilitation Companies and all the recalls we saw were appropriate.

Risk Escalation

The process of escalating cases to the National Probation Service in the event of an increase in an offender's risk of serious harm was improving. Staff confidence had grown and there was a greater investment in the value of the process in most of the Local Delivery Units we visited. Almost all the cases we saw had a clear and justifiable reason for starting the escalation procedure.

In some Local Delivery Units the process was described by staff and managers as working well and quite clearly it was; however, that was not the case in all Local Delivery Units with some staff highly critical of their local processes which, in our view, operated much more effectively in some places, than in others.

There was considerable debate among Community Rehabilitation Company and National Probation Service managers concerning cases where an offender had been arrested or charged but then not convicted of a serious offence. In some instances, the National Probation Service had been left holding an escalated case which was not classified as posing a high risk of serious harm. Better communication between Community Rehabilitation Companies and the National Probation Service would help to streamline the process. Further, there remains room for improvement in recording the required information on the case management system.

Recommendations

National Probation Service

- The National Probation Service should ensure that all staff are familiar with the Risk of Serious Recidivism/ Case Assessment System prioritisation matrix. (1.7)
- The National Probation Service should establish a quality assurance system in order to improve the accuracy of the completion of the Risk of Serious Recidivism tool. (1.14)
- The National Probation Service should ensure that a Risk of Serious Harm screening and where indicated as necessary, a full risk of harm assessment is completed in all cases prior to allocation to a Community Rehabilitation Company. (1.6, 1.20)
- The National Probation Service should improve the quality of its full risk of harm assessments, particularly with reference to the analysis of and management of risk of harm to children. (3.9, 3.24)
- The National Probation Service should ensure that a robust and timely risk management plan is in place for all high risk of serious harm cases. (3.11)

Community Rehabilitation Companies

- Community Rehabilitation Companies should focus on improving the quality of full risk of harm assessments. (2.11)
- Community Rehabilitation Companies should focus on improving the quality of likelihood of reoffending assessments. (2.8)
- Community Rehabilitation Company staff should ensure that an assessment of any diversity issues or barriers to engagement is completed and a plan put in place to address relevant issues. (2.6)
- Community Rehabilitation Companies should ensure they have effective management oversight structures in place for cases where there are concerns over the level of risk of harm. (2.22)
- Community Rehabilitation Companies should improve the quality of their recording of information concerning the risk review escalation procedure and breach process. (4.6, 4.16)

Inspection Methodology

In this inspection we have focused on work undertaken at the point of sentence and allocation by the National Probation Service (NPS), work undertaken by the Community Rehabilitation Companies (CRCs) and the NPS to manage offenders, and the interfaces between the two organisations in respect of enforcement and risk review. We have included work with those released on licence, and excluded those subject to a single requirement of unpaid work, an attendance centre, an exclusion or curfew.

The fieldwork for this inspection took place between March 2015 and May 2015. We looked at four months worth of work that had been undertaken between November 2014 and March 2015, with offenders who had received community sentences or had been released on licences. The first three to four months often equates to about one-quarter of the length of an intervention. Consequently, it is difficult for us to assess the long-term outcomes of the interventions, as they had not had time to take full effect.

We looked at 120 cases that had been allocated to the CRCs. Of these, 60 were community orders, 35 suspended sentence supervision orders and 25 licences. The sample was 76% male, 83% white British and 15% were from black and minority ethnic communities. Two percent were from other ethnic groups.

There were 45 NPS cases. Ten were community orders, 15 suspended sentence supervision orders and 27 licences. The sample was 89% male, just over four-fifths were white British and the remainder were from black and other minority ethnic groups.

We also inspected an additional 51 cases that had been considered under the risk review process between 01 August 2014 and 16 January 2015. Of those, 27 were community orders, 15 suspended sentence orders and 9 licences. The sample was 90% male, 84% white British and 14% black and minority ethnic groups. Two percent were from other ethnic groups.

In three Local Delivery Units (LDUs) we also examined practice regarding the Risk of Serious Recidivism (RSR) tool in greater detail. We inspected 59 RSR assessments, 28 from the main inspection sample and 31 external to it.

The case samples from the CRCs and NPS are different in many regards. The main differences relate to risk of serious harm levels and Multi-Agency Public Protection Arrangements (MAPPA) status. The NPS sample also contained a much higher proportion of licence cases and a lower proportion of female cases.

We visited six NPS LDU clusters and the associated CRCs. These were: Nottinghamshire (Derbyshire, Leicestershire, Nottinghamshire & Rutland CRC), Norfolk & Suffolk (Norfolk & Suffolk CRC), Tyne South (Northumbria CRC), Hammersmith, Fulham, Kensington, Chelsea and Westminster (London CRC), Dorset (Dorset, Devon & Cornwall CRC), North Wales (Wales CRC). A team of either seven or eight inspectors visited each area for three days.

We interviewed 38 NPS offender managers and 100 CRC offender managers who were responsible for the cases we examined. We also held six focus groups for middle managers in the NPS and six for middle managers in the relevant CRC. We interviewed 36 offenders using a semi-structured interview tool.

We have visited different geographical Local Delivery Units from those inspected in our previous report. It is not, therefore, possible to directly compare the findings or to say conclusively that any differences are representative of performance in England and Wales. We have, however, commented where we have seen indications of progress made on what we have seen as challenges in our previous *Transforming Rehabilitation* inspections.

Assisting sentencing and the assignment of cases

1

1. Assisting sentencing and the assignment of cases

Introduction

The NPS is responsible for assisting magistrates and judges in deciding the most appropriate sentence for individual offenders. This function can only be delivered through close working relationships with the CRCs. NPS staff need to understand what the CRCs can offer so that appropriate proposals can be made for sentencing. If the offender is currently supervised by a CRC information has to be gathered from the CRC and presented to the court. Where the offender is allocated to a CRC, information about the offender and the sentence needs to be passed quickly by the NPS to the CRC.

Proposals for sentencing are delivered in pre-sentence reports (PSRs) which can be an oral report, a written short format report or a full report. Reports may be delivered on the day of sentence, after a short adjournment or a longer adjournment, usually up to three weeks after sentence.

The PSR contains an analysis of the offence, the reasons for the offending behaviour, and identifies interventions to reduce reoffending. Reports should contain a judgement of the risk of serious harm that the offender presents. Where indicated, a full analysis of the risk of harm should be undertaken using the Offender Assessment System (OASys). Where a full analysis of risk of harm is needed, and has not been prepared before sentence, it should always be completed before the case is allocated to the appropriate organisation.

In order to allocate an offender to the correct organisation, the NPS is required to complete two further tasks. Firstly, the Risk of Serious Recidivism (RSR) calculation, which uses actuarial data to identify the likelihood (as a percentage) of offenders with certain characteristics going on to commit a seriously harmful offence in the next two years. Secondly, the Case Allocation System (CAS) which includes a Risk of Serious Harm (RoSH) screening tool to assist in identifying which organisation the offender should be allocated to.

Findings

Pre-sentence work

1.1. While all NPS LDUs had processes in place to check if offenders were known to the relevant CRC, there appeared to be little consultation pre-sentence about suitable sentencing proposals. CRC staff recognised that the requirement to present an increasing number of reports on the day of sentence left little time for NPS report writers to liaise with CRC staff.

1.2. Some NPS staff expressed concerns that they were becoming less knowledgeable about the services and types of supervision provided through the CRCs and that this would lead to difficulties in making appropriate proposals. We found, however, that there was a clear proposal for an appropriate community sentence in nearly all the cases inspected.

1.3. We saw some evidence of established systems designed to provide up to date information on current CRC cases, for example through the provision of response to supervision reports. Where this was not the case, some sentences were being made without input from CRC case managers, which meant that courts could not be fully appraised of the offender's situation or progress. The general view from CRC managers was that communication between organisations to assist sentencing was steadily improving, but needed to get better. For example, late requests for information concerning CRC cases from the NPS were producing strains on the CRCs, who were sometimes unable to respond in time.

1.4. Interface meetings, set up to address any issues concerning pre-sentence work had been established in some, but not all LDUs inspected. There were some senior manager meetings in place, but middle manager interface meetings were either not established, or were in their infancy.

1.5. Pre-sentence reports were produced in 141 out of 151 cases that led to a community sentence. The majority were short format typed reports (61), there were 44 full reports and 36 oral reports.

1.6. We assessed that reports were based on sufficient information for sentencing purposes in most cases but were concerned to find that only 62% were supported by a RoSH screening. A full risk of harm assessment had not been completed as required before allocation of the case to a CRC in six instances. Overall, we assessed nearly three-quarters of reports to be of sufficient quality. Though an area that needs continued focus, we did note an improvement since our last inspection.

The Risk of Serious Recidivism assessment

1.7. The RSR score must be calculated in every case, even where there is no information to indicate that the offender has shown any behaviour indicative of causing serious harm. An RSR prioritisation matrix issued by NPS in April 2015 removed the requirement to complete the RSR tool before allocation in cases that are automatically allocated to the NPS. While this is welcome, it did not appear to be widely understood by staff at the time of this inspection.

1.8. The RSR guidance document is complex and there is a need to refer to other schedules with regard to some relatively common offence types. Some staff we spoke to were not confident that they understood exactly what was expected of them. In our previous report we suggested electronically linking the guidance to the form might simplify the situation. We would suggest that this is still the case.

1.9. We dedicated an inspector to look in detail at the completion of the RSR tool in three of the six inspection areas. This included rescoring the RSR assessment. The sample consisted of 28 cases from the main inspection sample and 31 external to it. In some cases we spoke to the offender manager who originally completed the RSR tool.

