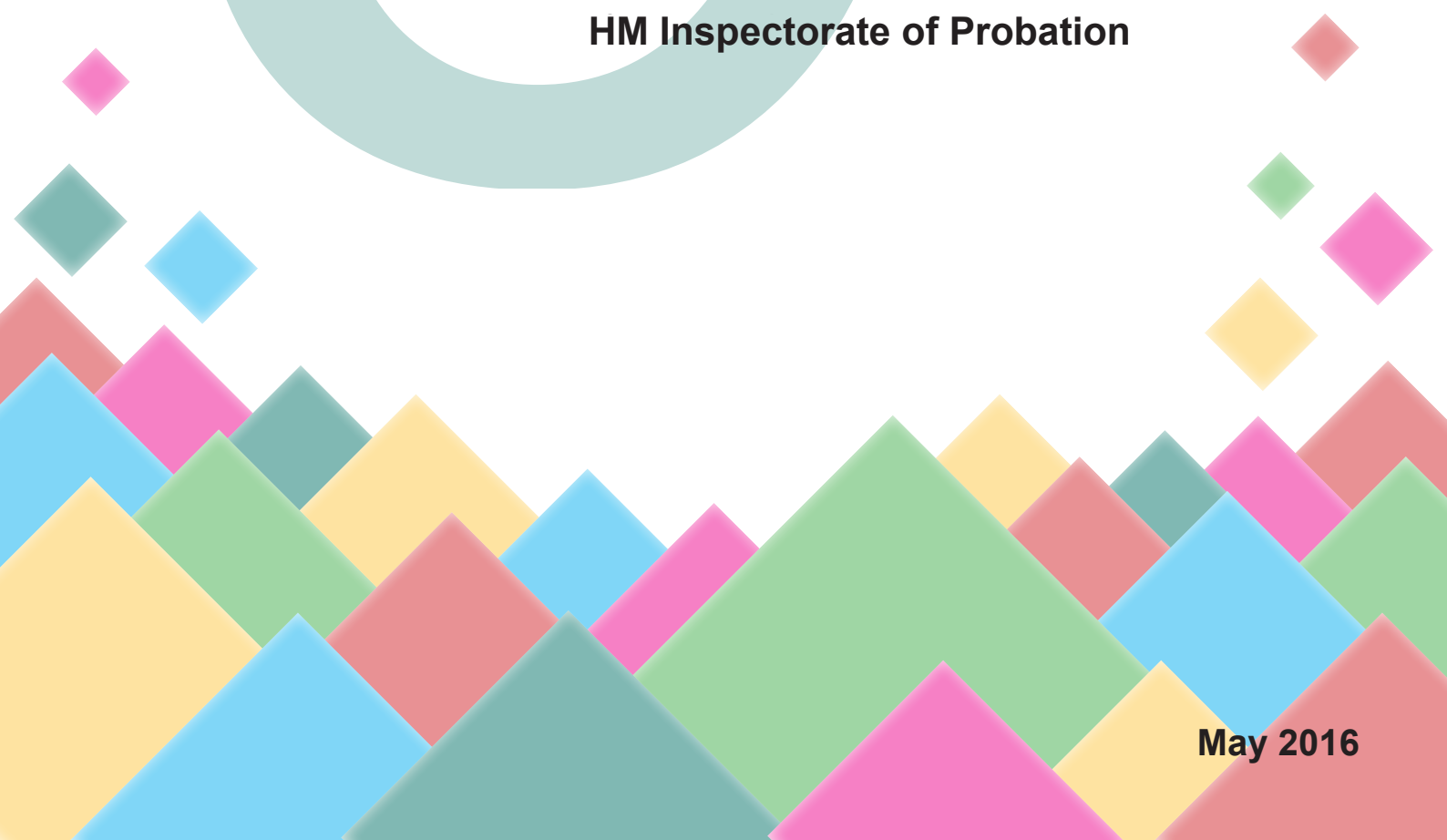


*Transforming Rehabilitation*  
**Early Implementation 5**

‘An independent inspection of the arrangements  
for offender supervision’

**HM Inspectorate of Probation**



**May 2016**

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# Foreword

This is the final report in a series looking at the implementation of the *Transforming Rehabilitation* programme. We report on the position as it is now, some 15 months after the transfer (from the state) of the ownership of Community Rehabilitation Companies.

The National Probation Service and Community Rehabilitation Companies are now working and communicating better together than they were in the months following implementation. We are happy to acknowledge improvements made to date and pleased also to recognise the good work undertaken in parts of the National Probation Service and in some of the Community Rehabilitation Companies. Some court work and staff training and morale remain sticking points, however, and we found as well that not enough is being done for people in prison as they prepare for release.

The new arrangements put an increased emphasis and dependency on the quality of court reporting, but it is still proving problematic, in part due to the demands of speedy justice. Oral reports are increasingly common, but a good system record and domestic abuse and child safeguarding checks are needed in all cases, so as to inform sentencing and enable Community Rehabilitation Companies to focus promptly and knowledgeably on the work needed to reduce reoffending. In addition, court staff need to be sufficiently aware of what Community Rehabilitation Companies can offer so as to advise the court appropriately in relation to rehabilitation activity requirements, a common feature of community sentences.

The poor or patchy morale we reported on previously is still evident, mainly in some of the Community Rehabilitation Companies. Some staff expressed concern about their competence to undertake their roles, and training had not always been delivered in a timely way to equip them with the skills required to enable them to undertake new or changed roles.

With the aim of reducing reoffending, *Transforming Rehabilitation* introduced supervision to all prisoners released into the community. We were particularly disappointed to note that in a substantial proportion of cases, not enough had been done before release to help the individuals with their accommodation, employment or finances.

Community Rehabilitation Company leaders have been understandably focused on implementing substantial change. For some this has been at a cost to quality assurance and effective management oversight of the day-to-day. With the new arrangements increasingly embedded, we hope to see increased emphasis on the quality of work over the course of the year.

By the time of publication of this report, our new adult inspection programme and methodology will have commenced. We will be reporting on the quality of probation work, and whether or not it is reducing reoffending, protecting the public and ensuring individuals abide by their sentence. In addition, we will take into account the findings from this and our earlier focus on *Transforming Rehabilitation* as we determine topics for thematic inspections this year.

Finally, we hope that the detail we provide in this report will assist the National Probation Service and Community Rehabilitation Companies as they review and develop their working practices.



**Dame Glenys Stacey**  
**HM Chief Inspector of Probation**

May 2016

# Executive summary

## Assisting sentencing and allocation of cases

Court staff from the National Probation Service prepare court reports to assist sentencing and then determine, on the basis of specified criteria, whether the case is to be allocated to the National Probation Service or to the Community Rehabilitation Company. Good court work is essential to assist sentencing, to allocate the offender to the right organisation and for effective work to start promptly.

We found that reports varied in quality, with written reports generally much better than reports presented orally. Unsurprisingly, assessments were generally better for cases allocated to the National Probation Service than to the Community Rehabilitation Companies; these are the higher risk and Multi-Agency Public Protection Arrangement cases and were more likely to have been adjourned for a written report, allowing the author more time to gather information. In some cases the risk of serious harm presented by the offender was not fully assessed, sometimes because checks had not been made to find out whether there were concerns about child safeguarding or domestic abuse, or the results of such checks had not been received. Where information was missing at the point of sentence, this should have been recorded on the allocation documentation, but was often missing or not always read by the responsible officer to whom the case was subsequently assigned. In addition, in some cases there was no written record of the oral report which had been presented to the court.

Some court staff had not received sufficient training, and lacked confidence in completing the necessary assessments. Some report writers did not know enough about the work offered by the local Community Rehabilitation Company, which made it difficult for them to propose interventions most likely to address the offender's problems. Sometimes they proposed a rehabilitation activity requirement 'to address offending behaviour', rather than a more targeted proposal which would help the responsible officer assigned to the case quickly to plan the appropriate work.

Inadequate assessment or recording at the court stage may result in the offender being allocated to the wrong organisation, or supervision proceeding on the basis of incomplete or inaccurate information. The National Offender Management Service had recently issued a new Probation Instruction to improve the quality of reports and information exchange.

## Early Work in the Community Rehabilitation Companies

Work should start promptly after sentence or release on licence so that individuals can be actively engaged in addressing their offending behaviour and other related needs. We found that offenders were generally allocated quickly to a responsible officer, but some did not meet them for over ten days. Arrangements were more efficient in one area where there was particularly good liaison between the court team and the office based case administrators.

In most cases appropriate sentence plans had been put in place to address an individual's offending related problems. They had not, however, always been involved in any meaningful way, reportedly because of the pressure to meet performance targets for completion. Most plans recorded how often there would be contact with the individual, but in over half it was not clear how the rehabilitation activity requirement days would be filled, a consequence of the lack of clarity in why this requirement was proposed to the court.

It was disappointing to find that over two-thirds of offenders released from prison had not received enough help pre-release in relation to accommodation, employment or finances; in one-third the necessary work had not started within four weeks of sentence or release. Notwithstanding the slow start to supervision, we saw many cases where responsible officers were working imaginatively with individuals to help them change their behaviour. Two-fifths had made progress on problem areas, although, with the exception of one area, where performance was much better less than one-third had improved their accommodation or their education, training and employment prospects.

The individual's attendance at appointments was usually monitored well, and formal warnings generally given where there were absences or unacceptable behaviour. We were told that responsible officers were discouraged from enforcing an order through the court because of financial penalties applied to the organisation; the positive consequence of this was that they worked hard to secure the individual's compliance.

The Community Rehabilitation Companies and the National Probation Service have to work closely together when it is necessary to return an offender to court because they are in breach of their sentence, or when the individual's risk of harm appears to be increasing and it is decided to transfer their supervision to the National Probation Service. In the early days of *Transforming Rehabilitation*, these 'interface' areas caused some concern, but on the whole the arrangements appeared to have improved.

Community Rehabilitation Companies are not responsible for managing offenders assessed as presenting a high risk of harm to other people, which means that the accuracy of risk analysis at the start of sentence is critical. We were impressed by Community Rehabilitation Company managers who told us that where a full analysis had not been undertaken by the National Probation Service, they expected their own staff to complete it. A number of Community Rehabilitation Company cases do, however, present a *medium* risk of harm, often because of domestic abuse or child safeguarding issues. In such cases we would expect to see a plan outlining how the risk will be managed, but these had not always been completed well enough. In some areas, a shortage of probation officers meant that probation service officers and agency staff were allocated medium risk of harm cases for which they felt insufficiently trained. Some senior probation officers were able to provide good quality, regular supervision, but others were stretched, covering several offices, and the quality of supervision they were able to provide was not good enough.

### **Early Work in the National Probation Service**

Most offenders allocated to the National Probation Service saw their responsible officer soon after sentence or release, although a few waited over ten days for their first appointment, which was too long. Most received an induction to make sure that they understood what was required of them. Overall, more people subject to supervision were involved in planning the work that would be done with them during their sentence than in our previous inspections, but this disguised marked differences between areas.

