An Inspection of Public Protection Arrangements Northern Ireland

June 2011

Criminal Justice Inspection
Northern Ireland
a better justice system for all

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Contents

List of abbreviations

CSOGP	Community Sex Offender Groupwork Programme
DoJ	Department of Justice
DRM	Designated Risk Manager, the person with lead responsibility to co-ordinate a risk management plan
IDAP	Integrated Domestic Abuse Programme
LAPPP	Local Area Public Protection Panel
MAPPA	Multi-agency Public Protection Arrangements (England, Wales and Scotland's equivalent of the PPANI)
MASRAM	Multi-agency Sex Offender Risk Assessment and Management procedures
NIHE	Northern Ireland Housing Executive
NIPS	Northern Ireland Prison Service
PBNI	Probation Board for Northern Ireland
PDP	Potentially Dangerous Person
PPANI	Public Protection Arrangements Northern Ireland
PPT	Public Protection Team
PPU	Public Protection Unit
PSNI	Police Service of Northern Ireland
ROSHO	Risk of Sexual Harm Order
SMB	Strategic Management Board
SOPO	Sexual Offences Prevention Order
SOTP	Sex Offender Treatment Programme
ViSOR	Violent Offender and Sex Offender Register

Chief Inspector's Foreword

The management of serious offenders, including sex offenders, in the community is a high profile and critically important aspect of the criminal justice system in Northern Ireland. This inspection is Criminal Justice Inspection Northern Ireland's (CJI's) fourth assessment of public protection arrangements in Northern Ireland. The purpose was to assess progress by criminal justice agencies in fulfilling their responsibilities since the last inspection, and particularly since October 2008, when the Criminal Justice (Northern Ireland) Order 2008 commenced.

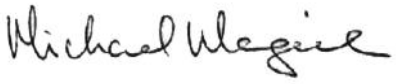
The inspection examined agency contributions to the public protection arrangements, and also took a broader view of other important matters such as risk management of Category 1 offenders and the contribution of the Police Service of Northern Ireland's (PSNI) Public Protection Units (PPUs). While some of these were technically not matters for the arrangements, they were inextricably linked to the Public Protection Arrangements Northern Ireland (PPANI). They affected agencies' fulfilment of their risk assessment and risk management responsibilities, whether undertaken within the PPANI arrangements or to fulfil other statutory functions.

The supervision of offenders in the community is not prison in the community and there will always be the possibility of serious crime being committed. No arrangements can mitigate all risks completely. This inspection examined the extent to which arrangements had changed over the past number of years and to what degree current public protection arrangements were operating effectively.

The PPANI are a set of administrative arrangements rather than a freestanding organisation. The legislation places a duty on organisations to work together and share information. Since the previous inspection, CJI has noted improvements across all the justice organisations that participate in the PPANI. These improvements include better communication between the criminal justice agencies and social services, a new assessment process that has provided greater consistency, improved managerial oversight, an increased use of court orders to manage sex offenders, and some good work undertaken by the PSNI PPUs. Public protection arrangements at an operational level have worked well and there is clear evidence that the current arrangements are stronger that what had been in place. A stronger legislative base has underpinned and strengthened current arrangements. The arrangements in Northern Ireland compare favourably with what exists elsewhere in Great Britain and the Republic of Ireland.

At a strategic level, we have some concern about the extent to which the inclusion of Potentially Dangerous Persons (PDPs) as a specific category within the arrangements could undermine their overall effectiveness. There needs to be a more focused view of what type of offender is suitable for entry into the arrangements, to ensure that organisations on the ground have the capacity to meet their responsibilities. In addition, we point to the importance of strong leadership within the PPANI agencies in order to communicate effectively with the community on the role they play within PPANI and, the work that is done to co-ordinate inter-agency responses.

The inspection was undertaken by Tom McGonigle and Brendan McGuigan. Support was provided by staff from Her Majesty's Inspectorate of Probation (HMI Probation). My thanks to all those who participated in the inspection process.