1.10. There were 40 cases with a score of lower than 5%. In 31 of these cases the variation between the score generated by the inspector and the score generated by the NPS was usually less than one percentage point, with some scoring exactly the same. In none of these cases would the RSR score have influenced the allocation decision. In the other nine cases, there was a variation of more than two percentage points. In three of those cases the difference would have taken the case above the 6.9% threshold for allocation to the NPS, and therefore the cases had been incorrectly allocated to a CRC. There appears to be more variation in this band than we found in our earlier report.

Practice illustration

In one case, we saw a 19 year old male sentenced to 16 months custody for burglary. The RSR score was recorded at 6.0% and the case was allocated to a CRC. Our rescore was 10.36%. The incorrect RSR assessment meant the case had been allocated to the wrong organisation. The RSR score was incorrect in the following areas:

- section 3.1 - date of first sanction – the basic calculation stated the RSR score was based on convictions for four years and missed the cautions, reprimands and warnings that stretched back another four years
- section 3.2 - number of previous sanctions - three cautions, reprimands and warnings were missed
- section 3.3 - number of sanctions for current/previous violent offences – all three cautions, reprimands and warnings were violent and not included.

1.11. In the 19 cases that scored 5% or higher, 14 were within two percentage points of the score generated by the inspector. One of these cases should have been allocated to the NPS rather than a CRC due to the RSR score passing the 6.9% threshold. Five cases showed a variation of greater than two percentage points. Of these five cases, we judged the score to be too high in three cases and too low in the remaining two. We saw one case which had been allocated to a CRC because the recorded RSR score was below the threshold of 6.9%, but our calculation of the RSR score took them above the threshold. There appears, however, to be less variation in this band than in our earlier inspection.

1.12. The variation between the inspector's RSR scores and those generated by the NPS was in most cases due to staff misunderstanding what information should be included, and where, in the RSR assessment. National Offender Management Service (NOMS) advise that RSR training has been offered to all relevant staff. During our inspection, we were told that not all had received the training and formed the view that staff often did not understand the guidance or how to complete the tool. Common errors included:

- the exclusion of cautions, reprimands and warnings
- the inclusion of breaches
- failure to follow the guidance on what counts as a violent offence
- incorrect recording of offences of drunk and disorderly, criminal damage and public order as non-violent
- offences such as aggravated vehicle taking were incorrectly counted as violent by some staff.

1.13. We found that staff had difficulty distinguishing between offences, convictions and sanctions. The more complex the offending history the greater the variation in the RSR score between the original and the rescore by the inspector. Where there was a longer and more complex offending history greater care was needed to ensure the correct data was entered into the RSR tool. We were told that locating all the relevant information for offenders could be very time consuming. Some NPS staff found this task difficult to complete accurately due to demands on their time to fulfil other court duties and continued to question the value of completing the RSR assessment for all cases.

1.14. We found no evidence of any quality assurance process to ensure the accuracy of the completion of the RSR tool. Some managers were aware of problems with the consistency of scores produced. Scores would sometimes be recalculated if found to be around the threshold of 6.9%, but there was no systematic approach.

1.15. We formed the view that the RSR score was primarily used as an allocation tool. Its purpose is to link an actuarial score with the practitioner's clinical judgements in the case allocation documentation, therefore ensuring a robust risk assessment has been completed pre-allocation. We could see little evidence of the RSR score informing practice concerning risk assessment. Rather as we found in our earlier report, it was completed towards the end of the assessment process and was, therefore, limited in its usefulness. After allocation we found the use of the RSR score to be very limited in either reviews of the risk of serious harm or within the risk review escalation process.

The Case Allocation System

1.16. Following completion of the RSR assessment the NPS is required to complete the Case Allocation System (CAS) in all cases. In this inspection we found that the CAS had been completed in three-fifths of cases (60%) that received a community sentence. This is a small reduction compared with our previous inspection and we would have expected to see the use of the CAS become more embedded over time. Completion levels across the six areas did vary. When it was done, the vast majority of cases had a CAS completed within one working day of sentence.

1.17. The CAS collates information through a RoSH screening assessment. This contains various sections within which staff indicate whether they have sufficient information to determine whether there needs to be a full risk of harm analysis completed. It is important that the CAS is as fully completed as possible, to enable the most thorough assessment of whether a full risk of harm analysis is required. We found that in the great majority of cases, the CAS was completed to a good standard, an improvement on our previous findings. As in our earlier report, it was often the case that where information had to be sourced externally from other organisations such as children's services or police domestic abuse units, we saw gaps in assessments. The timescale for completing the CAS was often too short for relevant information to be returned in time. Many cases were sentenced on the day through oral reports or had short adjournments for fast delivery reports.

1.18. In just under half of the cases, the CAS or other information indicated a need for a full risk of harm assessment prior to allocation to either the NPS or a CRC. This was completed in three-quarters of relevant NPS cases and just over half of relevant CRC cases. Where full risk of harm assessments were done, just over one-quarter for both the NPS and the CRCs were completed more than two working days after sentence. While we found greater clarity concerning respective roles, there were clearly still difficulties in obtaining the information or finding the time required to complete a full risk of harm assessment prior to allocation. The NPS needs to fulfil its identified role to produce those assessments.

Making the allocation decision

1.19. Following sentence, the NPS is required to allocate the case within two working days. We found in the main sample that almost all cases were allocated correctly. This is similar to our previous findings and suggests that the allocation process is operating successfully for most cases. When we investigated the allocation process in more depth through rescoring the RSR assessment, however, we found a small number of cases within the RSR sample were not allocated correctly.

1.20. Most risk of serious harm classifications were accurate; however, we heard from CRC staff that they were often allocated cases without a full risk of harm assessment being completed. This was supported by our findings in several cases we inspected. In the absence of a full PSR produced after a longer adjournment, we were much less likely to find that the full risk of harm assessment had been completed where required by NPS staff. This was recognised by NPS staff who explained that there was little time at court or post-sentence to complete a full assessment. If it was not done immediately post-sentence then the case allocation process quickly moved the case on to a CRC without the risk of harm assessment being completed. These findings replicate what was found in our earlier inspection, and continue to reflect the pressure on staff to deliver what is required with allocated resources within the timescales that exist.

1.21. There were different arrangements in place for communicating sentencing outcomes. Most LDUs used email to communicate; the NPS either contacted a central CRC email box or identified administrative staff. Given the target to see the offender within five working days of allocation by the NPS, we found a partial shift in both organisations towards group induction (but more so in the CRCs), compared with our earlier report. Most of the staff we interviewed were against the move towards group induction and wished to retain individual one-to-one appointments. They felt that it was important to see offenders and conduct their induction in order to start to build a positive relationship as soon as possible. We saw no evidence to suggest individual induction had been more effective than group induction.

1.22. We were informed by some CRC staff that full information on new cases was not always available at allocation. Sometimes the records just contained basic details and the supporting documentation such as the PSR, CAS, and RoSH screening. The full risk of harm assessment when completed followed on later. We saw evidence of this in some of the cases we inspected, and although improving, is similar to the findings of our previous inspection.

1.23. We received several comments from staff questioning the need to complete all the documentation associated with the allocation process in all cases. Some NPS staff felt that there was little purpose in using valuable time completing an RSR score or CAS when the case was going to be automatically allocated to the NPS for some other reason, for instance MAPPA eligibility. Furthermore, the CAS was seen as duplicating the RoSH screening required by OASys. Some CRC staff felt that they might get a more comprehensive set of documentation from the NPS if the NPS had more time to complete it. The removal of the need to complete the RSR assessment and the CAS for automatic NPS cases might facilitate this. There is an opportunity for the process to be reviewed and the potential for some resources to be released and utilised in a different way. This could achieve more comprehensive and accurate assessments in those cases which are being allocated to CRCs.

Recommendations

- The National Probation Service should ensure that all staff are familiar with the Risk of Serious Recidivism/ Case Assessment System prioritisation matrix. (1.7)
- The National Probation Service should establish a quality assurance system in order to improve the accuracy of the completion of the Risk of Serious Recidivism tool. (1.14)
- The National Probation Service needs to ensure that a risk of serious harm screening and where indicated as necessary a full risk of harm assessment is completed in all cases prior to allocation to a Community Rehabilitation Company. (1.6, 1.20)

Early Work in the CRCs

2

2. Early Work in the CRCs

Introduction

Once the NPS has allocated a case to a CRC, it is their responsibility to engage the offender in a plan to prevent or reduce reoffending and to manage any risk of harm that they pose. This chapter looks at the work of the CRCs to manage these objectives.

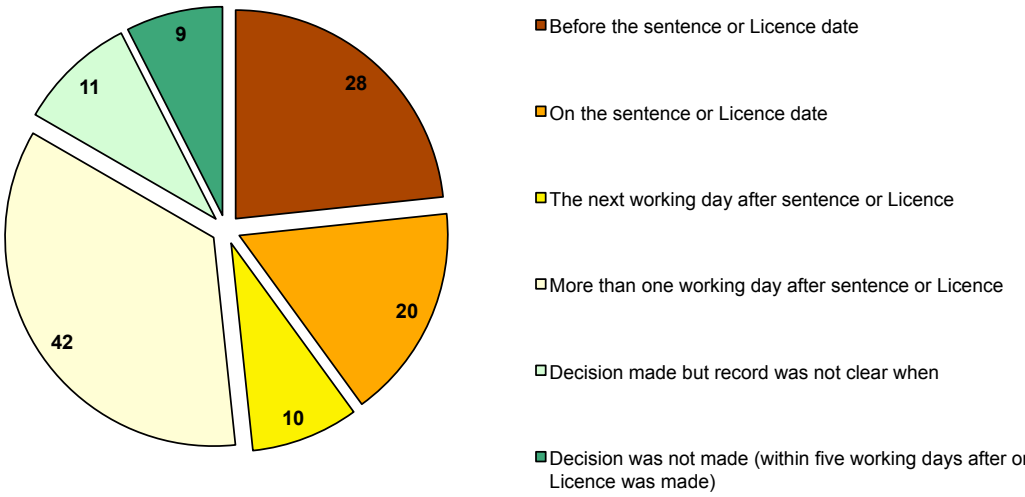
This inspection includes the timeframe following the introduction of new providers to deliver rehabilitation services. It is early on in the assumption of those responsibilities and the new contracts have only been in place with CRCs since 01 February 2015. The CRCs' delivery mechanisms had not been revised to any great degree from those in place pre June 2014. At the time of our inspection, the new owners were in the process of evaluating the organisations they had acquired and designing relevant delivery structures.