As in the Community Rehabilitation Company cases, resettlement needs had not always been addressed before release from prison, and constructive work did not always start promptly after sentence or release, although again some areas did better than others. In many cases we saw good, focused work to reduce reoffending and the risk of harm to others. Some individuals had, however, missed a number of appointments, some of which were recorded as acceptable without a rationale for this judgement. In three-fifths of National Probation Service cases, progress had been made on problems linked with offending, a better outcome than in the Community Rehabilitation Companies, particularly in relation to improvements in accommodation. In common with Community Rehabilitation Company cases, improvements in education, training and employment prospects were more disappointing.

Given the nature of National Probation Service cases, we would expect to see risk of harm to others assessed and managed well in all cases. Where a full risk analysis was completed, a quarter were not good enough, often because they had not been updated and did not draw on all available sources of information. Furthermore, one-third of risk management plans were not sufficiently thorough. Despite these deficits, we saw good work with many high risk offenders, with examples of effective joint work with specialist workers, good use of Multi-Agency Public Protection Arrangements and an active contribution to multi-agency Child Protection procedures. Approved premises were used well to provide appropriate restrictions and manage the risk of harm to others. We were pleased to note that the use of purposeful home visits had improved since our previous inspections. In summary, while some aspects of work in the National Probation Service still needed to improve, in a number of important areas, work in the National Probation Service was better than in the Community Rehabilitation Companies.

As in the Community Rehabilitation Companies, some middle managers felt stretched and were now covering teams across a large area, with reduced administrative support. They reported that they felt the pressure to meet performance targets at the expense of quality. While probation officers felt competent to manage their cases, some probation service officers were less confident having not yet received relevant training, for example in managing people who had committed sexual offences. Some felt very well supported by middle and senior managers, but others reported that they received little supervision.

## **Summary**

This is the fifth and final report in our series of inspections on *Transforming Rehabilitation*. In previous reports we have made a number of recommendations to the National Offender Management Service, the National Probation Service and the Community Rehabilitation Companies. Some progress has been made on a number of these recommendations but, given the scale of changes, it is perhaps not surprising to note that more progress is still required. We have not made any new recommendations at this stage but will be following up our findings during the course of our Quality & Impact inspection programme.

# 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 serious 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. At the time of this report being published, the new organisations will have been in place for almost two years. We think that is sufficient time for the arrangements to have bedded in. The table below shows the main responsibilities and interface between the two agencies.

| COURTS, REPORTS AND ALLOCATION  | INTERFACE   | DELIVERY  |   |  |  |
|---|---|---|---|--|--|
| <b>National Probation Service</b>   | <b>Community Rehabilitation Companies and National Probation Service</b>  | <b>National Probation Service</b>   |   |  |  |
| Prepare reports for court<br>Decide on case allocation  | Communicate and promote sentencing options<br>Commence orders promptly<br>Exchange information<br>Swift enforcement<br>Risk escalation promotes effective risk management | <table border="1"> <tr> <td data-bbox="1029 819 1497 1122">           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 data-bbox="1029 1122 1497 1308"> <table border="1"> <tr> <td data-bbox="1029 1122 1497 1308"> <b>Community Rehabilitation Company</b><br/>           Manages cases presenting low and medium risk of serious harm. Delivers interventions on low medium and some high risk cases         </td> </tr> </table> </td> </tr> </table> | 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. | <table border="1"> <tr> <td data-bbox="1029 1122 1497 1308"> <b>Community Rehabilitation Company</b><br/>           Manages cases presenting low and medium risk of serious harm. Delivers interventions on low medium and some high risk cases         </td> </tr> </table> | <b>Community Rehabilitation Company</b><br>Manages cases presenting low and medium risk of serious harm. Delivers interventions on low medium and some high risk cases |
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| <table border="1"> <tr> <td data-bbox="1029 1122 1497 1308"> <b>Community Rehabilitation Company</b><br/>           Manages cases presenting low and medium risk of serious harm. Delivers interventions on low medium and some high risk cases         </td> </tr> </table>    | <b>Community Rehabilitation Company</b><br>Manages cases presenting low and medium risk of serious harm. Delivers interventions on low medium and some high risk cases    |   |   |  |  |
| <b>Community Rehabilitation Company</b><br>Manages cases presenting low and medium risk of serious harm. Delivers interventions on low medium and some high risk cases  |   |   |   |  |  |

All court work is delivered by the National Probation Service. Where a full analysis of the offender’s risk of serious harm to others is required, the requirement is for this to 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 responsible officers who have no previous knowledge of the offender. Good communication between the National Probation Service and the Community Rehabilitation Company is crucial in ensuring the smooth allocation of cases, full transfer of information, and to make sure that proper breach and escalation procedures are followed.



# Inspection of *Transforming Rehabilitation*

This inspection is a continuation of HMI Probation's work to understand and report on the *Transforming Rehabilitation* landscape.

The scope of each of our *Transforming Rehabilitation* inspections is similar, but the detailed focus has varied to enable us to explore specific areas of practice as the *Transforming Rehabilitation* programme has progressed. Each of the five inspections has visited a different set of local delivery units. Importantly, by the time we completed the last of the inspections in this batch of six in February 2016 we had visited local delivery units within each of the 21 Community Rehabilitation Companies and each of the National Probation Service English divisions as well as Wales.

It is not possible to compare directly the findings from the different batches because we have inspected at different times during the *Transforming Rehabilitation* implementation. When we started, *Transforming Rehabilitation* had just commenced; when we inspected during *Transforming Rehabilitation* inspection 3, it was in the immediate aftermath of share sale. For later inspections, the working models of the Community Rehabilitation Companies owning companies were being developed and rolled out. In many instances, the final models and associated resourcing have not been finalised.

In this report, we comment where we have seen indications of progress made on the areas for improvement we have identified in our previous *Transforming Rehabilitation* inspections. We also comment when we have not seen progress, even though we expected to have seen it.

The previous *Transforming Rehabilitation* report (TR4) reviewed progress against recommendations made in the earlier reports. We have not tried to do that in the same systematic way here, as TR4 was published as recently as February 2016, the same month as this batch of six inspections concluded. Organisations to which recommendations from that report were directed would not have had sufficient time to address them.

We have made no new recommendations in this report. We expect the National Offender Management Service, the National Probation Service and Community Rehabilitation Companies to continue to address those from our previous reports, and we note that the NPS E3 (Effectiveness, Efficiency, Excellence) programme will address some of them.

Our previous three reports and their recommendations can be accessed through the following links:

<http://www.justiceinspectorates.gov.uk/hmiprobation/inspections/tr4/>

<http://www.justiceinspectorates.gov.uk/hmiprobation/inspections/tr3/>

<http://www.justiceinspectorates.gov.uk/hmiprobation/inspections/transformingrehabilitation2/>

We provide details of the inspection methodology in Appendix 2.

# Assisting sentencing and allocation of cases

1



# 1. Assisting sentencing and allocation of cases

## Summary

- Written reports were generally good, but many oral reports provided insufficient information to aid the courts with sentencing.
- Some court staff lacked knowledge about the Risk of Serious Recidivism score (RSR) and how to calculate this accurately.
- Too many Case Allocation System (CAS) forms included 'not known' answers.
- In a greater number of cases, domestic abuse and child safeguarding checks were required to inform risk of harm assessments.
- A Risk of Serious Harm (RoSH) screening, and analysis when required, were often not provided to the Community Rehabilitation Company (CRC) at allocation stage.
- Allocation of cases to the National Probation Service (NPS) and CRCs was timely and accurate.

## Findings

### Pre-sentence work

- 1.1. We found clear proposals for a community sentence or suspended sentence order in most reports (91%); in nearly every instance, the court made a community sentence or suspended sentence order.
- 1.2. We found no written record of just under one-third of the oral reports presented in court. That was similar to the findings from *Transforming Rehabilitation* inspection 4.
- 1.3. Most reports were of the appropriate type (90%), with no significant disparity between those that led to supervision by the CRC and those subsequently managed by the NPS. The percentage of oral reports (29%) was lower in this batch of inspections compared with *Transforming Rehabilitation* inspection 4 (38%). Oral reports were prepared, as expected, for cases that were almost exclusively then allocated to the CRC. They were of variable quality.
- 1.4. In one local delivery unit (LDU), probation service officer (PSO) court staff were insufficiently trained and ineffective in the court setting. In particular, they lacked confidence and knowledge in assessing risk of harm. Across the six inspections, we read a number of oral reports that we thought were of little value to the court, and provided an insufficient assessment of the individual and their offence.
- 1.5. A recently produced Probation Instruction (*PI 04/2016*) has clarified the requirements of report writers who produce on the day oral reports, including the need for them to analyse the offence and the individual's pattern of offending, their risk of harm and likelihood of reoffending. It also makes it clear that where the result of checks with social services and the police have not been received, it should be reported to the court so that the allocated responsible officer can follow up on those enquiries. All oral reports should be recorded in writing post-sentence (if not written beforehand) and uploaded to the case management system. Inadequate assessment at the court stage may result in the offender being allocated to the wrong organisation, or supervision proceeding on the basis of incomplete or inaccurate information. This risk should be reduced by the requirements outlined in the Probation Instruction.
- 1.6. Written reports, either standard or fast delivery were generally of sufficient quality. We read an excellent court report with a powerful analysis, based on the individual's offending history and lack of compliance with previous orders, which concluded that immediate custody should be considered. A suspended sentence order was imposed that was subsequently breached through the individual committing a new serious offence shortly after sentence. In a different LDU, a report produced on a

young person with severe learning difficulties and a prolific offending history was based on a layer 1 OASys rather than the layer 3 OASys that was required for the needs of the case.

