

Thematic Inspection Report: **Putting the pieces together**

*An inspection of Multi-Agency Public
Protection Arrangements*

A Joint Inspection by HMI Probation and HMI Constabulary

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Putting the pieces together

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Foreword

Offenders subject to Multi-Agency Public Protection Arrangements are often reluctant to change, difficult to accommodate and sometimes dangerous. As a result, they present enormous challenges to those agencies tasked with ensuring that the risk of harm they present to the public is effectively managed.

The establishment and development of these multi-agency arrangements is one of the success stories of the criminal justice system. It has enabled criminal justice and other organisations to work together in a structured way to improve public protection. What previously would have been seen as the exception, in terms of inter-agency cooperation, is now the norm across England and Wales.

We found numerous examples of information exchange between agencies, the effective control and restriction of offenders and a commendable commitment to work with difficult and intractable offenders. Despite this, the Multi-Agency Public Protection Arrangements need to evolve and change. Greater clarity is required in identifying the role of the lead agency in each case, along with more sophistication in risk management planning and improved recording of actions. The most fundamental change required, however, is for public protection activity to move from being primarily centred on the exchange of information about an offender to the *active* management of that offender through the multi-agency framework.

Whilst good progress has been made, there is still some way to go before we can confidently say that all reasonable action has been taken to manage the risk to the public presented by every offender subject to Multi-Agency Public Protection Arrangements. When the arrangements worked, it was because all the agencies had put the pieces of information together, assessed the level of risk and managed the offender collaboratively. The recommendations in this report are intended to help make this outcome more likely in every case.

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SUMMARY

The inspection

This inspection of the of the Multi-Agency Public Protection Arrangements (MAPPA) was agreed by the Criminal Justice Chief Inspectors Group and formed part of the Joint Inspection Business Plan 2011-2013. It was led by HM Inspectorate of Probation, supported by HM Inspectorate of Constabulary. Its purpose was to assess the effectiveness of MAPPA in reducing the potential risk of harm to others presented by identified offenders in the community through joint working and the exchange of relevant information.

We visited six areas and looked at a sample of cases managed through MAPPA. We examined the referral process and the plans to manage these offenders in the community drawn up at the MAPPA meetings. We then assessed the extent to which the agencies involved with the offenders took action and coordinated activity in response to the decisions made at the meetings. We also carried out a separate audit of the Violent and Sexual Offender Register (ViSOR), the database that contains information about most MAPPA eligible offenders.

Overall findings

The introduction of MAPPA placed, on a statutory basis, what previously had been a series of ad hoc arrangements for criminal justice agencies and other organisations to manage offenders deemed to present a risk of harm to others. It meant that staff in all agencies had, over time, to learn to share information and work collaboratively in order to assess and manage offenders who posed a risk of harm to the public.

The subsequent development of MAPPA improved the assessment and management of these offenders. Despite the significant challenges in dealing with such individuals, the level of cooperation amongst criminal justice and other agencies, as shown by this inspection, was impressive. We found a culture of trust and openness in the agencies involved that encouraged the thoughtful exchange of information between staff working with the offenders. We also saw much good practice in the way in which staff tried to balance the needs of communities and victims with those of the offender.

Given the nature of the offenders within MAPPA, it could be argued that all the cases should have been managed to the highest possible standard. Although, our findings were broadly positive, the inspection revealed a number of key areas for improvement which, in our opinion are crucial if MAPPA are to ensure that all reasonable action is taken to manage the risk of harm presented by an offender to others in the community.

Lead Agency

The national guidance, that sets out the way in which MAPPA are to operate, requires that a lead agency should be identified for each MAPPA eligible offender.

We found that, despite this clear guidance, the concept of one agency taking the lead for an offender within MAPPA, whilst acknowledged by staff, was underdeveloped and did not impact on the way in which cases were managed. In practice, each agency involved with a case tended to act in isolation from one another other and used the MAPPA meetings mainly to update partners and exchange information.

A clearer focus on a specified lead agency would promote a more coordinated approach to the management of each offender.

Risk Management Planning

We found that MAPPA rarely produced a comprehensive risk management plan.

In accordance with the national guidance, MAPPA should agree a risk management plan for each offender subject to multi-agency management. We found that this very rarely happened in a comprehensive way. In some cases, a list of short-term actions was identified; in others, actions were too vague or simply not identified at all. We did not see any examples of a jointly agreed MAPPA risk management plan, specifying how all the relevant agencies would work together to manage the individual's risk of harm to others, including contingency arrangements. Furthermore, actions for agencies identified by MAPPA were not always well integrated into the records of the relevant agency.

Most of the cases we saw were managed through a range of restrictive interventions, including curfews, approved premises, exclusion zones and surveillance. There was little question that these interventions were necessary, but they needed to be balanced by a focus on protective factors such as involvement in positive activities and constructive interventions designed to reduce the level of risk presented by the offender in the longer term. Offender managers and MAPPA as a whole paid little attention to what would happen to the offender at the end of supervision.

Active Management

Emphasis was too often placed on information exchange within MAPPA, rather than on the active management of an offender.

MAPPA meetings to review and plan work with offenders were well attended and held at the right frequency. The chairs of the meetings worked hard to ensure that all the participants were able to make a contribution. However, in many meetings, the emphasis was more on the exchange of information between agencies rather than on the development of strategies actively to manage the risk of harm presented by the offender. As a result, the chair did not always hold agencies sufficiently to account for their actions. In order to do this, chairs of meetings not only needed to be knowledgeable about process and procedures, they also needed to be assertive and have well developed skills in chairing and managing meetings.

Documentation

Minutes of MAPPA meetings were often not fit for purpose.

Minutes recording the details of MAPPA meetings were generally poorly written and presented. In many instances, there were delays in distribution and we found numerous examples of minutes that contained out of date information, or information that was wrong. Some were lengthy and difficult to read because discussions had been transcribed verbatim. In one area, the minutes contained pages of action points, whilst in others, there were almost none. As a result, the minutes were rarely used as a working tool and staff tended to develop their own recording systems. The poor quality of the minutes meant that the agencies within MAPPA would not always be able demonstrate that they had made defensible decisions in the event of a challenge.

ViSOR

We also undertook a detailed audit of the ViSOR records held on the offenders in the inspection sample. Our findings were disappointing. We found that ViSOR was not used as a shared working tool by police and probation staff, mainly because, whilst ViSOR was reasonably accessible to police staff, access by probation staff was severely constrained. In addition, the quality of the information held on the system was not always of a high standard.

Conclusion

In order to work well, all the participants in MAPPA need to work together to develop a shared view about the nature of the risk presented by an individual offender to the public, draw up a plan to manage that risk and then ensure that the plan is implemented, reviewed and updated in response to events.

In this report, we identify a number of areas where these elements of MAPPA work can be improved and we make a range of recommendations to address these findings.

RECOMMENDATIONS

The Senior Management Board should ensure that:

- organisations working within MAPPA are held to account through the MAPPA chair for their actions regarding offenders subject to MAPPA.

Chairs of level 2 and 3 MAPPA meetings should ensure that:

- a lead agency is clearly identified for every case and takes primary responsibility for managing the case
- a comprehensive risk management plan, specifying how the agencies involved will work together to manage the risk of harm presented by the individual, is drawn in every case and reviewed where necessary
- strategies are drawn up to minimise the risk of harm presented by the individual in the longer term when no longer subject to MAPPA
- minutes of all MAPPA meetings are timely, clear and provide an accurate record of decisions and actions agreed.

1. What did we want to find out?

Summary

This chapter outlines the inspection structure and methodology. It also provides a summary of the profile of the cases we inspected.

Key Findings

- Most MAPPA offenders in the inspection sample were male.
- Over half of the offenders in the sample had been convicted of sexual offences.

Background and Purpose

- 1.1 This inspection was agreed by the Criminal Justice Chief Inspectors' Group, following consultation with key stakeholders, as part of the Joint Inspection Business Plan 2011-2013 ⁽¹⁾. Its terms of reference were:
- » to assess the effectiveness of MAPPA in reducing the potential risk of harm to others by identified offenders in the community through joint working and the exchange of relevant information.

Methodology

- 1.2 The inspection was led by HM Inspectorate of Probation, with support from HM Inspectorate of Constabulary.
- 1.3 A set of criteria, informed by a scoping document was devised for the inspection based upon the existing policy and guidance relevant to the organisations inspected. The criteria for the inspection covered:
- » leadership and management
 - » identification of MAPPA offenders
 - » assessment of the level of risk of harm to others presented by the offender
 - » managing the individual's risk of harm to others
 - » victim safety.
- 1.4 In order to assess policy and practice against the criteria, we visited six locations: Brighton, Luton, Middlesbrough, Southwark, Swansea and Warwick/Leamington Spa. These places were selected to give different socio-economic and demographic profiles. The choice of metropolitan areas as well as smaller areas gave us access to a mix of rural and urban areas, with their different populations, from which to draw evidence.
- 1.5 We sought to undertake a detailed, strategic inspection of MAPPA cases, tracking their involvement with a number of different agencies. Our aim, as always, in conducting the inspection was to ensure that all action had been taken, as could

reasonably be expected, to manage the risk of harm presented by the individual case to others. However, even when we judged offenders to have been well managed, we could not preclude, given the nature of the cases involved in the inspection, the possibility that they could reoffend.

- 1.6 A case assessment tool was developed, piloted and refined prior to the inspection. Fieldwork was undertaken between January and March 2011. In each location we selected nine cases which were managed within MAPPA. The relatively small number of cases enabled us to examine in detail MAPPA documentation in order to ascertain what the multi-agency management sought to achieve.
- 1.7 In addition, we read records and interviewed the probation and police staff directly involved with the offender. Finally, wherever possible, we interviewed staff in other agencies who had been part of the multi-agency assessment and planning process, or had directly referred individuals into the MAPPA. By adopting this methodology we answered some key questions: whether there was clarity about what the MAPPA hoped to achieve, whether staff in the range of agencies involved knew what this was and whether actions were carried out as agreed at the MAPPA meetings.
- 1.8 The cases covered a range of offence types, although the majority were sexual offenders (55%). Nineteen of the fifty-four cases inspected, were defined as the most serious and critical individuals who were often the subject of significant media and public interest (level 3 cases see 2.8) and 22% had committed offences of violence. The remainder had committed a range of offences including robbery, burglary, arson and blackmail. The individuals displayed the following characteristics:
 - » 96% were male,
 - » 70% were white British,
 - » 15% were black or black British.
- 1.9 Evidence for the inspection was also obtained from a range of practitioners and managers interviewed during the fieldwork.
- 1.10 We also carried out a detailed audit of the ViSOR database which contained details of MAPPA eligible offenders in the sample. This is included as a separate chapter to the report.

2. The Role and Purpose of MAPPA

Summary

This section outlines the role and purpose of MAPPA, its statutory basis, details of the guidance issued about the offenders who are eligible and the levels of management applicable to those offenders. It also describes the different offender assessment tools available and ViSOR, the national database used to record details of appropriate MAPPA offenders.

