

A follow-up inspection of Multi-Agency Public Protection Arrangements

A joint inspection by HM Inspectorate of Probation and
HM Inspectorate of Constabulary

October 2015

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Foreword

Working with the most dangerous and high profile offenders, Multi-Agency Public Protection Arrangements (MAPPA) provide a forum for different agencies, both within and outside the criminal justice system, to come together. Rigorous and robust plans are developed to address the offending behaviour presented by the offenders, and MAPPA ensures they are put into practice.

The quality of work with this group of offenders, informed by good assessments and robust planning, should be of the highest standard. We should expect to find that everything is being done that could possibly be done to manage the risk of serious harm posed by offenders managed within MAPPA. The consequences for failing to do this work to that high standard can be huge.

Our initial inspection of MAPPA in 2011 found that much good work was being done, but there were areas of practice that required improvement. This follow-up inspection was agreed by the Criminal Justice Chief Inspectors' Group to see if the recommendations from the last inspection had been implemented and to review current practice.

It is encouraging to report that recommendations from the last inspection had been substantially implemented, and overall the quality of work was improved. Chairing of meetings had improved, with a greater focus given to active risk management. However, risk management planning is still confused and inconsistent, active engagement of some Duty to Cooperate agencies remains work in progress, and there needs to be a strategic commitment from both the National Offender Management Service and Strategic Management Boards to harness the benefits of ViSOR.

MAPPA is now well established, but reporting measures remain mainly focused on processes. This report encourages the National Offender Management Service to develop appropriate outcome-focused Key Performance Indicators that will better evidence the effectiveness of MAPPA.

The recommendations in this report are designed to further improve the quality of work with offenders managed under MAPPA, and we believe that if they are implemented that goal will be achieved.



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October 2015

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Summary of findings

The inspection

This follow-up inspection was agreed by the Criminal Justice Chief Inspectors' Group and formed part of the work stream identified in the Joint Inspection Business Plan 2014-2016.

HM Inspectorate of Probation led the inspection, supported by HM Inspectorate of Constabulary. The objectives of the inspection were to seek to establish how far the recommendations in the 2011 joint report *Putting the pieces together – an inspection of Multi-Agency Public Protection Arrangements* had been implemented by the agencies involved, and whether improvements to practice had resulted.

We visited six areas and spoke to strategic and operational staff of all grades from the organisations involved in MAPPAs. We conducted interviews relating to 48 cases using a case assessment tool we had devised, and reviewed the use made of ViSOR, the database that contains information about most MAPPAs eligible offenders.

Overall findings

In our original report in 2011, we asserted that MAPPAs had undoubtedly improved the assessment and management of offenders managed at level 2 or 3. We acknowledged there were some key areas for improvement if MAPPAs were to demonstrate all reasonable action had been taken to manage the risk of harm presented by the offender to others in the community.

We made five specific recommendations in the original report, and have assessed through this reinspection the progress made in addressing them.

Lead Agency

There is a requirement in National Guidance for a lead agency to be identified for each MAPPAs eligible offender. Despite that guidance, our initial inspection found that a clearer focus around the specified lead agency was required, in order to promote a more coordinated approach to the management of each offender. We recommended that *'Chairs of level 2 and 3 MAPPAs meetings should ensure that a lead agency was clearly identified for every case and took primary responsibility for managing the case'*.

In this inspection, we found that the concept of lead agency was now better understood, and, in a high percentage of cases, the lead agency was nearly always identified in the minutes, although this information was not always captured in ViSOR.

Risk Management Planning

In the original inspection, we found MAPPAs rarely produced a comprehensive risk management plan. We recommended that *'Chairs of level 2 and 3 MAPPAs meetings should ensure that a comprehensive risk management plan, specifying how the agencies involved will work together to manage the risk of harm presented by the individual, was drawn up in every case and reviewed where necessary'*.

In this reinspection, we found that risk management actions identified were more relevant and appropriate than we found in 2011. However, overall there remained room for improvement. In particular, we struggled to find that the lead agency updated their agency risk management plan following the previous MAPPAs meeting, and that there was not always consistency between the MAPPAs risk management plan and the lead agency risk management plan. We think references to agency risk management plans and MAPPAs risk management plans are unhelpful and confusing, and the lead agency risk management plan should automatically become the MAPPAs risk management plan.

Active Management

We commented in 2011 on an emphasis within MAPPA meetings on general information exchange rather than focusing on the risk of harm posed by the offender and developing plans to manage that harm. We observed Chairs of level 2 and 3 meetings did not sufficiently hold agencies to account for their actions. We made two recommendations: The first was for the *'Strategic Management Board to ensure that organisations working within MAPPA were held to account through the MAPPA Chair for their actions regarding offenders subject to MAPPA'*. We found progress against this recommendation, with meetings now demonstrating a greater focus on active management of the offender, and Strategic Management Boards and Chairs of level 2 and 3 meetings seeking to hold agencies to account for their actions. We still found occasions where actions set within the MAPPA were not undertaken promptly or within the required/specified timescale, and issues still arose around getting the right people from, in particular, the Duty to Cooperate agencies, to attend.

The second recommendation was for *'Chairs of level 2 and 3 MAPPA meetings to ensure that strategies were drawn up to minimise the risk of harm presented by the individual in the longer-term when no longer subject to MAPPA'*. We saw good examples of where this was undertaken, and some are included within this report. However, on occasion we found offenders coming to the end of their sentence without sufficient consideration of how outstanding risks were to be addressed.

Documentation

In 2011, minutes of MAPPA meetings were *'often not fit for purpose'*. We said the quality of the minutes meant MAPPA agencies would not always be able to demonstrate they had made defensible decisions in the event of a challenge. Our recommendation was that *'Chairs of level 2 and 3 meetings should ensure that minutes of all MAPPA meetings were timely, clear and provided an accurate record of decisions and actions agreed'*.

In this reinspection, we found that minutes of MAPPA meetings had improved albeit there were marked differences across the areas we visited. Generally, minutes were timely, but not routinely posted into ViSOR promptly. Actions set in the meetings, and recorded in the minutes, were generally clear, proportionate and appropriate. There was still inappropriate copying and pasting of old information; a lack of clarity regarding attendees; a failure to accurately record within the risk management plan critical information relating to licence conditions and other restrictive interventions.

We visited two areas that were using the 'Four Pillars' model for running their meetings, and four that were not. We found strengths in Four Pillars, but, as with the conduct of meetings generally, the quality of the notes was primarily related to the skills and organisational expertise of the Chairs and those taking the minutes.

ViSOR

Although we made no recommendation in relation to ViSOR, we were disappointed in what we found in 2011. Police, prisons and probation staff did not use ViSOR as a shared working tool. Where they did use ViSOR, the quality of the information provided was rarely of a high standard.

Our findings four years later are not very different. While we saw some good use made of ViSOR, particularly by the police, overall insufficient progress had been made. Within the National Probation Service, reasons for not using the system related to a lack of terminals and/or trained staff. Many prisons were not partnered to the offender's ViSOR record. Even when they were, the prison rarely recorded relevant information.

Conclusion

Overall, this reinspection found there had been measurable improvement in the quality of work undertaken with MAPPA offenders managed at level 2 and 3 compared with 2011.

However, risk management plans were still not good enough, the quality of minutes, while undoubtedly better, remained inconsistent, and Responsible Authorities and Duty to Cooperate agencies were not always appropriately represented at level 2 and 3 meetings.

This reinspection makes a number of recommendations, which, if actioned, should further improve the quality of MAPPA work.

Allowing for the fact that at 31 March 2014, 97% of MAPPA offenders were managed at level 1, and the scope of this inspection did not include for a detailed review of level 1 MAPPA cases, we think this is an area of work that could lend itself to a joint inspection in its own right. We could see that there were marked differences in the way that different areas reviewed these cases. There has been a progressive reduction in the percentage of cases managed at level 2 and 3, and such an inspection would be designed to provide assurance that level 1 cases are being managed at the correct level and to a sufficient quality. Therefore, we recommend that the Criminal Justice Chief Inspectors' Group give consideration to such an inspection being included in a future joint inspection programme.

Recommendations

The National Offender Management Service Offender Management and Public Protection Group should ensure, within six months*, that:

- guidance relating to ViSOR is reviewed, and all MAPPA category 2 cases are registered at sentence
- NPS offender managers have convenient access to ViSOR terminals
- guidance relating to the level of police attendance at MAPPA level 3 meetings is reviewed, to better reflect the organisational changes at management level that have taken place within the police
- the lead agency risk management plan should become the MAPPA risk management plan, and, if not, a clear rationale should be provided for the difference
- outcome-focused Key Performance Indicators are produced
- the MAPPA minutes template (MAPPA B) incorporates a question about Critical Public Protection Case registration and funding/support/guidance.

Strategic Management Board Chairs should ensure, within three months*, that:

- the current prison is partnered to a MAPPA offender's ViSOR record
- probation and prisons use ViSOR as an active risk management tool, with relevant staff appropriately trained
- a timely multi-agency approach is deployed to screening of all MAPPA referrals
- all referrals to MAPPA for level 2 or 3 management are of a sufficient quality, clarify what the added value is, and identify other agencies required to contribute
- outcomes relating to reoffending by MAPPA offenders are collected and reported to the Strategic Management Board.

Chairs of level 2 and 3 meetings should ensure, within three months*, that:

- all minutes of meetings clearly identify required attendance, actual attendance, role details and absence
- all minutes of meetings contain current information relating to all licence conditions and restrictions in place for the offender
- all minutes are posted to ViSOR within the required timeframe
- every MAPPA action is fully accounted for and the outcome incorporated into the minutes.

The National Police Chief Council's lead for the Management of Sexual and Violent Offenders should ensure, within six months*, that:

- the Management of Sexual and Violent Offenders working group develops an action plan for training provision to ensure that it is coordinated nationally and available and accessible to officers in the early stages of their tenure as a police offender manager.

Police Forces should ensure, within three months*, that:

- all violent offenders managed at MAPPA level 2 and 3 are allocated a named police offender manager
- neighbourhood policing teams are made fully aware of Registered Sex Offenders living within their policing areas.

The National Police Chief's Council (in collaboration with the College of Policing) should ensure, within six months*, that:

- the national policing leads for Integrated Offender Management and MAPPA jointly review opportunities for Integrated Offender Management to enhance the management of MAPPA level 2 and 3 offenders.

Note: * - within x months of the date of this report

**What did we
want to find out?**

1

1. What did we want to find out?

In this section, we set out the inspection scope and methodology. We also summarise the profile of the cases we inspected.

- Half of the offenders had been convicted of a sexual offence.
- Half were Registered Sex Offenders (RSOs).
- Three of the offenders were children or young people under 18 years old.
- All but one of the offenders were male.

Purpose

- 1.1. This reinspection was agreed by the Criminal Justice Chief Inspectors' Group and formed part of the work stream identified in the *Joint Inspection Business Plan 2014-2016*. The objectives of the inspection were *'to seek to establish how far the recommendations from the 2011 joint report had been implemented by the agencies involved, and whether improvements to practice had resulted'*.

The Inspection Process

- 1.2. We selected six MAPPAs for the inspection. We identified two areas where our intelligence indicated we were likely to find good performance; the other four areas provided a mixture of urban and rural; shire and metropolitan. We anticipated seeing a variety of work that would help us identify good practice and areas for improvement.
- 1.3. We were mindful that this was a reinspection, so we tried to retain much of the original case assessment tool used in the 2011 inspection in order to help us judge the progress made against the original recommendations (albeit we were inspecting in six different areas from the ones where we conducted the initial inspection).
- 1.4. In producing the list of cases to be inspected, our approach was to sit down with the MAPPA coordinators/managers in the six areas and identify cases that were within the general timeframe within which we wanted to inspect. Ideally, we hoped to look at cases that were around 6 to 12 months post-release. Pragmatically, in a few instances we had to step outside of that general approach. Following discussion with each of the MAPPAs coordinators/managers, we confirmed the list of eight cases we would inspect in each area.
- 1.5. Fieldwork took place between November 2014 and January 2015. We visited the following six MAPPAs¹ - Leicester, Leicestershire & Rutland; Greater Manchester; Hampshire & the Isle of Wight; London; Dyfed Powys; Kent.
- 1.6. In each MAPPA area, we interviewed the allocated offender manager(s) from the NPS and the police. Where there was no designated police offender manager in place, we spoke to a supervising officer from the team responsible for the offender wherever possible. We also read relevant paper and computer-based records, including the minutes of the MAPPA meetings. Our aim was to seek to

¹ Leicester, Leicestershire & Rutland MAPPA sits within the National Probation Service (NPS) Midlands division, and is co-terminus with Leicestershire Police; Greater Manchester MAPPA sits within the NPS North West division and is co-terminus with Greater Manchester Police; Hampshire & the Isle of Wight MAPPA sits within the South West and South Central NPS division and is co-terminus with Hampshire Constabulary; London MAPPA sits within London NPS division and is co-terminus with the Metropolitan Police Service; Dyfed Powys MAPPA sits within the Wales NPS division and is co-terminus with the Dyfed Powys Police; Kent MAPPA sits within South East and Eastern NPS division and is co-terminus with Kent Police.

ascertain whether all action had been taken, as far as could reasonably be expected, to manage the risk of harm to others posed by the individual. That was an important judgement to make, as, even if we judged an individual offender to have been well managed, there remained the possibility they could reoffend.