- 1.7. Some areas were routinely making checks with social services and police domestic abuse units at the report stage, and promptly chasing up replies when not provided. In some other areas, checks were carried out in relation to written reports where there was an adjournment, but not always on oral reports. One responsible officer told us their area did not undertake checks in all cases, but they were done if there was a risk flag for child safeguarding or domestic abuse on the case management system. Another responsible officer from a different area said police checks were only done if the index offence was domestic abuse or there was readily available evidence/information that required it. We were also told by a different responsible officer that checks were made: "*when required*", but once the request was made the report writer would not follow up whether a reply was received or not. When we asked one report writer what their organisational policy was with regard to police and social services checks, they replied they were unsure. The increasing divergence in practice is of concern, but the new Probation Instruction should lead to greater consistency.
- 1.8. Relying on the index offence to make a decision about whether or not to undertake the checks is not a defensible position. Without information from the police and social services, the accuracy of any RoSH assessment undertaken is uncertain. In this batch of inspections, more than half of all CRC cases were recorded as presenting a medium risk of serious harm to others. A not insignificant number of medium risk of serious harm cases had been allocated to the CRC without the benefit of a full RoSH analysis having been completed.
- 1.9. About one-third of the reports we read did not have a sufficient RoSH assessment. Unsurprisingly, for cases that were allocated to the NPS (i.e. high risk of serious harm and/or Multi-Agency Public Protection Arrangement (MAPP) eligible cases), the assessments were better than for cases allocated to the CRC. This was primarily because more of the reports had the benefit of a sufficient adjournment period to allow the report writer to gather the necessary information and carry out the required checks (for example with social services and the police) to inform an accurate RoSH assessment. For the cases allocated to the CRC, about two-fifths of the RoSH assessments were insufficient. That overall figure disguises quite marked differences between the areas we inspected. In two of the areas in which we inspected, only about one-third of the pre-sentence reports (PSRs) were based on appropriate RoSH assessments. Conversely, in Humberside every one of the 26 RoSH assessments contained in PSRs was of a good quality (8 of the cases were subsequently allocated to the NPS and 18 to the CRC).
- 1.10. In fact, every PSR we reviewed in Humberside was recorded in writing, and all but one was of good quality, with validated information and an appropriate focus on actual and potential risk to victims. The Hull court possessed a well organised and managed probation team, well supported by administrators who were highly effective in the provision of necessary information.
- 1.11. Across the six areas inspected, we thought the content of PSRs was sufficient in three-quarters of the relevant cases. Most reports contained clear proposals. A number of staff involved in writing reports told us, however, that they had insufficient knowledge of the offending behaviour work offered by their CRC. That limited their ability to propose the most appropriate interventions. Pre-court discussions with the CRC did not always take place, even when the offender was known to that agency. Report writers told us it was more likely to take place when CRC staff were located in close proximity to NPS staff. During this round of inspections, we saw some CRC teams vacating previously occupied joint premises. Both NPS and CRC staff expressed concerns about the quality of information sharing that would take place once they were no longer co-located.
- 1.12. For Offender Rehabilitation Act cases, some report writers admitted having insufficient knowledge about Rehabilitation Activity Requirement (RAR) days. This meant a number of proposals and subsequent sentences included high numbers of days 'to address offending behaviour' for individuals who were lightly convicted and/or possessed few needs. That was not helpful to the responsible officer subsequently assigned the case, who had the responsibility of producing a meaningful sentence plan that delivered the sentence of the court and addressed the offending related needs of the individual within a tight timeframe.

## The Risk of Serious Recidivism assessment

- 1.13. NPS court staff calculated the RSR score in almost all of the cases that were subsequently allocated to the CRC in a timely way, i.e. on or within one day of the date of sentence, although a not insignificant number of RSR scores were not completed for cases allocated to the NPS. While those cases were allocated to the NPS correctly by dint of the risk of serious harm classification or MAPPA eligibility, NPS guidance was not followed. Some report writers and court staff we spoke with remained unclear about the circumstances under which an RSR assessment was not required pre-sentence.
- 1.14. We found eleven cases with an RSR score of 6.90 or higher (the threshold for automatic allocation to the NPS). The NPS had been correctly allocated each of those cases.
- 1.15. We inspected the accuracy of RSR calculations as a specific part of our *Transforming Rehabilitation* inspections 2 and 3. In those inspections we found inaccuracies in the scoring, some of which led to incorrect allocations. We also found many staff did not understand what information should be included and where in the RSR assessment, despite training having been provided. We did not repeat that exercise during this batch of inspections. While we found some cases where we thought the RSR score seemed unlikely, in none of those cases did we think it would have led to the case being managed by a different agency from the one to which it was allocated. Some report writers, particularly PSOs, admitted to still not feeling confident in carrying out the RSR calculations, and remained unclear about what constituted a violent offence.

## The Case Allocation System

- 1.16. The CAS was completed, and in a timely way, in most cases.
- 1.17. Disappointingly, nearly one in four contained significant questions marked 'not known'. In many instances, this information was available. This has been a recurring finding from our *Transforming Rehabilitation* inspections. As increasing numbers of oral reports are prepared, the NPS needs to make sure that they have sufficient arrangements in place in court to reduce the number of 'not known' answers, even though the timetable for getting some of the information is clearly problematic.
- 1.18. We found cases where the CAS did not record the need for a full RoSH analysis, but other information showed why one was required. Many cases allocated to the CRC did not contain a RoSH screening (70%). In one area, Humberside, three-quarters of RoSH screenings were completed, while in two other areas only 6% and 9% of RoSH screenings were undertaken prior to allocation.
- 1.19. In one half of the cases where a RoSH analysis was required, it was not undertaken prior to allocation. The figures were, unsurprisingly (as they were the cases that posed the highest risk of serious harm), better for cases allocated to the NPS (76%) compared with those allocated to the CRC (30%). Those broad figures mask some marked differences between the six areas we visited. In one area, none of the cases allocated to the CRC contained a full RoSH analysis despite the fact that we thought 23 cases required one. At the very least, we expected to see a clear record on the CAS of what the responsible officer to whom the case was assigned needed to do to complete the analysis and to manage risk of harm. That information was often lacking on the CAS though, and, when it was included, the responsible officer to whom the case was subsequently assigned did not always read it.
- 1.20. We formed similar judgements from this round of inspections as those found previously in *Transforming Rehabilitation* inspection 4. Many court staff did not use the CAS to provide a comprehensive risk assessment.
- 1.21. We agreed with most of the RoSH classifications of the cases in our sample. For the small number of cases where we disagreed, in two in three cases it was because we thought the level was too low.

## Making the allocation decision

- 1.22. The timeliness and accuracy of allocation decisions was good. Two cases were allocated in error to a CRC, but were transferred back to the NPS soon thereafter by agreement without use of the risk escalation process. The NPS was allocated two cases in error.
- 1.23. We found two cases where, in our view, the NPS correctly identified at the point of allocation a need for the case to be returned at a future date for a risk review, and the CRC was informed accordingly. In six further cases we thought a subsequent risk review was required, but that need had not been identified by the NPS and communicated to the CRC.
- 1.24. At the point of allocation, case records contained a clear and accurate assessment of the offender's risk of harm to others (72%); likelihood of reoffending (81%); other needs and vulnerabilities (75%), and actual and potential barriers to engagement (69%). Every case allocated to the NPS in Humberside contained a clear and accurate assessment in relation to each of the four domains listed above, while they scored above 80% for each of the domains for cases allocated to the CRC.

## Progress against previous recommendations

| Previous recommendations   | Progress   |
|--|--|
| <p>The National Probation Service and the Community Rehabilitation Companies must ensure that relevant information held by either party is shared efficiently at the court hearing stage. The National Probation Service must inform the Community Rehabilitation Company of all hearings involving cases under their jurisdiction, including the results of bail hearings. Any information provided by the Community Rehabilitation Company should be shared with the court. (<i>Transforming Rehabilitation - Early Implementation 2</i> recommendation)</p> | <p>Progress not sufficiently evidenced in this batch of inspections.</p>   |
| <p>The National Probation Service should ensure that all cases have a risk of harm screening in place prior to allocating a case to the Community Rehabilitation Company. Where possible, if the screening indicates the need for a full assessment this should be undertaken prior to the allocation. (<i>Transforming Rehabilitation - Early Implementation 2</i> recommendation)</p>  | <p>Progress still required</p>   |
| <p>The National Probation Service should ensure that all staff are familiar with the Risk of Serious Recidivism/Case Assessment System prioritisation matrix. (<i>Transforming Rehabilitation - Early Implementation 3</i> recommendation)</p>   | <p>Some progress made, but more required.</p>  |
| <p>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. (<i>Transforming Rehabilitation - Early Implementation 3</i> recommendation)</p>  | <p>The NPS has issued guidance from November 2015 (which post-dates the court or release on licence date of all the cases in this batch of inspections), and the CAS form now incorporates a full risk of harm analysis section.</p> |



# Early Work in the CRCs

# 2



## 2. Early Work in the CRCs

### Summary

- Assignment to an individual responsible officer was, generally, timely but some offenders did not see their assigned responsible officer within ten days of the start of their sentence or release on licence.
- Likelihood of offending and risk of harm assessments and corresponding plans did not sufficiently involve the person under supervision.
- Induction for those released on licence or sentenced took place promptly and was appropriately individualised.
- Constructive work with the individual under supervision did not always start promptly but, overall, the work delivered focused on the behavioural changes the individual had to make.
- Child Protection and safeguarding concerns were not always responded to appropriately.
- Diversity issues were assessed and addressed in many of the cases involving women who had offended.
- Frequency of contact with the individual under supervision was appropriate.
- Effective management oversight was required in more cases.

### Findings

#### Assignment, induction and first appointments

- 2.1. The assigned responsible officer should meet with the individual who has offended as soon after sentence or release on licence as possible, in order to provide enough time to get to know them and discuss the offence and their individual circumstances. That early engagement helps to inform a comprehensive and accurate assessment and enables production of a plan of work that, if delivered, will address the individual's offending and other related needs. It also makes it more likely that they will engage with their sentence and comply with the requirements of their order or licence conditions.
- 2.2. Assignment to an identified responsible officer was completed within one day of sentence in slightly more than half of the community and suspended sentence order cases allocated to the CRCs. In a small proportion of those cases, assignment did not take place within five working days following the making of the order. Timeliness of assignment to a responsible officer for licence cases was similar, which was surprising bearing in mind there had been more time to assign those cases as part of good preparation for their release.
- 2.3. Within one working day of sentence, three-fifths of offenders sentenced to a community order or suspended sentence order had a clear appointment provided to see a member of staff in the CRC.
- 2.4. The first appointment (arranged with any member of staff) was set for within two working days of sentence in slightly less than one-third of the inspected community and suspended sentence cases. First appointments for those on licence took place more promptly, as was to be expected.
- 2.5. In two-thirds of community and suspended sentence order cases, the first planned appointment with the assigned responsible officer was scheduled for within five working days of sentence. We were concerned that the assigned responsible officer did not have a planned appointment with the individual who had offended arranged for within ten days of sentence in 9% of the relevant cases. In our view, that was not good enough and was a clear barrier to getting the offender actively engaged in a timely and meaningful assessment and sentence plan to reduce their likelihood of reoffending.