Key Facts

- Three key agencies, police, prisons and probation, form the Responsible Authority for MAPPA.
- A number of other agencies have a statutory Duty to Cooperate with MAPPA.
- Most MAPPA eligible offenders are managed at level 1 by an ordinary (single) agency.
- The two main assessment tools used are: OASys, which assesses the likelihood of reoffending and risk of harm to others, and RM2000, which assesses the risk of reconviction.
- ViSOR was implemented in police forces and later introduced into the probation and prison services.

The Framework

- 2.1 The Sex Offenders Act 1997 required convicted sexual offenders to notify local police of their names and addresses. It also created an expectation that the police would begin to assess and manage the risk to the public posed by each individual in conjunction with probation.
- 2.2 MAPPA was introduced in 2001 under the Criminal Justice and Court Services Act 2000 and subsequently strengthened by the Criminal Justice Act 2003, as the statutory arrangements for managing sexual and violent offenders. It provided a mechanism whereby the agencies involved could better discharge their responsibilities and protect the public in a coordinated way. It is not a statutory body in itself and each agency retains its full responsibilities and obligations. The 2010 Green Paper, *Breaking the Cycle. Effective Punishment, Rehabilitation and Sentencing*⁽²⁾, endorsed the benefits of the MAPPA, whilst acknowledging that:
'No government can or should ever promise to eliminate risk entirely, but we will ensure that this system continues to be properly delivered'.
- 2.3 The Responsible Authority consists of the police, prison and probation services. They are charged with the responsibility of ensuring that MAPPA is established in their area under the direction of a Strategic Management Board (SMB) comprising senior managers from the relevant organisations.

- 2.4 Other agencies have a 'Duty to Cooperate' with the Responsible Authority. They are:
- » Local Authority Social Care Services
 - » Primary Care Trusts, other NHS Trusts and Strategic Health Authorities
 - » Jobcentre Plus
 - » Youth Offending Teams
 - » Local Housing Authorities
 - » Registered Social Landlords who accommodate MAPPA offenders
 - » Local Education Authorities
 - » Electronic Monitoring providers
 - » The United Kingdom Border Agency.
- 2.5 Central funding was provided to establish MAPPA and ViSOR. In most areas the police and probation services had allocated resources, normally through the appointment of a MAPPA coordinator together with some administrative support, to enable the arrangements to be implemented.
- 2.6 The most recent guidance on MAPPA was produced in April 2009⁽³⁾ by the Public Protection and Mental Health Group (PPMHG) in the National Offender Management Service (NOMS). The guidance sets out the purpose of MAPPA as follows:
- 'to help to reduce the reoffending behaviour of sexual and violent offenders in order to protect the public, including victims, from serious harm'.*
- 2.7 The guidance states that all relevant agencies should work together to:
- » identify all eligible offenders
 - » complete comprehensive risk assessments that take advantage of coordinated information sharing across the agencies
 - » devise, implement and review robust risk management plans
 - » focus the available resources in a way which best protects the public from serious harm
- 2.8 To be eligible for MAPPA, offenders must be in one of the following categories:
- » **category 1:** Registered sex offenders (RSOs)
 - » **category 2:** Violent and other sexual offenders who receive a sentence of 12 months imprisonment or more. It includes those detained under hospital orders or guardianship
 - » **category 3:** Other dangerous offenders – those who do not meet the eligibility criteria under category 1 or 2, but are considered by the responsible authority to pose a risk of harm to the public which requires multi-agency management.
- 2.9 Once categorised the offender is allocated to one of three levels of management (although the level of management can change over time in the light of assessment):

- » **level 1** - Ordinary agency management; where the risks posed by the offender can be managed by the agency responsible for the supervision/case management of the offender
 - » **level 2** - Where the risk of harm to others requires active involvement and coordination from other agencies to manage the presenting risks
 - » **level 3** - Where there is a requirement for active involvement by senior managers from the agencies involved in order to commit significant resources and/or where there are significant media and/or public interest issues.
- 2.10 Level 2 and 3 MAPPA cases are subject to a requirement to hold regular meetings comprising the representatives of agencies involved with the offender. The minimum frequency of these meetings is set out in the MAPPA Guidance 2009. The guidance also contains a standard document set for minutes of meetings and other activities such as referral and information exchange.
- 2.11 Most MAPPA eligible offenders are managed at level 1. The MAPPA Annual Report 2009-2010 published by the Ministry of Justice reported the following national breakdown:
- » level 1: 38,702
 - » level 2: 8,793
 - » level 3: 843
- 2.12 There are two main assessment tools in place for MAPPA offenders:
- » **Risk Matrix 2000 (RM2000)** – the assessment tool currently approved for use by prison, probation and police staff in relation to sexual and violent offenders. It focuses on the risk of reconviction.
 - » **OASys** – used by the prison and probation services to identify the risk of reconviction and then enable the worker to assess the level of risk of harm to others and likelihood of reoffending. OASys also incorporates a violent offending predictor.
- 2.13 ViSOR is a national database of all offenders who have sexual offender registration conditions imposed upon them following criminal conviction and information on violent and potentially dangerous people. ViSOR was implemented across the police forces in 2005. It was subsequently rolled out to the probation service in 2007 and to the prison service in 2008. The NOMS ViSOR business model requires probation input onto ViSOR in relation to category 2 and 3 cases managed at either level 1 or 2. The police input details of category 1 level 1 offenders. Guidance was issued on how information should be shared on MAPPA cases that are not required to be inputted onto ViSOR.
- 2.14 Guidance and instructions on the way in which ViSOR should be used by police staff was issued by the National Policing Improvement Agency (NPIA) in 2010⁽⁴⁾. NOMS also issued guidance and instructions about how ViSOR should be used within Probation Trusts (see chapter 8).

3. Identification, classification and assessment

Summary

This section outlines the arrangements we found for the identification of MAPPA eligible offenders and the ways in which management levels were assigned to the offenders.

Key Findings

- Full exchange of information had not taken place in all cases prior to taking the decision to manage an offender at level 1.
- Referrals into MAPPA were not always timely.
- The lead agency in each case was not always identified.
- Overall assessments of risk of harm to others were of a reasonable standard, but there was confusion amongst participants in MAPPA about what risk meant.

Identification of Eligible Cases and Assignment of Management Level

- 3.1 The MAPPA guidance requires that the relevant agencies identify all MAPPA eligible offenders with whom they are in contact. All police MAPPA cases and all probation level 2 and 3 cases will have a VISOR record to which the MAPPA coordinator in each area will have access so that they can calculate the number of MAPPA eligible offenders in their area. Most probation level 1 cases will not have a VISOR record and probation must therefore identify all such offenders on their case management system so that the MAPPA coordinator can retrieve the relevant details as required.
- 3.2 Whilst we focused on level 2 and 3 cases, we also investigated the arrangements for the assessment of level 1 cases in each locality. The most recent joint inspection⁽⁵⁾ of the management of sexual offenders in the community had raised concerns about the robustness of processes for the classification of level 1 cases and in March 2011 NOMS issued best practice guidance to supplement the existing instructions⁽⁵⁾. Implementation of guidance post-dated the fieldwork for this inspection.
- 3.3 We found that in three of the areas visited, either police or probation decided unilaterally on the level 1 designation without reference to other agencies. This meant that these decisions were taken without the full range of information being available. In contrast, in the three other locations, such decisions were made jointly. For example, in Southwark, a screening meeting was held by police and probation to decide on the management level of all MAPPA eligible cases.
- 3.4 It was unclear how effective the review systems were for level 1 cases in ensuring that they continued to be managed at the correct level. We also found that in some cases, where an offender managed at either level 2 or 3 was recalled to prison, they were rightly lowered to level 1, but that this sometimes meant that

there was insufficient time for a level 2 or 3 MAPPA meeting to be set up on their eventual release.

- 3.5 We concluded that, when thoroughly assessed and reviewed, the designation of level 1 to a case was helpful, because it allowed for an enhanced level of case management with the opportunity to exchange information with other agencies. The extent to which this opportunity was taken varied and it was clear that different thresholds operated across the areas visited as to when a case should be referred to level 2 or 3.
- 3.6 We took the view that MAPPA should be reserved for those offenders where agencies needed to work together to manage the risk of harm presented by an offender to the public or any complexities such as a high level of media interest in a particular case, and that if staff had full confidence in the level 1 arrangements, the need to refer to levels 2 or 3 might be reduced. In this respect, it was significant that three relatively straight-forward cases in the sample were assessed by probation staff as presenting a medium risk of harm to others but managed at level 2. This was surprising given the role and purpose of MAPPA. In addition, aggregated data from HMI Probation's Offender Management Inspection programme indicated that level 1 MAPPA cases were not significantly better managed than offenders who were not within MAPPA; this finding reinforced the need for the level 1 mechanism to be meaningful.
- 3.7 On occasions, it was clear that the designation of a higher MAPPA management level was a tactic to lever resources for a case rather than an expression of the needs of the case. In one locality, the approved premises only accepted referrals of level 3 offenders. In one particular case in this area, the level 3 designation was agreed, but as soon the offender arrived at the approved premises, was reduced to level 2. Some cases were assigned to a higher level of management simply because of the seriousness of the offence rather than the need to involve a range of agencies in the case. For example, we found three cases in the sample where there was no multi-agency involvement, yet they were still managed at level 2.
- 3.8 Referrals to MAPPA were not made within the required timescale in 30% of cases in the sample, although there were often practical reasons for delay. The overwhelming majority of cases were released from prison and we found in a number of cases that the prison had identified the MAPPA eligible offender six months prior to release (as required in the guidance) but the offender manager in the community had not then referred the case to MAPPA promptly because of uncertainties about the release address. Given the nature of some of the cases within the sample, this was understandable.
- 3.9 In some prisons, the concept of Offender Management was under developed and it was therefore unsurprising to find so little evidence of good preparation for release. The variable quality of Offender Management arrangements in prisons meant that the opportunities for good planning in MAPPA were missed. There were some exceptions to this. In Brighton and Luton, we found excellent links with local prisons and MAPPA eligible offenders were moved to the local prison immediately prior to release in order to facilitate effective planning.
- 3.10 Information was supplied to the MAPPA meeting from prisons or young offender institution in 82% of relevant cases. However, the quality of the information varied. The information supplied was normally in written form, with few instances

of the use of video-conferencing or attendance in person by prison staff. The flow of information from custody to the community was crucial to effective assessment and subsequent management of the offender's risk of harm to others but was often somewhat unreliable. Where an offender had been in a number of prisons during a sentence, crucial information about their behaviour and progress at the earlier stages of their sentence was frequently lacking. We nevertheless found some examples of good practice. In one case, a long list of adjudications relating to the offender and his potential risk of harm to others had been supplied to the meeting by the prison.

- 3.11 Even when information had been supplied by the prison or young offender institution it was not clear how MAPPA had taken account of it in 22% of the cases examined.