1.7. Of the 48 cases we inspected:

- 17 were managed at level 3 prior to the most recent release from prison, (albeit at the time of the inspection 11 were being managed at that level)
- 25 were convicted of sexual offences; 16 of violent offences
- 25 were RSOs
- 38 were 'lead' managed by the NPS; 8 by the police, and 2 by a Youth Offending Team (YOT)
- 47 were male
- 3 were under 18 years old; 4 were over 60 years of age
- 10 were category 3 cases.

1.8. Evidence for this inspection was also gathered from interviews conducted, in each area, with:

- MAPPA coordinators/managers
- Lead senior managers from the three Responsible Authorities
- Duty to Cooperate agency representatives
- Lay advisers
- Chairs of level 2 and 3 meetings
- Focus groups of police officers involved in sexual and violent offending work
- YOT managers.

1.9. We observed one or more MAPPA meetings in each area we visited, something we did not do in 2011.

1.10. We reviewed ViSOR in relation to the individual cases we inspected, and spoke with some ViSOR administrative staff.

The role and purpose of MAPPA

2

2. The role and purpose of MAPPA

This section outlines the statutory basis for MAPPA, its role and purpose and details of the national guidance with regard to eligibility and levels of management applicable to MAPPA offenders. We explain the different agencies that contribute to MAPPA.

We describe the different offender assessment tools used and the national offender database (ViSOR) that records information about appropriate MAPPA offenders.

MAPPA

- 2.1. *The Criminal Justice Act 2003* provides for the establishment of MAPPA in each of the 42 criminal justice areas in England and Wales.
- 2.2. The key purpose of MAPPA is '*to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders*'. To achieve that, there is a requirement on the local criminal justice agencies and other bodies dealing with offenders to work in partnership in dealing with these offenders.
- 2.3. MAPPA bring together the police, probation and prison services into the MAPPA Responsible Authority for each MAPPA area. MAPPA areas are co-terminus with police force areas, as set out in the *Police Act 1996*. A number of other agencies are under a Duty to Cooperate with the Responsible Authority. The Duty to Cooperate agencies are:
 - Local authority social care services
 - Health Trusts and Authorities
 - Youth Offending Teams
 - Home Office Immigration Enforcement
 - Local housing authorities and certain registered social landlords
 - JobCentre Plus
 - Electronic monitoring providers
 - Local education authority
- 2.4. MAPPA is not a statutory body, but a mechanism through which agencies discharge their statutory responsibilities and protect the public in a coordinated manner.
- 2.5. The Responsible Authority has responsibility for establishing a Strategic Management Board (SMB) to include senior managers from the relevant organisations. The Responsible Authority also has a duty to ensure risks posed by specified sexual and violent offenders are assessed and managed appropriately.
- 2.6. Statutory guidance is issued by the National Offender Management Service (NOMS) on behalf of the Secretary of State. NOMS Offender Management and Public Protection Group (OMPPG) published the most recent MAPPA guidance (version 4) in 2012. It introduced a number of, mostly minor, changes to the 2009 guidance. Subsequent to the issuing of the 2012 guidance, there have been a number of updates issued.
- 2.7. MAPPA guidance requires that relevant agencies within MAPPA should:
 - identify and record all eligible offenders immediately following sentence

- share relevant information on offenders
- undertake thorough risk assessments
- manage offenders at the right level, for the right amount of time
- ensure there is an effective risk management plan (RMP) applicable to the individual offender, that is reviewed
- deploy resources to manage identified risk in the most efficient and effective manner.

2.8. Eligibility for MAPPA requires an offender to be in one of the following categories:

- **Category 1**
Registered sexual offender
- **Category 2**
Murderer or an offender who has been convicted of a violent or other sexual offence under Schedule 15 of the Criminal Justice Act 2003 and has been sentenced to 12 months or more in custody. It also includes those detained under hospital orders.
- **Category 3**
Other dangerous offender: a person who has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm and which requires multi-agency management.

2.9. Once categorised, an eligible MAPPA offender is allocated to one of three levels of management. Over time, the level of management can change following reassessment.

- **Level 1**
Ordinary agency management where the risks posed by the offender can be managed by the agency responsible for the supervision or case management of the offender.
- **Level 2**
Active multi-agency management that adds value to the lead agency's management of the risk of serious harm posed.
- **Level 3**
Active enhanced multi-agency management where the management issues require senior representation from the Responsible Authority and Duty to Cooperate agencies.

2.10. The MAPPA annual report for 2013/2014 showed that at 31 March 2014 there were 65,083 MAPPA eligible offenders. Around 71% were category 1 (RSOs), while 97% were managed at level 1.

	Category 1	Category 2	Category 3	Total
Management Levels	Registered sexual offenders	Violent offenders	Other dangerous offenders	
Level 1	45,250	17,798	-	63,048
Level 2	797	787	293	1,877
Level 3	55	64	39	158
Total	46,102	18,649	332	65,083

The overall number of eligible MAPPA cases is substantially higher than when we last inspected in 2011. The number managed at level 1 has increased while the numbers managed at levels 2 and 3, as well as

the number of category 3 offenders, has decreased. This may reflect an increasing confidence of agencies to manage dangerous offenders in a multi-agency context without necessarily requiring formal MAPPA meetings.

2.11. The two main assessment tools for MAPPA offenders are:

- **Offender Assessment System (OASys)**; used by the NPS and the Prison Service to assess the likelihood of reoffending and risk of serious harm of offenders over the age of 18. It incorporates a violent offending predictor.
- **Risk Matrix 2000 (RM2000)**; an evidence-based risk assessment tool, using static factors only, for men aged 18 and over with at least one conviction for a sexual offence committed after they were older than 16 years old. It predicts the likelihood of reconviction for a sexual or violent offence.

2.12. ViSOR is a central store for up to date information about offenders. The three Responsible Authorities have access to, and responsibility for updating, the database. All category 1 offenders and other MAPPA offenders who are managed at level 2 and 3 require a ViSOR record.

**Outcomes achieved:
did MAPPA make a
difference?**

3

3. Outcomes achieved: did MAPPA make a difference?

This section reports what we found in relation to the effectiveness of MAPPA.

- In three-quarters of cases, all reasonable action had been taken to keep to a minimum the offender's risk of harm to others.
- Most of the MAPPA offenders had not reoffended.
- Good measures were instituted to protect victims in most cases.
- Cases were managed at an appropriate level.

- 3.1. NOMS has introduced a system of monitoring through Key Performance Indicators (KPIs). These relate to cases being reviewed within defined frequencies, disclosures having been considered and decisions recorded, and agencies appropriately attending SMBs and level 2 and 3 meetings. These are important things to measure, and, while they are not measures of 'outcomes', they are appropriate means of accounting for behaviours and actions.
- 3.2. MAPPA coordinators told us that KPIs relating to attendance were a way of holding other agencies to account, particularly some of the Duty to Cooperates. They said if MAPPA did not measure and report on their attendance, it may have been more difficult to gain their engagement. We thought that was a valid argument for retaining the measures.
- 3.3. However, some KPIs are worded in a way that could encourage perverse behaviour. For example KPI MAP008 which, in relation to SMB meetings, says '*100% attendance by each Responsible Authority or Duty to Cooperate Agency where invited*'. If someone is required to attend but does not because they were not invited, then that does not generate a negative response irrespective of the fact that the meeting did not have the benefit of that agency's required contribution. KPIs should be smarter, and, wherever possible, outcome-focused.
- 3.4. During this inspection, we looked at qualitative measures relating to outcomes. Probably the most important question we asked was '*has MAPPA taken all reasonable action to keep to a minimum the offender's risk of harm to others?*' All reasonable action was taken in three-quarters of the cases, five percentage points higher than the 70% score achieved in the 2011 inspection. We also found that the police and probation had taken all reasonable action to minimise the risk of harm posed by the offender in most of the cases.
- 3.5. We were interested in reoffending by offenders subject to MAPPA. Four of the 48 offenders whose cases we inspected had been convicted for another sexual or violent offence since they entered MAPPA on the most recent occasion, while a further 4 offenders had been convicted for a lesser offence. None of the offenders whose cases we inspected had received a caution. Reoffending for this cohort of offenders was lower than the figure we reported in 2011; at that time, 30% had received a caution or conviction. In three of the four cases where the offender had been convicted for a further sexual or violent offence, we thought all reasonable action was taken to minimise the risk of harm posed. The practice example below relates to the one case we inspected where further action was required.

Practice example

Rob's index offence was assault on an adult male, but his main risk management needs related to his history of domestic violence against female partners. At the start of MAPPA involvement, the risk assessment identified future partners as being at high risk of harm. Reoffending was assessed as imminent. A key requirement was for Rob to live at his mother's house as part of the plan to reduce the likelihood of domestic violence. Police and probation conducted joint home visits to the mother's house between the first MAPPA meeting and the time when Rob perpetrated an assault on a new partner. However, all but one of those home visits was announced. These satisfied police and probation that he was living at his mother's house, when in fact he was not. He had been living with his new victim for at least one week before the assault took place.

- 3.6. Although not part of this inspection, a recent research report into reoffending by MAPPA offenders was of interest. The MAPPA team within the OMPPG commissioned, from Ministry of Justice Analytical Services, a reoffending study of offenders subject to MAPPA (categories 1 and 2 only) who were sentenced between 2000 and 2010. The report *Reoffending Analysis of MAPPA Eligible Offenders* was published in March 2015, and its headline finding was that reoffending rates were falling for those offenders who had been subject to MAPPA.
- 3.7. Management of the threat to identifiable victims or potentially identifiable victims was effective in four-fifths of the cases we inspected. In 87%, there was no further victimisation.

Practice example

Darren's manslaughter conviction was for the death of his sister's boyfriend, whom he blamed for encouraging her use of heroin. Release was imminent. His offending was associated with the sexual abuse he and his sister had received from their uncle when they were children, for which he retained feelings of guilt for not having been able to protect his sister. A timely initial MAPPA meeting was convened that initiated actions to check where the uncle was currently living and find out more about Darren's feelings towards him. They also asked the Victim Liaison Officer to make contact with Darren's sister, as she was the partner of the victim of the index offence. They identified child protection issues for Darren's grandchildren through the completion of a genogram and social network exercise.

- 3.8. The offender complied with the requirements of the sentence in over two-thirds of the cases we looked at, which was higher than last time. In every case where the individual did not comply, appropriate enforcement action was taken.
- 3.9. Of the 48 cases inspected, we found that at the point of inspection the management level had decreased in 13 cases (28%), and increased in 5 (11%). In the remainder, the management level stayed the same as it was when the case first came into MAPPA. We do not draw conclusions from this information as increasing the level can be just as much an indicator of effective MAPPA oversight as decreasing the level. Overall, we felt that MAPPA meetings were held at the right level.

Practice example

Mark was a prolific sex offender living in Leicestershire, whose level fluctuated from level 2 to 3, and then back to level 2, before de-escalation to level 1. Most agencies contributed well to the MAPPA meetings. There was particularly close working between police and probation, and good contact with the offender's family. Engagement with the offender was impressive; Mark voluntarily agreed to tagging, and he asked for his Sexual Offender Prevention Order (SOPO) to be tightened. Victim Liaison Officers were determined in their efforts to seek out previous victims and ensure they were safe and supported.

- 3.10. Most of the offenders whose cases we inspected had served long sentences for sexual or violent offences. At the time of this inspection, they had been released for a relatively short period. Consequently, we thought it unlikely we would see evidence of their risk of harm having reduced. However, of the 48 cases we looked at, we considered that risk of harm had reduced in almost one-fifth.

Conclusion

- 3.11. As we said in the original inspection report into MAPPA, measuring the effectiveness of MAPPA is difficult because of the nature of the offenders managed at level 2 or 3. In 2011, our findings were largely positive in terms of reoffending and the protection of victims.
- 3.12. Because of the resources that go into the critical few cases that are managed at MAPPA level 2 or 3, the threshold to be applied in respect of risk assessment and risk management should be set at a high level. These are, after all, the most dangerous and/or difficult offenders to manage.
- 3.13. Overall, we found that compared with 2011 fewer offenders whose cases we inspected had reoffended. We also found that measures to protect victims were put in place in a higher percentage of cases, and that, in more cases compared with the initial inspection, all reasonable action had been taken to minimise the risk of harm posed by the offender.
- 3.14. While there remains scope for improvement, overall we thought MAPPA was doing good work.

Identification, classification and assessment

4

4. Identification, classification and assessment

In this section, we review the arrangements we found for identification of eligible MAPPAs offenders and assignment of management levels.

- We were not confident all MAPPAs eligible cases were identified, particularly those managed by YOTs and mental health.
- There was not always a multi-agency approach to determining which cases are managed at level 1.
- Referrals into MAPPAs were often of a poor quality and not timely.
- Feedback about referrals to referring officers was generally comprehensive and timely.
- Lead agency status was identified in minutes, but not always recorded on ViSOR.