Findings

Assignment, induction and first appointments

2.1. We found that almost half of the cases allocated to a CRC had an offender manager identified within 24 hours of sentence or release on licence, whereas our earlier inspection had found this in over two-thirds of cases. Within a week most cases had been assigned to an offender manager. The PSR author is no longer the potential offender manager, and the need to transfer information between the NPS and the CRCs can slow things down. Delays in seeing the offender manager can result in offenders failing to comply with their orders and ultimately to an unsuccessful period of supervision. Please see figure 1.

Figure 1
When was the assignment to an identified officer made?
- CRC cases



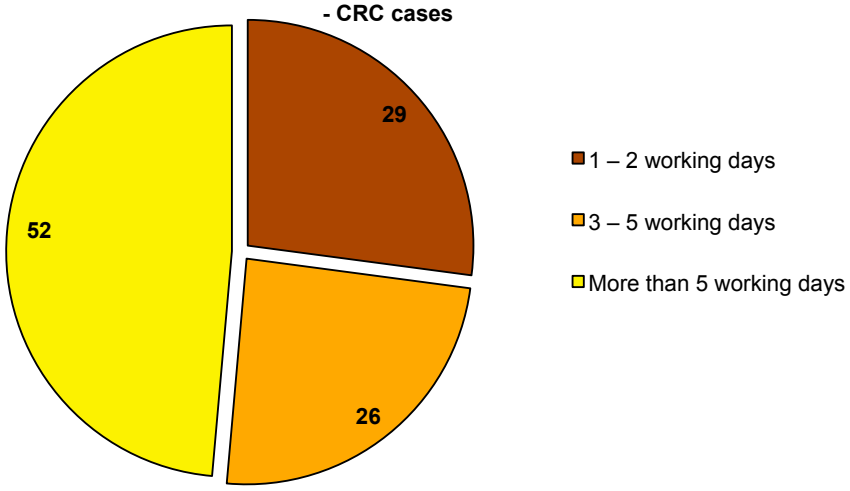
2.2. In just over half of the cases in the sample, that first appointment was with the offender manager, a fall from what we had previously found. We formed the impression that this was the preferred way of engaging with offenders and was viewed by offender managers as the most effective method for building a positive relationship. Due to time, staffing and performance target constraints, however, this was not always possible to offer.

2.3. Group induction was used in over one-third of cases. At this appointment the great majority of cases were given their next appointment with their offender manager. Where that was not possible, reporting was dealt with through duty arrangements. We found a greater use of group induction

reporting in this inspection in response to the realities and demands of resources and performance targets.

2.4. Just over one-quarter of offenders were seen by their offender manager within two working days of sentence or release, a deterioration from our earlier inspection. A further quarter was seen within five days and just under half in more than five days. Please see figure 2.

Figure 2
Number of days between sentence or release and the first appointment with the offender manager
- CRC cases



2.5. As recommended in our previous report, we believe that every effort should be made to ensure the offender manager and offender meet at the earliest opportunity after sentence or release to draw up a sentence plan and manage any risk of harm issues. Failure to do so increases the potential for non-compliance.

2.6. It is important that all aspects of an offender's circumstances and experience are assessed to enable a thorough and robust plan to be put in place to deliver the sentence. There was a sufficient assessment of diversity factors and potential barriers to engagement in just under two-thirds of cases, an improvement on our previous findings. In just over half of these cases we saw a plan in place to address diverse needs and overcome barriers to engagement. This is a slight improvement on our earlier report but clearly there needs to be significant improvement to ensure that these barriers and issues are effectively addressed by staff in order to give supervision every chance of success.

2.7. Some managers commented that they were understaffed, and that staff were under pressure and found it difficult to deliver the performance targets required. We were told by others that the situation was relatively promising, with managers and staff feeling positive about delivering good performance. In summary, there was a mixed view about the impact of the changes brought about by the *Transforming Rehabilitation* reforms.

Managing the offender

2.8. At the start of sentence or release on licence just over half (63 out of 118) of cases had a sufficient assessment of the likelihood of reoffending; in nearly one-third, the assessment was insufficient, a fall in performance since our previous report. In nineteen cases there was no assessment.

2.9. Following assessment, we found that initial sentence planning was completed in time in just over half of the cases. Appropriate objectives were set in a similar number of cases. There had been a sufficient assessment of community factors and social support in two-thirds of those cases, and the same proportion had been signposted or referred to relevant providers.

2.10. We saw a similar risk of serious harm profile as in our previous report, but with a reduction in the number of cases that had no risk of serious harm level recorded. None of the cases managed by the CRCs were assessed as presenting a high risk of serious harm. The largest proportion (59%), were assessed as presenting a medium risk of serious harm, 38% were assessed as low risk of serious harm, with no risk level recorded in the remainder.

2.11. Where required, we saw a sufficient Risk of Serious Harm screening in nearly two-thirds of cases. There was a sufficient full analysis of risk of serious harm in just under half of relevant cases. In just over one-third of cases, the assessment was insufficient and nearly one-fifth of relevant cases had no assessment. Assessments drew on all available sources of information in less than two-thirds of cases. There was sufficient analysis of risk of serious harm to children in 70% of relevant cases. In too many cases the level of risk of serious of harm was not being identified or satisfactorily addressed. The following practice example highlights the importance of effective assessment; the inspector commented:

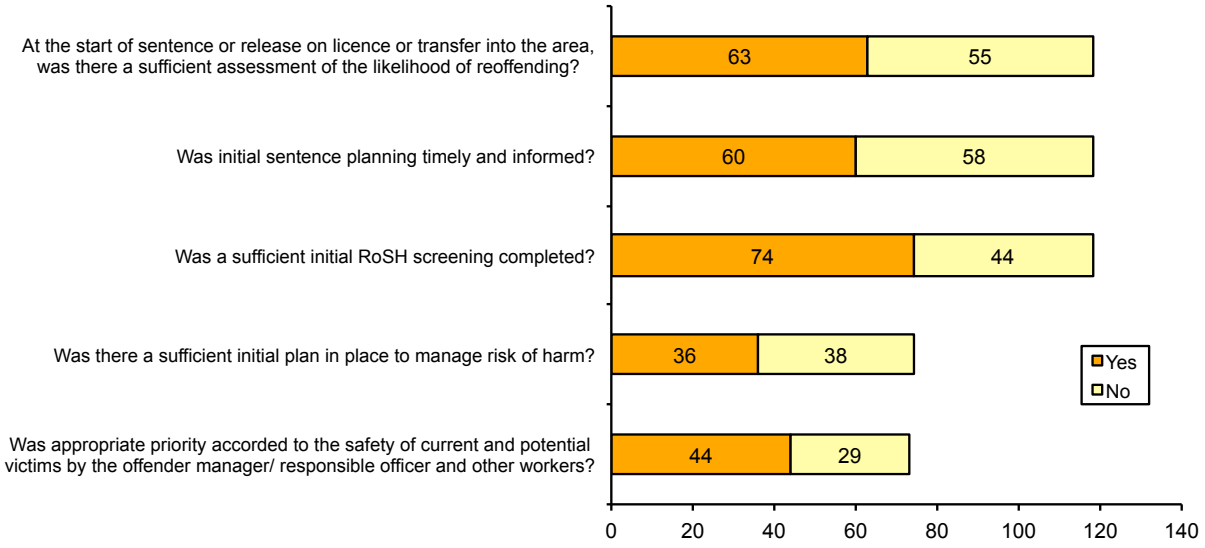
> "The assessment was not sufficient, the offender manager failed to identify relevant previous behaviour, for example, sexual activity with a child under the age of 13 years who became pregnant as a result. The CAS and RSR were also factually incorrect - missing the sexual offence, it was not until the new alleged offence of sexual activity with a girl aged 14 years became known did the offender manager look into exploring previous behaviour and found the previous incidents. There was no evidence of initial checks with the police or children's services".

2.12. Once risk of harm issues have been identified it is essential that an effective plan is devised to control and reduce those risks. The risk management plans were sufficient in just under half of the relevant cases. In just over one-third of instances they were insufficient and the remainder had no plan. While we saw some improvement in the quality of risk management plans from our previous inspection, CRCs need to prioritise improving the quality of risk management plans in order to effectively manage and reduce the risk of serious harm posed by the offenders they manage.

2.13. We judged there was an appropriate priority accorded to the safety of current and potential victims by CRC staff in 60% of relevant cases. In too many cases, offender managers had not recognised or planned effectively to manage the issues concerning current or potential victims.

2.14. A summary of our key findings for managing the offender can be found in figure 3.

Figure 3 - Managing the Offender - CRC cases



Delivering the sentence

2.15. Appointments offered to offenders to deliver the requirements of the sentence were appropriate in the large majority of cases inspected. The frequency of contact arranged with the offender was in line with the demands of the sentence plan in over three-quarters of cases, and the delivery of interventions addressed the identified risk of harm posed to others by the offender in the same proportion of cases.