Lead Agency

- 3.12 The concept of lead agency was not well embedded in practice; this theme is developed later in the report. We took the view that the lead agency (or the key worker from that agency) needed to take ownership of the case and coordinate activity from the start of its referral to MAPPA. Whilst the MAPPA guidance required that a lead agency was identified for each case, this was essentially an administrative exercise in practice, usually determined by which agency had referred the case to MAPPA. For the most part, the police took the lead on RSOs and probation on community sentences and post-custodial licences. In the small number of cases where a YOT was supervising a MAPPA eligible offender, a YOT worker took the lead.
- 3.13 When interviewed, staff did not consider the designation of a lead agency as important and it was indicative of the lack of importance attached to the concept that we found that the lead agency was not always clearly recorded in the MAPPA documentation. Some staff interviewed were unable to articulate the concept of a lead agency or explain what the term meant to them.

Assessment

- 3.14 We considered that the initial assessments on the cases we inspected were, for the most part, accurate. However, in all the areas we visited, police and probation employed different assessment tools. The police used RM2000 for sexual offenders (category 1) to measure risk of reoffending and probation used OASys for category 2 cases to assess the likelihood of reoffending and risk of harm to others. This was potentially confusing. In addition, little attention was paid by probation staff to the violent offending predictor element of OASys, which was significant given the violent nature of many MAPPA offenders.
- 3.15 We were also concerned, as we found in our inspection of sexual offenders in 2010 (6) that words such as 'High Risk' meant different things to different people and were used to denote different things. For example, high risk could sometimes be used to refer to risk of reoffending and, at others, to risk of harm. In addition, for health professionals the words had a different context and meaning. There was a need, therefore, to develop a common language and understanding in order to ensure that all the agencies were clear about the crucial issues. The role of the

MAPPA meeting chair was central in shaping and determining this process. Unfortunately, we did not see much evidence of these debates taking place.

- 3.16 We did not find any examples of formal processes that meant that offenders were informed of their MAPPA status and what it entailed. Some staff reported concerns that knowledge of their MAPPA status might be unhelpful in managing certain offenders so this issue should be considered on a case by case basis. Similarly, little attention was paid to the need to engage offenders in managing their own level of risk of harm to others and develop exit strategies for when formal supervision and MAPPA oversight processes were no longer in place.

Conclusion

- 3.17 In the areas where there was an exchange of information in relation to level 1 cases, it was clear that MAPPA added value to the management of these cases. In those cases where the decision rested with a single agency, it was difficult to see what advantage MAPPA offered and the classification process appeared to be an essentially administrative exercise.
- 3.18 The working cultures we found were cooperative and open and illustrated the excellent progress MAPPA had made in the time that it has been in existence. The lack of prominence given to the designation of a lead agency in every case, by staff we met, was an important finding and, we believe, an aspect of practice that needed to be given greater attention if MAPPA was to be effective. We took the view that not only did the concept of a lead agency establish a clear line of accountability; it also had the potential to move the work of MAPPA from a focus on information sharing and exchange to active management of the risk of harm presented by offenders to others.
- 3.19 The lack of clarity and the use of inconsistent terminology in relation to *Risk of Harm to others* created the potential for confusion amongst the MAPPA participants when assessments were discussed.

Practice example:

As part of the information sharing agreements in Middlesbrough, MAPPA offenders were flagged on information systems in the local general hospital. The purpose of this was to help ensure that other agencies were alerted if the offender or someone related to the offender presented at hospital, in order that appropriate action could be taken. This was particularly relevant for victims of domestic violence.

4. Doing what needs to be done

Summary

This section outlines the actions and decisions agreed at the MAPPA level 2 and 3 meetings in relation to the cases we inspected. It comments on the frequency of meetings, the quality of the minutes, whether actions were clearly identified and agencies held to account for their actions. It also comments on the effectiveness of risk management plans (RMPs) drawn up as part of the MAPPA process.

Key Findings

- The frequency of meetings was for the most part, satisfactory.
- Attendance at meetings was good.
- Decisions about disclosure of information about offenders to third parties were well managed and reviewed.
- Meetings were an effective way for individual agencies to exchange information about an offender.
- RMPs were underdeveloped and there was little evidence of contingency planning.
- The participating agencies were not always held to account by the meeting chair for the actions identified in the meetings.
- Minutes were often unclear and not timely
- ViSOR was not used as a working tool.

Frequency and Attendance at Meetings

- 4.1 The MAPPA guidance specifies the frequency of meetings for level 2 and 3 cases. In 91%, of the cases we inspected, the required frequency had been met in all or most instances. In all the localities visited, level 2 meetings were timetabled at regular intervals, whereas level 3 meetings were more likely to be held as and when they were needed; these systems worked well.
- 4.2 The frequency of meetings provided regular opportunities for cases to be discussed, but the volume of cases meant that little time was available for in-depth discussion. We came across examples of level 2 meetings that were scheduled at 15 minute intervals, making detailed analysis and planning impossible. This problem was mitigated in the small number of cases where the concept of the lead agency was well embedded and the lead worker was able either to present a well structured summary of the issues that needed to be taken forward to the meeting or to meet formally with colleagues from the other agencies involved in the case outside of the main meeting. For example, in Brighton, a structure of professionals meetings met outside the main panel meeting to take forward actions identified by the panel. We would commend such

an approach, provided these additional meetings were accurately documented in order to ensure proper accountability. The approach was similar to that adopted in child protection, whereby a full child protection conference was held to set the strategy and maintain oversight, then reconvened some months later, with a core group coordinating information exchange and operational delivery.

- 4.3 Attendance at meetings by representatives of the Responsible Authorities and Duty to Cooperate agencies was generally satisfactory, although in one or two areas prison staff were understandably not always able to attend physically because of the travelling involved. In another area, police officers who managed RSOs did not attend meetings, although their manager did so. For the level 3 meetings we found that in all areas except one, where the police seniority level needed to be higher, the attendees were of sufficient seniority to take decisions and commit resources. The presence of these senior managers, who could bring influence to bear on the issues presented by very complex and dangerous offenders, brought added value to the level 3 meetings.

Documentation

- 4.4 The MAPPA guidance prescribes a standard template to be used to capture information from MAPPA meetings. This template provides a framework setting out the basic details of the case, names of the workers involved, the nature of the offender's risk of harm to others and the actions necessary to manage it. The minutes are therefore a crucial tool for communication and establishing accountability within the multi-agency management approach. Their importance was further underlined by the fact that, in respect of the cases in our inspection sample, information was normally reported orally, rather than in the form of written reports.
- 4.5 We found in 24% of cases that the minutes did not clearly identify all the required actions from the statutory and Duty to Cooperate agencies in all or most instances. This meant that in almost one in four of the cases we were not confident that participants in the meeting knew what was expected of them. Too many of the actions related to the exchange of basic information, rather than actions designed *jointly* to manage the offender's risk of harm to others. In addition, the actions were often vague, e.g. *'To notify all agencies of changes in mood.'* Some were not related to risk of harm to others, e.g. *'To register with a doctor'*, whilst others were often actions that were part of an agency's normal practice e.g. *'Update OASys.'* Where we judged that actions had been clearly identified, we found they included the required actions, the name of the individual responsible, were realistic and achievable within relevant timescales.
- 4.6 It was possible to identify the required actions in around three-quarters of cases. We found very few cases where MAPPA had drawn up a full RMP informed by an assessment of the offender's risk of harm to others and detailed activity of all the agencies involved with the offender, as required by the guidance. Usually the plan was simply a list of actions, in some a short-term tactical plan. Others replicated OASys without reference to other agencies. The lack of emphasis given to the principle of a lead agency may have contributed to this state of affairs because in the absence of a clear steer from the chair of the meeting, each agency appeared to take responsibility for drawing up their own internal, rather than joint, RMP

then using the meeting to exchange information. We saw little evidence of contingency planning in the RMPs. Although much attention was paid to restrictive interventions, such as curfew conditions and strict reporting arrangements, too little attention, in our view, was given to the promotion of protective factors that might reduce the risk of harm to others, such as attendance at specialised offending behaviour programmes or the involvement of wider support mechanisms in the community.

- 4.7 In only 65% of the cases had the actions required from the previous meeting been clearly reviewed. Too many actions were noted to be '*completed*' or '*ongoing*'. More scrutiny was needed to ensure the impact of taking or not taking a particular action was evaluated. The problem was compounded in at least one of the localities we visited where the large number of action points precluded anything more than a cursory review. In addition, the rationale was not always clearly articulated when a decision was made to change the level of MAPPA management.
- 4.8 We found a lack of clarity about the role and purpose of the minutes. For many, the primary consideration seemed to appear to be a desire to record everything that was said in order that a decision-making audit trail was created. In one area, minutes were transcribed verbatim from tape recordings. This meant that the documents were little help in terms of creating a crisp summary of the actions that needed to be taken. There were also other problems with the quality of the minutes. We found numerous examples of out of date material pasted in from one set of minutes to another, little editing of extraneous material and inaccuracies that remained uncorrected. The chairs of meetings did not appear to give a steer to minute takers about what was required and this situation was compounded by the lack of experience of some minute takers. More direction and leadership was needed.
- 4.9 The minutes of the meetings were not always dated and in only 47% of cases were they always produced in a timely manner. We did, however, find some examples of good practice despite this disappointing finding. In two areas, the actions for individuals were emailed out the day after the meeting. In general, the minutes were not used as a working tool by practitioners and, in the worst cases, we found that minutes were issued shortly before the next meeting. This meant that workers developed their own systems to keep track of what was happening. In one area, the police officers kept a separate file and, as a result, never referred to minutes.
- 4.10 We found the minute structure cumbersome. The reasons for the delays in issuing minutes seemed primarily to revolve around workload. The number of cases and the length of the minutes meant that they took time to type up and there were also often delays in getting the minutes approved by the meeting chair. In one area the delays were compounded by the fact some Duty to Cooperate agencies did not have access to secure email facilities and minutes had to be sent out by alternative means. The MAPPA in one locality were piloting the new national document set issued by the PPMHG, but staff took the view that there were few advantages to this.
- 4.11 The culture of most meetings was one of information exchange between the agencies rather than one of active management. The promotion of active risk

management should, in our view, have been a primary role of the chair of the MAPPA meeting. It was significant that we found evidence in only 55% of cases that the MAPPA held the relevant agencies to account for their actions. We found a tendency for the chairs to take at face value what partners said. For example, in one case, extensive delays in probation obtaining permission from a psychiatrist for police use of a report in evidence for a sex offender prevention order (SOPO) application went unchallenged. In another case, non-attendance by a social worker whose presence was critical to the outcome of the meeting was not pursued by the chair. In other instances, tasks were allocated to the offender manager that were more properly the responsibility of the meeting chair, for example, asking the offender manager to find out why a representative from another agency had not attended a meeting.