Identification of eligible cases and assignment of management level

- 4.1. Chapter 6 of the MAPPAs guidance relates to identification and notification of MAPPAs offenders. Five agencies are responsible for identifying MAPPAs offenders within three days of sentence. They are the police, probation, the prison service, YOTs and mental health services. In addition, any agency, not just the Responsible Authorities and Duty to Cooperates, may refer a case for consideration as a category 3 offender.
- 4.2. YOTs use one of three different case management systems. One of them, Careworks, does not have the capacity to capture or flag MAPPAs information. Some MAPPAs coordinators/managers told us they were not confident all YOT and mental health cases were notified, despite training having been provided. The Youth Justice Board has ensured, in the development of Asset Plus, the new assessment tool for YOTs, that MAPPAs is fully integrated.
- 4.3. In the months leading up to the inspection, HMI Probation did some checks on the prison case management system, P-NOMIS, in half a dozen prisons to see if prison staff had identified MAPPAs cases correctly. We found that MAPPAs cases were often not accurately captured on the prison case management system, and, where they were, sometimes the levels at which they were managed was incorrect. Some offenders had more than one registration, with previous periods as a MAPPAs nominal not closed, and new registrations subsequently added. This was confusing. While aware of this problem, prisons were not sufficiently prioritising the resources to cleanse the data. We found a similar picture on this inspection.
- 4.4. A recent update to the MAPPAs guidance introduced a MAPPAs Q screening form. This form places responsibility on the lead agency to determine the legality of the MAPPAs eligibility status for the offender, then to decide if two or more agencies need to meet and actively collaborate to develop and implement a multi-agency RMP. In the light of those answers, the referrer completing the form should be able to say if the case requires active multi-agency management at level 2 or 3, or if it is appropriate to manage the case at level 1. We saw use made of this screening form, in the way prescribed, in three of the areas we visited. Where the screening so indicated, the lead agency then completed the MAPPAs referral form (MAPPAs A). Generally, the offender manager and their line manager undertook initial screening decisions. Sometimes the police were involved, which we thought was good practice. Duty to Cooperate agency representatives indicated that they would also like to be involved in the screening process.

- 4.5. In two areas, a MAPPA A referral form, or very close variant, was completed by the offender manager and screened by the MAPPA team to determine whether the case was suitable for level 2 or 3 management. We found, in those instances, completion of the form by the offender manager was done to a poor standard.
- 4.6. Leicestershire & Rutland used a locally developed screening form. They used this form in relation to both MAPPA and Integrated Offender Management (IOM) multi-agency management. Those making the referrals did not always complete the screening form to a sufficient quality. The screening panel, comprising appropriate staff from MAPPA and IOM, then decided whether IOM, MAPPA or a single agency approach was appropriate. We observed a screening meeting, and were impressed with the level of discussion that took place and the quality of the feedback provided to the referring officer. In Leicestershire & Rutland, the MAPPA A referral form for use in the initial meeting was only then completed if the local screening meeting had confirmed the case was appropriate for level 2 or 3 management. We thought this was a comprehensive approach, which enabled good consideration of the issues, led to informed decision making, and produced good feedback.
- 4.7. Overall, in those areas that used the NOMS MAPPA screening form (MAPPA Q), there was insufficient information about the case for us to gauge the accuracy of the decision about whether it required multi-agency management or not. In the other three areas, we thought the quality of the referrals was often insufficient, and did not provide sufficient information about the case or what benefits level 2 or 3 management would bring.
- 4.8. In total, we looked at 48 referrals not accepted for multi-agency management at level 2 or 3. Two-thirds did not provide information about the likelihood of reoffending; half did not sufficiently address the individual's risk of serious harm; only 10% included anything about the imminence of serious harm. Surprisingly, just 12% were clear about which Duty to Cooperate agencies the referring officer wanted to invite to the MAPPA meetings and why. In only half of the rejected referrals could we find an agency risk assessment, while just 12% included a RMP. We only found one referral that made sufficiently clear what the special issues were that required inter-agency involvement over and beyond what ordinary single agency management could provide. Despite the generally poor quality of the referrals, we noted that four-fifths received a response within ten days of receipt of the referral. Almost three-quarters of the responses gave good quality feedback to the referring agency, and it was clear to us that those making the decision used other sources of information to inform them, including looking at OASys and nDelius (the probation case management system) records. We could see entries on nDelius entered by local managers and MAPPA staff regarding the referrals and the consequential decisions.
- 4.9. Some areas deployed a rigorous 16 week review process for all level 1 MAPPA cases, which involved both probation and police. In other areas, this process was less well developed.
- 4.10. In Kent and Dyfed Powys, MAPPA category 2 level 1 cases were not only identified, but recorded on ViSOR. While not a national requirement, we thought it was a positive initiative as it allowed information about the offender, usually someone who had committed a violent offence, to be captured throughout their time in prison. Management level does not necessarily correlate to the risk of serious harm an offender poses, so if all MAPPA category 2 cases were registered on ViSOR their behaviour and other relevant information could be recorded from the date of sentence. That would be a more comprehensive approach than the current arrangements whereby information on MAPPA category 2 offenders is only recorded on those who are managed at level 2 or 3. As the level is not usually set until six months before release, partial information is recorded for those offenders currently.

- 4.11. Where a case was identified for consideration of management at MAPPA level 2 or 3, a MAPPA A must be completed and sent to the MAPPA coordinator. For offenders who are in custody, referral must take place at least six months before release. We found that two-thirds of referrals where the offender was in custody were timely, which was slightly worse than we found four years ago. Overall, we considered just under half of all referrals were timely and comprehensive.

Practice example

Amy had been part of a sex cult in a small rural community. The case had notoriety way beyond the immediate locality. Other females involved in the offending had already been released and were being managed within MAPPA. Amy was allocated to the same NPS offender manager who was managing one of the other women involved in this case. This was sensible because of that person's knowledge of the case, particularly the complexity of relationships and multiplicity of victims. The offender manager made a timely referral of Amy's case to MAPPA, and the first level 3 meeting was held a year before her anticipated release date. This provided MAPPA agencies sufficient time to plan for her release, and, in particular, identify appropriate accommodation well away from the other offenders and the location where the offending took place.

Lead Agency

- 4.12. In our last report, we commented that the concept of lead agency was not embedded in practice. We recommended that the lead agency should be '*clearly identified for every case and take primary responsibility for managing the case*'.
- 4.13. MAPPA guidance states that the lead agency is the agency with the statutory authority and responsibility to manage a MAPPA offender. This management involves appropriate information sharing to identify risk. The lead agency has primary responsibility for referring the offender to level 2 or 3 MAPPA management or for continuing management at level 1.
- 4.14. All six MAPPAs we visited had addressed the recommendation from the original inspection, and clearly identified the lead agency within the MAPPA minutes in nearly every case we inspected. In one area, the lead agency for category 1 sex offenders who were subject to current supervision by the NPS or a YOT was always the police. This was a departure from national guidance.
- 4.15. Recording on ViSOR which Responsible Authority was leading the offender's management was often insufficient. Lead agency status was not clearly recorded in one-fifth of the cases reviewed. In one area, it was not recorded for any of the cases reviewed despite having been identified in the offender's MAPPA meeting minutes.
- 4.16. MAPPA guidance designates a number of responsibilities to the lead agency. Overall, there was clear understanding of the concept of lead agency. However, occasionally the behaviours we observed indicated some passivity by the offender manager with an inappropriate deference to the meeting Chair. MAPPA guidance is, however, clear; the objective of multi-agency management is '*to add value to the lead agency's management of the risk of harm posed by the offender*'. It is not to replace it.

Assessment

- 4.17. Initial assessments were generally accurate, but needed greater analysis of the risks posed by the offenders. Past behaviour or offending was often insufficiently explored, particularly when it differed from that more recently demonstrated. In the last inspection, we commented on the

different assessment tools used by the police and probation – RM2000 and OASys respectively. RM2000 measures the risk of reoffending of sex offenders, while OASys assesses the likelihood of reoffending and risk of harm to others. However, on the last inspection a common theme that occurred, particularly in our meetings with the Duty to Cooperate agencies, was the confusion they felt about the generic term of 'high risk'. 'High risk of what?' was a frequently asked question. During this inspection, the Duty to Cooperate representatives we interviewed did not raise this as an issue, which indicates there is now a shared understanding of the terminology.

- 4.18. Assessment of an offender's risks was generally based on information shared within MAPPAs. Minutes of meetings reflected updates by all agencies involved about the risk of harm posed by the offender, albeit children's social care services were sometimes slow to provide information.
- 4.19. MAPPAs minutes showed clear evidence of contributions by relevant agencies and a joint analysis of ongoing risk. However, probation or youth offending team risk assessments were not always updated following the MAPPAs meeting to capture the further risks or progress discussed and agreed in the meeting.
- 4.20. In our last inspection, we did not find any examples of formal processes that indicated offenders were informed of their MAPPAs status and what it entailed. We found a different picture this time. Some areas were routinely notifying offenders of their MAPPAs status, particularly level 3 offenders. We saw examples of offenders actively contributing their own views of their risk, with that information then shared within the MAPPAs meetings. In the MAPPAs meetings we observed in Leicestershire & Rutland and Dyfed Powys, the offender's views were communicated to all the agencies attending the meeting, and helped inform the overall risk assessment and consequent plan.

Conclusion

- 4.21. Identification of MAPPAs cases was usually timely. However, the prison case management system often did not accurately record MAPPAs cases and the level at which they were managed. This meant, as we saw in our pre-thematic Prison Offender Management Inspections, the prison was less likely to take a proactive approach to pre-release planning.
- 4.22. We thought the lack of a rigorous and consistent multi-agency approach to screening cases prior to referral to MAPPAs for level 2 or 3 management was an omission, and did not provide sufficient assurance that cases not referred did not require multi-agency management at level 2 or 3. A review of MAPPAs level 1 cases might appropriately be something that the Criminal Justice Chief Inspectors' Group (CJCIG) will want to consider as a subject for a future joint inspection.
- 4.23. Where a view was formed that a referral to MAPPAs should be made for management at level 2 or 3, the quality of the referral was often poor. In particular, many referrals failed to state clearly why a case was being referred to MAPPAs, and whom the referring officer wanted to invite. This risked inappropriate cases being considered, and people/agencies not invited to the meeting who would otherwise have had a contribution to make to the case.
- 4.24. Identification of the lead agency was obvious from the minutes, but needed to be recorded on ViSOR so that this information was clear to those from the three Responsible Authority agencies who needed to know who was responsible for the case.
- 4.25. There is currently no national expectation that information about violent offenders managed at level 1 is recorded on ViSOR, although two MAPPAs areas were registering those cases. We think there would be benefits to the sharing of information, risk management and pre-release planning if all MAPPAs cases were registered from the date of sentence.

**Doing what
needs to be done**

5

5. Doing what needs to be done

In this section, we comment on the frequency of MAPPA level 2 and 3 meetings and the quality and timeliness of minutes. We also report on whether agencies working within MAPPA undertook required actions, and where Chairs held them to account.

- Frequency and planning of meetings was good.
- Attendance at meetings was generally good, but neighbourhood policing teams were rarely represented.
- Disclosure of information to third-parties took place and was reviewed.
- Actions were completed, but the outcomes were not always clear.
- Compared with 2011, meetings were less focused on general information sharing and more focused on the risk of harm posed by the offender and the consequential planning.
- Chairs were active in holding agencies to account.
- MAPPA RMPs and minutes were better than 2011, but there remained room for improvement.
- NPS and prisons did not use ViSOR as a working tool.

Frequency and Attendance at Meetings

- 5.1. MAPPA guidance states that level 2 meetings should be held at least once every 16 weeks, and level 3 meetings at least every 8 weeks. Those frequency levels were broadly achieved in all but one of the cases we inspected. This was a better result than we found in 2011. Coordinators had developed good systems for planning these meetings, with level 2 meetings generally scheduled on a frequency basis, and level 3 meetings, dealing with the critical few, scheduled as required.
- 5.2. Unlike 2011, we observed MAPPA meetings in all six of the areas we inspected on this reinspection. We usually saw one or two cases discussed at each meeting, but in one area many cases were discussed with less time available for each individual case. It was interesting to see the different approaches and styles adopted in the meetings we observed. In general, chairing of meetings was professional. On occasion, the process got in the way of the purpose. As an example, at one meeting the word 'risk' was not discussed until over an hour had elapsed. The Chair had been overly focused on information exchange, and ensuring everybody at the meeting had the opportunity to update on the offender irrespective of whether or not that information related to their risk of harm. In that particular case, we were not confident that everybody understood the risks, and, therefore, we felt less than confident the risk management planning was sufficiently well informed.
- 5.3. Every MAPPA we visited had an up to date protocol between the relevant agencies. Attendance at level 2 and 3 meetings was generally good, but social services and health did not always show up for meetings at which they were expected. The comment from one Prison Governor was that *'Health need to take on board that they have a duty beyond the doctor patient relationship'*.