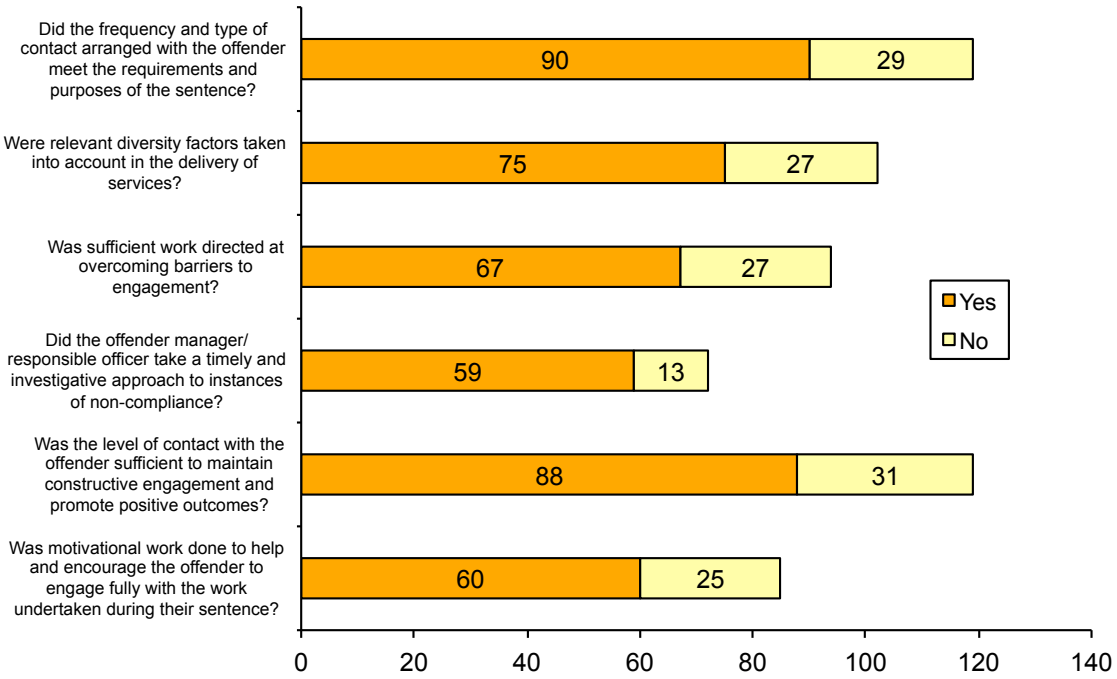
2.16. We were encouraged to see that the CRCs were achieving relatively good levels of contact, and that diversity issues and barriers to engagement were being addressed in a good proportion of cases. Specifically, diversity issues were recognised in the delivery of services in just under three-quarters of relevant cases. Sufficient work was directed to overcoming barriers to engagement in a similar proportion of cases. Motivational work to help and encourage the offender to engage fully with the work undertaken during the sentence was completed to a sufficient standard in nearly three-quarters of relevant cases.

2.17. The delivery of interventions was clearly recorded in most cases, allowing us to identify which interventions were being used to address offending behaviour. Interventions had been delivered promptly or there was a plan in place to deliver them in nearly three-quarters of cases. Though some interventions were behind schedule, a small number of cases had no specific intervention planned.

2.18. We were pleased to see that in almost all inspected cases, the offender manager monitored attendance across all aspects of the sentence. In the great majority of cases offender managers were quick to investigate non-compliance. In just under half of the cases there was unacceptable behaviour and in most of those cases offender managers issued a timely formal warning. Enforcement action was pursued against seven licence cases, of which five were recalled. Fifteen community cases subject to enforcement proceedings were enforced, leading to nine proven breaches. In most of the relevant cases, offender managers had made sufficient efforts to re-engage with offenders following enforcement and to encourage them to comply with the order, an improvement on the findings in our previous report.

2.19. A summary of our key findings in delivering the sentence can be found in figure 4.

Figure 4 - Delivering the Sentence - CRC cases



Reviewing the work with the offender

2.20. Given the four month scope of the inspection, we did see 43 cases where we judged there was a need to review the assessment of the likelihood of reoffending. In just under half of these we assessed the review to be of sufficient quality. Just under one-quarter were insufficient and 13 cases had no review, when there should have been one. Where we saw reviews, in most cases offender managers had responded promptly to significant change, taken into account changes to relevant factors and set appropriate future review dates. Reviews could be improved by ensuring all relevant information was sought from other workers involved with the offender's case.

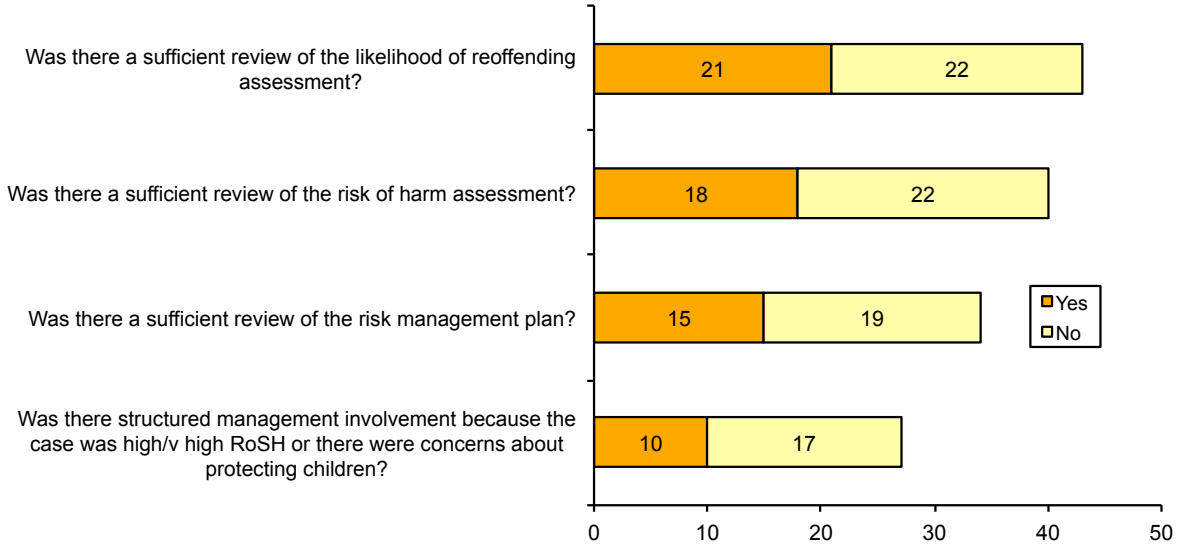
2.21. Reviews of the risk of serious harm assessment were insufficient in more than half of the relevant cases. Too often, offender managers had either failed to seek or to utilise relevant information from other sources or agencies. We saw 34 cases which, in our view, required a review of the risk management plan. Only 15 were reviewed to a sufficient standard. Nine reviews were insufficient, the major deficiencies being a lack of pertinent information, a failure to anticipate possible changes in risk of harm and inappropriate timescales for future reviews. In ten cases there had been no review.

2.22. We would expect to see management involvement if circumstances in a case indicated there were concerns over high risk of serious harm or issues concerning protecting children. Such oversight ensures that a level of experience and knowledge can be applied to ensure issues are identified, actions to address them are appropriate and that risk of harm is subsequently reduced. We were disappointed to find management involvement to be effective in just over one-third of such cases in this inspection.

2.23. We were able to assess if there had been a further conviction or other disposal for an offence committed since the start of the order or licence in 119 cases. In 15 cases there had been another conviction; in 4 cases another disposal. It was encouraging to see that in the large majority of cases there had been no further conviction or disposal.

2.24. A summary of our key findings for reviewing work with the offender can be found in figure 5.

Figure 5 - Reviewing the work with the offender - CRC cases



Recommendations

- Community Rehabilitation Companies should focus on improving the quality of likelihood of reoffending assessments. (2.8)
- Community Rehabilitation Companies should focus on improving the quality of full risk of harm assessments. (2.11)
- Community Rehabilitation Company staff should ensure that an assessment of any diversity issues or barriers to engagement is completed and a plan put in place to address the issues. (2.6)
- Community Rehabilitation Companies need to ensure they have effective management oversight structures in place for cases where there are concerns over the level of risk of serious harm. (2.22)

Early Work in the NPS

3

3. Early Work in the NPS

Introduction

Since 01 June 2014 the NPS has been tasked with the responsibility of managing certain groups of offenders; those who have committed a sexual or violent offence eligible for management under MAPPA, have been assessed as presenting a high risk of serious harm, with a score over 6.89% on the RSR tool, certain foreign nationals and public interest cases are managed by the NPS.

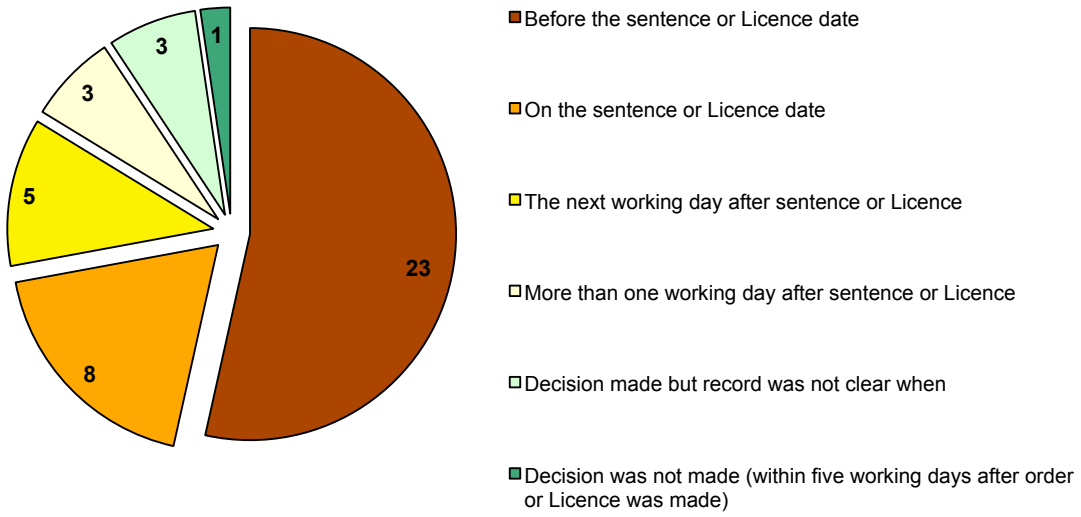
During this inspection we assessed 45 cases managed by the NPS. This included community orders and licence cases. We conducted six focus groups with NPS middle managers and interviewed some offenders supervised by the NPS.