Disclosure

- 4.12 The Criminal Justice and Immigration Act 2008 placed a duty on MAPPA Responsible Authorities to consider disclosure to third parties such as partners or potential victims in every case. This aspect of practice was well signposted and recorded in the minutes. Disclosure of this type was clearly recorded in 96% of applicable cases and reasons given in 76%. There were complexities and challenges in disclosure practice. For example, in one case a sexual offender had made friends with a number of women and the police had to obtain details of their mobile phones in order to make contact with them.

Victim Safety

- 4.13 Action was taken to ensure victim safety in 78% of cases. Where a victim liaison officer regularly attended the MAPPA meetings, the likelihood of victim safety issues being brought to the attention of the meeting increased considerably. (The victim liaison officer attended in 63% of cases where they were actively involved with a victim.) In one Brighton case, the victim liaison officer's contact with victims (the families of abused children) was probably instrumental in dissuading them from contacting the press; had they done so, it would have made the management of the case more difficult. We saw little acknowledgement in cases potentially involving domestic violence of the existence of Multi-Agency Risk Assessment Conferences (MARAC) by the MAPPA meetings. However, in Luton we found an excellent example of a victim safety plan. In order to protect an offender's ex-wife and child who had moved to another county, a contingency plan had been drawn up detailing the steps to be taken by the police and children's services in the event of the man making contact with his former family.
- 4.14 It was not always clear what had been done to protect victims or potential victims who had emerged as part of the investigations into an offender's criminal history or lifestyle prior to their referral to MAPPA.

ViSOR

- 4.15 ViSOR rarely contained the full details of the MAPPA meetings and actions were often not recorded in the right sections of the database, nor was it always regularly updated. Whilst the police recorded details of RSOs on ViSOR, it was

seen primarily as a bureaucratic exercise. Probation staff rarely accessed the system, aside from administrative staff inputting the details of category 2 MAPPA cases. Similarly, we found few examples of prison staff using ViSOR in an active way in order to manage offenders deemed to present a risk of harm. A detailed account of our ViSOR findings is set out in Chapter 8 of this report.

Conclusion

- 4.16 It was clear that MAPPA had become an established and well-used resource. Many of our findings about level 2 and 3 meetings were broadly positive, but some significant weaknesses remained. The quality of the documentation in many cases was not sufficient to demonstrate proper accountability and the absence of a comprehensive MAPPA RMP undermined the collaborative nature of the work. Most meetings needed to move beyond information exchange to a more active style of management of the offender. In order to do this the chairs of those meetings needed to be more assertive in holding participants to account.

Practice example:

In Brighton good work took place in respect of a 14 year old prospective victim whom the offender had befriended and was 'dating'. The work included disclosure to her mother and later to her, but most significantly through surveillance work the offender was shown to be in breach of his SOPO and received an 18 month custodial sentence.

5. Managing Risk of Harm: the agencies

Summary

This section outlines how well the Responsible Authority and Duty to Cooperate agencies took forward the actions identified in the MAPPA meetings in order to effectively manage the risk of harm to others presented by offenders subject to MAPPA.

Key Findings

- Probation RMPs were completed but did not always contain details of the MAPPA decisions and actions.
- Probation staff were effective in exchanging information and in most cases carried out the actions identified at the MAPPA meeting.
- Approved premises provided an important element for the supervision and containment of MAPPA eligible offenders, but offender managers needed to give greater emphasis to planning constructive interventions with offenders.
- Exit strategies for offenders finishing supervision were underdeveloped.
- Police officers were effective in exchanging information and had carried out the actions identified in the MAPPA meeting in the majority of cases.
- Home visits were made by police officers to RSOs, although more attention needed to be given to the purpose of these visits.
- Prison staff were not always well integrated with MAPPA as a result of frequent transfers of prisoners between prisons.
- Social care staff worked effectively with criminal justice staff in working to protect children from dangerous offenders.
- Problems with establishing a clear psychiatric diagnosis in some cases hindered the effectiveness of mental health workers in MAPPA.
- Housing authorities were good at responding to the challenge of working with MAPPA eligible offenders in the community.

- 5.1 We sought to follow-up the MAPPA process by examining how well the agencies assessed and managed the risk of harm to others presented by the offenders in the case sample.

Probation and YOT

- 5.2 There were four cases in the sample that were supervised by a YOT. Overall, we found that YOT staff lacked confidence in the MAPPA processes and eligibility criteria. In two cases, the referral into MAPPA was late. However, we found positive engagement with mainstream children's services in one case and in

another, the eventual transfer to probation was well managed. YOT staff often felt that the needs of some young people were not met by the range of agencies which made up the MAPPA in most areas as they focused on adult's services. In response, a number of YOTs preferred to manage these young people through their own internal risk management mechanisms. These findings were consistent with those of HMI Probation's core programme of youth offending inspections and merited further investigation.

- 5.3 Although there was an up to date probation RMP in OASYs in 90% of the relevant cases, it incorporated the actions identified at the MAPPA meeting in less than half (48%). A number of these RMPs referred to MAPPA but gave insufficient detail and, in most cases, the actions of other agencies, such as police visits to RSOs, were not referenced, thus reducing the effectiveness of joint work between the two agencies.
- 5.4 Information exchange about offenders between agencies and probation was reasonably good outside the actual MAPPA meetings. In 80% of cases we judged that probation or YOT staff had communicated with other agencies in a timely and effective way about risk management issues. Similarly, other agencies communicated with probation effectively in 72% of cases. In one case in Swansea, the offender manager had informed the prison of an increase in the level of risk presented by an offender who had been recalled for breach of his licence. As a result, the prison provided interventions for the offender to address his sexual offending.
- 5.5 In 92% of cases, actions identified by MAPPA were either always or usually carried out by the offender manager, YOT case manager or others working on their behalf and then reported back to MAPPA in a timely way in 91% of cases. A good example of this work was the inclusion of specific conditions in an offender's post custodial licence following decisions taken at a MAPPA meeting.
- 5.6 In all the localities we visited, the allocation of MAPPA cases was restricted to a small number of specifically identified staff, sometimes working in joint police and probation teams. The trust and understanding that had built up in these arrangements was valued by practitioners. In those areas where plans were being made to extend the work to a wider staff group, considerable anxiety was expressed amongst practitioners about how this system would work.
- 5.7 The recording of actions and activities arising from MAPPA meetings were not always very clear in probation and YOT records. In Brighton, this problem had been successfully addressed by having a clearly marked section of the probation electronic case record for MAPPA.
- 5.8 Contact levels were appropriate to the risk of harm level in the vast majority of cases. Only just over half of the offenders in the sample had complied fully with the requirements of the post custodial licence or community sentence, but enforcement action had been taken in all except one case.
- 5.9 Appropriate priority was paid to victim safety in 83% of relevant cases by the offender manager or case manager. Actions emerging from the MAPPA were taken and reported to the MAPPA in a timely manner in 92% and 87% of cases respectively.

- 5.10 All reasonable action to manage an offender's risk of harm to others was taken by probation and YOT staff in 83% of cases. This was a higher percentage of cases than we found for the MAPPA process as a whole when the same question was posed. It should also be noted that an analysis of HMI Probation's Offender Management Inspection findings concluded that MAPPA cases were generally better managed in terms of risk than non-MAPPA cases.
- 5.11 ViSOR was underused by probation staff. Brighton and Swansea were included in a pilot project that involved a number of other Probation Trusts to allow probation staff easier access to the system. Whilst there were positive reports about the impact of the pilot in other areas, unfortunately, neither pilot in the areas we visited had succeeded in achieving this aim. Problems remained in all six areas in terms of the accessibility of ViSOR for probation staff because of the lack of terminals and the security constraints that inhibited its use. This meant that, confusingly, information was recorded in different places; including the ViSOR, OASys, probation case records and in MAPPA documentation. The scope for errors in the transcription of information was considerable.
- 5.12 There was evidence of effective management oversight in only 63% of cases, although 91% of staff interviewed felt that they received sufficient management support and oversight.
- 5.13 Most of the cases we saw were managed through a range of restrictive interventions, including curfews, approved premises, exclusion zones and surveillance. There was little question that these interventions were necessary, but they needed to be balanced by a focus on protective factors such as involvement in positive activities and constructive interventions designed to reduce the offender's risk of harm to others. We saw few references to the range of intervention programmes available that could have contributed to effective risk management such as substance misuse programmes. There was also a need to plan in more detail what would happen to the offender at the end of supervision. Little attention was paid to exit strategies by both offender managers and by MAPPA as a whole.

Practice example:

Following release from prison to live in Southwark, the offender was subject to a mix of restrictive and constructive interventions. He had been helped to find suitable work, undertook a challenging sexual offender programme and engaged in psychotherapy sessions at a local clinic. He was also subject to strict licence conditions that included high levels of contact with his offender manager and prescribed where he could live.

Approved Premises

- 5.14 Approved premises were used in 35 of the 54 cases to manage offenders presenting a high risk of harm to others. In many cases, the offender had only been released from custody because of the additional level of surveillance and restriction that was offered by the approved premise. Not surprisingly, staff from approved premises had a high profile in MAPPA, attended meetings and actively contributed to discussion in 80% and 81% of cases respectively. In addition, in

almost all the cases, the actions required of the approved premises were carried out and reported back to MAPPA in a timely manner.

- 5.15 We found numerous examples of approved premises providing a very high degree of oversight of MAPPA offenders. The offenders were often subject to strict curfews and significant restrictions on their movements that sometimes involved signing in at the approved premises at hourly intervals.

Practice example:

In Middlesbrough, good links had been established between the approved premises and adult social care services. In one case, a package of support for an elderly offender had been arranged to help him live in the approved premise.

Police

- 5.16 The requisite actions arising from the MAPPA meetings were carried out by the police and reported back to the MAPPA in 96% and 94% of cases respectively. In one case in Middlesbrough, police officers had undertaken to escort the offender on release from prison to an approved premise and had taken prompt action to facilitate the offender's subsequent arrest for breach of licence conditions. In another case in Luton, the police had liaised with a neighbouring police force to obtain information about an offender's gang affiliations.
- 5.17 Where the police were the lead agency (for RSOs), just under three-quarters of the cases contained a police RMP on ViSOR, but the plan was not consistent with the actions set out in the MAPPA meeting in just over a two-thirds of relevant cases. The RMPs varied greatly in quality and we had little sense of them as robust, visible documents that were used as working tools by police officers. Despite this, we found some promising initiatives. In Middlesbrough, the police MAPPA coordinator completed a separate police RMP on ViSOR following reviews and pulled the specific police actions from the MAPPA RMP onto ViSOR. In Southwark, reference was made to both the police and probation RMPs in the meetings but unfortunately there was not a robust system for ensuring that the two sets of plans were consistent.
- 5.18 Police officers dealing directly with the cases did not always attend MAPPA meetings in two areas we visited. They were normally represented by a police sergeant. The rationale for this process appeared to be one of efficiency and a desire to ensure that best use was made of the officer's time. This was understandable, although more effective timetabling of the cases to be discussed at the meetings might well have meant that the officers could have been present.
- 5.19 Visits to RSOs and violent offenders were considered appropriate to the needs of the case in 88% of relevant cases and compliant with force policy in 90%. In a number of situations, the frequency of visits exceeded that prescribed by policy. We found some examples of joint visits with probation staff in Middlesbrough, but overall the use of visits was somewhat formulaic. Little attention was paid to varying the frequency as a result in changes in the level of risk of harm presented by the offender to others. For example, offenders in approved premises had more visits than offenders living in mainstream accommodation.