Dr Michael Maguire
Chief Inspector of Criminal Justice in Northern Ireland
June 2011

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Executive Summary

This is CJI's fourth inspection of Northern Ireland's public protection arrangements. Our purpose was to assess progress by criminal justice agencies in fulfilling their responsibilities since the last inspection, and especially since October 2008, when the Criminal Justice (Northern Ireland) Order 2008 commenced. This legislation established a framework for the Public Protection Arrangements Northern Ireland (PPANI) to replace the Multi-agency Sex Offender Risk Assessment and Management (MASRAM) procedures. The Criminal Justice Order strengthened the arrangements by placing them on a legal footing and extended their remit by adding certain violent offenders to the sexual offenders with whom they already dealt.

The PPANI are a set of administrative arrangements rather than a freestanding organisation, and the new legislation deliberately did not set up a dedicated body to deliver public protection. Rather, it placed a duty on the relevant agencies to work together and share information. They were given an annual budget (currently £190,000 per annum) on the basis that agencies were expected to retain individual responsibilities.

The context within which these arrangements operate is important. The proportion of sexual offenders who are reconvicted for further offences is known to be low, but their crimes cause understandable concern. Inspectors recognise that supervision in the community can never provide the total containment afforded by imprisonment and risk to the public can never be eliminated. We therefore sought evidence that the agencies did all that was reasonably possible in this high profile aspect of their work.

Within this context we concluded that the PPANI worked well at an operational level. Significant energy had been invested in preparing for the Criminal Justice Order. There was also clear evidence that previous inspection recommendations had been implemented and the PPANI were stronger than MASRAM in several ways. These included:

- a new co-located Public Protection Team (PPT) comprising police, probation and social services was rigorously managing the most serious offenders and Potentially Dangerous Persons (PDPs) in the community;
- Social Services contribution to the PPANI had significantly improved by deployment of dedicated personnel;
- the legislative basis and a revised, more detailed Manual of Practice had increased the confidence of operational personnel;
- a new risk assessment process provided greater consistency;
- an increased use of court orders to help manage sexual offenders;
- managerial oversight of operational practice had improved since the last inspection;
- the PSNI - who managed most of the offenders - did so within a better structure. They were more clear about their roles within the PPANI and the quality of police files had improved since the last inspection; and
- offender hostels, all run by voluntary sector organisations, continued to provide a very important public protection service in support of the PPANI.

Inspectors heard concerns about the strategic level of the arrangements, in particular about chairing the Strategic Management Board (SMB). However, this appeared to have been resolved in November 2010 when the SMB agreed the justice agencies would rotate the chairing arrangements in future. The SMB was also too large and included several organisations which did not need to routinely participate.

There had been some difficulties with staffing to co-ordinate the arrangements, particularly the Co-ordinator and Head of Communications roles. The Communications post had been suppressed and the Co-ordinator post was vacant at the time of inspection. The facility for media support in particular, was missed by personnel at all levels. Public expectations are high and the PPANI agencies need to be adept at explaining what can and what cannot be achieved.

The design of both posts were flawed in certain respects: there was role conflict as they had both been members of the SMB, to which they reported. There had also been lack of agreement about who should recruit and employ them.

Agencies were also investing disproportionate resources in their PPANI work. This was best reflected in Probation Board for Northern Ireland (PBNI) data which showed that at 1 April 2010, their PPANI staff costs represented 13% of the overall agency budget, whereas offenders subject to the PPANI only represented 5% of their overall caseload.

There were also operational matters that required attention. In particular because the criteria were too broad, the inclusion of PDPs within the PPANI was overwhelming the PSNI who were responsible for the vast majority of their risk management. Other options already existed to manage PDPs in the form of bail conditions and child protection procedures. Nonetheless, we confirm the importance of PPANI agencies continuing to identify and manage the 'critical few' PDPs.

The PSNI need to plan for steady growth in the number of offenders subject to their supervision. They currently manage 70% of all notifiable sex offenders cases, and this is growing incrementally as half of those offenders are required to notify for life. A reduction in the numbers of PDPs would assist considerably at this stage.

The profile of victims had been raised by the new PPANI procedures, although staff in some cases were more focussed on the processes of offender risk assessment and management. The PPANI agencies must continuously remind themselves and their staff of why they are doing this work - to protect past and potential future victims - rather than to fulfil processes.