- 2.6. We note that the National Offender Management Service (NOMS) contract requires the CRC to have a face-to-face appointment with the offender within five working days of sentence, and it does not specify that appointment has to be with the assigned responsible officer. We think a prompt appointment should be arranged with the assigned responsible officer in order to establish a good and meaningful relationship between the responsible officer and the individual under supervision from the beginning. Most of those on licence were given a first planned appointment with their assigned responsible officer within five days of their release from custody.
- 2.7. In all but one of the cases we inspected where the first appointment was not with the assigned responsible officer, the offender was then given a clear reporting instruction to attend to see the assigned responsible officer.
- 2.8. Nearly every offender allocated to the CRC received an induction. Most were delivered on a one-to-one basis, and were timely and sufficiently individualised.
- 2.9. In Hull (Humberside), we noted that while first appointments were not issued at court, it did not have an adverse impact on getting the individual into the office promptly following sentence. Indeed, we found first appointments arranged promptly with the assigned responsible officer. This was because of good liaison between the NPS court team and case administrators within the CRC, with the reservation of slots in responsible officers' diaries. This meant that administrators could make appointments in the confidence the responsible officer would be there to see the offender for their first appointment and not a duty worker. Induction was delivered one-to-one by the responsible officer, even for those offenders reporting directly from custody on the day of release.
- 2.10. There was sufficient assessment of diversity factors and potential barriers to compliance in three-quarters of the cases, but recording did not always sufficiently capture the assessment. Plans said how diversity factors and barriers to compliance would be addressed in two-thirds of cases.

## **Managing the offender**

- 2.11. Likelihood of reoffending was assessed at the start of sentence in nearly all cases (93%). Most were timely, and almost two-thirds were of sufficient quality. The main reasons for an assessment being insufficient were because it failed to draw fully on all available sources of information (29%); failed to include relevant information from the offender's home and social life (27%), and/or insufficiently assessed their accommodation situation (27%).
- 2.12. Most CRC cases had an initial sentence plan in place (92%). Sentence plans set objectives that were appropriate to the purposes of sentencing (90%) and addressed the individual's likelihood of reoffending (85%) and harmful behaviour (80%). Where there were risks to children, they were insufficiently addressed in one-third of the initial sentence plans. In those instances where there were risks to children, we expected at least to see appropriate support and monitoring included.
- 2.13. Nearly three-quarters of sentence plans set appropriate objectives, and included a timeframe for reviewing progress against the objectives. While four-fifths of the cases included an appropriate timeframe for review, only one-third identified the changes needed that would prompt an unscheduled review. In one area, an offender's religious beliefs were not assessed or taken into account at the start of sentence. The individual subsequently received warnings, later withdrawn, for failing to attend appointments scheduled for religious festivals important to their faith.
- 2.14. In almost three-quarters of cases, the planned level and pattern of contact with the offender were recorded in sentence planning, but in considerably more than half of the relevant cases (57%) there was a lack of clarity about how RAR days would be allocated. We saw some cases with excessive amounts of RAR days, and a lack of pre-court consultation with the CRC meant responsible officers were struggling to know how to fill those days. That was particularly problematic when the proposal in the PSR was 'to address offending behaviour', and there was a lack of clarity within the report as to what work might be undertaken.
- 2.15. We thought the offender was actively and meaningfully involved in the assessment and planning to reduce their likelihood of reoffending in almost three in five cases. We found instances where the

responsible officer completed an initial assessment of the offender and produced an initial sentence plan without having met the offender. When we asked why, we were told it was because of the need to meet performance targets with the consequential financial penalties that would be imposed if not met. While we were not unsympathetic to the financial consequences, it could not excuse the fact that those assessments and plans were not meaningfully reviewed within a short timeframe thereafter, with the benefit of the offender's perspective and situation fully incorporated.

- 2.16. Four-fifths of RoSH screenings were completed to a sufficient quality at the start of sentence or release on licence, and most were timely (94%). We found that 15% were inaccurate. Responsible officers completed a full analysis of sufficient quality where required in two-thirds of cases. The analysis was not completed in 15% of cases where required, often because of deficiencies in the initial RoSH screening. Where we assessed the quality of the RoSH analysis was insufficient, the main reasons were that it failed to draw fully on all available sources of information (29%); there was insufficient analysis of risk to known adults (17%) and children (18%).
- 2.17. We noted in quite a few instances that information included in the CAS form had not been read by the responsible officer. Some said they did not know about the CAS, or where to find it on nDelius. As some NPS court officers were using the CAS as a conduit for information sharing in relation to activities that required doing but which they had not had time to undertake, it was concerning that potentially critical information was subsequently overlooked. We were impressed by senior managers in two CRCs who told us that while it was the responsibility of the NPS to undertake a full RoSH analysis pre-allocation when required, they knew it did not always happen, and they expected their own staff to then complete it at the start of the order. In the areas we inspected, joint meetings were held between NPS and CRC managers to review interface and other matters.
- 2.18. Child Protection and safeguarding issues were clearly recorded on the case management system in three-fifths of cases, which was a lower proportion than we found in NPS cases. Performance among the CRCs was varied in regard to this measure, with two of the areas clearly recording these matters in less than a third of their relevant cases.
- 2.19. About two-thirds of cases we inspected from CRCs required a risk management plan (RMP). In 16% of the cases where a plan was required it was not completed. Of those that were completed, around three-fifths were of sufficient quality. Reasons for insufficiency included the plan not accurately describing how the objectives of the sentence plan and other activities would address risk of harm issues and protect victims (44%), and failing to include contingency planning and events that would prompt a review (40%). Bearing in mind the dynamic nature of many of the cases managed by CRCs that require a risk management plan, for example domestic abuse perpetrators, and findings from our previous reports, we had expected to see better performance against this measure.
- 2.20. In just under three-fifths of cases, the offender was actively involved in all plans and arrangements to manage their own risk of harm, including constructive and restrictive interventions. This was another measure where we found variable performance, with Humberside and Thames Valley involving those under supervision in a higher proportion of their cases.
- 2.21. In those few CRC cases where restrictive requirements in licences and community orders were included, in most instances it was appropriate, proportionate to the risk of harm and likelihood of reoffending posed by the offender and minimised the risk to actual or potential victims.

## **Delivering the sentence**

- 2.22. The needs an individual in prison had in relation to accommodation, education, training and employment (ETE), finance, benefit and debt were not sufficiently met pre-release in more than two-thirds of the relevant cases we inspected. In only one-fifth of the cases was there evidence of information sharing between the responsible officer, Through the Gate resettlement staff in custody and any others providing Through the Gate services.
- 2.23. Constructive work with the offender did not start within four weeks of sentence or release on licence in one-third of cases. In one CRC, in over half of their cases constructive work had not started

within four weeks of sentence or release. That was a barrier to preventing those individuals from reoffending. That particular CRC recorded the greatest percentage of offenders, whose cases we inspected, reoffending during the first four months of their sentence or release on licence (paragraph 2.46).

- 2.24. In almost three-quarters of cases, responsible officers and others assisting them considered diversity factors in the delivery of the sentence. In a slightly smaller proportion, sufficient work was delivered to overcome the barriers to engagement. In a Lancashire case, the offender was rapidly losing his eyesight, and a number of positive initiatives were deployed to help him engage with and complete his sentence. The individual was helped to get to appointments with the CRC, and A3 photocopied written materials were provided to facilitate their participation in groupwork and one-to-one work. We saw a number of cases involving women offenders whose diversity issues were assessed and responded to appropriately. In Wiltshire, a women-focused, multi-professional approach was used to keep one particular woman safe and prevent her reoffending. She had access to a women's drug rehabilitation requirement (DDR) group and women's centre, and support from a dedicated female responsible officer. By contrast in a different area, a woman under supervision with an unpaid work requirement, who had been assessed as unsuitable for an agency placement because of the nature of her offence, was placed on a mixed workgroup. She remained there even after she became pregnant. There was no evidence that she had been offered an alternative way to undertake her unpaid work.
- 2.25. In two-thirds of cases where motivational work was required, to help and encourage the individual under supervision to engage fully with the work undertaken during their sentence, it was delivered.
- 2.26. In slightly less than two-thirds of the cases, work with the offender maintained sufficient focus on the behavioural changes required to reduce reoffending, with Wiltshire performing well against this measure. One case from that area concerned a prolific offender who stole to fund a heroin habit. The Integrated Offender Management responsible officer put a marker on the offender's car so that if they drove under the influence of heroin, they could be charged if stopped. This was a good incentive for the individual not to drive under the influence, encourage them to engage with their DRR, and keep the public safe. In a different case, the individual was heard to shout racist insults during the offence for which they were convicted. The responsible officer, as part of their initial work with the offender, tested any discriminatory views held by the individual by completing an exercise about stereotypes.
- 2.27. Specific interventions, including delivery of programmes, were delivered to encourage and challenge the offender to take responsibility for their actions and decisions relating to offending in slightly less than two-thirds of the cases, with Wiltshire again performing well. In an impressive West Midlands case, the responsible officer was a qualified probation officer and had good understanding of domestic abuse perpetrator behaviour. They delivered a structured programme (SIADA) with the individual that worked through issues of personal responsibility, blame and denial.
- 2.28. Purposeful home visits can make an important contribution to the accurate assessment and appropriate management of risk of harm to others. HMI Probation takes the view that they should be undertaken where, for example, the offender has a history of domestic abuse and is living with a partner, where there are Child Protection issues, or where the offender is not attending appointments and has not responded positively to warning letters. Each case requires the responsible officer to ask 'what is the purpose of a home visit in this case?', and 'what am I seeking to establish from undertaking a home visit?' While many of the CRC cases did not need a home visit, we thought more than half did.
- 2.29. In those cases where we thought a home visit should take place, it was made in less than half. Repeat visits took place in half the cases where required. In Lancashire, an offender had not attended appointments for two weeks, supposedly because of ill health. The responsible officer had no phone number for the individual, so went to their 'care of' address only to discover they were no longer living there but at a different address. That visit enabled re-establishment of contact without the need for breach.
- 2.30. Multi-agency Child Protection procedures were used effectively in 18 out of 31 relevant cases,

which was not good enough. We saw a number of cases where readily available information indicated concerns but where these were not recognised and necessary action taken. For instance, in one case the individual who had offended was a pregnant woman. She had had a previous child removed from her care because of lack of care/neglect. Timely contact was not made with children's social care services to ascertain the facts. A thorough assessment and analysis were required, but not achieved.