- 5.20 Information sharing by police officers took place in 98% of the cases. The links with probation offender managers were very good and information was exchanged in a spirit of trust and openness. However, links between the police and their community policing team colleagues were not always so strong. Information about RSOs living in the community was not always passed on to these teams and the opportunity to gather intelligence about them from community policing teams was rarely taken up.
- 5.21 All reasonable action was taken by the police to minimise the risk of harm presented by the others in 91% of cases. This again compared favourably with our assessment of the MAPPA as a whole in relation to this issue.
- 5.22 There was evidence of management supervision and oversight in 63% of cases. All of the police officers interviewed indicated that they received sufficient management oversight to support them in working with MAPPA offenders.

Practice example:

In Luton, police and YOT staff worked together to ensure victim safety. In one case, a breach of licence was only discovered when a trawl by the police of closed circuit television recordings within an area supported the allegation that the young person had entered an exclusion zone, close to where his victim lived.

Prison

- 5.23 In over half of the cases, the prison was not represented at the MAPPA meeting where an offender was in prison or recently released. Much of this was due to the fact that prisons often had to serve a number of MAPPAs in different parts of the country and it was difficult to release staff to attend meetings, even if they were reasonably close. On occasions, good use was made of Annex F – the form used to record and transmit information about MAPPA offenders from prisons to the MAPPA meetings.
- 5.24 Although the identification of MAPPA eligible offenders by prison staff was reasonably prompt, there was little evidence that the identification and eventual referral to MAPPA by the offender manager had been made in the context of thorough planning and preparation for release. The priority appeared to be to complete the process, rather to consider the wider implications of the activity. We saw little attention paid by MAPPA to pre-release planning and few examples of MAPPA chairs actively requesting information from prisons. In Luton, however, the presence of the MAPPA administrator from HMP Bedford at the MAPPA meetings meant that this type of information was more likely to be produced.
- 5.25 Where there were specific actions for the prison, staff were clear about what was required in 73% of relevant cases. Unfortunately, it then transpired that the actions had been taken in only 60% of relevant cases. We found some examples of good practice; in Swansea, effective liaison between MAPPA and prison staff meant that a prisoner was stopped from writing to a potential victim.
- 5.26 Changes in an offender's circumstances were communicated to other agencies in a timely way in 71% of cases. Prison staff shared relevant information with MAPPA in 76% of cases. Staff from Hindley Young Offender Institution kept the YOT case

manager informed about a young person's progress and behaviour in custody in a helpful way. On the other hand in another institution, details of an offender's drug tests in custody were available but it was only when the offender manager requested them were they produced for the MAPPA. We also found two other cases where problems with medical confidentiality precluded full details of an offender's health problems being made available to MAPPA.

- 5.27 In another example of good practice, Swinfen Hall Young Offender Institution produced a very detailed report for the MAPPA meeting from a forensic psychologist, at the point of release, that detailed what the young person had achieved in custody, and what still needed to be done with him. This was helpful information which informed work with the young person during the community phase of his sentence, particularly in its early stages.
- 5.28 ViSOR was available to prison staff, but did not appear to be used as a way of managing either the exchange of information or the offender's risk of harm to others.

Practice example:

A MAPPA offender on remand was transferred from Swansea to Cardiff prison. The prisoner was assigned an offender supervisor in prison (despite being on remand). Following a MAPPA meeting in Swansea the offender supervisor was tasked with briefing wing staff about the risk of harm to others the man presented and issues to look for. The offender supervisor provided valuable information to MAPPA about the networks the offender was creating and the people to whom he was writing. This information helped inform the RMP.

Duty to Cooperate Agencies

- 5.29 A range of other agencies had a Duty to Cooperate with MAPPA. The most common were children's social care services, involved in 30 cases, reflecting child protection concerns. This was followed by health services (emphasising the prevalence of mental health problems amongst many of the offenders) in 29. Housing authorities were involved with 20 offenders as there was often a need for move-on accommodation from approved premises for offenders subject to MAPPA.
- 5.30 It was clear that without the existence of MAPPA, action would not always have been taken by these organisations in the cases we inspected. Overall, we were impressed by the commitment of the Duty to Cooperate agencies in the way they worked with criminal justice organisations. Most of the agencies had nominated a 'single point of contact' in order to ensure that communication did not break down, whilst ensuring that information remained confidential. A small number of agencies did not have secure email, but this did not impact significantly on the way they worked.

Social Care

- 5.31 In 79% of relevant cases, the agency was aware of the actions agreed at the MAPPA meeting and was clear what they had to do in 88%. It was apparent in the

cases in the inspection sample that social care services rarely had direct involvement with the offender, but were often involved with children and/or adults with whom the offender had contact. This meant that they brought an important different perspective to the case than the other agencies, focused rightly on the protection of the child or vulnerable adult with whom the offender had contact. In one case in Luton, we found that social care services had played a major role throughout in supporting and protecting an offender's partner and child. They initiated communication with probation and police, provided evidence for the offender's recall from a hostel in Sunderland and took a more central role with his release from prison as he was not then subject to supervision on licence by probation.

- 5.32 Social care services attended MAPPA meetings in 79% of relevant cases. In Luton, the Independent Reviewing Officer attended all MAPPA meetings so that they could act in cases with no current social work involvement as the point of contact for supplying past information where relevant and pursue further enquiries. This arrangement worked well.
- 5.33 Social care services carried out the actions identified at the MAPPA meeting and reported it back in 84% of cases. In one case, in Southwark, the social worker had supported the partner (who was the victim), instigated child protection measures and organised a house move to another borough.
- 5.34 In 80% of cases social care services told other agencies of any changes in circumstances and relevant action in a timely way. In 70% of cases they shared relevant information about the offender with MAPPA.

Health

- 5.35 In 76% of relevant cases, the health agency was aware of what actions had been agreed at the MAPPA meeting and was clear what they had to do in 84%. Difficulties in coming to an agreed diagnosis about an offender's mental health meant that it often took a long time to decide on the best course of action.
- 5.36 There was good attendance at meetings by specialist mental health staff. In Warwick/Leamington Spa, the contribution of forensic community psychiatric nurses was especially helpful. In Brighton, some problems had occurred in the past, apparently partly as a result of organisational restructuring, in securing the attendance of health workers, but appeared to have been resolved through the efforts of the MAPPA SMB. We did not see any cases where a General Practitioner (GP) had an input and it was significant that details of an offender's GP were not included on the MAPPA referral form, despite the fact that for many of the offenders in approved premises, good links existed between the approved premise and local GPs.
- 5.37 Health professionals were clear about what they had to do in 84% of cases, but only carried actions out in 60% of cases. A major issue in all areas was the number of cases with difficult mental health problems and a lack of clarity about personality disorder diagnosis, which meant that mental health services were often not provided.
- 5.38 Health services shared relevant information about the offender with MAPPA in 88% of relevant cases. Aside from the two cases where information had been

withheld by the prison, referred to earlier, we found few problems with the concept of medical confidentiality and that when requests for medical information were framed in the context of public protection, it was made available. The information sharing agreements and protocols that were in place in all six areas provided a framework within which it was possible to work effectively. For example, despite several previous unsuccessful attempts to get an offender from Middlesbrough into residential psychiatric care, after discussion of the case at MAPPA meetings, he was admitted under a section of the Mental Health Act 1983. Prior to this he often presented at the general hospital Accident and Emergency Department. The security manager there had provided a good link between MAPPA and medical staff, ensuring that the offender's deteriorating mental state and potential for violence was recognised.

Local Housing Authorities and Registered Social Landlords

- 5.39 Housing authorities were aware of the actions agreed at MAPPA meetings and were clear about what they had to do as a result in 89% of relevant cases. Attendance at meetings was good and actions were carried out in the vast majority of cases. The meeting was updated in 89% of cases and relevant information was shared with other agencies in 72% of cases.
- 5.40 The contribution of housing authorities to the work of MAPPA was impressive in all the areas we visited. The existence of MAPPA had reinforced to housing authorities their wider responsibility to individuals and the importance of integrating them in the community. It was clear that in the cases we saw, the framework that MAPPA offered had made a difference to how offenders were dealt with by housing authorities and registered social landlords. There were tensions in this approach as the authorities sought to balance the needs of the offender with those of the wider community. For example, Southwark Housing attended a MAPPA meeting and arranged funding and support for an offender when he left the approved premise in Southwark, even though he had not been a Southwark case on release, would not return to the borough and there was no requirement for them to contribute actively to the case. Similarly, in Brighton, although the local authority decided that it did not have a formal duty in relation to a particular offender, it still helped the offender to gain privately rented accommodation, liaising closely with the offender manager.
- 5.41 Housing authorities were prepared to vary their policy in the light of public protection concerns. In Warwick, the MAPPA coordinator had contacted Warwick District Council Housing Department in order to try and secure suitable post approved premises accommodation for a violent man. The housing authority suspended their normal 'choice based' letting policy and made a special case for him.
- 5.42 In four cases, a registered social landlord was involved with a MAPPA offender. Their contribution in all cases was positive. The registered social landlords were aware of the issues, attended the meetings, and were clear about the actions required, carried them out, reported back to MAPPA and shared information about the offender.
- 5.43 We found good examples of integrated planning. In Middlesbrough, the housing provider had taken on the role of responsible landlord from the Borough Council

and was assigned a tenancy for the offender. In this case, the tenancy agreement was linked to an SOPO.

Electronic Monitoring Providers

- 5.44 Providers of electronic monitoring were involved in one case but had not been invited to participate in the MAPPA.

Jobcentre Plus

- 5.45 Jobcentre plus was not involved in any of the cases in the inspection sample. We were told that, as a result of national guidance, Jobcentre staff were understandably reluctant to become involved in MAPPA meetings regarding offenders with whom they had no contact, although in some cases they would have been able to provide a useful perspective on the offender's employability. However, they would supply information about offenders with whom they were actively involved.

Conclusion

- 5.46 We found that staff in the relevant organisations readily exchanged information and took their responsibilities seriously. At times, this work appeared to be independent of MAPPA, for example, some cases needed greater coordination of home visits by police and probation staff. There was also insufficient integration of the MAPPA decisions with probation and police recording systems, most notably OASys. Approved premises played a valuable role in providing a degree of oversight and containment of a large proportion of MAPPA offenders, but this approach needed to be balanced with a focus on constructive interventions if the risk of harm presented by such offenders was to be reduced in the longer term.