The Northern Ireland Prison Service (NIPS) was better engaged with the PPANI than in the past. However, it needed to further increase its commitment, for example, to inter-agency training and by increasing the offending behaviour programmes provided in prisons. Inspectors recognise the importance of observing prisoners' rights, but suggest the practice of sharing victims' representations with prisoners needs to be continuously balanced against the protection of the victim.

Local Area Public Protection Panels (LAPPPs) were the most regular and tangible manifestation of the PPANI in action with an average of 22 panels convened each month. The process was more structured and consistent than in the past. Minor cultural differences between the agencies were apparent at some meetings. However these were recognised and being addressed.

A range of communication improvements had been introduced and were generally working well, but written and verbal communication could always be better. One example of this was the circulation of SMB minutes which did not reach all relevant personnel in the agencies. Given the number of agencies involved and complexity of the issues, the PPANI agencies must always pay close attention to their internal and inter-agency communications.

While a legislative basis had been provided for the PPANI, there were still areas where further development was required. These included the limitations in PBNI's ability to enforce certain prison licence requirements when offenders moved to another jurisdiction. Operational agencies were also frustrated that there was no notification requirement for violent offenders within the PPANI. Inspectors were told that work was in hand in relation to these matters. We urge this be brought to a prompt conclusion and that the agencies be kept up to date with progress in the interim.

Recommendations

Strategic recommendations

- The existing arrangements for SMB chairing should continue as scheduled until September 2012. A review should be completed by April 2012 with a view to rotating the chair on a three-yearly basis. The other agencies to be considered for chairing the SMB should be the Northern Ireland Prison Service and the Probation Board for Northern Ireland *(paragraph 2.14)*.

- The PPANI should amend the criteria for including PDPs within the arrangements to ensure only the 'critical few' alleged offenders remain. For example, they might only be brought into the arrangements when the PPS has decided to prosecute and they meet other relevant, stringent criteria relating to previous offending history and the current index offence *(paragraph 3.20)*.

Operational recommendations

- The 2012 review should also take account of wider strategic responsibilities including subgroup and Local Area Public Protection Panel chairing *(paragraph 2.15)*.

- The following should no longer be required to routinely participate in the SMB or its subgroups, but should be available on an 'as and when required' basis: Departments of Social Development, Employment and Learning, Education, the Office of Social Services and Youth Justice Agency; and
  The Health and Social Care Board should be requested to nominate a representative to replace the Office of Social Services on the PPANI SMB *(paragraph 2.19)*.

- PPANI personnel should be recruited and employed by the Department of Justice *(paragraph 2.40)*.

- A fundamental review of PPANI staff roles and grades should be undertaken. The outcome should ensure the PPANI media strategy aim of 'increasing public confidence in the arrangements' is delivered; and should provide clearer role boundaries and line management structure *(paragraph 2.46)*.

- The SMB and its subgroups should refocus their business planning processes to ensure the plans deliver clearer business outcomes *(paragraph 2.49)*.

- The Local Area Public Protection Panel audit data should be analysed and fed back at a joint session of the core agencies to optimise all aspects of the Local Area Public Protection Panel process *(paragraph 3.10)*.

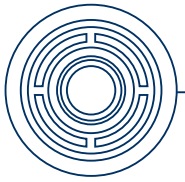
- The NIPS should commit to greater engagement with PPANI training provision *(paragraph 3.23)*.

- The PPANI registration and deregistration processes should be subject to regular quality assurance to ensure timeliness and accuracy *(paragraph 3.32)*.

- The PPANI SMB should re-establish a Victims subgroup with the aim of ensuring that victim issues remain a priority for all those who participate in the arrangements *(paragraph 4.2)*.

- The PSNI should reinstate operational discretion to decide whether or not prosecution is required in the event of offenders' failure to notify *(paragraph 4.30)*.

- The NIPS should strengthen its Offender Behaviour Programme delivery structure, develop programmes for deniers and improve its Offender Behaviour Programme database *(paragraph 4.53)*.