- 2.31. In most cases where there were restrictive requirements in licences and community orders, they were monitored fully. Against this measure, Thames Valley and West Midlands monitored restrictive requirements fully in every case we inspected that they managed.
- 2.32. The individual's attendance was monitored in almost all of the cases we saw. Humberside had good joint arrangements with the police whereby a police community support officer would deliver the initial enforcement letter in appropriate cases along with details of the next appointment.
- 2.33. While clear and timely formal warnings were given to the offender in about four-fifths of cases where there were absences or instances of unacceptable behaviour, enforcement proceedings, where required, were taken in about three-quarters of relevant cases.
- 2.34. One responsible officer told us that while they: "*believed good enforcement leads to good compliance*", their organisation's approach was to discourage enforcing orders or licences. Enforcement was the interface issue we heard about that was still seen as the most problematic some eighteen months after *Transforming Rehabilitation*. A number of responsible officers said that they had been told not to recommend 'revoke and resentence', because it would lead to a financial penalty for the CRC. We also heard about delays created because, in some areas, breach packs were returned to the CRC for amendment or additional information.
- 2.35. Some responsible officers commented about a lack of feedback from court teams about court decisions (one responsible officer said they found out about one result from the offender). Other responsible officers said they were insufficiently trained in relation to the new breach pack. We also heard positive stories. One responsible officer told us that while at first they thought the enforcement procedures were deskilling, arrangements now worked well in their area following the initial teething problems, with breach reports now being reviewed by managers before being sent to the NPS. A different responsible officer said they had only completed one breach report: "*I followed the guidance available which went smoothly.*"
- 2.36. None of the cases where recall proceedings were taken for breach of licence was subject to the risk escalation process. In every case where the CRC enforced the breach, recall was the outcome, with half subject to fixed term recalls and the others standard recalls.
- 2.37. We were disappointed to find, in a third of cases where the individual was breached, insufficient effort was made by the CRC responsible officer to re-engage them and encourage their commitment to continued engagement. One responsible officer said that because of discouragement by managers towards breaching offenders, a positive aspect to that approach was that responsible officers worked harder to gain the individual's compliance.
- 2.38. In four-fifths of relevant cases, enforcement action was clearly recorded within appropriate timescales on the case management system.
- 2.39. In three-quarters of relevant cases, the responsible officer and other workers accorded appropriate priority to the safety of current and potential victims. In a slightly smaller proportion of cases, concerns about victims were clearly recorded on the case management system.
- 2.40. We inspected two CRC cases where escalation to the NPS had started. While there had been no informal discussions on the escalations, the process was working well and the decisions to escalate were appropriate. Responsible officers, when asked how risk escalation processes were working in their area, were, generally, satisfied with the arrangements and told us the process was clear.
- 2.41. The frequency and type of contact with individuals under supervision was in line with the planning, and met the requirements and purpose of sentencing in four-fifths of cases. There were variations between the CRCs in relation to this measure, with two CRCs attaining figures of less than 70%.



Sometimes frequency of appointments was reduced when little had been achieved in relation to achievement of desired outcomes, and the case management system did not provide the reason. We saw some cases where the frequency of appointments increased, as in the instance of an individual who made a suicide attempt and the responsible officer clearly documented that they were moving contact from fortnightly to weekly as a result and the reasons why.

- 2.42. We made a recommendation within our first report *Transforming Rehabilitation - Early Implementation* regarding the need for the nDelius flags to be accurate. Most flags matched the circumstances of the case (84%), with Humberside having accurate flags in all but 2 of the 35 cases we inspected.
- 2.43. Contacts and the delivery of interventions were clearly recorded on the case management system in most cases (83%), although that figure was adversely affected by one CRC's performance (57%). We were impressed by some of the recording we saw in Humberside. Responsible officers were recording details of the contact, and then analysing it to see if it had an impact on risks the offender posed or if there were any implications for the sentence plan.

### **Reviewing the work with the offender**

- 2.44. The likelihood of reoffending was reviewed sufficiently in two-fifths of cases where required. In one inspected area we found many reviews carried out in the immediate weeks preceding the inspection, even though in many instances we did not think there was a need for a review. It was disappointing to see that in many of the reviews, they were 'clones' of the initial assessment and where there were any changes they were insignificant. In that particular area, staff told us managers said they must do written reviews in time for the inspection. This was a fundamental misunderstanding by some managers of what we look for or expect, and a waste of responsible officers' time. Reviews should be appropriate for the needs of the case. At the four month stage, some cases required a written review, but many did not. Our view is that reviewing progress with the individual who has offended is a key aspect of working with them, and may not always require completion of a formal review document.
- 2.45. There was a review of sufficient quality of the risk of harm assessment in two-fifths of the cases where required. Reasons for insufficiency were because they failed to take into account changes in relevant factors (27%); failed to incorporate information sought from others (28%), and contained an insufficient analysis of risk (27%). In half of the cases where there was a change in the offender's risk of harm, it was recognised quickly and there was an appropriate response by the responsible officer.
- 2.46. There was a sufficient review of the RMP in one-quarter of the cases where required. The RMP was not reviewed in half of the cases where we thought a review should have been completed.
- 2.47. There was a review of the work with the individual in two-fifths of cases where necessary. In half of the required cases, the offender was sufficiently involved in reviewing their progress.
- 2.48. We found evidence of effective structured management involvement or oversight in one-third of cases where it was required, for instance cases where the risk of serious harm warranted it or because there were concerns about protecting children. Bearing in mind the lack of experience of many CRC responsible officers, we thought that lack of management oversight in some of the most difficult cases was concerning. Where we expected to see effective management oversight on the case management system, it was recorded in half the cases.

### **Impact and outcomes**

- 2.49. We found 16% of individuals under supervision, whose cases we inspected, had been convicted of a further offence committed since sentence or release on licence for the offence that we were inspecting. That finding was adversely affected by one area where 29% of the offenders whose cases we inspected had been convicted of a further offence. In one, admittedly extreme, licence

case, the individual was not visited while in custody. The post-release OASys and sentence plan were not completed until six weeks after release, by which time the individual had already reoffended. Very little offending behaviour work had taken place in that case, and the contact log was conspicuous by the absence of entries.

- 2.50. We wanted to see if sufficient progress had been made in relation to factors identified as making the individual more likely to reoffend. We judged that sufficient progress had been made at the four month stage in slightly more than two-fifths of the cases we inspected. Commendably, sufficient progress was achieved in two-thirds of Wiltshire's cases.
- 2.51. In this batch of inspections, we asked specific questions seeking to establish if sufficient progress had been achieved in relation to an offender's accommodation and ETE issues. We assessed that sufficient progress was made in relation to both in slightly less than a third of the cases. These were disappointing figures. Wiltshire's performance in relation to improvements in accommodation (70%) and ETE (59%) was the highest.
- 2.52. All reasonable action was taken to minimise the offender's risk of harm to others and protect the public in almost two-thirds of the inspected cases, but in Humberside the figure was over three-quarters.

## Leadership and management

- 2.53. There was, generally, logic about assignment of cases to probation officers (POs) and PSOs, with the POs receiving the higher risk cases, particularly the domestic abuse perpetrators. A shortage of POs in some CRCs meant PSOs were allocated higher risk domestic abuse cases. One PSO with nine years' experience said they had not received domestic abuse training and had limited knowledge of child safeguarding issues, but was currently handling a number of complex cases where the individual who had offended was either the perpetrator or victim of domestic abuse. Many PSO responsible officers expressed to us their concerns about managing domestic abuse cases for which they felt insufficiently trained. We also came across agency staff who told us they were not provided with training.
- 2.54. Responsible officers gave a mixed message about their training and the quality of supervision they received. During these inspections, we did see some association between how responsible officers perceived the management support and training they received with the quality of the work we inspected. In general, responsible officers in the CRCs were less positive about their supervision and training compared with those in the NPS.
- 2.55. There was recognition that SPOs had a difficult role. In a number of areas, SPOs covered multiple offices. Sometimes they were only in an individual office for one or two days a week. One responsible officer told us: *"very little supervision is provided by the organisation. The organisation assumes offender managers are competent and don't require regular supervision; they can just get on with it."* Another responsible officer said: *"A lot of management contact is by e-mail. It feels as if I work for a faceless organisation. Many of the domestic violence case have significant Child Protection issues that are time consuming and require attendance at inter-agency meetings. Senior managers do not recognise these demands."* At the end of one inspection, we fed back to the senior manager: *"... senior managers were seen negatively and as being distant, both in terms of being unavailable/invisible and unsympathetic/unsupportive"*.
- 2.56. We were pleased to hear different views from other responsible officers. One said that they: *"received supervision monthly or when required. My senior has an open door policy. The quality is also good, well recorded and copies of notes are given to us."* A different responsible officer told us: *"I receive regular supervision and the quality is very good. In an ideal world, I would like to see more of her, but she is very busy. The senior manager is brilliant; he knows everyone's name."*

## Progress against previous recommendations

| Previous recommendations   | Progress   |
|--|--|
| <p>Community Rehabilitation Company managers must ensure that offenders engage with their assigned officer at the earliest opportunity. Where a group or duty induction is used, an appointment with the offender manager should always be provided as part of this process. (<i>Transforming Rehabilitation</i> - Early Implementation 2 recommendation)</p>  | <p>Progress made.</p>  |
| <p>On receipt of an allocated case, Community Rehabilitation Company staff should review the risk of harm screening or full analysis that has been completed as part of the pre-sentence report process and ensure that they have all the information necessary to confirm the risk of serious harm level posed by the offender. Where necessary, they should review the risk management plan and ensure that it forms the basis for the necessary work to manage the risk of harm posed by the offender. (<i>Transforming Rehabilitation</i> - Early Implementation 2 recommendation)</p> | <p>Progress still required.</p>  |
| <p>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. (<i>Transforming Rehabilitation</i> - Early Implementation 3 recommendation)</p>   | <p>Progress made in assessing diversity issues, but, where required, progress is still required in plans saying how the relevant diversity issues will be addressed.</p> |
| <p>Community Rehabilitation Companies should focus on improving the quality of likelihood of reoffending assessments. (<i>Transforming Rehabilitation</i> - Early Implementation 3 recommendation)</p>   | <p>Progress still required.</p>  |
| <p>Community Rehabilitation Companies should focus on improving the quality of full risk of harm assessments. (<i>Transforming Rehabilitation</i> - Early Implementation 2 recommendation)</p>   | <p>Progress made, but more required.</p>   |
| <p>Community Rehabilitation Companies should ensure that the plan to manage the offender throughout the sentence should be kept under review to ensure that it remains focused and relevant. (<i>Transforming Rehabilitation</i> - Early Implementation 3 recommendation)</p>  | <p>Progress still required.</p>  |
| <p>Where appropriate the management of medium risk offenders should include purposeful home visits, repeated as necessary. (<i>Transforming Rehabilitation</i> - Early Implementation 2 recommendation)</p>  | <p>Progress still required.</p>  |
| <p>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. (<i>Transforming Rehabilitation</i> - Early Implementation 2 recommendation)</p>   | <p>Progress still required.</p>  |

# Early Work in the NPS

# 3





# 3. Early Work in the NPS

## Summary

- Initial contact with the assigned responsible officer was timely.
- Better engagement with individuals under supervision would have improved the quality of assessments and plans.
- Constructive work with the individual under supervision did not always start promptly, but, overall, the work delivered focused on the behavioural changes required of the individual.
- We saw good use made of meaningful home visits.
- Frequency of contact with the individual under supervision was appropriate.
- Middle managers were respected, but supervision was too focused on performance measures rather than improving the quality of work delivered by responsible officers.