Findings

Assignment, induction and first appointments

3.1. We were pleased to see that most cases had been assigned to an identified offender manager either before sentence or within one working day of sentence or release on licence. In three cases the assignment was more than one working day after sentence or release and in one case it had taken more than five days. In three cases the record was not clear. Please see figure 6.

Figure 6
When was the assignment to an identified offender manager made?
- NPS cases

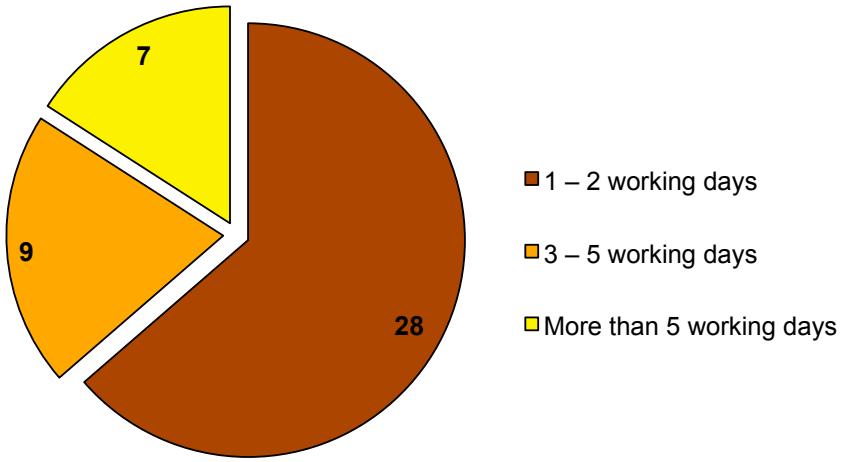


3.2. Three-quarters of offenders were given their first appointment date either before or on the day of sentence. In almost three-quarters of cases the first appointment was with the NPS assigned offender manager. We found that group induction was used in only one case. In three cases further induction was not required as those offenders were currently undergoing similar contact. The focus within the NPS Local Delivery Units we visited was primarily upon individual inductions with offender managers, rather than a move towards group inductions.

3.3. Swift and positive engagement with offenders post-sentence can greatly assist successful supervision. Offenders were seen by their assigned offender managers within one to two working days in almost two-thirds of relevant cases. Nine cases were seen in three to five working days, the remaining seven cases in over five days. There is evidence that offenders were offered timely

and individualised inductions in over three-quarters of the cases we inspected. The speed of engagement with offenders had improved since our last inspection. Please see figure 7.

Figure 7
Number of days between sentence or release and the first appointment with the offender manager - NPS cases



3.4. We examined whether diversity issues and barriers to engagement had been assessed and that clear actions were identified to address them. We found there was a sufficient assessment in well over three-quarters of relevant cases. Clear recording of action to overcome these issues, however, was not as evident, with less than two-thirds of case records containing plans on how barriers were to be overcome.

Managing the offender

3.5. We saw a sufficient assessment of the likelihood of reoffending posed by the offender at the start of sentence or release on licence in more than two-thirds of cases (70%); this was similar to our findings in our previous report. In three cases, the assessment had not been completed. In nearly one-quarter of cases the assessment was insufficient. The main deficiency, however, was timeliness; assessments were being done too slowly after sentence or release on licence. Considering the NPS is managing high risk of serious harm cases this is an area for improvement. Assessments inform plans, which produce actions. A delay in assessment may cause a delay in action in reducing reoffending.

3.6. We judged sentence plans to be of a sufficient standard in just over two-thirds of assessed cases. Plans were not completed in two cases. Where they were completed, appropriate objectives were set in over three-quarters of cases. In the large majority of these cases, staff had identified and built into the plan actions to promote community integration and improve social networks. Offenders had been signposted or referred to a service provider based on those plans in over three-quarters of relevant cases.

3.7. Building a relationship and the motivation to comply with the sentence plan is important in addressing reoffending. The more an offender feels they have an investment in the order, the more potential there is for successful outcomes. We looked at whether the offender had been actively involved in the sentence planning process and found this involvement sufficient in nearly three-quarters of relevant cases. Diversity had been addressed sufficiently in sentence planning in just less than three-quarters of relevant cases.

3.8. The NPS manages the high risk of serious harm cases, and in just under three-quarters of relevant cases, we saw a timely RoSH screening. In our judgement this screening was accurate in most cases. Nevertheless, one-quarter of high risk of serious harm cases had late screenings which, in our view, is an area that needs to be improved.

3.9. A full initial analysis of the risk of serious harm was completed on time in just over three-quarters of relevant cases, an improvement on our previous findings. Where it was done, we found the analysis to be sufficient in just over half of the cases. Five cases had no analysis completed where we judged they should have. Deficiencies were found in the following areas:

- the details of children with whom the offender had contact with were not included in 11 cases
- there was insufficient analysis of the risk of serious harm to children in 11 cases
- the assessments did not draw on all available sources of information in 11 cases
- assessments were not timely in 9 cases.

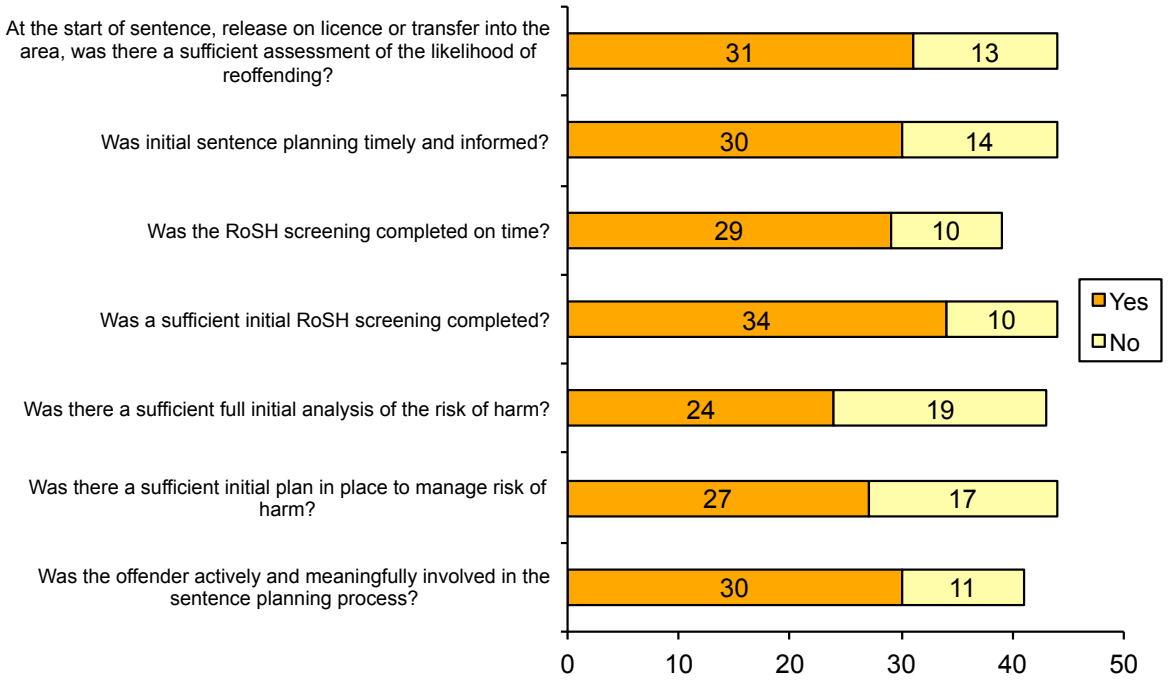
3.10. We saw that some LDUs we visited had experienced staff shortages. We had been told that it had not always been possible to complete assessments on time and that staff felt pressured by the workload. It is concerning, however, that deficiencies in the risk of harm assessments had not been identified and addressed by quality assurance systems and that so many had been signed off locally as sufficient when they failed to adequately analyse risk of harm to children. In one case an inspector noted:

> "There was no evidence of management oversight of the case. The offender did not disclose where he lived and had a history of domestic violence. He said that his partner had a child. No action had been taken to ensure this information was investigated further".

3.11. A good initial analysis of risk of serious harm should lead to a robust, clear risk management plan that controls or reduces the risk of serious harm posed by the offender. We found that the quality of risk management plans had not improved since our last inspection and was sufficient in under two-thirds of cases. There was no plan in 4 cases, and 13 were judged insufficient and did not address the risk of serious harm issues in the case.

3.12. A summary of our key findings for managing the offender can be found in figure 8.

Figure 8 - Managing the offender - NPS cases



Delivering the sentence

3.13. We looked to see whether the frequency and type of appointments arranged with offenders were adequate to support the delivery of the sentence or licence. We found what was offered appropriate in the great majority of cases. Actual contact with the offender was sufficient and in line with the plan proposed in most of the cases we inspected. We were pleased to see this level of appropriate contact with offenders.

3.14. Diversity factors were taken into account in over three-quarters of relevant cases. Sufficient work was directed at overcoming barriers to engagement in a similar proportion of those cases. Recording of the delivery of interventions was clear in most cases.

3.15. The NPS offender managers were very good at monitoring offender attendance across all parts of the order or licence. We saw offender manager oversight in all of the cases we inspected. There was also a timely and investigative response to non-compliance in almost all relevant cases. Where unacceptable behaviour was identified by the offender manager, we saw clear and timely formal warnings issued in the vast majority of cases.