6. Management and Leadership: the impact on practice

Summary

This section outlines the impact of the national and local strategic framework for MAPPA on practice.

Key Findings

- The MAPPA Guidance 2009 provided a helpful framework.
- There was a strong commitment at senior management level in all the relevant agencies to work together. As a result, policies agreed at SMB level impacted on operational practice.
- The way in which MAPPA coordinators were deployed varied, but they had a very significant influence on the operational practice and quality of the MAPPA.
- Performance monitoring focused on inputs and more attention needed to be given to outcomes.

The Impact of the National Structure

- 6.1 Whilst the senior managers to whom we spoke saw themselves primarily accountable to their constituent agencies, most were aware of the Responsible Authority National Steering Group. This group provided a strategic framework within which the local SMB developed its business plan.
- 6.2 The PPMHG within NOMS provided support and guidance about working with offenders who presented a significant Risk of Harm. Key performance indicators on MAPPA work were introduced in 2008 and the most recent of a series of guidance documents had been issued in 2009. The guidance was comprehensive and was seen as helpful to those working with offenders subject to MAPPA. However, a number of senior managers we interviewed expressed the view that the guidance tended to be overly detailed and too process oriented.
- 6.3 The PPMHG also provided support, in the form of additional resources, to fund provision for those offenders who were deemed to be Critical Public Protection cases in the sense of their risk of harm to the public and/or their high public profile. We saw a number of examples where this support had been well used. This included, funding for extra staff in an approved premise to provide an enhanced level of supervision for particular individuals who presented a very high risk of harm to others.

Strategic Management Board

- 6.4 The SMB was well established in the six areas we visited and both the Responsible Authority and Duty to Cooperate agencies were clearly committed to working together. The few situations where there had been problems with attendance at

the SMB by some agency representatives appeared to have been successfully resolved. However, concerns remained in some areas about the high turn-over of police representatives.

- 6.5 In one area, we concluded that the seniority of the police representative on the SMB was insufficient to take strategic decisions on behalf of the local force. It was significant that, in the same area, we also took the view that the police chairs of MAPPA level 2 and 3 meetings were not of a suitably senior rank.

- 6.6 All except one SMB had at least one lay advisor, as required by the guidance. Whilst most SMB members welcomed their presence and saw them as providing a balance to the professionals in the meeting, we did not find any examples of where the lay advisor had any direct impact on operational practice. However, most chairs of SMBs took the view that the lay advisors had the potential to provide an added dimension to the work of the Board. This comment from one chair was typical:

'The lay advisors give a sense of how it looks. As a result of their presence everyone round the table tends to simplify things and speak in a language that everyone understands'.

- 6.7 All the SMBs had developed information sharing protocols that set out the rules for engagement within MAPPA and other settings. Systems were well developed for the dissemination of the findings of serious case reviews. One SMB was part of a reciprocal arrangement with other agencies in its region to undertake reviews. Another SMB had carried out a review on a case where one was not required by the guidance but the members took the view that it was important to reflect on the quality of the practice in the case in order to learn lessons for the future.

- 6.8 Given the high profile nature of the work and the potential for offenders subject to MAPPA to commit serious further offences, all the SMBs visited had recognised the need for a communication strategy. These ranged from very detailed documents to very simple ones which stated that they would respond to any incident on a case by case basis.

- 6.9 Most performance monitoring centred on the key performance indicators. A number of SMBs questioned the relevance of this approach and were beginning to explore ways of assuring different aspects of quality in the MAPPA process and to consider more outcome focused scrutiny of activity. In one area, a programme of observation visits to MAPPA meetings by SMB members had been implemented whereby the chair of the meeting was provided with feedback about the quality of the meeting. One senior probation manager thought that too much emphasis was placed on monitoring the processes around MAPPA and too little on examining the quality of the decisions made.

- 6.10 Despite the publication of an annual report, business plan and an arrangement in one area for MAPPA chairs to attend an SMB, we found little awareness of the SMB amongst operational staff in the localities we visited; this did not, however, appear to have had an adverse impact on practice. More importantly, we saw how individual agency representatives on an SMB had been able to impact on the practice of their organisations. For example, prison governors were able to influence the transfer policies of other prisons in respect of prisoners who were eligible to be included in MAPPA. Attendance at MAPPA meetings was good, and

problems, whether with attendance by particular agencies at level 2 or 3 meetings or in securing resources, were often escalated to the SMB for resolution.

- 6.11 All the SMBs had commissioned and organised training on MAPPA work. Particular attention had been paid to the needs of Duty to Cooperate agencies and briefing events had been held in a number of areas. This was a very encouraging finding. In another area, the coordinator held regular training meetings with MAPPA chairs. Some sort of MAPPA training had had been provided to 72% of the police officers we interviewed and 90% of them felt well trained in working with MAPPA offenders. Similarly, 73% of probation staff had received training and 87% felt that this training had helped them.

Leadership and the MAPPA Process

- 6.12 Police and probation had provided funding for the MAPPA infrastructure in all areas. Typically, this comprised funding for administrative and coordinating posts, including staff to input data onto ViSOR. The prison service did not provide funding, although resources had been accessed at NOMS regional level in two areas to support their contribution to MAPPA. In one area, some funding had been provided from the Primary Care Trust. It was clear however, that for police and probation, even though their budgets had contracted, the level of resourcing would continue, given the high profile nature of the work.
- 6.13 A MAPPA coordinator was in place in four of the six areas visited. In one area the role was graded as an administrator, but the individual carried out similar functions to their coordinator colleagues. In London, the work was coordinated by local managers and administrators in each borough, with a small team at the centre that comprised the MAPPA executive office, which serviced the SMB and produced performance data and policy advice. The role of staff in each area was crucial in helping to ensure that MAPPA guidance and SMB policy was translated into operational practice. A variety of different models were in operation, ranging from a single coordinator in one small area to a devolved arrangement in Southwark, where operational police and probation middle managers were responsible for the local arrangements. There were advantages and disadvantages to any of these structures and SMBs needed to consider carefully their effectiveness as it was clear many of them had grown up in an organic and incremental way.
- 6.14 We found that MAPPA worked well where senior managers provided a strong sense of leadership so that all the relevant agencies were aware of their responsibilities and the shared duty to protect the public. Equally important, was the need for the chairs of MAPPA meetings to exercise leadership in holding agencies to account, pull together information, and ensure that an active plan to manage offenders' risk of harm to others was developed. In this respect, the significance of the lead agency in following through decisions taken within MAPPA was critical. When MAPPA worked well, it was because all the agencies had put the pieces of information together, assessed the level of risk presented by the offender to others and managed it together – thus ensuring better public protection by making collective defensible decisions.
- 6.15 Significant progress has been made in inter-agency work and the improvements to the system since the advent of MAPPA had been dramatic. The next stage of

the journey was to build on this solid foundation and develop a confident and assertive approach to the proactive management of offenders who presented a significant risk of harm to the public. This required not only good guidance and procedures but an increased focus on developing skills of working together and leading people.

Conclusion

- 6.16 At a strategic and operational level we found a commitment to working together amongst the agencies that comprised MAPPA. The culture of cooperation was often set at the SMB level, and was then reflected at other points in MAPPA. The MAPPA organisational infrastructure was generally robust, with support and guidance provided from the central PPMHG. Much emphasis had been placed on process oriented feature of MAPPA both at SMB and national level. In order for MAPPA to move from a mechanism used primarily to exchange information to one that focuses on the active management of the risk of harm presented by the offender to others, more attention should be paid to the nature of leadership within MAPPA. The strategic focus of the SMB was important in this, as was the need to strengthen the concept of the lead agency. However, the most significant issue was the quality of the leadership displayed by MAPPA chairs, whether dedicated MAPPA coordinators or mainstream managers. The need to hold others to account and draw-up and review effective plans to manage the level of risk presented to the public by MAPPA eligible offenders not only required thorough knowledge of policies and processes, but also excellent skills in chairing meetings and exercising proper authority.

Practice example:

The Warwickshire SMB carried out a Serious Case Review on a probation supervised offender and found that the offender was managed at level 1, but should have been managed at a higher level. As a result the SMB instigated an audit of all level 1 cases to ensure there were no other offenders being managed at the wrong level.

7. Outcomes; did MAPPA make a difference?

Summary

This section sets out our findings in respect of the effectiveness of MAPPA.

Key Findings

- All reasonable action had been taken to keep the offender's risk of harm to others to a minimum in over two-thirds of cases.
- The MAPPA management level had decreased in half of the cases.
- Most of the offenders had not reoffended.
- Victims and potential victims had been protected in most cases.

- 7.1 Most performance monitoring at SMB level focused on inputs such as frequency of meetings and the record of attendance. Whilst these were important factors to monitor and where necessary improve, we found little evaluation of outcomes in the six areas we visited. With this in mind, we attempted to identify some of the key outcome measures for MAPPA work.
- 7.2 In assessing the case sample overall, we judged that all reasonable action had been taken to keep the offender's risk of harm to others to a minimum in 70% of the cases. When the same question was asked of police and probation action the percentages were 91% and 83% of cases respectively. Whilst MAPPA was good at sharing information, it was not as effective at managing that information in relation to risk of harm. Insufficient emphasis was given to the overall assessment of the offender's risk of harm to others and the factors that contributed to its escalation or reduction. The approach tended to start with the offender and proceeded immediately to the actions that would be taken with him or her. As a result, much of the activity was reactive and short-term, with an emphasis on restrictive interventions. The actions needed to be linked much more specifically to the assessment of the offender's level of risk within the framework of the overall MAPPA RMP.
- 7.3 When MAPPA worked in this way, the results were impressive. For example, in Middlesbrough a complex and difficult sexual offender, who was assessed as presenting an escalating risk to the public, posed a challenge to all the agencies working with him. MAPPA brought pressure to bear on the responsible housing provider to continue to offer a tenancy, despite their concerns about the risk he presented to the community. The police and offender manager jointly provided high levels of supervision and monitored his behaviour. Social care services were also involved in assessing levels of adult care services necessary.
- 7.4 In half of the cases, the MAPPA management level had decreased, although in four cases it had increased. Whilst this was generally a positive finding, we found that in a number of cases the rationale for reducing the management level was not always clearly articulated.

- 7.5 We did not anticipate that the risk of harm to the public would diminish in relation to most of the offenders in the inspection sample because of the nature of their offending behaviour. This proved to be true, and in only in four cases had the offender's level of risk reduced. However, only 16 out of the 54 offenders in the case sample had been cautioned or convicted of a further offence since they entered MAPPA. A research study by the Ministry of Justice⁽⁷⁾ also reported similar positive results in relation to reoffending. The study found that offenders released from custody between 2001 and 2004 (i.e. after the implementation of MAPPA) had a lower one-year reconviction rate than those released between 1998 and 2000.
- 7.6 In 83% of the cases the threat to victims had been effectively managed and only three potentially identifiable victims had been victimised. Although as the MAPPA guidance points out:

'The absence of disaster is not enough as an evaluation strategy.'