- 5.4. It was not always evident from the minutes whether there was clarity about who was expected at the meeting, whether those expected were there, or if those attending had sufficient knowledge and expertise in relation to the case and were able to commit to actions agreed at the meeting. Attendance lists did not always give the designation or role of the person attending. This was a particular problem for those areas where local government and other administrative boundaries were complex. In one case we inspected, different people from children's social care services attended meetings and openly professed a lack of knowledge of the discussions that had taken place at the previous meetings. While a waste of time, it made their ability to contribute to the risk of harm assessment and plan less likely. In that instance, the Chair wrote to children's social care services to seek to remedy this problem. Generally, Chairs seemed more active in following up attendance than we had found in 2011, but getting the right people to attend remained a problem for MAPPAs.
- 5.5. In some areas, the police did not have named offender managers for violent offenders managed at level 2 and 3. Instead, a police manager, usually a Detective Inspector, attended the meeting and took responsibility for taking forward the actions. However, they were rarely the person responsible for delivering the actions arising. The example below demonstrates the pitfalls of there not being a named police offender manager.

Practice example

Stephen was a category 3 level 2 offender who had been accepted for multi-agency management after he received a suspended sentence order with supervision for a domestic violence assault, an offence that paralleled his previous offending behaviour in relationships. His risk of serious harm was 'very high', following indications that future offending of a similar nature was imminent. However, important actions emerging from the MAPPAs meetings were not actioned by the police in a prompt way. This case had no police offender manager allocated to it, and the Detective Inspector who attended the meeting had overlooked the need to allocate the actions to one of their team.

- 5.6. With the exception of Dyfed Powys, the police did not adhere to the levels of seniority for attendance at level 3 meetings as set out in MAPPAs guidance. In most MAPPAs, attendance was by a Chief Inspector rather than a Superintendent. Senior police managers told us there had been a reduction in the number of Superintendents that made this requirement impossible to achieve. They said there was no operational impact on this departure from guidance, as Chief Inspectors were now carrying a workload and responsibility that was similar to that carried by a Superintendent a few years ago. In those instances where managers one grade lower than that set out in the guidance represented the police, we did not observe a detrimental impact on their contribution to the meetings. Our view was that if a Chief Inspector could lead a murder inquiry, they should be able to represent the police at a level 3 MAPPAs meeting.
- 5.7. In all the cases we inspected, there was at least one police representative present. However, in terms of the attendance by police officers dealing directly with cases, the results were mixed, and similar to those found in the 2011 inspection. Only two of the six forces inspected demonstrated evidence of regular attendance by practitioner officers. However, where those officers did not attend their supervising managers usually did. There was little evidence of neighbourhood policing teams regularly attending MAPPAs meetings, and little evidence of officers from those teams being actively consulted or briefed about MAPPAs offenders being released into their local community. Given the nature of their role and the high number of MAPPAs offenders being managed within the community, some of whom were no longer subject to statutory supervision requirement restrictions, this was considered to be a missed opportunity for MAPPAs to tap into an important source of community knowledge and intelligence gathering. Where it did occur, it produced positive results.

Practice example

In Hampshire, a neighbourhood Police Community Support Officer (PCSO) had attended an offender's MAPPA meeting and provided valuable information about the offender's recent movements in the community. This included telling MAPPA that the offender had been seen in the company of a child with whom he should not have been in contact.

Documentation

- 5.8. Arising from the last inspection, we recommended that *'minutes should be timely, clear and provide an accurate record of decisions and actions agreed'*.
- 5.9. Compared with 2011, production of minutes was timelier. There had clearly been a focus on achieving this. In Leicestershire & Rutland, all the minutes for each of the eight cases we looked at were timely. The Greater Manchester performance was also good. In Dyfed Powys, action points from the meetings were distributed immediately following the meeting, even if the minutes themselves took longer to arrive. We saw similar practice elsewhere. We thought this was helpful.
- 5.10. We were surprised to hear about practice in one area, whereby sometimes insufficient sets of minutes were provided at meetings for everyone to have a copy. In that particular instance, there were three or four sets on the table for 'the agencies to fight over'. We think it is important for sufficient sets of minutes to be available for everyone attending to have their own copy.
- 5.11. We found that actions to be undertaken were clearer and more relevant than we had found in 2011. There was also greater rigour in reviewing the actions. Most MAPPAs set deadlines for actions that were appropriate for the individual circumstance.
- 5.12. Nearly all the actions allocated from the previous meeting were recorded as having been completed in accordance with the timeframe set. Actions were far more proportionate and relevant than we found in 2011. However, we found it frustrating, as the example below shows, that occasionally we saw an action reported as having been completed, but could not then see what the outcome of that action had been.

Practice example

Jack had left three mobile phones in the Approved Premises prior to his recall to prison. MAPPA asked the YOT police officer to check what information was contained on the phones. At the following meeting, the minute reported *'phones checked for intelligence'*. However, nowhere in the minutes did it then say what the YOT police officer had found on the phones. Having charged the YOT police officer with the task of checking the phones, and having asked him if he had carried out the action, it was incumbent on the Chair to find out what had been on the phones, or, if not asked, for the YOT police officer to volunteer the information.

- 5.13. Arising out of the last inspection, we made the following two recommendations to be delivered by Chairs of level 2 and 3 MAPPA meetings: They should:
 - *'ensure that 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 up in every case and reviewed where necessary'*
 - *'draw up strategies to minimise the risk of harm presented by the individual in the longer term when they are no longer subject to MAPPA'*

- 5.14. MAPPA guidance states: *'Having assessed the risk that each offender poses, the MAPPA agencies need to manage that risk. This will entail the preparation of a detailed and robust Risk Management Plan'*. In 2011, we found very few detailed and robust MAPPA RMPs. This time, we found evidence of improvement, but results were still disappointing. The MAPPA A template for referrals asks for the agency RMP to be broken down into 'Restrictive Factors/Interventions', 'Rehabilitation Factors/Interventions' and 'Protective Factors/Interventions'. Most of that MAPPA A referral information is then carried across into the MAPPA B minutes. The RMP uses the same headings. Too often, we found the initial agency RMP was carried across from MAPPA meeting to MAPPA meeting without change, and by default it became the MAPPA RMP. In many instances, the RMP was insufficiently updated or, occasionally, inaccurate. In one case we inspected, the RMP included a 'no contact' condition with a person who had sadly died.
- 5.15. Although we could evidence lots of risk management activity, and this was generally well done and recorded, we were often frustrated to find within the Restrictive Factors/Interventions section of the RMP, expressions such as 'licence conditions' or 'SOPO'. Contingency measures often just listed 'breach if fails to comply'. In addition, details of what work was going to be undertaken with the offender to rehabilitate or protect them was often not spelled out in the RMP. What this meant was that in many cases it was unclear what the contribution of all the agencies around the MAPPA table was to the overarching MAPPA RMP.
- 5.16. Sometimes we saw 'home visits' included as part of the plan, but not the details of when and by whom. We thought what one drugs worker told us was illuminating. They said they did not contribute to risk management, as all they did was visit the offender a few times a week at his home to administer his medication. That lack of awareness of how all the agencies around the table were contributing to keeping victims and potential victims safer was disappointing. In that case, the drugs worker may have had more day-to-day contact with the offender than anyone else.
- 5.17. We also thought it was important the minutes captured, within the RMP, details of licence conditions and restrictive orders, such as SOPOs, Violent Offender Orders or RoSHOs, in full and accurately². We attended one level 3 meeting where the sex offender was living out of area a few hundred miles away. Those in the room or on the telephone asked numerous questions of the police about the SOPO. We thought if details of the SOPO had been included within the MAPPA RMP, then everyone at the meeting would have been aware of exactly what the offender was, and was not, allowed to do, and would be better prepared to respond to any breach. The meeting would also have been more concise.
- 5.18. The meetings we observed that demonstrated the most thorough considerations of risk assessment, and the actions needed to address the issues arising, were the level 3 meetings we observed in Leicester and Carmarthen, the pilot areas for Four Pillars. However, while the model clearly gave shape to the considerations, the most important thing from our point of view was the skills of the Chair in applying the model properly, ensuring the right people were around the table and that they knew what they had to do to take the required actions forward. In both Leicester and Carmarthen, the meetings were well chaired by the local MAPPA coordinators. In particular, in Leicester the Chair clarified with the lead agency that the agency RMP had been updated and relevant information input to ViSOR.
- 5.19. Overall, we thought RMPs were better than four years ago but still needed improvement. We thought only two-fifths were of sufficient quality. The best RMPs we read were those produced by Leicestershire & Rutland. That MAPPA, together with Dyfed Powys, was a pilot area for Four Pillars, which was developed by De Montford University based upon work in Scotland with high risk offenders and then adapted for use in England and Wales. However, even in those two areas the actions set under the Four Pillars complement the existing plan, and it was not always easy to

² Sexual Offences Prevention Orders (SOPOs) and Risk of Serious Harm Orders (RoSHOs) have been replaced by Sexual Harm Prevention Orders (SHPOs) and Sexual Risk Orders (SROs) as a result of amendments made to the *Sexual Offences Act 2003* by the *Anti-social Behaviour, Crime and Police Act 2014*.

find that existing plan. One prison governor who was a member of an SMB, and attended level 3 meetings, told us that a summary section within the MAPPA documentation would help to draw the plan together. She described it as *'and in conclusion, the RMP is ...'*

- 5.20. In many instances, the RMP was insufficiently updated even when there had been notable change. An Inspector reporting on one case said: *'The RMP from the referral is adopted as the MAPPA RMP without change. It is pulled through to each meeting note even though it quickly becomes irrelevant.'*
- 5.21. With regard to drawing up strategies to minimise the risk of harm presented by the individual in the longer-term, when they are no longer subject to MAPPA, we found a mixed picture. In some cases, the offender was subject to a long period of licence; in others, the offender had just been released or release was imminent. In those instances, it was too early to expect to see preparation for longer-term strategies. In other cases, we saw good consideration given to exit planning. We also saw examples where the case petered out at sentence end, with risk factors still unaddressed. The examples below show both sides of the picture.

Practice example

Dave was an elderly sex offender with a lifelong history of offending against pre-pubescent males. He had received a high level of appropriate restrictive interventions and support under Leicestershire & Rutland MAPPA for more than two years. He was released to Approved Premises. Inter-agency support and monitoring enabled MAPPA to be sufficiently confident to allow him to move to independent living, with the assistance of a support worker. At the time of the inspection, he remained offence-free, still subject to appropriate restrictions via his SOPO, on anti-libidinal medication and in receipt of one-to-one voluntary support.

Practice example

Jon was a violent offender, managed at category 3 level 2. He had a history as a domestic abuse perpetrator, was involved in the gangs and drugs world, and had weapons offences in his history. Released from prison at his sentence end date, this entry on the case record when his sentence was ending was very telling: *'... conducted a planned visit to finalise Jon's release plan. A friend is collecting him as soon as Jon has had a haircut and bought new clothes. We gave Jon our mobile numbers, and told him to call us when he has arrived. He has agreed to spend a few nights in a bed and breakfast'*. This was not a good plan for release of a man who was involved in gang activities, and posed a risk of serious harm to known and unknown people as well as his own children. There had been insufficient consideration as to engagement with Jon once his sentence had ended.

- 5.22. In Greater Manchester, we inspected cases from Tameside Metropolitan Borough. The IOM team in Tameside, known as Spotlight, included a violent offender cohort, something we rarely see as IOMs have historically focused on prolific acquisitive offenders. However, the Spotlight team in Tameside was responsible for violent offenders managed in MAPPA. All the officers in the team were trained in the Management of Sexual and Violent Offenders (MOSAVO), and attended MAPPA meetings. The IOM monitored violent offenders when they came to the end of their sentence in order to seek to protect victims, as the cases below demonstrate.

Practice example

Good work was undertaken prior to Phil's re-release from prison in October 2014 at sentence end date. The IOM team succeeded in getting him to engage in voluntary contact and support, and frequent contact took place thereafter in relation to his mental health, rehousing and substance misuse. His release from prison was managed well; he was collected from the gate, and escorted to arranged accommodation with funding secured for him to reside there for two weeks. Police carried out surveillance, and comprehensive measures were put in place to protect potential victims. Greater Manchester MAPPA management of the monitoring and victim protection issues was good, as was the supportive engagement provided to the offender by the IOM team.

Practice example

Derek had served a two year prison sentence for a violent assault on a 64 year old male who he believed was a sex offender. While in prison, Derek had expressed an intention to kill a sex offender if he had an opportunity. After initial release, he was recalled to prison (because of threats, drug misuse and entering an exclusion zone). Due to this and concerns about his behaviour, Derek remained there until his sentence end date. The police identified those individuals who were at risk and placed 'markers' on their addresses. Police surveillance was instigated for two weeks following Derek's release, which led to the conclusion that he was not seeking to visit any of the people who had been identified as at risk. The PCSO within the IOM helped Derek obtain benefit entitlements, arranged fishing activities as a diversionary activity, and, consequently, gained Derek's engagement.