## Findings

### Assignment, induction and first appointments

- 3.1. Assignment to an identified responsible officer was within one day of sentence in about four-fifths of the community and suspended sentence order cases allocated to the NPS. Timeliness of assignment to a responsible officer for licence cases was better, which was to be expected bearing in mind there had been more time to assign those cases as part of good preparation for their release.
- 3.2. Within one working day of sentence, three-quarters of offenders sentenced to a community order or suspended sentence order had a clear appointment provided to see a member of staff in the NPS.
- 3.3. The first appointment (arranged with any member of staff) was set for within two working days of sentence in one-third of the inspected community and suspended sentence cases, with a further half of the individuals receiving a first appointment within five working days. Most first appointments for those on licence took place on the day of release or the following day.
- 3.4. In three-quarters of community and suspended sentence order cases, the first planned appointment with the assigned responsible officer was scheduled for within five working days of sentence. All but one of the other cases had a first planned appointment scheduled for within ten working days of sentence. While a majority of those on licence received a first appointment with their assigned responsible officer within the first two days of release, we noted that five offenders from our sample waited over ten days for their first appointment. That was too long.
- 3.5. In all but two of the NPS cases we inspected where the first appointment was not with the assigned responsible officer, the offender was then given a clear reporting instruction to attend to see the assigned responsible officer.
- 3.6. Nearly every offender allocated to the NPS received an induction. Only one induction was not timely, and most were individualised. A Hertfordshire responsible officer recorded the following on the case management system, which we thought provided good evidence of ensuring the individual who had offended had a good start to their order: *“Attended for initial appointment, went through induction including explaining what his requirements mean and is expected of him. Discussed the times and days when it will be convenient for both of us to meet, although stressed that internet sex offender programme sessions are set. Discussed sentence plan, explained what it is and that we will start gathering information for it next week.”*

- 3.7. There was sufficient assessment and recording of diversity factors and potential barriers to engagement in four-fifths of the cases.

## **Managing the offender**

- 3.8. The likelihood of reoffending was assessed at the start of sentence in nearly all cases. Most were timely, and almost four-fifths were of sufficient quality. The main reasons for an assessment being insufficient were that it failed to draw fully on all available sources of information (22%), and/or was not new or was insufficiently revised from a previous assessment (17%).
- 3.9. All NPS cases had an initial sentence plan in place. The offender was meaningfully involved in almost three-quarters of the plans, which although better than TR4 is still not good enough if the objective of the sentence plan is to gain the offender's understanding, compliance and engagement with what they will be doing on their order or licence. The lack of involvement of the offender in developing the sentence plan may explain why, overall, we thought just three-quarters of the plans set appropriate objectives. That finding disguises some noticeable differences between the six areas we inspected. Humberside responsible officers sufficiently engaged with the individual under supervision in every case, and they and Lancashire produced plans that contained appropriate objectives.
- 3.10. Nearly every NPS RoSH screening was completed to a sufficient quality at the start of sentence or release on licence. A full analysis was completed, and to a sufficient quality, in three-quarters of the cases. Where we assessed the quality was insufficient, the main reasons were because it failed to draw fully on all available sources of information (25%); there was insufficient analysis of risk to children (22%), and was not new or was insufficiently revised from a previous assessment (15%).
- 3.11. Child Protection and safeguarding issues were clearly recorded in most cases (83%), but, bearing in mind the nature of the cases managed by the NPS, we would have expected better performance against this measure.
- 3.12. In Lancashire, we inspected a case involving a male sex offender. All risk factors were clearly identified and careful consideration given to the children who were potentially at risk, including the offender's eleven-year-old grandson. The responsible officer submitted a referral to children's social care services and the grandson's parents signed a safeguarding agreement not to allow unsupervised contact.
- 3.13. More than two-thirds of the cases had an initial RMP that was of sufficient quality. Most of the plans were timely and addressed the factors identified in the risk of harm assessment. Slightly more than a third, however, failed to include relevant contingency planning and events that would prompt a review, or did not accurately describe how the objectives of the sentence plan would address risk of harm issues and protect actual and potential victims. There was clearly still work to do to address our previous recommendation that the NPS should make sure that a: "timely and robust risk management plan is in place for all high risk of serious harm cases".
- 3.14. In just under three-quarters of cases, the offender was actively involved in all plans and arrangements to manage their own risk of harm, including constructive and restrictive interventions. This finding mirrored our judgements about the involvement of offenders in their likelihood of reoffending assessments and sentence plans. Humberside and Lancashire actively engaged the offender in more than 90% of the relevant cases.
- 3.15. Restrictive requirements were included in licences and community orders when required.
- 3.16. Only five MAPPA cases were managed at level 2, and none at level 3. We thought they were managed at the correct level. For the five MAPPA level 2 cases, the referrals were timely and clearly recorded.

## Delivering the sentence

- 3.17. We were disappointed that the needs an individual in prison had in relation to accommodation, ETE, finance, benefit and debt were not sufficiently met pre-release in two of the five relevant cases we inspected. In none of the cases was there evidence of information sharing between the responsible officer, Through the Gate resettlement staff in custody and any others providing Through the Gate services.
- 3.18. Constructive work with the individual under supervision did not start within four weeks of sentence or release on licence in almost one-third of cases. That overall figure conceals differences between the six areas. Thames Valley and Humberside commenced constructive work promptly in a high percentage of their cases.
- 3.19. In almost three-quarters of cases, diversity factors were taken into account in the delivery of the sentence. In a similar proportion, barriers to engagement were addressed appropriately.
- 3.20. In four-fifths of relevant cases, motivational work was delivered to help and encourage the offender to engage fully with the work undertaken during their sentence.
- 3.21. The individual's attendance was monitored in almost all of the cases we saw, and in four of the six inspected areas in every instance. We saw some cases with too many acceptable absences, and sometimes absences were marked as acceptable although the rationale was not recorded on the case management system. In one area, and consistent with our findings in the January 2016 report *A Thematic Inspection of the Delivery of Unpaid Work*, one offender was stood down from their unpaid work four times in a three month period. That was demotivating for the individual concerned, and not helpful in gaining their compliance with the rest of their order.
- 3.22. Work with the offender maintained sufficient focus on the behavioural changes required to reduce reoffending in most cases (81%). Lancashire and Humberside both performed well against this measure.
- 3.23. In two-thirds of cases, specific interventions, including delivery of programmes, encouraged and challenged the offender to take responsibility for their actions and decisions relating to offending. In Thames Valley, the proportion was considerably higher. In Wiltshire, a responsible officer had completed lots of work with the individual under supervision, including one-to-one work on their treatment needs as identified in the SARN. Help was provided, and they gained supported accommodation and a job. To improve their self-esteem and positively occupy their time, a mentor and Circles of Support were provided. Polygraph testing was about to be used in order to challenge the individual's self-reporting.
- 3.24. In some areas, NPS responsible officers were unaware of the programmes and services provided by their local CRC.
- 3.25. In TR4, we commented on improvements observed at that time against a previous recommendation from this series of inspection reports relating to the need for purposeful home visits, repeated as necessary, for medium and high risk of harm offenders. We were pleased to see in this batch of inspections that, in most cases, appropriate and purposeful home visits were made. If it had not been for a lack of home visits in one area (36%), the overall figure would have been considerably better. Lancashire carried out an initial and purposeful home visit in every case where required, and repeated it as necessary.
- 3.26. MAPPA operated effectively in 4 out of 5 relevant cases.
- 3.27. ViSOR was used effectively in three-quarters of cases where required. While pertinent information was, generally, provided to ViSOR, many responsible officers said they never or rarely used the system despite relevant information about all their registered sex offenders and MAPPA level 2 violent offenders being held on ViSOR. One responsible officer said they knew nothing about sex offences committed by a particular offender within the previous two years, although that information was recorded in ViSOR. The RoSH assessment in that particular case was consequently incomplete and insufficiently informed.

- 3.28. Multi-agency Child Protection procedures were used effectively in 12 out of 17 relevant cases. We saw cases where responsible officers had invited themselves to Child Protection conferences in order to provide the most up to date information to the meeting about the offender's behaviour and response to supervision.
- 3.29. In most relevant cases, restrictive requirements in licences and community orders were monitored fully. Despite that overall finding, we came across a few cases where the responsible officer was unaware of the terms of restrictive measures, for example, a football banning order and restraining orders. The details were not included in the RMPs, and, without knowing what the offender was not permitted to do, it was difficult for the responsible officer to reinforce the measures or know whether the offender was in breach of the restriction.
- 3.30. Approved premises were used effectively as a restrictive intervention in 21 out of 23 cases.
- 3.31. We inspected one case in the NPS escalated from the CRC. Informal discussion on the escalation had not taken place. The first contact between the NPS and CRC following the referral took place within 24 hours, and the NPS took a decision to accept the case. The activity that led to the escalation was recorded on the case management system, and, in the opinion of the Inspector, the decision for the transfer from the CRC to the NPS was a defensible and correct one.
- 3.32. Enforcement of orders and licences was appropriate where required in most cases, but there were variations across the six areas. In most cases, there was clear recording on the case management system of the enforcement action within an appropriate timescale.
- 3.33. There were fewer NPS cases, proportionately, where breach took place compared with those managed by the CRC. In all instances following breach, sufficient effort was subsequently made by the NPS responsible officer to re-engage the offender and encourage their commitment to continued engagement.
- 3.34. In four-fifths of relevant cases, the responsible officer and other workers accorded appropriate priority to the safety of current and potential victims. Concerns about victims were clearly recorded on the case management system in three-quarters of cases. Wiltshire and Humberside recorded concerns in a considerably higher proportion of relevant cases. In a Humberside case, the offender was a young man who had served a long sentence for sexual offences against a child neighbour. Excellent consideration for the victim was demonstrated, with an additional licence condition added after his release from prison to exclude him from a town to which the victim had subsequently moved. In a different area, we inspected the case of a violent offender given a suspended sentence order that was revoked following new offences. The responsible officer never thought to tell the victim liaison officer, even though the custodial element was over 12 months.
- 3.35. In a couple of the areas we inspected, we saw some good joint working in relevant cases with the personality disorder consultant/psychologist, who offered advice on appropriate approaches to deploy in working with the offender.
- 3.36. The frequency and type of contact with offenders was in line with the planning and met the requirements and purpose of sentencing in nearly all of the inspected cases. Two-thirds of cases enjoyed at least eleven face-to-face appointments in the first 12 weeks of their sentence or following release on licence, while a further quarter received between 6 to 10 appointments in that period.
- 3.37. We found most nDelius flags were accurate (88%), with each of the 17 Wiltshire cases inspected correct.
- 3.38. Recording of contacts and work undertaken by the individual under supervision was sufficient in most cases. We found key documents on the case management system in most cases, which was an improvement from previous Early Work *Transforming Rehabilitation* inspections.