Section 1

Inspection Report

CHAPTER 1:

Introduction and context

1.1 The Public Protection Arrangements Northern Ireland (PPANI) were created by the Criminal Justice (Northern Ireland) Order 2008. They built on previous MASRAM arrangements that had been in operation since 1997 with the aim of reducing the risks posed by sexual offenders. Entry into the PPANI process was automatic upon notification as a sexual offender, which in turn was mandatory upon conviction for most sexual offences. The length of notification could extend from a minimum of five years to a maximum of life. Since the last CJI inspection in 2007[1], certain violent offenders and certain alleged offenders designated as 'Potentially Dangerous Persons' (PDPs) had also been brought into the arrangements.

1.2 The Criminal Justice Order placed the arrangements on a statutory footing and introduced a new sentencing framework which removed automatic 50% remission from custodial sentences in the cases of some prisoners. The new legislation also provided compulsory supervision after release and provided for curfews and electronic monitoring.

1.3 Other practical features of the new PPANI included a co-located (police, probation and social services) Public Protection Team (PPT) and dedicated chairpersons for Local Area Public Protection Panels (LAPPPs). A comprehensive training programme was delivered to staff and the Manual of Practice was comprehensively rewritten to take account of the new provisions.

1.4 All in all, establishment of the PPANI and supporting legislation represented the most significant development in Northern Ireland's public protection arrangements since their inception. Additional investment of £1.7m was provided in the first year to assist with a range of new responsibilities including the introduction of the PPANI.

1.5 It was estimated by the PPANI agencies that sexual offending in Northern Ireland was underreported by as much as 80%; and that there were around 11,000 people in Northern Ireland with convictions for sex offences, most of which predated commencement of formal public protection arrangements[2]. Consequently, the number of people subject to PPANI notification - and therefore whose risks the criminal justice agencies could assess and manage - represented only a small percentage of those who may pose a risk to the public.

1 The management of sex offenders, - follow-up review, Criminal Justice Inspection Northern Ireland, November 2007 http://www.cjini.org/CJNI/files/67/67eca591-a625-4da9-8eb0-280b8dd8c97c.pdf

2 "Managing the Risk" NISOSMC Annual Report 2008, Page 33

The March 2008 rate of sex offenders in Northern Ireland was 46 per 100,000 population. This compared to 61 per 100,000 in England and Wales, and 57 per 100,000 in Scotland (March 2009 figures).[3]

1.6 On 30 September 2010, there were a total of 1,356 offenders who were subject to risk management by the PPANI agencies. A total of 1,207 were in the community and 149 were in custody. Table 1 outlines the community cases by Designated Risk Manager (DRM) agency and risk category.

Table 1 PPANI community cases September 2010

	PSNI DRM	PBNI DRM	Other agency DRM	TOTAL
Category 1	716	307	3	1026 (85%)
Category 2	121	50	3	174 (14.5%)
Category 3	2	5	0	7 (0.5%)
TOTAL	839 (69.5%)	362 (30%)	6 (0.5%)	1207

1.7 This table shows that the majority of those being supervised in the community were Category 1 cases. These offenders all had to be assessed within the PPANI process, but as they were deemed to pose lower levels of risk they were no longer required to be managed on a multi-agency basis.

1.8 The majority of Category 3 cases were in custody, and in fact there had never been more than 12 Category 3 offenders in the community at any point in time since commencement of the PPANI. Category 3 cases represented 2.2% of the total notifiable offenders, identical to the Scottish level and slightly higher than the rate in England and Wales of 1.3%.

1.9 Table 1 also reveals that the PSNI was responsible for risk managing the majority of cases in the community. The total number of offenders subject to notification had grown incrementally - it had only been 793 on 30 November 2004. This upward trend - representing an additional eight cases coming into the PPANI each month - will continue and will pose logistical issues for all the agencies involved, particularly the PSNI. The PBNI was receiving an average of six new PPANI offenders onto community supervision each month, but these were for time-limited periods and their supervision would pass to the PSNI once the statutory probation element had been completed.