Disclosure

5.23. Disclosure is the sharing of specific information about a MAPPA offender with a third-party who is not involved in the MAPPA, in order to protect the public. Disclosure in relation to *all* MAPPA offenders should be considered at *each* review meeting. From reading the minutes, we evidenced consideration of disclosure in just over four-fifths of the cases, with reasons provided in three-fifths. Bearing in mind there is a specific section within the minutes template for disclosure, we expected a better response. Sometimes, the boxes were blank, while sometimes information was copied and pasted from previous meeting minutes, and did not relate to the new meeting. Disclosure considerations at the different MAPPAs varied, with Leicestershire & Rutland and London always showing evidence of appropriate consideration. London was also good at reporting on the reasons for the disclosure.

Practice example

Pete, a sex offender, was demonstrating an escalation in his offending behaviour. London MAPPA was concerned that Pete's partner could be a potential victim. In particular, they were concerned she could be involved in illicit sexual practices with Pete non-consensually. The police visited her to ascertain her position in the relationship, and gave her full disclosure of his offending history.

5.24. In one case, the minutes said in relation to disclosure '*see summary in body of notes*'. However, the body of the notes was then updated in the next meeting, and the disclosure still said '*see summary in body of notes*'. Those present would have been confused about what the disclosure was, and to whom it was to be made.

- 5.25. Information from MAPPA meetings regarding disclosure decisions was recorded on ViSOR in three-fifths of the cases we inspected, with performance best in Leicestershire & Rutland and Greater Manchester.

Practice example

Denis was a RSO who had received a long prison sentence for repeated sexual offences against his partner's ten-year-old sister. Prior to Denis's release, Greater Manchester Police and probation made joint visits to his family. This enabled disclosure of information to them about the risks he posed to his nephews and nieces, the licence and SOPO restrictions and the reason for children's social care services involvement.

Victim Safety

- 5.26. In the last inspection, we said the likelihood of victim safety issues being brought to the attention of the meeting increased considerably when a probation victim liaison officer regularly attended the MAPPA meetings. In this inspection, we found that in almost three-quarters of the cases where victim liaison officers were actively involved with the victim, or where there were victim issues that required specific attention, they attended the meetings. This was a ten percentage point increase compared with our 2011 inspection. Action to ensure victim safety was taken in all but one of the relevant cases we inspected, which was considerably higher than we found in the last inspection. Information in relation to the victim was nearly always reported to MAPPA in a timely way.
- 5.27. In one case, the victim liaison officer was not supporting the girlfriend of a manslaughter victim, saying it was outside of their remit. Part of the reason why the offender manager referred the case to multi-agency management was to bring about a change in that position. MAPPA influence worked, and the victim liaison officer sought to make contact via the girlfriend's drugs worker.

ViSOR

- 5.28. Inspectors found most police forces used ViSOR effectively, with systems and processes in place to ensure information about offenders was recorded or transferred appropriately from other IT systems onto ViSOR. However, by comparison we evidenced little progress in the quality and frequency of ViSOR use by the other Responsible Authority agencies. In three-fifths of the cases inspected, those agencies recorded information infrequently in the preceding 12 months. In seven of those, they had not recorded any information at all.
- 5.29. Some ViSOR issues identified in the 2011 report had been actioned. In particular, offenders' convictions were recorded on ViSOR in all of the records reviewed, with widespread recording of the offender's modus operandi. The offender's current MAPPA level was clearly recorded, even when it had recently changed. However, one-third of the sex offender cases had no RM2000 risk assessment recorded, and, in a further six cases, the assessment had not been authorised by a supervisor. In almost a half of the relevant cases, the risk level recorded on ViSOR was different from the level at which the offender was actually being managed.
- 5.30. One police force had insufficient terminals for the number of police officers requiring them, while in a different area, a recent IT upgrade had resulted in problems that were proving difficult to resolve and leaving officers with unnecessary and considerable difficulties in simply gaining access to the system. In that second area, the quality and frequency of ViSOR entries by the police was markedly lower than we found in the other five areas.

5.31. Generally, there was poor use made of the bespoke case management functions within ViSOR. Key information was often placed in the activity log function, which was inappropriate. For example, disclosure decisions were usually found within the meeting minutes rather than in the relevant part of the system. Personal details, such as notable distinguishing habits and sexual interests were rarely recorded. As a result, information was harder to locate or not as comprehensive as it should have been. There were exceptions.

Practice example

In Dyfed Powys, police officers had recorded notable and distinctive personal information about the offender, as well as specific details of the offender's previous conviction and modus operandi dating from the 1990s, before ViSOR. This was good practice given the offender's impending release and his previous offence's similarity to his most recent offending behaviour.

- 5.32. We found few examples of direct input by NPS offender managers. Often, information relating to their involvement was recorded via second-hand entries by police officers or ViSOR administrative staff based on information they received. This lack of direct involvement often related to the continued difficulties NPS staff had in accessing the system, a similar picture to that identified in the previous inspection. We found one MAPPA area where all the trained MAPPA administrators had been transferred to the Community Rehabilitation Company (CRC) in June 2014 when the split in probation work had taken place. This seemed to be an example of inordinately bad planning. None of those staff would now be using their ViSOR skills, as the CRC does not manage any MAPPA cases. Some MAPPA coordinators reported a lack of ViSOR terminals within the NPS.
- 5.33. We found a paucity of prison input into ViSOR in the cases we inspected, with little evidence of prisons taking an active role in the updating of ViSOR records. In London, we saw evidence of one prison providing ongoing security intelligence updates on an offender's ViSOR record. In Dyfed Powys, we found similar entries on an offender's record made by a designated ViSOR coordinator based at a local prison in the area, something not found elsewhere during the inspection. However, these were the exceptions rather than the rule. Given prisons' status as one of the three joint Responsible Authority agencies, this was particularly disappointing.
- 5.34. In NOMS North East division, a pilot has recently taken place whereby intelligence reports are submitted by prison security staff into the new prison security intelligence database that is then analysed by staff sitting within an intelligence hub. It is then placed in ViSOR (within the activity log and intelligence attachments), when that information is assessed as relevant to the offender's risk of harm to others or reoffending. This information is often transferred in near 'real' time due to the operational role and structure of the hub. We thought that this was an interesting initiative.
- 5.35. Often, the final prison location was not set as a partner to the offender's ViSOR record. MAPPA guidance states that *'while the offender is in custody, the prison establishment will request partnership from the Probation Trust or the police for MAPPA offenders who are on ViSOR. The police or the Probation Trust should create the Prison Service (the prison establishment where the offender is located) as a partner to the ViSOR record in all cases. The Prison Service will ensure that the record is updated with relevant information'*. In one-third of the applicable cases inspected, the relevant prison was not 'partnered' to the individual's ViSOR record.
- 5.36. YOTs are not one of the designated Responsible Authority MAPPA agencies, but are actively involved in the management of relevant MAPPA offenders. Although the inspection saw some examples of MAPPA offenders under the jurisdiction of local YOT teams, we found no evidence of the YOT having any input or indeed access to the ViSOR system. We think there should be a review of their access in relation to ViSOR, perhaps through their seconded police officers.

- 5.37. Minutes of level 2 MAPPA meetings should be produced within ten working days and the level 3 MAPPA meetings within five working days. They should be sent via secure email to the relevant recipient, and stored on ViSOR. While minutes were generally timely, in two-thirds of the cases we inspected the minutes were posted late into ViSOR. Performance across the areas we visited varied greatly. In one area, only one of the eight cases had their minutes posted into ViSOR in a timely way; however, in Leicestershire & Rutland the minutes from all eight cases were posted into ViSOR promptly.
- 5.38. We found inconsistencies in how details of police officers specifically assigned to manage MAPPA offenders were recorded. This information was evident on ViSOR in just over half of the cases we looked at. Details of those officers' supervisors were also not always recorded. We consider this unhelpful and likely to cause confusion to any system users familiarising themselves with both the case itself and the specific points of contact within each agency. As previously observed, the policy regarding management of MAPPA offenders by specific officers varies from force to force with not all MAPPA offenders having a dedicated police manager.

Conclusion

- 5.39. Our findings in relation to level 2 and 3 meetings were generally positive, and we found performance overall was better than in 2011.
- 5.40. To aid accountability, meeting Chairs needed to be clearer about attendance at meetings. However, they were more active in holding agencies/individuals to account for their actions than we found in 2011.
- 5.41. In the last inspection, we reported on the lack of a single integrated MAPPA RMP. Although the RMPs from Four Pillars areas were better, and the quality of plans we saw during this inspection overall had improved compared with 2011, we still struggled to see comprehensive RMPs that fully contained all necessary actions. MAPPA guidance talks about MAPPA RMPs and lead agency RMPs. We are not sure why the former would be different from the latter. Responsibility for the case resides with the lead agency. Other agencies contribute to that RMP. We think the offender should only have one plan, and the lead agency plan should be the MAPPA plan and vice versa.
- 5.42. While police used ViSOR effectively, there had been little progress in the use of ViSOR by prisons and the NPS since 2011. This was disappointing, and negated the purpose of ViSOR as a key tool in the effective management of offenders and other persons posing a risk of harm to the public. As a multi-agency system, its effectiveness is dependent on the quality and timeliness of information and intelligence recorded within it along with consistency in the interpretation of that data.

Managing risk of harm: the agencies

6

6. Managing risk of harm: the agencies

This section reports how well agencies within MAPPA contributed to the assessment of the offender's risk of harm to others, whether they undertook the actions required of them in the meeting, and if there was a robust MAPPA RMP established to manage effectively the risk of harm the offender presented. We comment on how well MAPPAs had responded to the relevant recommendations from the original MAPPA inspection.

- Many lead agency RMPs inaccurately and/or insufficiently incorporated MAPPA decisions and actions.
- Probation staff shared relevant information with others, and undertook actions identified for them at the MAPPA meeting.
- Appropriate priority was afforded to victim safety.
- Approved Premises staff and victim liaison officers were active contributors to MAPPA meetings.
- Police officers routinely exchanged relevant information about MAPPA offenders, and undertook actions set for them in the meetings.
- Not all police forces identified and allocated offender managers to work with violent offenders.
- Police generally undertook visits to offenders in accordance with local policy, but their visits and the visits carried out by Duty to Cooperate agencies were incorporated infrequently into the MAPPA RMP.
- The contribution of prisons to MAPPA was generally good.
- Duty to Cooperate agencies contributed well to MAPPA, but were not always represented by the right person.

Youth Offending Teams

- 6.1. We inspected three cases supervised by a YOT. In one of those cases the lead agency was the police, which was contrary to national guidance but in line with practice in that area. We realise, with so few YOT cases being managed within level 2 and 3 MAPPA, that it is difficult to draw conclusions from such a small number of cases.
- 6.2. In one case, the seconded probation officer in the YOT was conscientious in what they did but overly passive in the MAPPA meeting we observed; they took actions from the Chair of the meeting, and did not take a lead role. This was the person who had most contact with the young person, and this failure to assert authority felt inappropriate. Issues of accountability were unclear as a result.
- 6.3. In two of the three cases where the YOT was involved, referral into MAPPA was late. In all of them, the MAPPA RMPs failed to incorporate all the necessary multi-agency actions required to manage the risk of harm. In one case, there were indications of child sexual exploitation, but this had not been recognised or acted upon.

- 6.4. In two of the cases, communication between the YOT and relevant other agencies took place in a timely and effective way in relation to risk of serious harm issues. In all three cases, the YOT undertook all the required actions from MAPPA and reported on those actions. They paid appropriate priority to the safety of identified victims.
- 6.5. HMI Probation has just carried out an inspection into Serious Case Reviews in YOTs. We reviewed 30 Critical Learning Reports submitted to the Youth Justice Board on serious incidents that occurred in the first 4 months of 2014. One of those cases, although meeting the criteria for MAPPA, was not identified before the serious incident happened. Identification of MAPPA cases by YOTs at the point of sentence remains an area for improvement.
- 6.6. We met YOT managers in all six of the MAPPA areas we visited. Some managers were more knowledgeable about MAPPA than others were, and, in those instances, were able to articulate the benefits that MAPPA provided. One YOT manager said that they would encourage their staff to make a referral when they had difficulty gaining the engagement of a specific agency. In that particular MAPPA area the referral process automatically meant the case was discussed at a level 2 meeting, as there was no multi-agency screening undertaken. We have a reservation about that blanket approach.

Probation

- 6.7. There was an up to date RMP in OASys in three-quarters of the relevant cases, which was a worse performance than last time. It incorporated actions identified at the MAPPA meeting in half of the cases, a similar picture to 2011. Too often, the plans were lacking in detail, and were, on occasion, inaccurate. For instance, we read an OASys RMP that reported an offender's non-contact conditions with only a few of the people with whom they were not allowed contact. We also saw exclusion areas inaccurately described, with precise configurations of boroughs or geographic areas replaced in the RMP with something different. Those were problematic differences, if everybody involved in the case was under a different understanding of who the offender was not allowed to have contact with or the exclusion zone boundaries. As with last time, we hardly ever saw information included in the OASys RMP relating to home visits by the police or other agencies.