Conclusion

- 7.7 Measuring the effectiveness of MAPPA was difficult given the nature of the offenders who were eligible for inclusion in the multi-agency arrangements and the complexity of inter-agency linkages. Overall, our findings were broadly positive in terms of reoffending and the protection of victims. In a reasonably large number of cases we took the view that all reasonable action had been taken to keep to a minimum the offender's risk of harm to others. However, this should have been the case in a greater proportion of cases. This finding suggested that there was still significant scope for improvement in the way MAPPA operates if it was to fulfil its full potential.

8. ViSOR: detailed findings

Summary

This section outlines the detailed findings of the inspection of the ViSOR records available in relation to the MAPPA eligible offenders in the inspection sample.

Key Findings

- ViSOR records were rarely completed in line with the national guidance.
- Other forms of record keeping were still used alongside ViSOR.
- Difficulties with access and problems of usability meant that ViSOR was not used as a working tool by police and probation staff and had yet to fulfil its full potential.

ViSOR

- 8.1 The ViSOR is a confidential, national database designed to hold details of MAPPA offenders. Its purpose is to assist police, probation and prisons in their joint work to assess and manage the risks posed by sexual, violent and other dangerous offenders within the MAPPA framework. It is used primarily as an offender management system, specifically by police; however, it can also be used to identify potential suspects for violent crimes or sexual offences and as a tool to assist in the management of information.
- 8.2 ViSOR was implemented across police forces in 2005. It was rolled out to the probation service in 2007 and to the prison service in 2008. In accordance with the current NOMS ViSOR National Implementation model, access by the probation service was restricted to certain individuals/roles, severely limiting its effectiveness as an operational tool; however, at the time of the inspection, extensions to the model were being piloted in a number of areas, including two of those inspected.
- 8.3 National standards for ViSOR were not developed until 2008, three years after its implementation, by which time significant variations had developed in data inputting and quality. These standards were introduced to provide the Responsible Authority agencies with clear direction as to the use of ViSOR (updated with publication of Version 2.0 by NPIA in late December 2010).
- 8.4 The responsibility for creating and managing ViSOR records is as follows:
- » category 1 offenders – police
 - » category 2 offenders – probation service (currently only applicable to those offenders being managed at MAPPA level 2 and 3)
 - » category 3 offenders – where the offender has been actively managed by the probation service on licence and at its expiry the management has been transferred to category 3 or they are being managed by probation on a community order, probation remain responsible for the creation and management of the case on ViSOR. In all other cases, the police would be responsible.

- 8.5 All cases held within ViSOR are known as 'nominals'. Each nominal can have up to 43 'attachments', which can contain a range of information about the offender and offending, e.g. name, address, convictions, known associates, modus operandi (MO), etc.
- 8.6 The ViSOR records examined for this inspection included 32 category 1 offenders, 15 category 2 offenders and five category 3 offenders (one of which was created by police).

Findings

Convictions

- 8.7 The decisions or disposals of courts, tribunals or other bodies, including police cautions for MAPPA offenders should be recorded in the Convictions attachment. An examination of the ViSOR records revealed that in the case of five (9%) nominals, no conviction was recorded (two probation and three police nominals).

Modus Operandi (MO)

- 8.8 Of the 47 nominals where convictions had been recorded, it was found no MO had been recorded in respect of eight (17%) of the cases (six probation and two police). The recording of an MO is important as it provides the context and specific details of a nominal's offending behaviour. ViSOR is intended to be a tool to assist in the identification of patterns of offending that can be used to identify potential suspects for violent crimes or sexual offences, making this a clear area for improvement.

Risk Assessments

- 8.9 Of the 32 category 1 ViSOR nominals examined, the current RM2000 was not recorded in five cases. Two of these nominals had been recalled to prison within a very short time of being released. In the remaining three (9%) nominals, one had not been re-assessed despite the offender being convicted of a further serious sexual offence; one had not been reassessed despite being convicted of an additional violent offence and in the last case, there was no RM2000 recorded at all. Without a current risk assessment in place, it was not always apparent how these individuals were being managed at an appropriate risk level.
- 8.10 RM2000 assessments should have been fully completed and countersigned by a manager, who was appropriately trained. Of the 27 RM2000s recorded on ViSOR, eight (29%) had not been countersigned by a manager. This negated any supervisory check of the veracity of the identified risk level.
- 8.11 The combination of risk assessment tools, information sharing and professional judgement meant that, ultimately, an offender could be managed at a different risk level than that arrived at through the use of one assessment tool. Where this occurred with a category 1 offender, the police should clearly record the rationale to manage at a different risk level on ViSOR. Of the 27 nominals with RM2000s recorded on ViSOR, 20 (74%) were being managed at a different risk level from

that identified, but the rationale was not recorded in the case of four (14%) nominals.

- 8.12 The rationale for managing a nominal at a different risk level should have been recorded in the appropriate field within the RMP. This only occurred in 13 (81%) of the relevant nominals, with the remaining three (19%) having the rationale recorded within the RM2000.
- 8.13 Where there is more than one agency involved in the management of an offender, it is essential all the relevant agencies are consulted to identify which agency is the lead agency (unless clearly identified at a level 2 or level 3 MAPPA meeting). This is particularly important in, for example, the case of a category 1 offender (police responsibility) who is being managed in the community on a licence or community order (probation responsibility).
- 8.14 Of the 52 ViSOR nominals examined, only four (7%) of these had a clearly identified lead agency recorded (three probation and one police). An additional two ViSOR nominals incorrectly had prisons recorded as the lead agency. This should not have occurred as prisons are only meant to be 'partnered' to nominals (have access to their records for purposes of exchanging information) whilst they are held in their custody, the lead status remaining with an agency in the community. Ten (19%) of the nominals, however, indicated they were under 'joint management', but it was not clear which agency was involved.
- 8.15 Where more than one agency is involved, an agreement should be reached as to the overall risk level at which the nominal will be managed. This consultation should be done to ensure the lead agency has access to all relevant information when reaching their decision. Each agency is expected to record on ViSOR the result of their risk assessment using their preferred methodology. The police position regarding RM2000 has been previously detailed. In the case of probation it was anticipated that OASys details, where exchanged, would be recorded on ViSOR.
- 8.16 Of the 52 ViSOR records examined, only 21 (40%) nominals had details of the relevant OASys assessment recorded (9 probation and 12 police). In 19 (90%) of these nominals, the relevant details were recorded within the OASys tab on the Risk Assessment attachment, whilst the remaining two nominals had the details incorrectly recorded in Activity Logs. In the remaining 31 ViSOR records, probation owned 11 of the nominals and police owned 20. This demonstrated a wide disparity in the practice of sharing and recording OASys assessments. This was further evidenced during interviews with police and probation staff, who confirmed they do not routinely exchange such information.

MAPPA Level

- 8.17 Establishing an offender's MAPPA level is an integral part of the management of offenders within the MAPPA framework. Any increase or decrease in the level should be entered onto ViSOR within at least three days of receipt of that information. Examination of the ViSOR records revealed that in the case of 21 (40%) nominals, the level of management had either increased or decreased, but had not been clearly recorded on the individual nominal records (8 probation and 13 police). This shortcoming demonstrated how the effectiveness of ViSOR can be

seriously compromised as a management tool for MAPPA offenders, as it relies on the quality and timeliness of information and intelligence being clearly recorded within it.

- 8.18 ViSOR is also used by MAPPA coordinators to draw management report information from to calculate the number of MAPPA eligible offenders they have in their community. If MAPPA levels are not regularly updated, any data drawn from the system will be incorrect and potentially misleading.

Exchange of Information

- 8.19 As described in the previous MAPPA level section, each user agency is required to enter onto ViSOR any information it holds, or is aware of, that is relevant to the management of a nominal. Examination of the ViSOR records revealed that in 19 (36%) nominals, information between agencies had been exchanged either by telephone, face-to-face or email contact. In these instances, the information exchanged was recorded on ViSOR as a confirmation that it had taken place, but the system itself was not used to facilitate the actual exchange. Some record was made in 18 (34%) nominals (both police and probation) of prisons using ViSOR to exchange information but in the case of 10 (19%) probation nominals, there was no record of any other agencies exchanging information.

MAPPA Meeting Minutes

- 8.20 Records of all MAPPA meetings held must be entered on to ViSOR within the RMP attachment of the respective nominal. In four of the areas inspected, the MAPPA meeting minutes were recorded in the appropriate meetings tab of the RMP. In one area, the MAPPA meeting minutes were recorded in the Activity Logs of the individual nominals, however, this practice did not allow for a supervisor to review and validate any RMP resulting from the meeting, which in this case was not replicated in the RMP tab. The remaining area recorded the MAPPA meeting minutes as standalone minutes on ViSOR, with no direct link to any of the nominals detailed in the minutes. This practice made it extremely difficult to follow the agreed MAPPA risk management planning process for these nominals as, again, the RMP resulting from the meeting was not clearly replicated in the RMP tab. This further had the potential to cause confusion, e.g. if the nominal moved to another force area and their ViSOR record was transferred, their full risk management history would not be readily viewable by the receiving public protection unit staff.
- 8.21 The ViSOR Standards indicate that the records of MAPPA meetings must be entered on to ViSOR within 5 working days for level 3 meetings and within 10 working days for level 2 meetings. This rarely happened. In one area, MAPPA meeting minutes were on occasions taking over ten months to be recorded onto ViSOR, with several subsequent meetings having been held in the interim period, which also were not recorded on the system.

Risk Management Plans

- 8.22 A current RMP is required for all active nominals on ViSOR. It should record the 'Risk Level Managed At', identify the risks that the ViSOR nominal posed, and show how they were going to be managed, by whom and when. The inspection team found a wide variance in practice being used, both across and within the areas inspected.
- 8.23 As detailed previously, the MAPPA RMPs were of varying quality, and in most instances lacked detail. Each of the police areas differed in their approach to RMPs.
- » One area recorded a standard RMP on a nominal entering the MAPPA framework but thereafter did not record any RMPs on ViSOR other than to indicate the nominal would be managed as per the MAPPA RMP.
 - » Another created minimal RMPs after home visits and as a minimum created at least one every six months for their low risk nominals.
 - » In one area a supervisor created new RMPs every 16 weeks for nominals, regardless of their risk or management level. These were recorded on ViSOR, however, offender management staff advised us they were unaware this process was in place.
 - » In yet another area RMPs were created when the nominal entered the MAPPA framework but these were not being updated (despite reviews being undertaken), even when their management level either increased or reduced.
 - » In one, RMPs were created when the nominal entered the MAPPA framework but these were not being updated (despite reviews being undertaken) even once they had been recalled to prison. In at least three cases, the offender had been returned to prison and the area was continuing to hold MAPPA meetings whilst no change had been made to the RMP.
 - » In one area, the approach varied with some nominals having new RMPs whilst others did not.
- 8.24 RMPs were not generally clearly recorded on ViSOR. This resulted in an unclear picture of what the police and other agencies were trying to achieve or what the overall risk management strategies were. This situation was exacerbated by the fact that it was sometimes unclear which agency had overall authority and capacity to manage the risks presented by the nominal effectively.
- 8.25 Our findings in this inspection were similar to those in the joint inspection report on sexual offenders, which identified the following areas for improvement:
- » despite the fact that the ViSOR file sample related to offenders who were being managed by the police and supervised by probation, the RMPs recorded on ViSOR tended to relate solely to police activity
 - » whilst it might be expected that the main focus of police action would be on home visits, RMPs lacked detail and did not always have clear timescales set for completion of action actions

- » where an MAPPA RMP also existed, the actions were rarely transposed onto the ViSOR RMP attachment (although a record was held within the MAPPA minutes).