1.10 The incremental growth rate is further illustrated by the data in Table 2. Once offenders have completed their periods in custody and/or under

3 NISOSMC Annual Report "Managing the Risk" 2008; and the Scottish Centre for Crime and Justice Research Briefing 1/2010 MAPPA in Scotland

probation supervision, 51% of the current PPANI cohort will remain subject to notification (and therefore risk management, almost all by PSNI) for the remainder of their lives. Life notification is automatic for any offender receiving more than two and a half years imprisonment.

Table 2 Duration of offenders' notification periods - 30 September 2010

Life	497 (51%)
5 - 10 years	152 (16%)
0 - 5 years	328 (33%)
Total	977

CHAPTER 2:

The PPANI strategy

Legislative developments

2.1 The relevant agencies had worked closely with the Department of Justice (DoJ, and previously the Northern Ireland Office) in advance of legislative changes, and had developed new structures, a Manual of Practice and training to implement the Criminal Justice (Northern Ireland) Order 2008 successfully.

2.2 The Criminal Justice Order specified the organisations that were to participate in the PPANI. These were the:

- PSNI;
- PBNI;
- Departments of Education, Employment and Learning, Social Development, Health, Social Services and Public Safety;
- Health and Social Care Board and Trusts;
- Education and Library Boards;
- Northern Ireland Housing Executive; and
- National Society for the Prevention of Cruelty to Children.

The Northern Ireland Prison Service (NIPS) and the Youth Justice Agency (YJA) did not have to be specified in the legislation because of their status as "next steps" agencies within the responsibility of the Northern Ireland Office (now the DoJ), but both automatically had a role in the arrangements. In another development, two lay advisors were appointed to the PPANI in April 2009.

2.3 Certain violent offenders began to be included in the arrangements on a phased basis from October 2008. These included those convicted of violent offences against children and vulnerable adults and PDPs. In April 2010, domestic violence offenders were brought into the arrangements; and hate crime perpetrators were scheduled to be added from April 2011.

2.4 The Criminal Justice Order provided for the Secretary of State for Northern Ireland to issue statutory guidance to the agencies. The purpose of the guidance was to facilitate co-operation and information exchange between the agencies. The guidance also required them to keep the arrangements under review and to issue an Annual Report.

2.5 A major piece of work was undertaken to revamp the Manual of Practice. The new version was detailed, but comprehensive and clear. It compared favourably with the voluminous Multi-agency Public Protection Arrangements (MAPPA, the English, Welsh and Scottish equivalent of the PPANI) Guidance, which was characterised as problematic

in some areas, especially Scotland. The MAPPA were also described as being bureaucratic, difficult to understand, restrictive, using the wrong criteria and thereby excluding some serious offenders. Those involved in design of the new PPANI aimed to ensure these problems did not apply in Northern Ireland. In this respect, it was significant that the Republic of Ireland, following a worldwide review of approaches to public protection, had endorsed the PPANI as the model for its proposed new public protection arrangements.

2.6 There was also progress on wider fronts which supported public protection work. For example, a protocol for sharing information on the management of sex offenders between the PBNI and the Irish Probation Service was implemented in May 2010; and an interface is due to be established with the Northern Ireland Safeguarding Board which is scheduled to commence in 2011.

Structure

2.7 Because the PPANI were designed as a set of arrangements rather than as a freestanding body, the Criminal Justice Order 2008 had deliberately not put a structure in place. The local manifestation of the PPANI were LAPPPs - there were an average of 22 LAPPPs each month, held throughout Northern Ireland and in the three prisons. These met to consider individual cases and were chaired by Probation Area Managers. The other core attendees were PSNI and Social Services.

2.8 The arrangements were overseen by a Strategic Management Board (SMB) comprising senior representatives from the specified agencies, and the two lay advisors also usually attended. The SMB had a co-ordinating function to ensure compliance between the agencies and help them meet their statutory requirements.

2.9 Core responsibilities of the SMB were specified as monitoring, especially the risk management of Category 3 cases; establishing effective communication between agencies; publishing an Annual Report; planning longer term development; training; media strategy; and business planning.