Practice example

In this case the offender manager reviewed OASys at the right times, e.g. on release and after the case was deregistered from MAPPA. However, they reduced Matthew's risk of serious harm to medium, although there was nothing in the RoSH analysis or RMP to lend support to that decision or to evidence why MAPPA at level 2 was no longer necessary. The RMP failed to include information regarding Matthew's HIV status, the role of his mentor, or the support he received from his supported accommodation, and was never updated.

- 6.8. Sharing of information about an offender was generally good when it was made by probation to other agencies. In 87% of cases, we judged that probation had communicated with other agencies in a timely and effective way about risk management issues. This was a seven percentage point increase on 2011. Offender managers in Leicestershire & Rutland and Dyfed Powys communicated effectively in every instance.
- 6.9. Our inspection found that probation officer offender managers felt they were not always informed by other agencies about the MAPPA offenders with whom they worked. This could be, however, because many probation officers do not, as we have said elsewhere in this report, have access to VISOR terminals. In those instances where they have access to VISOR, many probation officers do not routinely use it as a risk management communication tool. This is a finding from our original

inspection. This inspection did find there was evidence the probation offender manager was communicating with other agencies in order to obtain updates on the MAPPA offender prior to the next meeting.

- 6.10. In 91% of cases, actions identified in MAPPA were always or usually carried out by the offender manager, or others working on their behalf, and reported to MAPPA in a timely way. This was a similar picture compared with 2011.
- 6.11. Probation Trusts were abolished in June 2014, and work was split between the NPS, who manage all MAPPA and high risk of harm cases, and the CRCs, who manage low and medium risk of harm cases. Consequently, all the cases we looked at were within the NPS. It meant there were fewer offender managers managing a greater number of MAPPA cases each than had been the case back in 2011.
- 6.12. We found in 2011 that in 83% of relevant cases, offender managers gave appropriate priority to victim safety. This time, the figure had increased to 89%. Actions emerging from MAPPA were undertaken and reported to MAPPA in a timely way in nearly every case, and in a greater percentage than we found in the initial inspection.
- 6.13. ViSOR remained underused within the NPS. In one area, there was a plan to train senior probation officers by the end of April. However, the MAPPA manager told us that offender managers very rarely asked to look at ViSOR. Overall, there was little evidence of offender managers having ViSOR at the centre of their thinking or having knowledge about the facility to link the nDelius contact record with ViSOR as the following example evidences.

Practice example

A MAPPA sex offender met with his probation offender manager, and disclosed that he had begun living part of his life under a new female identity. The offender manager did not communicate this information to police or record it on the offender's ViSOR record. Shortly after, police officers conducted an unannounced visit to the offender's home and were surprised to find evidence of the offender's new identity, including items of female clothing. This intelligence should have been shared.

- 6.14. We saw evidence of greater use of positive activities and constructive interventions on this inspection. Two areas used Four Pillars, and the agenda and meeting minutes template focused attention of all present upon Supervision; Monitoring and Control; Interventions and Treatment; and Victim Safety Planning. Importantly, there was an expectation that the RMP should incorporate the offender's views on the risk they presented. It also asks what success will look like for the offender. It is for the offender manager to provide that information.

Practice example

This Dyfed Powys offender was living out of the area, and was about to be transferred. The offender manager travelled to the new area for two days in order to do one-to-one women's sexual offending work with her in relation to social adjustment and risk management planning. She also took the opportunity whilst in the new area to source and view appropriate accommodation for this woman for when she moved on from the Approved Premises in which she was residing.

- 6.15. Polygraph testing is a recent additional tool that can be included in licence conditions with certain sex offenders. In one case in London, excellent liaison took place with the polygraph tester to ensure the four questions asked would best demonstrate the offender's compliance or non-compliance.

- 6.16. In a similarly high percentage of cases to 2011, the offender manager or others working on their behalf had levels of contact with the offender that were appropriate to the MAPPA level the case was being managed at, and the risk of harm posed by the offender.
- 6.17. The offenders in most of the cases inspected were released around the summer of 2014, which was when Probation Trusts were abolished and work transferred to the NPS or CRCs. NPS middle managers will, therefore, have been busy dealing with staffing and case assignment and allocation issues, as well as ensuring reports were written for the courts. However, it was disappointing that we could evidence effective management oversight of risk of harm issues in just three-fifths of the cases - a similar figure to 2011, although that overall figure masks some differences between the six areas we visited.
- 6.18. We saw evidence on the nDelius record of managers endorsing MAPPA referrals, and providing good rationales for doing so. However, the poor quality of many countersigned referrals we looked at, with missing or insufficient information, indicated management scrutiny was not thorough enough.

Approved Premises

- 6.19. Approved Premises were used in three-fifths of the cases to manage the risk of harm the offender presented to others.
- 6.20. Approved Premises staff and managers played a key role in MAPPA meetings, actively attending and contributing in 86% of the cases we looked at which was slightly higher than in the last inspection. In all but one of the cases we inspected, actions required of the Approved Premises to manage risk of harm were undertaken and reported to MAPPA in a timely way.
- 6.21. Approved Premises provided an invaluable role in offering additional surveillance and restriction. Sometimes, had it not been for the provision of a place at an Approved Premises, the offender may not have been released. In some instances, we saw MAPPA making, and receiving, additional funding from NOMS for additional cover in an Approved Premises for an offender managed at level 3 registered as a Critical Public Protection Case (CPPC).
- 6.22. We saw instances of Approved Premises going beyond what might have reasonably been expected of them. In Hampshire, managers at an Approved Premises accepted an elderly sex offender with vascular dementia when the local hospital discharged him before a more suitable placement was found. The Approved Premises took him back, and provided, in effect, a care service for which they were untrained. This offender was moved to an appropriate residential care placement once adult social services had completed a proper assessment on him.

Victim Liaison

- 6.23. In 73% of relevant cases, victim liaison officers from probation attended MAPPA meetings where they were actively involved with the victim or where there were victim issues that required specific attention. This was a ten percentage point increase on the last inspection. In all but one of the relevant cases we inspected, actions emerging from MAPPA in relation to the victim were undertaken. In all but two of the cases, reporting to MAPPA about those actions was timely.
- 6.24. In one case, there had been no victim liaison input with 'victim not being from the local area' cited as the reason. There was not enough information about the victim to understand if this was relevant, or if a victim liaison officer from another area should have been involved. In that case, it was unclear who was supporting the victim.

Police

- 6.25. In 94% of cases, the police carried out requisite actions emerging from MAPPA. In the same percentage of cases, the police confirmed to MAPPA the actions that had been undertaken. These were similar figures compared with 2011.

Practice example

In Greater Manchester, the police installed a home alarm at the home of this domestic violence perpetrator's previous victim, who was the offender's former partner and mother of his child. In addition, they implemented safeguarding measures for three former partners through restraining orders and information disclosures in conjunction with their Domestic Violence Unit officers. Following release, the offender proceeded to commit a domestic violence assault on a 'partner' who was hitherto unknown to agencies. After absconding from the scene, the offender was arrested at his ex-partner's house after police had worked with her to arrange it. This demonstrated good investigative work, which limited the chances of the offender carrying out further offences and led to a successful prosecution of the offence for which he was wanted.

- 6.26. Visits to RSOs Offenders and violent offenders were compliant with force policy, and appropriate to managing the case sufficiently in 90% and 86% of the cases respectively; similar to 2011. Visit regimes were rarely incorporated into the MAPPA RMP.
- 6.27. In most cases, details of visits were not recorded by police in the 'visits' attachment of ViSOR. However, in one London case both the visits attachment and 'visits' tab within the 'Risk Management Plan' attachment had been updated to record details of visits carried out to the offender. This included joint police/probation visits at NPS offices and unannounced police visits to the offender at the Approved Premises where he was residing.
- 6.28. Seemingly achievable visit schedules by police officers to sex offenders were more difficult to manage in the more rural areas because of the longer journey times required to complete them. One officer made 5 unsuccessful attempts to make a single unannounced visit to an offender who lived 90 minutes journey time away.
- 6.29. Caseloads of police officers working with MAPPA offenders were generally in line with the findings from the 2010 inspection entitled *Joint Inspection on Management of Sexual Offenders in the Community - Restriction and Rehabilitation: Getting the Right Mix*. However, in one area caseloads were substantially higher and, in our view, unacceptable. In that area, the visit regime was out of step with national guidance.
- 6.30. At the time of the inspection, there was a national move towards the introduction of the Active Risk Management System (ARMS), a structured assessment process to assess dynamic risk factors known to be associated with sexual reoffending, and protective factors known to be associated with reduced offending. At August 2015, 850 police officers and staff had been trained and the NPS was in the process of training trainers to deliver ARMS to probation staff so that all category 1 offenders have the same risk assessment and management plans. The objective is to provide police and probation with information to plan the management of convicted sex offenders in the community. The initial resource requirements to reassess all existing sex offenders will be high, but once introduced is designed to produce a more appropriate overall visit schedule.
- 6.31. Information sharing from the police to MAPPA took place in 98% of cases, the same figure as in 2011. We inspected the case of one offender managed as a Terrorism and Counter-Terrorism (TACT) offender. The work of MAPPA was characterised by timely referral, excellent exchange of information and effective assessment and management of risk. Information from the prison was good, and the

Approved Premises appropriately used on first release. An extensive range of restrictive measures provided assurances about his conduct, and disclosures made to the Mosques he attended once the counter-terrorism unit approved them. Assessed using the extremism risk guide, he engaged in prison and following release with the *'Healthy Identity Intervention'*, an intensive programme designed for extremists and delivered by a psychologist. The Central Extremism Unit provided him with a mentor. He was allowed to leave the Approved Premises in a staged and monitored manner, following social services assessment in respect of any potential risks to his children. We interviewed the offender. He told us he understood what 'being on MAPPA' meant. He knew when meetings were scheduled, what his plan was and whether there were any changes to it. He said reporting arrangements were responsive to his diversity needs.

- 6.32. This was a successful and well-managed case, and the offender fully complied. However, we had some concerns that MAPPA did not understand all his risks as the counter-terrorism unit did not regularly attend MAPPA meetings nor did they provide an update. We were not able to access some of the records or other information in relation to this offender because of the security classification. Guidance on working with terrorists and domestic extremists is comprehensive, and the issue we found in this case may have been resolved if timely advice had been sought from the specialist officer within OMPPG. It is not beneficial for MAPPA to be actively contributing to the management of a case if, for security reasons, it is not fully informed of all the risks.
- 6.33. In most cases, the police took all reasonable action to minimise the risk of harm presented to others by the offender.

Practice example

Ray was convicted following an episode of escalating offences whereby he would approach women who he did not know and make indecent, offensive and lewd suggestions. More recently, he had committed assaults against women. Police and probation in Ealing managed this case well. Tight licence conditions were imposed when he was released to the Approved Premises. When Ray moved back to his own address with his partner, the police conducted surveillance on him through a camera (which recorded his coming and going from the home address) and a three day foot surveillance once it was established that he was absent from the home for periods during the day. No concerning behaviour was observed. He engaged well and was downgraded to MAPPA level 1. At sentence end, he engaged voluntarily with the Sex Offender Treatment Programme.

- 6.34. We interviewed police offender managers in all the cases where one was allocated. As mentioned earlier in this report (paragraph 5.5), in a couple of the areas police offender managers were not identified or allocated to work with violent offenders. Whilst acknowledging workload issues, we think the lack of a named police offender manager is a potential cause for confusion and lack of accountability. ViSOR records for those offenders often failed to give clear indications as to the relevant points of contact for the case. This could cause difficulties for staff in other Responsible Authority agencies in understanding whom to contact.
- 6.35. Some of the forces we inspected had recognised that the IOM teams had the capability to manage a cohort which included violent offenders and as such were able to provide management for some category 2 and 3 MAPPA offenders. Greater Manchester Police had delivered the package to all of its IOM officers in recognition of the different approach required for managing this group. Other forces we visited had not considered any such use of their IOMs for managing violent offenders, which we found surprising given the increasing demands placed on forces of managing increasing number of RSOs.
- 6.36. Most police offender managers said they had received training in relation to work with MAPPA offenders and were sufficiently well trained. Four-fifths said they were sufficiently skilled in using ViSOR. Every police offender manager we interviewed said they felt supported and received sufficient management oversight.

- 6.37. We expected to find that all police offender managers would have undertaken the MOSAVO training course, the usual requirement for this specialist role. Indeed, in one force all officers working with MAPPA offenders had received this training. Elsewhere, evidence of its delivery to officers was more sporadic with some trained officers working alongside untrained colleagues. In general, we found that most dedicated police offender managers were experienced officers or trained detectives, and had completed an equivalent of the MOSAVO course.
- 6.38. In Greater Manchester, offender managers were recruited externally into its Sex Offender Management Unit (SOMU), but all officers spoken to had received the MOSAVO training within the first few months of taking up their post. They also received other induction training courses, had opportunities to shadow more experienced officers and completed a specific Personal Development Plan that was regularly discussed with line managers. We thought the induction programme and training provided was evidence of good practice.