3.16. Enforcement proceedings were pursued in ten licence cases; one case was returned to custody on a fixed term recall, the other nine on standard recalls. Three community cases were breached at court; two were proven, and one had not been concluded at the time of the inspection. In most cases, staff made a sufficient effort to re-engage the offender and encourage their commitment to the order or licence. We found that enforcement action was clearly recorded within appropriate timescales in almost all cases.

3.17. We were pleased to find that NPS staff maintained a high level of contact with offenders and that almost all relevant cases had evidence of constructive engagement. Offender managers, however, were not always able to maintain a focus on work to reduce reoffending as identified in the original plan. Perhaps as a result, we saw that specific interventions were delivered as planned in just over two-thirds of cases and delivered late in nearly one-fifth. Six cases had no specific interventions planned at all. We saw high levels of contact which were not always translated into effective time spent on interventions to reduce reoffending.

3.18. Offenders received sufficient assistance to improve or sustain social networks and sources of support within the family and community in the great majority of cases. Offender managers were good at providing assistance with accommodation and in addressing gang membership. There was less focus, however, in other areas of work particularly in addressing discriminatory attitudes among offenders. We found that appropriate motivational work to help encourage engagement was undertaken in almost three-quarters of relevant cases.

3.19. There was an effective use of restrictive requirements within the NPS. In almost all relevant cases the use of restrictive requirements such as electronic monitoring, restraining orders or additional orders, such as Sexual Offences Prevention Orders, was appropriate. Once in place, these requirements were monitored fully in community sentences and licences in most cases. Approved premises were used effectively in the vast majority of relevant cases.

3.20. We judged there was an appropriate priority accorded to the safety of current and potential victims by NPS staff in 84% of cases (32 out of 38). The concerns of the victim were taken into account by the offender manager in most of those cases and we could identify specific actions designed to address those concerns in the majority of applicable cases.

3.21. A key area of work for the NPS is in managing changes to the risk of serious harm posed by an offender and ensuring there is a quick and appropriate response to these changes. We were pleased to find there was an appropriate response to changes in the risk of serious harm in all relevant cases. The NPS could further improve practice by ensuring these changes are clearly recorded. In our view, in one-quarter of the cases changes were not clearly recorded on the case management system.

3.22. The use of home visits within the NPS to support assessment and case management was not as high as we judged it should be. A purposeful home visit was carried out, because of the high risk of serious harm associated with the case, in just over half of the cases where we felt it was necessary. This did not improve over the course of the order or licence. Just under half of cases that required a repeat home visit , due to risk of serious harm or Child Protection issues, had received one.

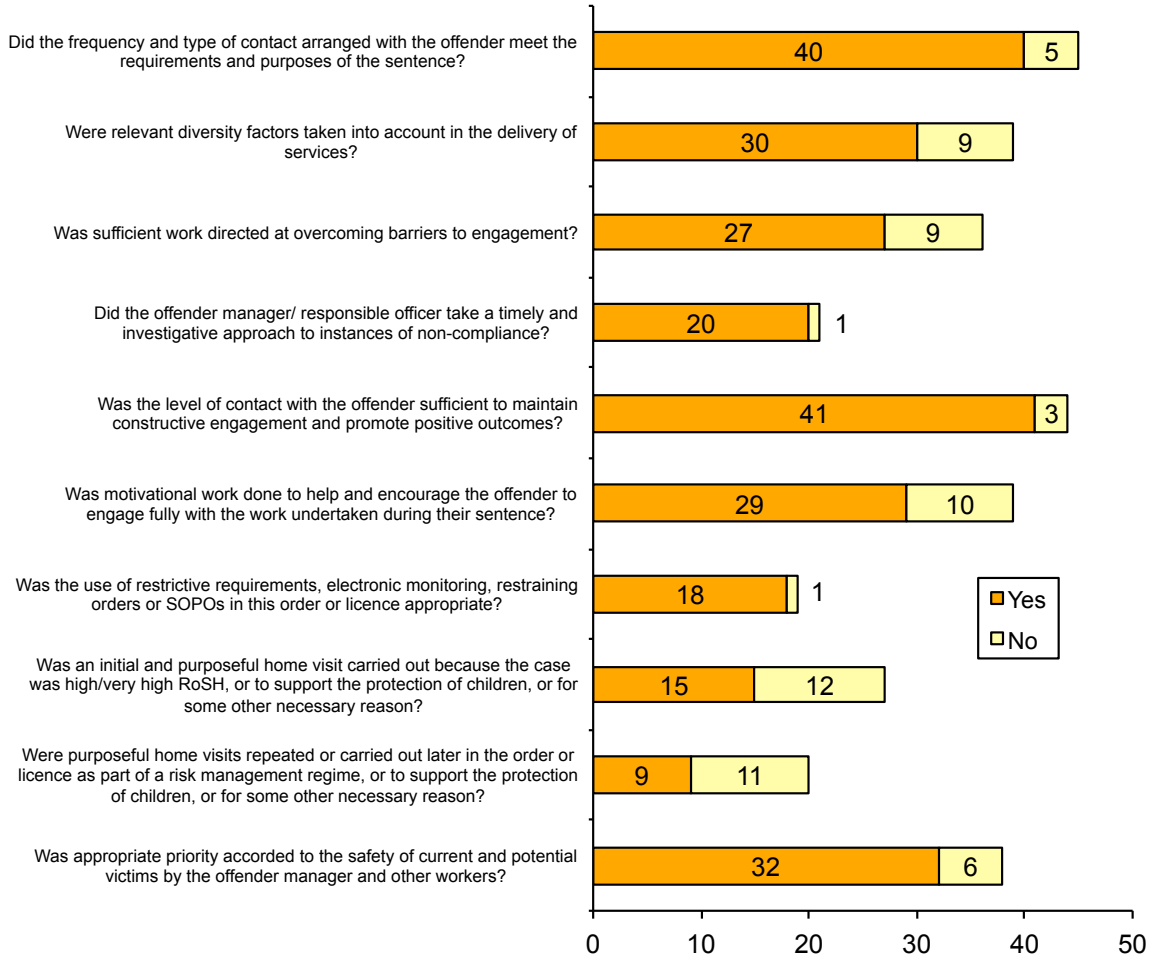
3.23. There were 32 MAPPA cases within the sample, 27 of these were managed at level 1 and 5 cases at level 2. We agreed that all cases were being managed at the correct level. We found that MAPPA procedures were operated effectively in all relevant cases. Actions were clearly recorded and followed through, reviewed appropriately and staff working with the offender contributed effectively to MAPPA. VISOR, however, was only used effectively where required in under half of the relevant cases.

3.24. The effective use of multi-agency Child Protection procedures is central to managing and reducing the risk of harm to a particularly vulnerable group within society. Multi-agency Child Protection procedures were used effectively in under two-thirds of relevant cases (9 out of 15). In cases where they were not, decisions taken within the multi-agency Child Protection procedures were:

- not clearly recorded in 5 cases
- not communicated, followed through or acted upon in 6 out of 14 relevant cases
- not reviewed appropriately in 6 out of 14 relevant cases
- not all staff working with the offender contributed effectively to the procedures in 7 cases.

3.25. A summary of our key findings in delivering the sentence can be found in figure 9.

Figure 9 - Delivering the sentence - NPS cases



Reviewing the work with the offender

3.26. In our view, reviews of the likelihood of reoffending assessments were required in 26 cases. The large majority had been completed to a sufficient standard. In three cases a review was not completed when it should have been. We made similar findings in respect of reviews of sentence plans.

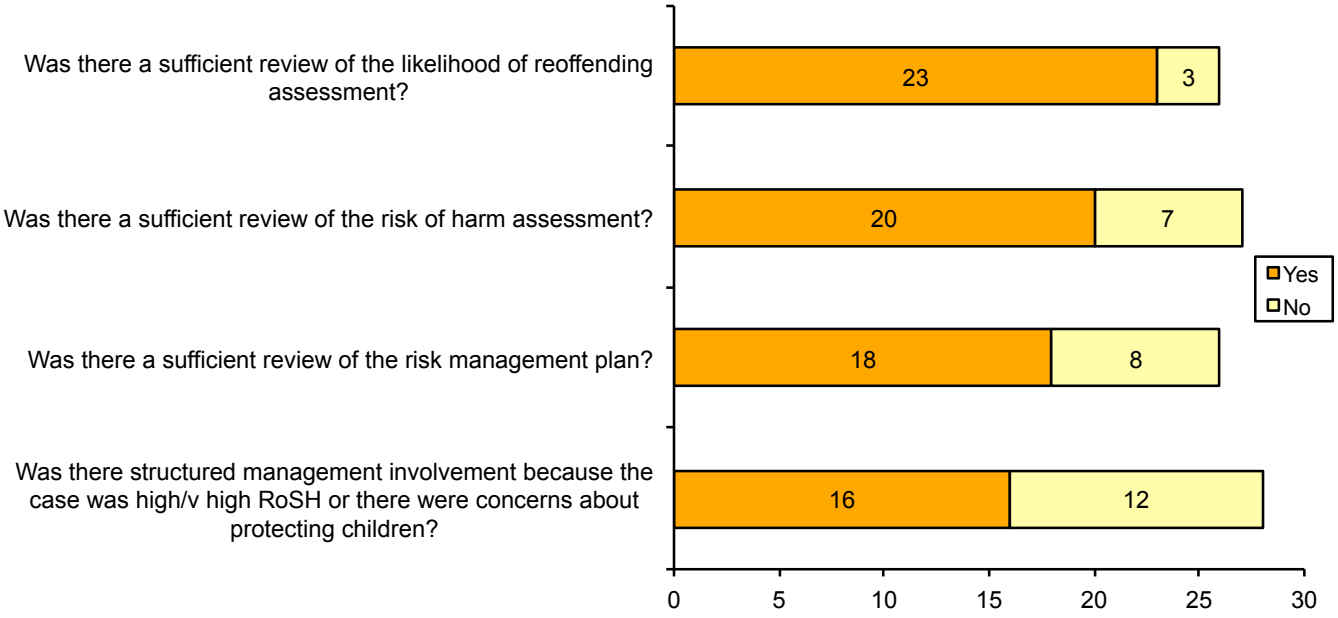
3.27. The review of the risk of serious harm assessment was sufficient in nearly three-quarters of cases. In three cases the review was insufficient. The remainder lacked analysis or had not drawn upon available information, for example from other agencies.