## Reviewing the work with the offender

- 3.39. The likelihood of reoffending had been reassessed in three-quarters of cases where required, but it was of sufficient quality in just under two-thirds.
- 3.40. There had been a review of sufficient quality of the risk of harm assessment in slightly less than half of the cases where required. Reasons for insufficiency were because they failed to take into account changes in relevant factors (37%); failed to incorporate information sought from others (37%), and contained an insufficient analysis of risk (35%).
- 3.41. There was a sufficient review of the RMP in half of the cases where required.
- 3.42. There was a review of the work with the offender in over three-quarters of cases where necessary. Three-fifths of completed reviews were of sufficient quality. The offender was sufficiently involved in the review of their progress in a similar proportion.
- 3.43. We found evidence of effective structured management involvement or oversight in slightly less than half of the cases where we thought it was required. In Thames Valley, the figure was three-quarters while both Humberside and Lancashire returned figures considerably better than the average. This was a less good performance compared with what we found in *Transforming Rehabilitation* inspection 4, but illustrates the fact that we were inspecting in different areas with different expectations of managers.
- 3.44. Middle managers, generally, admitted to us that they no longer had the time to devote to the same level of supervision that they historically provided. One, for example, was managing three field teams across a large geographical area, with reduced administrative support. In one area, middle managers acknowledged that they had been responsible for counter-signing inadequate assessments and plans. They said the pressures of performance targets meant that they had to sign them off even though they knew they were not good enough. One manager said that they would now make sure they made an entry on the case management system requiring the necessary improvements to be made and by when, and would then check to see that they were rectified within the required timescale. That was something we thought a sensible and practical response, although we think the aim should be to get the assessment and plan right first time.

## Impact and outcomes

- 3.45. One-tenth of offenders whose cases we inspected had been convicted of a further offence committed since sentence or release on licence for the offence that we were inspecting. This was better than our findings in *Transforming Rehabilitation* inspection 4.
- 3.46. Sufficient progress had been made in relation to the factors identified as making the individual more likely to reoffend in slightly more than three-fifths of the NPS cases.
- 3.47. We assessed that sufficient progress had been achieved where required in relation to an offender's accommodation needs in almost three-fifths of the cases. In contrast, the NPS only delivered improvements in relation to ETE in one-third of the cases where improvement was required. In one area, we were told there was no ETE provision currently being offered by their CRC and that was having an impact on the offender receiving help with their ETE needs. The best early outcomes in relation to accommodation were achieved by Lancashire (73%), while the Thames Valley was achieving the best early outcomes for ETE (60%).
- 3.48. All reasonable action was taken to minimise the offender's risk of harm to others and protect the public in almost three-quarters of the cases.



## Leadership and management

- 3.49. We found marked differences in the responses we received from responsible officers when we asked them about the quality of their supervision and management. While there were differences between areas, even within the same area we received mixed messages.
- 3.50. We were told assignment of cases was not always consistent with the responsible officer's knowledge confidently to manage the offender. For instance, one responsible officer undertaking training said they were assigned a sex offender and had to complete the initial OASys, but had not, at that time, received the necessary training. More thought needed to be given to the cohesiveness of training delivery alongside assignment of cases, ensuring the two are aligned correctly. Some staff said training was often delivered at a location a long distance away from their office or home location, which had a negative impact on their work.
- 3.51. We asked responsible officers about whether they felt sufficiently trained to undertake their current role within the NPS. While PO responsible officers were, generally, satisfied and felt suitably competent and confident, a number of PSO responsible officers we spoke with were less confident. Sometimes they told us they managed offenders who had carried out certain types of offences for which they had not yet received training, for example sex offenders. Some of those undertaking PQF training also told us their training had not kept abreast of assignment of cases. In one area, staff were three months away from qualification but had not yet received training in PSRs or Risk Matrix 2000. In a number of instances, joint working of cases by those undertaking training with more experienced POs impressed us.
- 3.52. We also asked court staff about their training. In one area, with a part-time SPO who was also responsible for a field team, the court was, at the time of our inspection, only staffed with PSOs. They told us they did not feel overly confident, and we thought the quality of the oral reports produced in that area was not good enough. The court staff did not have sufficient knowledge about RSR, CAS, report writing and, more importantly, the nature of probation work, to make an effective contribution.
- 3.53. Responsible officers were, generally, positive about their immediate line managers, and were forgiving about the lack of time spent helping them with their work. Many told us that the focus of supervision had switched since *Transforming Rehabilitation* and was now about delivering performance measures, rather than helping responsible officers with their work and offering advice about the difficult and dangerous offenders with whom they were working. On a positive note, a responsible officer said: "*My line manager is outstanding, but things have been tough in the NPS. She has focused very well on our personal and professional development*".
- 3.54. In a different area we were told responsible officers received little support from middle managers, as they were themselves unsupported. One responsible officer from that area told us they had not received supervision for 12 months, and they never saw a senior manager. During the course of this inspection, we interviewed a number of agency responsible officers. We were concerned that in two areas, agency workers told us that while supervision was provided to responsible officers employed by the NPS they themselves did not receive any. That was inappropriate.
- 3.55. Despite some of the critical comments reported in the previous paragraph, we received many positive comments from individual responsible officers about the open door policy of their line manager, and the time and effort they provided to them. It was, overall, a mixed picture as it was for senior managers.

## Progress against previous recommendations

| Previous recommendations   | Progress                                 |
|--|--|
| <p>The National Probation Service should ensure that for all cases presenting a medium or high risk of serious harm, there is a full initial assessment of the offender and the risks they pose. (<i>Transforming Rehabilitation - Early Implementation 2</i> recommendation)</p>                            | <p>Progress made, but more required.</p> |
| <p>The National Probation Service should improve the quality of its full risk of serious harm assessments, particularly with reference to the analysis and management of risk of harm to children. (<i>Transforming Rehabilitation - Early Implementation 3</i> recommendation)</p>                          | <p>Progress still required.</p>          |
| <p>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. (<i>Transforming Rehabilitation - Early Implementation 3</i> recommendation)</p>  | <p>Progress still required.</p>          |
| <p>The National Probation Service should ensure that for all cases presenting a medium or high risk of serious harm, a comprehensive risk management plan is completed at the start of their community sentence or licence. (<i>Transforming Rehabilitation - Early Implementation 2</i> recommendation)</p> | <p>Progress still required.</p>          |
| <p>Where appropriate the management of medium and high risk offenders should include purposeful home visits, repeated as necessary. (<i>Transforming Rehabilitation - Early Implementation 2</i> recommendation)</p>   | <p>Progress made, but more required.</p> |

# The views of service users

# 4





# 4. The views of service users

## Introduction

We offered individuals under supervision whose cases we were inspecting, the opportunity to participate in an interview with the inspectors. We interviewed 55 offenders using a semi-structured interview tool. In each area we managed to speak to some offenders from both the NPS and CRCs; overall, 20 individuals were managed by the NPS and 35 by the CRCs. Slightly less than two-thirds of the offenders were subject to a community sentence, the rest were on a licence. We are grateful to the CRCs and NPS for helping set up the interviews and to the offenders with whom we spoke.

## Findings

- 4.1. Offenders were, generally, positive about their experience of being interviewed for their PSRs. One woman from the Thames Valley said:

“I had an interview before my sentence at the Crown Court. It took about an hour. I was very scared and the woman who interviewed me put me at ease. I thought I was going to custody and I did not want to leave my children. The lady in the interview explained what a suspended sentence would mean for me, as that was what she was recommending.”

- 4.2. In a different case, an African man said English was not his first language, and the interview felt rushed and only lasted fifteen minutes. Bearing in mind the language barrier, this seemed not enough time to gather the required information to produce a report that sufficiently informed the court.
- 4.3. All but two of the individuals who were interviewed for a court report said their individual circumstances were taken into account, for example, their health, childcare, travelling to the office. One Hertfordshire offender said he was given a PSR interview slot in the evening because he was working in the day.
- 4.4. We wanted to ascertain if offenders sentenced to community orders or suspended sentence orders were clear about when and where to go, in relation to their involvement with either the CRC or NPS, upon leaving court. All but one of those we interviewed said they were clear. In Wiltshire, an individual said the report writer who had completed an on-the-day oral report had spoken with them immediately after sentencing. The individual was told the location, date and time of the appointment and had it explained that appointments could be arranged around his work. In a different area, the offender said they were given an appointment but nobody was expecting them when they arrived at the CRC office. Staff at the CRC office did not have the court paperwork, and knew nothing about his case.
- 4.5. Every one of the offenders we interviewed said they had an induction. In over four-fifths of the cases, the assigned responsible officer delivered it. In the West Midlands, one individual being supervised by the NPS told us:

“I had an induction, and was then given my next appointment. I was given leaflets about what was and what was not expected. If I was going to be late, there were clear instructions what I had to do. I have an exclusion zone, and I understand the exclusion zone and the boundaries are very clear. I know I must not contact my co-defendants.”

- 4.6. A different offender managed by the NPS in Lancashire said his responsible officer had visited him in prison to talk about his release arrangements and explained what he could and could not do. When he then arrived at the approved premises following release, he received a full induction. One woman managed by a CRC reported a different experience. When she arrived for her first appointment with her responsible officer, a different person delivered her induction. While this individual said everything was explained to her, she had been so anxious about meeting her responsible officer that, when she realised she would be seeing a different person with whom she would not be having a continuing relationship, she had: “kicked off”. That was not a great start to her order.
- 4.7. Seventeen offenders said they had not attended all their appointments, but only 9 said they had received any sort of warning or been returned to court. That correlated with what we found during this batch of inspections. One Thames Valley CRC offender told us that they:

“... completed their unpaid work in record time, and attended every probation appointment, this included work with my offender manager, the Building Better Relationships programme and Rehabilitation Activity Requirements. I have worked on employment skills, had help to complete application forms, and have certificates which will help me with a job.”

Some individuals admitted to having received warnings for their behaviour rather than failing to attend. One told us that he had received warnings for taking a ‘legal high’ drug and then received a final warning for failing a drug test.

- 4.8. Most offenders had something going on in their lives that were acting as a barrier to making them less likely to offend. Encouragingly, nearly all said their responsible officer was helping them as much as possible. We heard about responsible officers being flexible with appointment times for those in employment, or responding sensitively to issues of sickness or bereavement. One CRC individual who had offended said:

“I have missed a couple of sessions due to relationship problems, which my offender manager has helped me with. She is great and works with me rather than against me.”

- 4.9. We wanted to find out about the frequency of reporting, bearing in mind that the offenders we were speaking with were sentenced or released from prison only about four months previously. Almost half said they were seeing their responsible officer weekly. That overall percentage masked differences between the NPS and CRC. A greater percentage of NPS offenders said they were seeing their responsible officer weekly compared with those supervised by the CRC, which is what we would have expected. One person supervised by the NPS was residing in an approved premises outside of their home area, and their order was being overseen by a PO from the area in which the approved premises was located. They had seen the local responsible officer, but, apart from telephone contact, had never met their home responsible officer since their release from prison. They were worried about their future housing needs being met, and did not feel adequately supported.
- 4.10. Most of the individuals told us that their responsible officer had spoken with them about the current offence that had caused them to be supervised by the NPS or CRC. One who was supervised by the CRC in Wiltshire said:

“We talk about what I did, and I feel really ashamed for what I did and for having to come to probation. We look at what I could do differently, such as walking away.”