2.10 The SMB had four subgroups – Policy and Practice, Communication, Training and Accommodation. These met quarterly in advance of the SMB and in many ways were its engine room. They did much of the detailed work and provided reports and recommendations for formal approval to the SMB.

2.11 CJI Inspectors observed meetings and viewed SMB minutes and subgroup reports. These were detailed sets of papers which addressed relevant strategic issues. Attendance levels at the SMB and its subgroups were consistently high and usually at the right level. Nonetheless, there were matters that required attention, in terms of both structure and functioning of the arrangements.

SMB chairing

2.12 A PSNI Assistant Chief Constable had chaired the SMB since formal arrangements commenced in 2001. However in April 2010, the Northern Ireland Policing Board raised concerns about a police officer fulfilling a role for

which he was not directly accountable to the Policing Board, and suggested that they would have to refrain from chairing shortly thereafter. The situation was exacerbated because the PPANI Policy and Practice Co-ordinator was due to resign in May 2010 to take up another position, and the Head of Communications contract had expired in December 2009.

2.13 The (then) NIO had completed a review of chairing arrangements for the SMB in September 2009. It considered options including single agency chairing, chairing on a rota basis or appointing an independent chair. There was a strong consensus that there were no problems with the current arrangements, and the review concluded that the PSNI should continue to chair for another three years. This was based on the fact that police had *"by far the biggest role in delivery of the arrangements."* The then Minister of Justice wrote to the Assistant Chief Constable in September 2009 asking the police to continue chairing for a further three years.

2.14 The issue of chairing was a key concern for SMB members during much of 2010, but appeared to be resolved in November 2010 when SMB members agreed to rotate the chair among the justice agencies. Inspectors consider that an operational criminal justice agency must chair the SMB in order to maintain public confidence in an often misunderstood set of arrangements. For that reason **we recommend the existing arrangements for SMB chairing should continue as scheduled until September 2012. A review should be completed by April 2012 with a view to rotating the chair on a three-yearly basis. The other agencies to be considered for chairing the SMB should be the Northern Ireland Prison Service and the Probation Board for Northern Ireland.**

2.15 As the PBNI chaired three of the four sub committees plus all the LAPPPs, at the time of this inspection, we also suggest the SMB chairing arrangements should not be considered in isolation. **We therefore recommend the 2012 review should also take account of wider strategic responsibilities including subgroup and Local Area Public Protection Panel chairing.**

SMB membership

2.16 Several SMB member agencies - the Departments of Education, Social Development, Employment and Learning, plus the Office of Social Services and the Youth Justice Agency - queried the validity of their continued participation in the SMB, on the basis that they currently had little to contribute. For example, the Department of Social Development was identified as important to the arrangements on the basis that the Social Security Agency - for whom they were the sponsoring Department - had access to information about benefits' claimants, including addresses. This information could be useful to police if missing PPANI offenders needed to be located. Detailed protocols were set up to manage the data-sharing process and the Department of Social Development had attended all SMB meetings since inception. However, their job was done and there appeared to be no merit in their continued attendance - they could always come along as and when necessary.

2.17 A single senior manager represented all five Health and Social Care Trusts. Each Trust had at least three relevant programmes of care - Child Protection, Learning Disability and Mental Health. The single representative could not possibly take responsibility for all these areas of practice nor take decisions on their behalf; and it was difficult for him to ensure that SMB decisions were fed back consistently to each programme of care within each Trust. These issues were recognised and good progress was being made in optimising levels of Health and Social Care Trusts participation and feedback following appointment of specialist personnel from each Trust to the PPANI operational levels.

2.18 Although the Office of Social Services had a province-wide brief its focus was on policy advice, and they suggested an operational perspective - from the Health and Social Care Board who commissioned all social services in Northern Ireland - would be more appropriate.