Actions

- 8.26 The RMP attachment on ViSOR contains an Actions tab where actions allocated at the MAPPA meetings should be recorded and assigned to an identified individual to complete. The results of these actions should also be recorded in the same tab, thus ensuring a clear audit trail for the completion of such tasks.
- 8.27 Of the 32 category 1 nominals examined on ViSOR, only one area with five (16%) nominals was correctly recording their actions in the actions tab. These unfortunately were not being resulted, and it appeared they were still outstanding in some cases up to 18 months after being allocated.
- 8.28 In 20 (74%) of the remaining cases, we found no clear recording that any actions had been allocated or completed. The only means of establishing if actions had been allocated and completed was to 'trawl' through the various sets of MAPPA meeting minutes recorded in the different locations on the system as previously identified.
- 8.29 In the seven (26%) remaining cases, some mention of the allocated actions had been recorded in activity logs, but these did not always make it apparent that the tasks had emanated directly from MAPPA meetings. This latter practice of recording some detail in the activity logs appeared to be down to some individuals' professionalism as opposed to any policy directive to adopt the process.

Supervisory Reviews

- 8.30 Routine supervision, supported by effective auditing/health checks is particularly important in relation to risk assessment and risk management. As can be seen from the previous RMP section, a number of varying practices had been adopted in relation to reviewing RMPs, none of which exactly met the stipulated review periods as detailed in the MAPPA Guidance. Two of the areas had no formal review process in place. The Association of Chief Police Officer (ACPO) NPJA 2010 Guidance states that supervisory officers should ensure that police actions resulting from each RMP are implemented and reviewed at least every 16 weeks, depending on the level of risk identified. It states that actions from RMPs should be completed and recorded and supervisors should check that all actions are completed within a set timescale. As can be seen from the Actions section, we found very limited evidence that actions were or even could have been monitored and it was apparent that supervisors were over-reliant on staff completing such tasks without any formal monitoring being involved. MAPPA is a potentially high risk area of business for the police, and therefore it was surprising that high standards of professional practice and intrusive supervision were not more evident.

Access and use of ViSOR

- 8.31 In interviews with probation staff, we learned that little had changed since publication of our thematic report on sexual offenders in 2010 in relation to probation staff being able to access and use ViSOR. The national NOMS guidance in its present structure did not lend itself to ViSOR being utilised as an effective means of electronic communication. Staff again reported frustrations that offender managers could not access the system directly and had to request viewing facilities through an SPO.
- 8.32 Two of the areas inspected were involved in piloting an extended access programme, supported by NOMS, whereby probation staff would be able to access the system direct. In one area, staff had been trained to use the system but technical difficulties in identifying appropriate computer terminals and associated problems had delayed the pilot's introduction and it had still to start. In the other pilot area, offender managers reported satisfaction at being able to access ViSOR. However they were restricted to a 'read-only' access, which meant they had to revert to other means of communication to exchange information, which again was a cause of frustration for them.
- 8.33 Other issues staff highlighted which restricted their use of ViSOR was the fact that it was very slow to operate and still had to be used as a stand-alone system (as users could not toggle between different computer applications) so involved double-keying information. New staff experienced problems in navigating around the system and untrained staff still found it difficult to obtain assistance to access the system physically. A recurring issue highlighted was the confidential nature of the system, which made staff cautious about its use; even those involved in the extended pilot reported concerns in this regard.
- 8.34 ViSOR is primarily used by the police as an offender management system, but it can also be used to identify potential suspects for violent crimes or sexual offences and as a tool to assist in the management of information. Indeed, the ACPO, NPIA Guidance urges forces to take every opportunity to maximise the potential of ViSOR.
- 8.35 From interviews with public protection unit staff, however, we learned that in one area a paper-based system was still being used as their primary offender management tool and in another area, a standalone force electronic database was being used as their primary offender management tool. In both areas, staff voiced their concern that ViSOR was cumbersome to use and due to technical issues, e.g. whereby the system times out after 20 minutes if not used, they preferred to use their alternative systems. The result of these practices meant that not all relevant information regarding a nominal necessarily would necessarily be recorded on ViSOR.
- 8.36 The concept of ViSOR being introduced to act as a national multi-agency system for the effective management of offenders and other persons posing a risk of harm to the public was thrown into disrepute by such practices. The inspection section demonstrated the need for forces to put effective practices into place to monitor the use of ViSOR and ensure adherence to the ViSOR standards was being achieved.

Appendix A

Statement of Purpose

HMI Probation is an independent Inspectorate, funded by the Ministry of Justice and reporting directly to the Secretary of State. Our purpose is to:

- report to the Secretary of State on the effectiveness of work with individual offenders, children and young people aimed at reducing reoffending and protecting the public, whoever undertakes this work under the auspices of the National Offender Management Service or the Youth Justice Board
- report on the effectiveness of the arrangements for this work, working with other Inspectorates as necessary
- contribute to improved performance by the organisations whose work we inspect
- contribute to sound policy and effective service delivery, especially in public protection, by providing advice and disseminating good practice, based on inspection findings, to Ministers, officials, managers and practitioners
- promote actively race equality and wider diversity issues, especially in the organisations whose work we inspect
- contribute to the overall effectiveness of the criminal justice system, particularly through joint work with other inspectorates.

Code of Practice

HMI Probation aims to achieve its purpose and to meet the Government's principles for inspection in the public sector by:

- working in an honest, professional, fair and polite way
- reporting and publishing inspection findings and recommendations for improvement in good time and to a good standard
- promoting race equality and wider attention to diversity in all aspects of our work, including within our own employment practices and organisational processes
- for the organisations whose work we are inspecting, keeping to a minimum the amount of extra work arising as a result of the inspection process.

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

*HM Chief Inspector of Probation
6th Floor, Trafford House
Chester Road, Stretford
Manchester M32 0RS*

<http://justice.gov.uk/about/hmi-probation>

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Glossary of abbreviations

ACPO	Association of Chief Police Officers
<i>Duty to Cooperate</i>	Agencies identified under section 325(3) of the Criminal Justice Act 2003 as having a 'Duty to Cooperate' with the Responsible Authority, namely the police forces and prison and probation services, in the assessment and management of all MAPPA offenders
GP	General Practitioner
HMI Probation	HM Inspectorate of Probation
<i>Interventions; constructive and restrictive interventions</i>	<p>Work with an offender which is designed to change their offending behaviour and to support public protection.</p> <p>A <i>constructive intervention</i> is where the primary purpose is to reduce <i>Likelihood of Reoffending</i>. In the language of offender management this is work to achieve the 'help' and 'change' purposes, as distinct from the 'control' purpose. A <i>restrictive intervention</i> is where the primary purpose is to keep to a minimum the offender's <i>Risk of Harm to others</i>. In the language of offender management this is work to achieve the 'control' purpose as distinct from the 'help' and 'change' purposes.</p> <p>Example: with a sexual offender, a <i>constructive intervention</i> might be to put them through an accredited sexual offender programme; a <i>restrictive intervention</i> (to minimise their <i>Risk of Harm to others</i>) might be to monitor regularly and meticulously their accommodation, employment and the places they frequent, whilst imposing and enforcing clear restrictions as appropriate to each case.</p> <p>NB Both types of intervention are important</p>
MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together in a given geographical area to manage certain types of offenders. The National Guidance for MAPPA was contained in Probation Circular 54/2004
MARAC	Multi-Agency Risk Assessment Conference; part of a coordinated community response to domestic abuse, incorporating representatives from statutory, community and voluntary agencies working with victims/survivors, children and the alleged perpetrator.
MO	Modus operandi: taken from Latin meaning the method of operating or a person's manner of working. The term is often used by the police to describe the way in which a crime is committed.
NOMS	National Offender Management Service: the single agency responsible for both prisons and probation trusts.
NPIA	National Police Improvement Agency: a non-departmental public body which became operational in 2007. It supports the police by providing expertise in areas as information technology, information sharing and recruitment

OASys	Offender Assessment System: the nationally designed and prescribed framework for the probation and prison services to assess offenders, implemented in stages since April 2003. It makes use of both 'static' and 'dynamic' factors
PPMHGU	Public Protection and Mental Health Group
RMP	Risk Management Plan: sets out how the risk of harm to others will be managed
RSL	Registered Social Landlord: government-funded not-for-profit organisations that provide affordable housing. They include housing associations, trusts and cooperatives.
Risk of harm to others	Risk of Harm to others is the term generally used by HMI Probation to describe work to protect the public. In the language of offender management, this is the work done to achieve the 'control' purpose, with the offender manager/supervisor using primarily restrictive interventions that keep to a minimum the offender's opportunity to behave in a way that is a risk of harm to others
RSO	Registered sex offender: under the Sex Offenders Act 1997, as amended by the Sexual Offences Act 2003, all convicted sexual offenders must register with the police within three days of their conviction or release from prison. Failure to do so can result in imprisonment. They must inform the police if they change their name or address and disclose if they are spending seven days or more away from home.
SMB	Strategic Management Board: oversees the operation of Multi-Agency Public Protection Arrangements. It includes a range of agencies who are either responsible authorities or have a Duty to Cooperate
SOPO	Sex Offence Prevention Order: introduced by the Sexual Offences Act 2003 and replaced sexual offender orders and restraining orders. It is a civil measure available to the court when it convicts a person of an offence listed in <u>schedule 3</u> or <u>schedule 5</u> to the Sexual Offences Act 2003, or on the application of the police in respect of a person who has previously been dealt with for such an offence. The order places restrictions on the subject and triggers the notification requirements
SPO	Senior Probation Officer
ViSOR	Violent and Sexual Offender Register: has been used by the police as an offender management system since 2005, but also enables access to a wide range of information and intelligence, e.g. to identify potential suspects of violent or sexual offences. Access to it was subsequently rolled out to the probation service in 2007 and the prison service in 2008. In principle it provides the three services with a confidential, shared, national database to assist in the identification, risk assessment and management of sexual and violent offenders
YOT	Youth Offending Team: multi-disciplinary teams, established in each local authority areas and responsible for supervising young offenders and working with young people who are likely to offend.