Prison

- 6.39. Prisons are required to notify the offender manager of the release date or parole eligibility date of offenders eight months prior to release. Offender managers should refer relevant cases to MAPPA six months prior to release. We found that timely referral was made in two-thirds of the cases.
- 6.40. Prisons actively contributed to MAPPA meetings in most cases, either through attending the meetings or the provision of written reports. We saw good use made of MAPPA Fs (the forms submitted by the prison to MAPPA that share information about the offender). However, in a number of instances that information was copied and pasted from the prison database straight into the MAPPA F and then into the MAPPA minutes, irrespective of its relevance. Information from the meeting was not always sufficiently reviewed in the minutes, and old information remained which made it difficult to see how up to date or relevant the information was.
- 6.41. Prisons undertook the actions they had been set in 85% of the cases where required, and in a higher percentage they told MAPPA and other agencies what they had done. These were much better findings in relation to Prisons than 2011. In some areas we visited, the prisons were not visible in all the cases even when they might have had a contribution to make.

Practice example

David was a violent offender from Leicestershire, serving four years. Prior to his release, MAPPA asked the prison to consider the offender in an Internal Risk Management Team meeting, and to ensure prison staff monitored his risks. In particular, MAPPA asked the prison to identify any contact between David and his former partner who was a potential victim. MAPPA also asked the prison to arrange for David's transfer to a prison nearer his home prior to release.

The prison undertook all the above actions and reported to MAPPA in a timely way.

- 6.42. The contribution of the Prisons to Leicestershire & Rutland MAPPA was particularly active. They were involved in all eight cases, and did everything required of them, as the practice example illustrates.
- 6.43. We saw evidence of some good joint working between the police and prisons within MAPPA as the case below illustrates.

Practice example

This Londoner was in custody for breach of his SOPO. He had been living a concealed lifestyle with a woman who had four children. The extent of the depravity of his previous offending against children was not made explicit in the minutes of the MAPPAs meetings, but could usefully have been shared as an indicator of the serious risks that Brian posed to children and to the vulnerable woman he was in a relationship with. During his prison sentence, the prison shared information about their concerns that Brian had been speaking with his partner's children on the phone from the prison, despite this being in breach of his SOPO. The Metropolitan Police officer, who was managing the police involvement in the case, in close conjunction with officers from Avon & Somerset Police, ploughed through hours of recorded phone calls from the prison to retrieve three phone calls that proved he had breached his SOPO. Some worrying information was retrieved, and led to concerns that Brian's partner had been complicit in child sex offences (although many of the calls were in a coded language which had been difficult to decipher). Both Brian and his partner were arrested and Brian's cell was searched, whereupon photographs he was not allowed to have were discovered. Contact between Brian and the woman was blocked, and she subsequently removed herself from the family home to a safe house.

Duty to Cooperate Agencies

- 6.44. A number of agencies have a Duty to Cooperate with MAPPAs, as set out in paragraph 2.3 of this report.
- 6.45. Duty to Cooperate agencies had identified, or were in the process of identifying, single points of contact which seemed vital to getting the right people around the table able to take decisive action where required. In general, there was a clear and appropriate differentiation about the levels of staff representing the agencies at the level 2 or 3 meetings. One Duty to Cooperate representative said that at level 2, the contribution might be 'could get a bed', whereas at level 3 the response was 'will get a bed and this is where'.

Local Authority Social Care Services

- 6.46. Social care services were represented at MAPPAs meetings in 36 of the 39 cases where we thought they should have been. In 89% of relevant cases, social care services shared information about the offender with MAPPAs.
- 6.47. Representation at MAPPAs meetings was not always by the most appropriate part of social care services, or, occasionally by the right geographically located social services department. Sometimes, we saw the attendance of adult care services, when children's services would have been more appropriate, and vice versa. On other occasions, we saw a representative from the wrong social care services department attending. We think this is partly to do with the lack of precision provided by the person making the initial referral. We saw terms such as 'social services' as the agency to be invited, when what was required was fuller information with a named person identified together with the details of their employer, role and contact details. With the best will in the world, it is not realistic to expect the MAPPAs office to be able to target the invitations appropriately if the offender manager does not provide them.
- 6.48. In some cases, there was a delay in the information being shared or actions being completed. We saw examples where MAPPAs Chairs were proactive in seeking to expedite matters. We saw a few cases where the home social services area was contributing appropriately to the MAPPAs, but an out of area social services department, involved perhaps because of victim issues or in relation to a potential move of the offender to a new area, was difficult to engage. This sometimes had a detrimental impact on, for example, the offender's pre-release planning.

- 6.49. In 71% of the cases where required, social care services made an appropriately active contribution to the MAPPA meeting.

Practice example

This Hampshire offender was in contact with a cousin's family not included in the licence conditions that identified those to whom he was not allowed to have contact. However, the offender manager had assessed the offender as posing a high risk of serious harm to the cousin's family, including a baby daughter. This gave MAPPA concern. Children's social care services were asked to conduct a protective parenting assessment with the parents of the baby. They undertook the assessment, and subsequently informed MAPPA that the parents were able to protect the baby.

- 6.50. In over four-fifths of the cases where a MAPPA meeting asked them to do something, social care services undertook it and reported what they had done.
- 6.51. In a Dyfed Powys case, social care services undertook a home visit to assess the risks to the violent offender's wife and young children and provided helpful feedback to the consequential MAPPA meetings.
- 6.52. In a Hampshire case, adult care services undertook an assessment on an offender with dementia when mental health failed to carry it out. They then found the offender a residential care placement. They kept MAPPA informed.

Health Trusts/Authorities

- 6.53. Health trusts/authorities were represented at MAPPA meetings in 34 of the 38 cases where we thought they should have been. In 79% of relevant cases, they shared information about the offender with MAPPA. We found better performance in relation to health than we found in 2011.
- 6.54. We did not inspect any cases where mental health were the lead agency. In the last inspection, we did not see the presence of General Practitioners (GP) in any cases; this time we found a similar picture but a GP did attend in relation to one of the Leicestershire & Rutland cases. One coordinator told us that they often received a 'not coming' letter from GPs that says they are not willing to share information. Leicestershire & Rutland had produced a DVD that they issued to GPs and others about the work of MAPPA, and how the various agencies contributed.
- 6.55. In 73% of the cases where required, health trusts/authorities made an appropriately active contribution to the MAPPA meeting. However, in one area, a particularly unhelpful consultant community psychiatrist failed to attend MAPPA meetings in relation to two offenders. The consultant did not share relevant information about the offenders or do what was requested of them by the meeting. MAPPA found constructive approaches to resolve the issues in both cases, but could have escalated the problems earlier.
- 6.56. When asked to do something by MAPPA, health did it in 73% of the cases. In a London case, mental health played a key role in managing the risks. A consultant attended meetings. Recognising the voluntary nature of mental health provision, he ensured that the other agencies understood the limitations. The consultant fully engaged with MAPPA to ensure appropriate licence conditions were in place and that the offender's referral for treatment was prioritised and commenced before the end of sentence.
- 6.57. Health trusts/authorities told MAPPA what they had done in 74% of the cases.

Local Authority Housing Authorities and Registered Social Landlords

- 6.58. Housing Authorities were represented at MAPPED meetings in 22 of the 26 cases where we thought they should have been. In 95% of relevant cases, they shared information about the offender with MAPPED.
- 6.59. In 84% of the cases where required, housing authorities made an appropriately active contribution to the MAPPED meeting.
- 6.60. Where asked to do something by MAPPED, they did it in 82% of the cases.
- 6.61. Housing authorities told MAPPED what they had done in 88% of the cases.
- 6.62. Registered social landlords were represented at MAPPED meetings in four of the cases we inspected, albeit we thought they could have been represented at a further four. In all the cases where they were represented, they shared relevant information about the offender with MAPPED, made an appropriately active contribution to the meetings, carried out required actions and told MAPPED what they had done.
- 6.63. Move on accommodation for offenders from prison or an Approved Premises was often one of the trickiest issues for MAPPED to resolve, not helped by a view by some that an individual has deliberately made themselves homeless through the committing of an offence.
- 6.64. London MAPPED Executive Office and the Metropolitan Police Central Jigsaw (Public Protection) team had developed a protocol for MAPPED offenders and offenders returning from abroad with the local housing authorities across the City. This provided a range of measures for level 2 and 3 offenders in order to safeguard the public, protect potential future victims and allow them to be rehabilitated back into the community. For offenders who had served a MAPPED eligible sentence overseas, there was an agreement that allowed the Jigsaw team to distribute returning offenders to boroughs on a rota basis with the expectation that the allocated borough would secure appropriate accommodation within that area.

Practice example

A local authority in one area we inspected provides three 'MAPPED' flats for use exclusively for MAPPED offenders on a needs basis. These are located in different parts of the city and offer a first step for MAPPED offenders who may otherwise be homeless and, therefore, at greater likelihood of reoffending. One of the offenders whose case we inspected was provided with accommodation in one of the flats.

Other Duty to Cooperate agencies

- 6.65. Other Duty to Cooperate agencies include JobCentre Plus, Local Education Authorities, Electronic Monitoring Providers and Home Office Immigration Enforcement. Each of them only attended a minority of the MAPPED meeting held in relation to the cases we inspected, but generally contributed appropriately to the MAPPED meetings.
- 6.66. As previously stated, referrals did not always sufficiently identify whom the referring officer wanted at the meeting, and therefore agencies that might have had a contribution to make were not always invited. In some instances, representatives from the Duty to Cooperate agencies were core members of the MAPPED meeting and, therefore, attended even if they did not have a specific contribution to make to a specific case.
- 6.67. Electronic Monitoring Services (EMS) only attended one meeting, but contributed well. One EMS provider told us that there were very few MAPPED cases with electronically monitored curfews, which

we did not think was correct. In that area, EMS had provided a presentation to the SMB about Global Positioning Systems (GPS), and consequently thought that would elicit greater involvement by them in future MAPPA meetings. In one MAPPA area, the field service manager for the region said although he was invited to SMB meetings, he had never been invited to a level 2 or 3 meeting where the offender was subject to electronic monitoring.

- 6.68. JobCentre Plus were involved in four cases, albeit we thought they could have been involved in more. They did not always share information about the offender with MAPPA or contribute as actively as we thought they should. However, in the three cases where actions were set for them, JobCentre Plus always carried them out and told MAPPA what they had done. We liked the way that JobCentre Plus embraced the wider issues posed in the following MAPPA case from Leicestershire & Rutland.

Practice example

Billy was given 12 months imprisonment for racially aggravated violence and threats. He had a previous history showing a pattern of weapons offences and racist behaviour. He was assessed as posing a very high risk of harm to the public, and high risk of harm to staff. JobCentre Plus were actively involved in this case, and were also a potential victim. They were sensitive to the need not to exacerbate Billy's sense of injustice, and took a pragmatic view about him claiming benefits upon release. Under normal circumstances, he would have been referred to a work programme provider. However, a decision was taken not to refer him. Instead, he was registered for Jobseeker's Allowance. While not the most appropriate allowance, to change it would have meant an intensive regime of him attending the office and being assessed, with all the consequential risks.

- 6.69. Local education authorities were only involved in one case; in Leicestershire & Rutland. They actively contributed, did what they were asked to and reported to MAPPA appropriately.
- 6.70. Home Office Immigration Enforcement was involved in one London case, and contributed fully.

Conclusion

- 6.71. Probation RMPs did not always reflect what was agreed at the MAPPA meeting, and we found inconsistencies between the NPS RMP and the MAPPA RMP. We think removing the distinction and having one plan only will remove confusion and lead to a better plan that incorporates all the relevant actions and measures.
- 6.72. We found a greater focus in this inspection on constructive interventions, and commended the approach deployed in Dyfed Powys and Leicestershire & Rutland whereby the offender's view of their risks was routinely sought, incorporated into the RMP and shared with other MAPPA agencies.
- 6.73. Although individuals from children's social care services and health were attending MAPPA meetings, they were not always the right person or from the right part of their wider organisation. If the person making the initial referral had been clearer when making the referral who they wanted at the meeting, and provided the correct contact details, the likelihood of them actively contributing would have been greater.

Managing and Leadership: the impact on practice

6

7. Managing and leadership: the impact on practice

In this section, we describe the national and local strategic MAPPA framework and comment on its impact on practice.

- MAPPA guidance 2012 is a comprehensive framework for working with MAPPA offenders.
- KPIs insufficiently measure 'outcomes' for offenders managed within MAPPA.
- Senior managers within the Responsible Authorities and Duty to Cooperates were committed to making MAPPA work in their areas.
- MAPPA coordinators/managers were knowledgeable and respected within their local areas.