3.28. We also looked at reviews of risk management plans and found these sufficient in over two-thirds of relevant cases. The major deficiencies were in anticipating possible changes in risk of harm factors and developing robust contingency plans.

3.29. Management oversight has an important role in ensuring the risk assessment and management process is effective. In high risk of serious harm cases where there were concerns about protecting children, we found management oversight in only 16 out of 28 cases where we judged it necessary. We found that involvement to be effective in only six of those cases and consider this to be an area for improvement for the NPS.

3.30. A summary of our key findings in reviewing the work with the offender can be found in figure 10.

Figure 10 - Reviewing the work with the offender - NPS cases



Recommendations

- The National Probation Service should improve the quality of its full risk of harm assessments, particularly with reference to the analysis and management of risk of harm to children. (3.9, 3.24)
- The National Probation Service should ensure that a robust and timely risk management plan is in place for all high risk of serious harm cases. (3.11)

The breach and escalation of cases initially managed by the CRC

4

4. The breach and escalation of cases initially managed by the CRCs

Introduction

Community Rehabilitation Companies are expected to refer any case in need of enforcement action by the courts to the National Probation Service who will, if they are provided with the correct information and judge it to be appropriate, commence breach proceedings.

In addition, where a case is supervised by a CRC and the offender manager believes the risk of harm presented by the offender has increased to high, the case must be referred to the NPS using a process called 'risk review'. This process is undertaken by the supervising offender manager and reviewed by line management. There are four possible outcomes:

- if the NPS believe the threshold of high risk of harm has been crossed they must accept the transfer
- the NPS may decide that further information is required prior to a decision being made, and if so the CRC must gather this information
- the NPS may decide that the case has not reached the threshold for high risk of harm and therefore the CRC must retain management responsibility
- the NPS may defer the case for a further risk review at a specified time.

Findings for enforcement

Licences

4.1. Recall of a licence does not always indicate that the risk of serious harm posed by that offender has increased and the CRCs have discretion to recall licence cases without escalating them to the NPS. The case would remain with a CRC through any short term recall period until re-release on licence or the end of the sentence. CRC staff we talked to indicated that generally recalls were related to an increase in the likelihood of reoffending by prolific offenders managed within Integrated Offender Management teams.

4.2. There were seven CRC licence cases which required enforcement action and were not dealt with under the risk escalation procedure. Three resulted in standard recall and two in a fixed term recall. The recalls related to further prolific offending and in one case the offender left a drug rehabilitation unit. In another, the offender breached an exclusion zone several times. None of the circumstances, in our view, required the CRCs to escalate the cases to the NPS utilising the risk escalation procedures, and in all cases the action taken by the CRCs was appropriate.

4.3. In our earlier report we found a lack of clarity among CRC staff concerning when a case should be subject to a risk review and potential escalation to the NPS. In this inspection, staff had a greater understanding of the process for identifying which cases were eligible for the escalation process and which were not. A staff member in one location did comment that they had been advised to recall a case by the NPS instead of following the risk escalation procedure, but this did not appear to be a general issue. Overall, we felt that the appropriate cases were being recalled directly by the CRCs.

Community Sentences

4.4. We looked at the enforcement interface between the CRCs and the NPS. We found that out of the 119 relevant cases that had received a community sentence, 15 cases were referred to the NPS and returned to court in breach. Of those, nine had been proven, four were not concluded and two had been withdrawn.

4.5. Using the same inspection tool as in our earlier report we sought data on:

- the number of days taken from the alleged breach to a referral to the NPS
- the number of days that elapsed prior to the NPS applying for a court date
- the number of days to the first court hearing
- the number of days to the conclusion of the case, if one had been reached.

4.6. Previously, we had identified deficiencies in how the enforcement process had been recorded on nDelius. We found this was the case in this inspection as well and, therefore, it was difficult to extract the information we were seeking. Overall, we assessed that just under half of the relevant cases (7 out of 15) were managed appropriately through the enforcement process. In those cases which were not, we saw two cases that had not been passed to the NPS in time to meet the required timescales for breach. There were five cases where the recording of relevant information on nDelius was unclear and one case where nothing had been recorded.

4.7. Middle managers in several CRCs told us that they had experienced difficulties in progressing breaches. There was a perception in some LDUs that there was a high rejection level of breach packs that led, in some instances, to cases not ultimately progressing to breach. We also found, however, in other LDUs that processes were bedding in and that breach pack rejections were falling. Where the CRCs had established internal quality assurance processes to ensure high quality breach packs, such as in North Wales, the number of returns had fallen dramatically. Some CRC offender managers were critical of the high number of rejections for what they characterised as trivial spelling or grammatical errors. Also, there was a perception among staff from several different LDUs that their judgement concerning their assessments and proposals in breach reports was being questioned by those who did not have sufficient knowledge of the case.

4.8. Some NPS managers commented that they had also seen high rejection rates for breach packs. Also, some felt the quality of the CRC packs could be improved through training on what constituted evidence in a breach.

4.9. We saw some LDUs where NPS enforcement units were in place and dealt with all breach cases. In others there were more local arrangements; however, all the NPS Local Delivery Units we visited had specialist staff prosecuting cases. The effectiveness of the system in our view was highly dependant on the quality of the communication between CRC staff enforcing the case and NPS staff prosecuting it. In some instances the quality of the communication needed to improve.

4.10. In our earlier report, we found that the breach process was in most cases being efficiently managed by the CRCs and the NPS. In this inspection we found that performance had slipped overall, with some LDUs requiring significant improvement.

Findings for risk escalation

4.11. In addition to the main sample, we examined 51 risk review cases. Overall, we noted an improvement in practice in this area of work, since our last inspection. Staff and managers were more confident and there was a greater investment and understanding of the process. Recording of the process on nDelius, however, needed improvement. We found too many instances where risk review forms were not fully completed, had not been uploaded or the sequence and timing of events was unclear in the record.

4.12. We found there was some debate between CRC and NPS managers concerning situations where offenders were arrested or charged for serious further offending but were yet to be convicted. In some LDUs a number of cases had been escalated on this basis only for no convictions to result, leaving the NPS with a case not classified as high risk of serious harm. We saw some merit in a mechanism to allow cases to be de-escalated in those circumstances.

4.13. In almost all relevant cases the reasons for referral were clear and we supported the decision to initiate the escalation procedure. The guidance indicates that when considering a referral, an informal discussion with the NPS manager nominated as the single point of contact should be held.

We found this happened in nearly two-thirds of cases. We found that a formal risk referral document was completed in almost all relevant cases. We judged that risk referral to be of a reasonable standard and contained all the required information to enable a decision in just over three-quarters of the cases we inspected.

4.14. The first contact between the CRCs and the NPS occurred within 24 hours of referral in 33 out of 39 (85%) relevant cases. The NPS requested further information in six of those cases. The NPS accepted the risk review and escalation of the case in 79% of those referrals, 7 were declined and a small minority were identified for a further review at a future date.

4.15. Activity concerning the risk referral process was clearly recorded in the case management system in just over half of the cases inspected. Common issues we saw were:

- failure to sign referral forms by both the NPS and the CRCs
- not all discussions concerning the risk review were recorded on nDelius
- risk review documentation was not fully completed
- documentation was not uploaded to nDelius on time.

4.16. We were made aware of problems experienced in some Local Delivery Units we visited in uploading the risk review forms to nDelius. We saw an improvement in the quality and frequency of the risk review forms on nDelius as time moved on. One inspector commented:

> "While the quality of the assessment in the risk review documentation was completed to a good standard, it was not signed off by the CRC manager and, therefore, incomplete. The process was completed within the timescale, but not all relevant discussions were recorded on nDelius".

4.17. There were a number of approaches to managing the risk review process. Some NPS divisions had established specialist management teams to assess referrals. Other LDUs had local office based procedures in place, or nominated officers covering geographical areas. In some LDUs staff felt the process was clear and effective, others characterised the process as deskilling, cumbersome and confusing. We found that effectiveness was not dependent on the type of system; we saw examples of similar systems working well in some LDUs and poorly in others. Where the process was effective, we saw evidence of an open and constructive dialogue between staff and managers involved.

4.18. In one area, we were told that successful escalation rates were as low as one-quarter of the cases referred and we saw some evidence to support this. Staff informed us they often did not complete risk review documentation as it felt like cases were rarely accepted; this is a worrying situation. The risk review process is in place to ensure that where there are concerns that the risk of serious harm is escalating, the case can be reallocated to the NPS who have the resources to manage the risk of serious harm. We disagreed with the NPS decision to accept or decline the risk review referral in 5 of the 43 relevant cases (12%). Where we did disagree we felt the NPS decision was defensible in two of those cases. It is our view that we saw general improvement concerning the issues identified in our previous report in five of our inspection visits, but not in all six.

4.19. In the majority of the LDUs we inspected, however, we found an improvement on the situation we found in our earlier inspection. Over time, greater experience with the risk review process had led to staff and managers becoming more comfortable with the process and an improvement in the quality of the review.