- 4.11. Those who we interviewed were generally positive about their experience of supervision. One person being managed by the NPS said:

“My probation officer is kind and caring. He listens to me. I’m in a good place now and don’t want to mess up.”

4.12. A person managed by a CRC said:

“My OM has helped me with stuff outside of offending, relationship stuff, helped me access my credit report for instance, benefits and so on. I am attending the programme ‘Thinking ahead for women’. It is brilliant! I have learnt so much, and it has helped me to put things into perspective.”

# Appendices



# Appendix 1

## Acknowledgements

We would like to thank all the staff from the National Probation Service and the Community Rehabilitation Companies we inspected for their assistance in ensuring the smooth running of the inspection.

All inspectors are from HMI Probation.

|                                       |  |
|---------------------------------------|--|
| <b>Lead Inspector</b>                 | Tony Rolley  |
| <b>Inspection Team</b>                | Mark Boother<br>Vivienne Clarke<br>Joe Coleshill<br>Jenny Daly<br>Jo Dowling<br>Yvette Howson<br>Ruth Johnson<br>Nicola McCloskey<br>Yvonne McGuckian<br>Caroline Nicklin<br>Jon Nason<br>Amanda Paterson<br>Mike Ryan<br>Nigel Scarff<br>Mark Scott<br>Joe Simpson<br>Avtar Singh<br>Bob Smith<br>Liz Smith<br>Steve Woodgate<br>Tessa Webb |
| <b>HMI Probation Support Services</b> | Kevin Ball, <i>Senior Research Officer</i><br>Pippa Bennett, <i>Support Services Manager</i><br>Adam Harvey, <i>Support Services Officer</i><br>Oliver Kenton, <i>Research Officer</i><br>Lynne Osborn, <i>Support Services Officer</i><br>Alex Pentecost, <i>Communications Manager</i>   |
| <b>Assistant Chief Inspectors</b>     | Helen Davies<br>Sally Lester   |

# Appendix 2

## 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. We have included work with those released from custody on licence, and excluded those subject to a single requirement of unpaid work, an attendance centre, an exclusion or curfew. We also spent time in the local courts in each of the six inspections and interviewed the NPS courts manager and other NPS staff working in the courts.

The fieldwork for this inspection took place between October 2015 and February 2016. We looked at work undertaken with offenders who had received community sentences or those released on licences about four months prior to the inspection. That period equates to about one-quarter of the length of an average sentence or licence period. Consequently, it is difficult for us to assess the long-term outcomes of any delivered interventions.

In total, during the six inspections in this batch, we looked at 311 cases. The CRCs were allocated 209 of those cases, of which 103 were community orders, 46 suspended sentence supervision orders and 60 licences. The sample was 78% male and 22% female; 86% white, 4% black and minority ethnic, 4% from other ethnic groups, and 4% where ethnicity was not recorded; 93% were British.

There were 102 NPS cases in our sample, of which 25 were community orders, 20 suspended sentence supervision orders and 57 licences. The sample was 95% male and 5% female; 80% white, 8% black and minority ethnic, 6% from other ethnic groups, and 6% whose ethnicity was not recorded; 93% were recorded as British.

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. All high risk of serious harm cases and those classified as MAPPA offenders are allocated to the NPS. The NPS sample also contained a much higher proportion of licence cases and a lower proportion of female cases.

We visited six NPS local delivery unit clusters and the associated CRCs. These were:

Berkshire (Thames Valley CRC), West Midlands (Staffordshire & West Midlands CRC), Hull & East Riding (Humberside, Lincolnshire & North Yorkshire CRC), Lancashire (Cumbria & Lancashire CRC), Wiltshire (Bristol, Gloucestershire, Somerset & Wiltshire CRC), and Hertfordshire (Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire CRC). A team of eight inspectors visited each area for four days.

We interviewed 80 NPS responsible officers and 147 CRC responsible officers who had supervision of the cases we examined. We held six focus groups for senior managers in the NPS and six for senior managers in the relevant CRC. We also held six focus groups for middle managers in the NPS and six for middle managers in the relevant CRC. We interviewed Court Senior Probation Officers in each of the six areas we inspected, together with operational court staff and administrators. We interviewed 55 offenders using a semi-structured interview tool.

For this final batch of *Transforming Rehabilitation* inspections, we provided more comprehensive feedback to the CRC and NPS than we had done in previous *Transforming Rehabilitation* inspections. We held separate meetings with senior managers from the CRC and NPS of the inspected area on the Friday morning of the inspection week to give them emerging feedback. By that stage, we had received data in relation to a high percentage of the cases we had inspected. We then sent, early the following week, a written bullet point summary of our findings in relation to probation work undertaken by their organisation. That feedback highlighted good practice, and practice that required improvement. We are not publishing the individual feedback. Some senior managers indicated that they would be developing action plans to address the feedback we provided.

# Appendix 3

## Glossary

|  |  |
|--|--|
| <i>Allocation</i>  | The process by which a decision is made about whether an offender will be supervised by the NPS or a CRC.  |
| <i>Assignment</i>  | 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.   |
| <i>CAS</i>   | Case Allocation System – a document that needs to be completed prior to the allocation of a case to a CRC or the NPS.  |
| <i>Child Protection</i>  | Work to ensure that that all reasonable action has been taken to keep to a minimum the risk of a child coming to harm.   |
| <i>Circles of Support</i>  | Circles of Support is a community response to sexual offending, working in partnership with criminal justice agencies. The general aim is to reduce the risk of future sexual offending by supporting individuals who have committed sexual offences previously.   |
| <i>CRC</i>   | 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.   |
| <i>DRR</i>   | Drug Rehabilitation Requirement  |
| <i>Escalation</i>  | Escalation is used to describe the process where a case allocated to a CRC is referred to the NPS for reallocation on the grounds that an increase in the risk of harm posed by the offender now places that person within the category of those that should be supervised by the NPS.   |
| <i>HMI Probation</i>   | HM Inspectorate of Probation.  |
| <i>Interventions; constructive and restrictive interventions</i> | <p>Work with an individual that is designed to change their offending behaviour and/or to support public protection.</p> <p>A constructive intervention is where the primary purpose is to reduce likelihood of reoffending.</p> <p>A restrictive intervention is where the primary purpose is to keep to a minimum the individual's risk of serious harm to others.</p> <p>Example: with a sex offender, a constructive intervention might be to put them through an accredited sex offender programme; a 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.</p> |
| <i>LDU</i>   | Local Delivery Unit: an operation unit comprising of an office or offices, generally coterminous with police basic command units and local authority structures.   |
| <i>MAPPA</i>   | Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher risk of serious harm to others.  |

|  |  |
|--|--|
| <i>NPS</i>                                 | <p>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:</p> <ul style="list-style-type: none"> <li>• Those presenting a high or very high risk of serious harm.</li> <li>• Those managed under MAPPA arrangements.</li> <li>• Those with an RSR score over 6.89%.</li> <li>• Those eligible for deportation.</li> <li>• Those subject to deferred sentence.</li> <li>• Those where there is a 'public interest' in the case.</li> </ul>                |
| <i>nDelius</i>                             | National Delius: the national probation case management system which was rolled out through 2013 and early 2014.   |
| <i>NOMS</i>                                | National Offender Management Service: The single agency responsible for both prisons and probation services.   |
| <i>OASys</i>                               | Offender Assessment System: The nationally designed and prescribed framework for both Probation and Prisons to assess offenders, implemented in stages from April 2003.  |
| <i>Offender management</i>                 | A core principle of offender management is that a single offender manager takes responsibility for managing an offender through the period of time they are serving their sentence, whether in custody or the community. Offenders are managed differently depending on their risk of 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. |
| <i>Offender Rehabilitation Act</i>         | It was implemented in February 2015, and applies to offences committed on or after that date.  |
| <i>Probation Trust</i>                     | Until May 2014, probation services were delivered by Probation Trusts, working under the auspices of NOMS.   |
| <i>Responsible Officer</i>                 | This is the term used for the officer (usually previously entitled 'offender manager') who holds lead responsibility for managing a specific case from 'end to end'.   |
| <i>Restrictive requirements</i>            | Restrictive requirements are those requirements within a community order, suspended sentence order or custody licence where the primary purpose is to restrict the liberty of the individual. Examples include curfew, prohibited activity, residence and geographical exclusions.   |
| <i>PCSO</i>                                | Police Community Support Officers  |
| <i>PQF</i>                                 | Probation Qualifications Framework is the current training arrangement whereby probation officers and probation services officers are trained and qualified.   |
| <i>PSR</i>                                 | Pre-sentence report. This refers to any report prepared for a court, whether delivered orally or in a written format.  |
| <i>Rehabilitation Activity Requirement</i> | <p>Rehabilitation Activity Requirement (RAR): a requirement within a community order or suspended sentence order introduced by the Offender Rehabilitation Act 2014, which requires the offender to attend appointments and/or participate in activities for the purpose of their rehabilitation.</p> <p>This replaces the separate supervision and activity requirements under the Criminal Justice Act 2003.</p>   |



|                         |   |
|-------------------------|---|
| <i>Risk Matrix 2000</i> | Risk Matrix 2000 is a strategic actuarial tool designed for adult male sex offenders.   |
| <i>RoSH</i>             | Risk of Serious Harm: a term used in OASys. All cases are classified as presenting a low/ medium/ high/ very high risk of serious harm to others. HMI Probation uses this term when referring to the classification system, but uses the broader term risk of harm when referring to the analysis, which has to take place in order to determine the classification level. This helps to clarify the distinction between the probability of an event occurring and the impact/ severity of the event. The term Risk of Serious Harm only incorporates 'serious' impact, whereas using 'risk of harm' enables the necessary attention to be given to those offenders for whom lower impact/severity harmful behaviour is probable. |
| <i>RSR</i>              | 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 <i>Transforming Rehabilitation</i> .   |
| <i>Safeguarding</i>     | The ability to demonstrate that a child or young person's well-being has been 'safeguarded'. This includes – but can be broader than – Child Protection.  |
| <i>SARN</i>             | Structured Assessment of Risk and Need: An assessment tool that identifies key risk issues relating to sex offenders, and seeks to identify the long-term psychological risk factors relevant to the individual sex offender.   |
| <i>SIADA</i>            | SIADA is a structured piece of work that aims to address the behaviour of perpetrators of domestic abuse against partners or ex-partners. It is considered when the offender is not suitable for the Integrated Domestic Abuse Programme (IDAP), and can be delivered on an individual or group basis.  |
| <i>Through the Gate</i> | Through the Gate services are designed to help those sentenced to more than one day in prison to settle back into the community upon release and receive rehabilitation support so they can turn their lives around   |
| <i>ViSOR</i>            | 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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