The National Framework

- 7.1. A number of groups support the effective operation of MAPPA. The main ones are the Responsible Authority National Steering Group (RANSNG) and the National MAPPA team in the OMPPG within NOMS.
- 7.2. RANSNG is the national coordinating body that exercises oversight of MAPPA and is responsible for its continued development. The annual national MAPPA business plan produced by RANSNG is the document that the 42 SMBs mirror in their local business plans.
- 7.3. The national MAPPA team within NOMS OMPPG is a multi-disciplinary team made up of civil servants and seconded staff from the police and elsewhere in NOMS. Its remit is many and varied, but includes issuing MAPPA guidance on behalf of the Secretary of State, informing about policy and practice developments, and advising and supporting SMBs and Responsible Authorities on MAPPA issues.
- 7.4. During 2014, RANSNG has been considering KPIs in relation to MAPPA, recognising the limitations in the current measures. We endorse the need to introduce relevant indicators that are more outcome-focused, whilst concurring that perverse behaviours should not be encouraged. We welcome the recognition that effective use of ViSOR should be an integral part of managing a MAPPA offender. This will require an investment from NOMS and Responsible Authorities in IT and training.
- 7.5. We saw examples in this inspection where CPPC funding was received for additional staffing in Approved Premises for offenders who met identified criteria and were managed at level 3. One MAPPA we inspected was able to account for all their registrations and gave an account of where they had been successful in attracting additional money. A different coordinator/manager said there was less clarity about CPPC registration within their area, and consequently they had failed to receive some additional funding. We also heard from some coordinators about the additional support and advice local areas can access from the Head of CPPC in relation to sharing of good practice and encouraging them to think of organisational risks. The MAPPA minutes template MAPPA B does not currently have a trigger question to get MAPPAs to think about CPPC registration for level 3 cases. If there was such a question, that would focus the attention of MAPPA regarding central funding or guidance/support.

- 7.6. The College of Policing has a crime and community justice faculty. We noted during this inspection that not all police offender managers working with MAPPA offenders were MOSAVO trained. In some areas, this was because there was insufficient provision of training places within the local force to meet demand and little consideration given to collaborative arrangements with neighbouring forces. Police officers managing MAPPA offenders should be appropriately qualified. We consider that the MOSAVO working group, chaired by the National Police Chiefs' Council (NPCC) lead, is well placed to consider how best to ensure that MOSAVO training is coordinated and available and accessible to officers in the early stages of their tenure as a police offender manager.

The Strategic Management Board

- 7.7. There was an operational SMB in all six areas we visited. Four of them were currently chaired by a senior officer from the NPS, usually an Assistant Chief Executive or similar. An Assistant Chief Constable chaired the other two SMBs. Chairing tended to rotate between probation and police, although one of the probation Chairs had taken over from a Prison Governor Chair. Some of the Chairs we interviewed had only recently taken over their role. In Kent, the Chair of the SMB attended all MAPPA level 3 meetings. Representation by managers from the Responsible Authorities at MAPPA SMBs was in accordance with guidance, except in one area where the police representation was at a level lower than Assistant Chief Constable.
- 7.8. All the MAPPAs had a communications strategy, protocols with the agencies within their area, and a current business plan and annual report.
- 7.9. Attendance on the SMB was generally good, but we were told that it could be difficult to engage some agencies. The two main agencies where this was seen as a problem were health and social services. For both, the disparate and wide areas of work undertaken by their organisations meant it could be difficult to get people of a sufficient seniority to speak and act corporately.
- 7.10. Consideration of KPIs was routine business for SMBs. They were mainly measures relating to processes, were not overly demanding and the targets were substantially met. SMBs were alert to attendance of the right people at level 2 and 3 meetings. Prisons in Hampshire ensured that the senior forensic psychologist for the region attended all level 3 meetings as well as someone from the relevant prison.
- 7.11. Each SMB had at least one lay adviser, with the exception of one area. Some MAPPAs had used their lay adviser to contribute to Serious Case reviews. SMB Chairs and MAPPA coordinators/managers were generally positive about the contribution of lay advisers, commenting on their ability to ask difficult questions and to provide a helpful independent and external perspective. A lay adviser from Kent had suggested to the SMB in that county that Duty to Cooperate agencies might deliver a presentation on their work. Housing gave a presentation on their work in October 2014. This was particularly relevant in Kent, as housing was a problem with no ready supply of affordable accommodation.
- 7.12. MAPPA SMBs had commissioned audits of their work over the previous 12 months. Kent MAPPA had commissioned a series of audits on a variety of relevant subjects, and the results were reported to the SMB. We were encouraged to see that the findings of the Kent audits in relation to risk management and disclosure were comprehensive and resonated with our own findings during this inspection.
- 7.13. All MAPPAs were delivering awareness training. Hampshire provided four MAPPA awareness events a year on a multi-agency basis. In addition, they delivered MAPPA awareness training to single agencies across the county. This included YOTs, a Local Safeguarding Children's Board Chair, midwives, JobCentre Plus, health visitors, housing groups and church groups. Other MAPPAs adopted a similar approach.

Local MAPPA leadership

- 7.14. Police and probation provided funding for the MAPPA infrastructure in the areas we visited, and we were impressed with the way senior managers spoke about their counterparts and the way they worked together. Some MAPPAs had managed to secure additional funding from agencies working within the SMB, but in one area the coordinator was struggling to raise an additional £500 to provide some specific training.
- 7.15. In the six inspected areas, we observed a variety of models for the management and support of MAPPA. We readily acknowledge that the type of arrangement we saw in Leicestershire & Rutland whereby the coordinator and the local Public Protection Detective Inspector chaired all level 2 and 3 meetings between them would not have been feasible in a large Metropolitan MAPPA or London borough.
- 7.16. In London, a local borough manager and administrator coordinated the work whilst a small team at the centre serviced the SMB and produced policy advice and performance data. Ealing was one of the London boroughs piloting Share Safe, a web-based IT solution designed to ensure the security and efficiency of minutes.
- 7.17. Greater Manchester operated a variation on the London arrangement, while the other three areas operated a more traditional model akin to that operating in Leicestershire & Rutland.
- 7.18. We did not feel that any arrangement was necessarily inferior to another, although we do commend the quality of MAPPA work that emerged from Leicestershire & Rutland. The MAPPA level 3 meetings we observed were exemplary for the quality of the paperwork provided in advance, the attendance and contributions of Responsible Authority and Duty to Cooperate agencies, the chairing by the coordinator and the clarity and focus of the whole proceedings. Importantly, the meetings had a sense of gravitas and importance, which was appropriate as they are dealing with a very serious subject. We have observed elsewhere in this report that Leicestershire & Rutland always produced timely minutes, and, whilst we do not compare and contrast results relating to the inspected bodies within an inspection report, it is accurate to say their performance was consistently good.
- 7.19. MAPPA coordinators/managers were highly regarded by SMB members and operational staff with whom we spoke. They demonstrated good knowledge of their cases and genuine passion for the work.
- 7.20. Responsibility for chairing level 2 and 3 meetings varied across the MAPPAs we inspected. In some areas, detective inspectors and senior probation officer equivalents chaired level 2 meetings while MAPPA coordinators and/or more senior managers from the police and probation chaired level 3 meetings. In another area, probation tended to chair most of the meetings. Most Chairs said they had received relevant training, and felt confident in the role. We thought London's approach, whereby Chairs and administrators were trained together was a good idea.
- 7.21. The new arrangements that came in from June 2014, whereby all MAPPA cases subject to statutory supervision are now managed by the NPS, means that fewer officers are managing a greater number of these complex cases. Although many of the cases we inspected would have been at or about the point of release when we were conducting this inspection, we did not feel that the transfer of the cases we inspected from the Probation Trust to new officers within the NPS had had an adverse impact on the overall supervision of the case. However, some senior managers from the NPS told us that workloads for the NPS were higher than they had initially planned for because they had not anticipated taking non-MAPPA high risk of harm cases.

Conclusion

- 7.22. The 2011 MAPPA inspection made five recommendations. Four of the recommendations were for Chairs of level 2 or 3 meetings. That reflected the overall findings from the inspection on the quality of leadership displayed by MAPPA Chairs, whether they were dedicated MAPPA coordinators or mainstream managers. The conclusion was that *'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'*.
- 7.23. While the findings from the last inspection were broadly positive, we are clear that there have been improvements since 2011. MAPPAs are managing fewer level 2 and 3 meetings, despite the growth in MAPPA cases overall. They are being held to at least the minimum frequency set out in MAPPA guidance.
- 7.24. The complexity of agency geographical boundaries and frequent reorganisations, particularly of health, means that MAPPAs have to be continually vigilant. In a number of cases, we found something we thought should have been done was not done or someone was not present who should have been. However, overall it was clear that there was a much greater focus on holding others to account than we found in 2011. Chairs of level 2 and 3 meetings were less reticent about chasing people up, and, where they were unsuccessful, used the SMB Chair's influence.
- 7.25. MAPPAs had been successful in managing a potentially greater workload, by getting the right cases into level 2 and 3 meetings, and de-escalating them as soon as possible. This had enabled the workload to remain manageable.

Appendices

Appendix 1: Glossary

CPPC	Critical Public Protection Case.
nDelius	The case management system being used at the time of the inspection by the National Probation Service.
Duty to Cooperate	Agencies identified under section 325(3) of the <i>Criminal Justice Act 2003</i> 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
Four Pillars	Developed by De Montford University, the Four Pillars approach is designed to build supportive networks for offenders and enhance protective factors to minimise the risk of reoffending. It is a way of managing and assessing risk in a proportionate, transparent and balanced way. The Four Pillars approach has four key activities, Supervision; Monitoring and Control; Interventions and Treatment; and Victim Safety Planning.
GP	General Practitioner.
HMI Constabulary	HM Inspectorate of Constabulary.
HMI Probation	HM Inspectorate of Probation.
Constructive Interventions and Restrictive Interventions	<p>Work with an offender which is designed to change their offending behaviour and to support public protection. A constructive intervention is where the primary purpose is to reduce the likelihood of reoffending. In the language of offender management this is work to achieve the 'help' and 'change' purposes, as distinct from the 'control' purpose. A restrictive intervention is where the primary purpose is to keep to a minimum the offender's risk of harm to others. In the language of offender management this is work to achieve the 'control' purpose as distinct from the 'help' and 'change' purposes. Example: with a sexual offender, a constructive intervention might be to put them through an accredited sexual offender programme; a restrictive intervention (to minimise their risk of harm to others) 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>
IOM	Integrated Offender Management brings a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together.
KPI	Key performance indicator.
MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher risk of harm to others.

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.
MOSAVO	Management of Sexual and Violent Offenders; this training course provides police public protection unit practitioners with the skills and knowledge to enable them to identify and manage sex offenders, violent offenders and other dangerous offenders falling within the Multi-Agency Public Protection Arrangements.
NOMS	National Offender Management Service.
OASys	Offender Assessment System.
OMPPG	Offender Management and Public Protection Group (within NOMS).
P-NOMIS	Prison National Offender Management Information System; an operational database used in prisons for the management of offenders.
Responsible Authorities	Police, probation and prisons are the three Responsible Authorities within MAPPA.
Risk of harm to others	This is the term generally used by HMI Probation to describe work to protect the public, primarily using restrictive interventions, to keep to a minimum the individual's opportunity to behave in a way that is a risk of harm to others.
RMP	Risk Management Plan: sets out how the risk of harm to others will be managed.
RoSHO	Risk of Serious Harm Order is a civil preventative order imposed where a person aged 18 or over has done a specified act in relation to a child under 16 on at least two occasions. To seek a RoSHO, it is not necessary for the defendant to have a conviction for a sexual (or any) offence. A RoSHO prohibits the defendant from doing anything described in it. Under the <i>Anti-social Behaviour, Crime and Policing Act 2014</i> , RoSHOs, along with SOPOs and Foreign Travel Orders (FTOs) have been replaced by two new orders, Sexual Harm Prevention Order (SHPO) and Sexual Risk Order (SRO).
Registered Social Landlord	Government-funded not-for-profit organisations that provide affordable housing. They include housing associations, trusts and cooperatives.
RSO	Registered sex offender: under the <i>Sex Offenders Act 1997</i> , as amended by the <i>Sexual Offences Act 2003</i> , 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	Sexual Offences Prevention Order: introduced by the <i>Sexual Offences Act 2003</i> 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 schedule 3 or schedule 5 to the <i>Sexual Offences Act 2003</i> , 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. Under the <i>Anti-social Behaviour, Crime and Policing Act 2014</i> , SOPOs, along with RoSHOs and Foreign Travel Orders (FTOs) have been replaced by two new orders, Sexual Harm Prevention Order (SHPO) and Sexual Risk Order (SRO).
TACT	Terrorism Act (TACT) offenders have committed offences of terrorism, included in Schedule 15 of the <i>Criminal Justice Act 2003</i> .
ViSOR	ViSOR is a national confidential database that supports MAPPA. It facilitates the effective sharing of information and intelligence on violent and sexual offenders between the three MAPPA Responsible Authority agencies (police, probation and prisons). ViSOR is no longer an acronym but is the formal name of the database.

Appendix 2: Role of the inspectorates and code of practice

HMI Probation

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

www.justiceinspectorates.gov.uk/hmiprobation

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

HM Chief Inspector of Probation
1st Floor, Manchester Civil Justice Centre
1 Bridge Street West
Manchester, M3 3FX

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<http://www.hmic.gov.uk/>

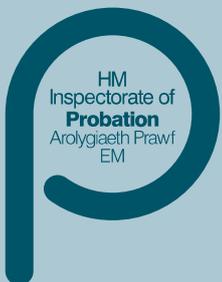
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Criminal Justice
Joint Inspection

Arolygiad ar y Cyd Cyfiawnder Troseddol



HM
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