Recommendations

- Community Rehabilitation Companies should improve the quality of their recording of information concerning the risk review escalation procedure and breach process. (4.6, 4.15, 4.16)

The views of offenders

5

5. The views of offenders

Introduction

We offered offenders in our sample, the opportunity to participate in an interview with the inspectors. We interviewed a total of 36 offenders using a semi-structured interview tool. In each area we managed to speak to some offenders from both the NPS and CRC. Overall, 10 individuals were managed by the NPS and 26 by the CRC; some had been subject to escalation due to increasing risk and had, therefore, been supervised by both organisations. Two-thirds of the offenders were subject to a community sentence, the rest were on a licence.

Findings

Court reports

5.1. Almost all offenders interviewed had a report prepared prior to sentence, though most could not remember what type of report had been prepared. Their recollection of the accuracy and fairness of the report was generally positive. A minority of individuals felt their report was unfair or inaccurate. We found that offenders felt the area where reports could be most improved was in taking into account individual circumstances such as health or childcare, barriers which might impede engagement. Offenders commented:

> "The report writer took a lot of time with me as I get anxious and overwhelmed, he explained the process, what would be in the report and his recommendation. He put me at ease."

> "It was a not fair report, in the sense that there were alleged facts that were not facts but which emerged at trial. The report was mentioning issues that were not used by the prosecution. I did raise the point pre-sentence but cannot remember the response."

Induction

5.2. Starting the order or licence positively can have a great impact on future outcomes. We asked offenders about their experience of this. Most said they were told where to report following sentence and to either a CRC or the NPS. Appointments were given by court officers following sentence or in some cases the offenders were already subject to supervision and had further appointments.

5.3. All but one of the offenders we interviewed said they had been through a formal induction where the rules, expectations and consequences for non-attendance were explained clearly. Overall, just over three-quarters of the offenders told us they had been inducted by their offender managers. Within the NPS this rose to 89% and in the CRCs fell to 70%, with more offenders in the CRCs experiencing group induction. Offenders were almost universally positive about their induction experiences; they did not distinguish between the value of an individualised or group induction. The issue was whether the method used gave them a clear understanding of what was expected of them. The only negative response was directed at the lack of clarity given in an individual induction.

> "My induction was with my OM [offender manager], she was very straight with me and clear on the rules, I never missed an appointment."

> "It was not all that clear, I was led to believe I was not allowed to leave the UK, but that was not correct. It was important as I could have breached it unknowingly."
>
> "I was given the information I needed and knew what was going to happen."

Compliance and enforcement

5.4. We asked offenders about how well they had complied with their order or licence. Just over two-thirds said that they had attended all appointments. We saw evidence from the interviews of staff identifying and addressing barriers to engagement. Offenders had clearly understood the need to evidence why they were not attending and in several cases had supplied evidence in the form of medical certificates and employment. Some offenders commented that:

> "Probation has been very understanding when I was unable to make appointments due to health or childcare issues".
>
> "I attended all appointments apart from ones I asked to be rearranged due to work".

5.5. Of those who admitted they had not attended as required, one-quarter had either received a warning or been returned to court. None of these offenders had a negative comment to make about their warning or breach, and seemed to accept the situation. Only two offenders informed us they had been arrested, cautioned or charged for further offending since the current order or licence had started.

Engagement

5.6. We asked offenders about how often they were seeing their offender managers. In this sample just over half of the offenders were seeing their offender manager once a week. Two were being seen more than once a week, and almost two-fifths either fortnightly or monthly. In the NPS, 60% of cases were being seen weekly, 20% fortnightly and 10% monthly. One case had terminated. Within the CRCs 54% of cases were being seen weekly, 23% fortnightly and 15% monthly. One offender was not sure of the reasons for the frequency of their reporting arrangements with their offender manager, stating:

> "[My appointments] used to be weekly - at Christmas had some telephone contacts. Saw her [offender manager] in January. Now seems to be every month or a phone call. I'm due to get a telephone call on 26 March and then will see her at the end of April. I didn't get it explained - am happy that is the arrangement. Waiting to get onto a programme - can't remember the name of it. No idea when this will start".

5.7. Another was not seeing their offender manager, but another worker:

> "I see the Women's Safety Worker [WSW] once every three or four weeks. We talk about any problems I had and the progress I have made. The WSW mentioned the offence in the last meeting last week - I explained why I did it."

5.8. We found little dissatisfaction among offenders with the services or nature of the contact with their offender managers. Over half of the offenders interviewed felt they did not have anything going on in their life that was a significant barrier to achieving what they wanted to with regard to reducing

further offending. Almost all felt that their offender managers were helping them as much as possible. Some comments were:

> "My mental health issues prevent me from making progress. I suffer from anxiety, personality disorder and PTSD [Post Traumatic Stress Disorder]. Yes she encouraged me to attend the personality disorder clinic which I would not have done for anybody else. She is an awesome probation officer who had a real calming effect on me, a really positive influence".

> "OM [offender manager] is great. Explains things - I can't blame everybody else. I need to grow up".

5.9. The only negative comments related to accommodation issues that may have been beyond the control of offender managers to solve. One offender commented to their offender manager:

> "If you've got the power to send me to prison you should also have the power to help me find a house".

Offence focused work

5.10. We were encouraged to find that all but two offenders interviewed had discussed their current offence with their offender managers. Feedback indicated offence focused work had been addressed early on in the order or licence, and in many cases the offender managers successfully maintained the focus throughout the order or licence. Some positive comments were:

> "We have discussed my offending and the impact the offence has had on the people in my life".

> "We talk about everything, how the week has been, and any topic at all. Yes we talk about my crime; she tells me what I can do and what not to do. Chats are useful. It's someone I can talk to, one-to-one, it helps".

> "We've recently being doing the impact on victims. How it upsets the general public and people around me. I take notes and this helps me control my alcohol usage. It has helped me not to smoke cannabis. I've reduced my consumption of alcohol and cannabis since working with my OM [offender manager]".

5.11. Even in those two cases where the offenders felt there was not a direct discussion of the current offence, it was evident from their comments that offender managers had identified either a means to address relevant issues, or priority areas of work to reduce the risk of reoffending. One refused to discuss his offence stating:

> "I refuse to talk about my specific crime as I get anxious and overwhelmed due to my mental health issues. I am happy to talk scenarios with my officer".

The other stated:

> "The focus is accommodation and drugs".

5.12. The above findings are similar to what we found in our earlier inspection. The vast majority of offenders are satisfied with the services and support they received from both the NPS and the CRCs at all stages of the assessment and supervision process. Court reports were seen as mostly accurate and fair, induction was informative and clear on expectations. Offenders felt their offender managers were, in most cases, helping them as much as they could to make progress. Where there

was enforcement action, offenders were not negative about the reasons or the process. As noted in our previous report, there have been major changes to the provision of services to offenders through the introduction of new providers and processes. From the offender's point of view these changes do not appear to have had a negative impact.

Appendices

Appendix I Acknowledgements

We would like to thank all the staff from the NPS and the CRCs we inspected for their assistance in ensuring the smooth running of the inspection.

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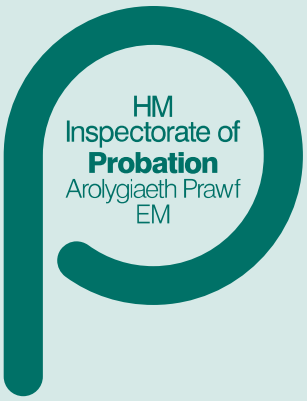
Appendix II
Glossary

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.
Allocation	The process by which a decision is made about whether an offender will be supervised by the NPS or a CRC.
Assignment	The process by which an offender is linked to a single offender manager who will arrange and coordinate all the interventions to be delivered during their sentence.
CAS	Case Allocation System – a document which needs to be completed prior to the allocation of a case to a CRC or the NPS.
CRC	Community Rehabilitation Company: 21 such companies were set up in June 2014, to manage most offenders who present a low or medium risk of serious harm.
Child Protection	Work to ensure that that all reasonable action has been taken to keep to a minimum the risk of a child coming to harm.
HMI Probation	HM Inspectorate of Probation.
Interventions; constructive and restrictive interventions	Work with an individual that is designed to change their offending behaviour and/or to support public protection. 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 serious 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 serious 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: multi-agency arrangements to work with those offenders thought to be most likely to reoffend; generally the arrangements include staff working for police, probation, drug treatment services and others.
LDU	Local Delivery Unit: an operation unit comprising of an office or offices, generally coterminous with police basic command units and local authority structures.
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 serious harm to others.
NPS	National Probation Service: a single national service which came into being in June 2014. Its role is to deliver services to courts and the parole board; and to manage specific groups of offenders: • Those presenting a high or very high risk of serious harm. • Those managed under MAPPA arrangements. • Those with an RSR score over 6.89%. • Those eligible for deportation. • Those subject to deferred sentence. • Those where there is a 'public interest' in the case.

nDelius	National Delius: the national probation case management system which was rolled out through 2013 and early 2014.
NOMS	National Offender Management Service: The single agency responsible for both prisons and probation services.
OASys	Offender Assessment System: The nationally designed and prescribed framework for both Probation and Prisons to assess offenders, implemented in stages from April 2003.
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 serious 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'.
Probation Trust	Until May 2014, probation services were delivered by Probation Trusts, working under the auspices of NOMS.
PSR	Pre-sentence report. This refers to any report prepared for a court, whether delivered orally or in a written format.
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.
RSR	Risk of Serious Recidivism: An actuarial calculation of the likelihood of the offender being convicted of a serious sexual or violent offence; this calculation was introduced in June 2014 as a required process in the implementation of Transforming Rehabilitation.
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.
ViSOR	ViSOR is a national confidential database that supports MAPPA. It facilitates the effective sharing of information and intelligence on violent and sexual offenders between the three MAPPA Responsible Authority agencies (police, probation and prisons). ViSOR is no longer an acronym but is the formal name of the database.



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