2.19 Because the PPANI were designed to deal exclusively with adults, the YJA only had one case within the arrangements. They were always fully included but to date never had any meaningful engagement. As such, they and the other Departments might use their time better by only attending the SMB as and when necessary. **We recommend the following should no longer be required to routinely participate in the SMB or its subgroups, but should be available on an 'as and when required' basis: Departments of Social Development, Employment and Learning, Education, the Office of Social Services and Youth Justice Agency; and we recommend the Health and Social Care Board should be requested to nominate a representative to replace the Office of Social Services on the PPANI SMB.**

Lay advisors

2.20 The two lay advisors were each appointed for a period of three years. This was an important development that was designed to provide independence within the PPANI, and also to help ensure that important matters such as victims' perspectives were given their due place.

2.21 The lay advisors received proper induction, were linked to MAPPA lay advisors and encouraged to attend SMB and sub committee meetings. However, both reported that they felt marginalised and that the potential of their roles was not being realised. Inspectors are aware these are new roles which are still in their early stages. The lay advisors role was due to be reviewed and Inspectors would urge that this opportunity be used to reaffirm the benefits their roles were intended to bring to the process.

Funding and allocation of agency resources

2.22 The central funding package provided to the PPANI by the DoJ for 2010-11 was £190,000. This funded the post of a Policy and Practice Co-ordinator, supporting administrative staff, and part funded a post of Head of Communications plus basic running costs. The funding amount represented a 26% uplift on previous MASRAM

funding in recognition of the additional work required at SMB level to deliver the new statutory arrangements. The DoJ's rationale was that central funding allowed the SMB to exercise a degree of strategic direction and oversight of the arrangements, but it was not intended as funding for the agencies' ongoing operational responsibilities.

2.23 Some SMB members were critical of the lack of "real" funding for the arrangements. In addition to provision in kind (mainly staff and premises) agencies were occasionally asked to supplement the core funding for specific events or publications. Some member agencies felt unable to contribute to these requests, especially when the issue was not germane to their primary business. It was also suggested that funding shortages could have been dealt with by more efficient use of the existing budget.

2.24 The main resourcing of the PPANI came from the PSNI, the PBNI and Social Services. The resources in kind that they provided represented substantial investments although these were not always easily quantifiable, especially when personnel fulfilled other roles in addition to their PPANI duties.

2.25 **The PSNI** provided premises and large numbers of personnel, particularly through eight locally-based Public Protection Units (PPUs), staff contributions to the co-located PPT, the PPANI Strategy and Policy Co-ordination Unit and the PPANI Administration Unit. Establishment of the PPUs represented major improvement as it provided dedicated staff for PPANI work. Responsibility for staffing PPUs lay with District Commanders, most of whom were reported to recognise this as a priority area of police work.

2.26 The PPANI Strategy and Policy Co-ordination Unit consisted of the Co-ordinator, Head of Communications, a part-time Events Co-ordinator and administrative support. The Administration Unit was staffed by PSNI personnel - a Sergeant, five Constables and four administrative staff - who were responsible for the communications and administration functions of the public protection arrangements. They carried out initial assessments and allocated risk categories to each sexual/violent offender/PDP and administered the LAPPPs, including completing minutes for each meeting.

2.27 The Administration Unit was a success, but the police complement was under threat as part of PSNI's 'Resource 2 Risk' strategy, which entailed uniformed officers returning to operational duties. If these staff are to be substituted, their civilian replacements must be fully trained and confident in the risk assessment and management of sexual and violent offenders.

2.28 There were mixed views within the PSNI about the Administration Unit's (and other specialists' such as the PPT) location within the organisational structure. They were located within the Criminal Justice Department which some felt was administrative only, making it difficult to get operational support and it was suggested the Crime Operations Department would be a better location.

2.29 This view was supported by the findings of a report prepared by three English police candidates for senior command: *"There is scope to ensure that the*

accountability mechanisms for delivery are clearer [in relation to internal police structures]...The PSNI model is neither devolved nor centralised which leads to a confusion of command.....It is unclear how the PSNI translates the concept of NIM (prioritisation of risk and then resources to meet the risk) into practical application – a Criminal Justice link rather than Crime Operations or District does not give the PPT an obvious link to those resources and there was anecdotal evidence of resources being sought through personal contacts, rather than any force level risk management process....''[4]

2.30 However, others felt that the Criminal Justice Department was a suitable location and extraction of officers for other duties was not a problem as it was being done on overtime. Inspectors were not made aware of any tangible problems caused by internal police structuring. Given the progress made by establishing and developing the PPUs, we refrain from making a recommendation in this area, but suggest it be kept under review.

2.31 **The PBNI's** contribution to the PPANI reflected a disproportionate input to output ratio. On 1 April 2010, PPANI staff costs (£2,525,488) represented 12.8% of PBNI's budget, whereas offenders subject to the PPANI represented only 5% of their overall caseload.

2.32 The PBNI provided dedicated middle managers to chair the LAPPPs, chairs and specialist staff for SMB subgroups, plus DRMs for 30% of PPANI cases. Like the police, they also participated in a range of other fora that were relevant to their PPANI work. These included Multi-agency Risk Assessment Conferences, Domestic Violence Fora, regional and Trust child protection committees, an Interdepartmental Strategy Group on Sexual Violent Abuse, Northern Ireland Adult Safeguarding Arrangements Partnership, and the Public Protection Advisory Group under the auspices of the Intergovernmental Agreement on Criminal Justice.

2.33 The co-located Public Protection Team (PPT) was established in December 2008 and based in PSNI premises. The team was well-resourced with joint managers from the PBNI (an Area Manager) and the PSNI (an Inspector), three Probation Officers, a Sergeant, four Constables, an office manager and an Administration Officer. A Social Worker was appointed to the team in January 2011.

2.34 ***Social Services*** engagement with the PPANI had improved considerably since the last CJI inspection. The appointment of a dedicated cadre of Principal Officers and Senior Practitioners to represent each of the five Trust areas began in December 2009, providing consistency and the opportunity to develop expertise. Some of the Senior Practitioners were co-located part-time with police Public Protection Units, which was reported as beneficial. This group of staff were developing useful internal links with other care programmes and establishing a collective identity. They met together on a bi-monthly basis, and met with their internal line managers each quarter, with the result that communication about PPANI matters within and

4 "A comparative study of the PPANI and the MAPPA." Police Senior Command Course candidates, January 2009

between Trusts was improving.

2.35 **The NIHE** was appropriately engaged with the PPANI at strategic and operational levels. It clearly had a relevant role because of the sensitivity of housing allocation for sex offenders, and the NIHE chaired the accommodation subgroup of the SMB.

2.36 **The NIPS** had become more engaged with the PPANI since the last inspection. Governors were now designated to attend LAPPPs, and *"NIPS Instruction to Governors 22/09 – NIPS Internal Public Protection Arrangements"* provided a detailed outline of responsibilities for both NIPS and seconded PBNI staff who worked in the prisons. As was the case when we conducted previous public protection inspections, the NIPS still depended heavily on seconded PBNI personnel to ensure their responsibilities were properly fulfilled.

2.37 There was a mismatch between the NIPS' expectations of the PPANI and what could actually be provided. For example, whereas the NIPS wanted LAPPPs to risk assess prisoners who were scheduled to be considered by the Parole Commissioners, this did not comply with the PPANI Manual of Practice which said prisoners must be imminently due for release before they could be risk assessed. An external report suggested *"The NIPS role has not been well-defined...Opportunities exist for the SMB to consider best practice in England and Wales in the management of high risk sex offenders while serving custodial sentences e.g. HMP Whatton... SMB may also wish to re-consider the recommendations from the 2005 CJI inspection which related to the prison services and satisfy itself that progress has been made against those recommendations."*[5]

Governance Arrangements

2.38 There was lack of consensus within the SMB about lines of accountability, in particular to whom the chair should report - their own agency's line management, the Permanent Secretary in the DoJ or the Minister of Justice? There was also a lack of consensus about who should employ the PPANI staff - the DoJ or one of the operational agencies?

2.39 There may never be a perfect answer to the first issue, so the best position is therefore to prioritise lines of accountability. CJI's view is that each agency must primarily answer for their individual performance through their own line management. Thereafter, the Minister of Justice, having provided statutory guidance for the arrangements may consequently be considered to 'own' them. The agencies agreed the PPANI are primarily a set of arrangements that lie within the justice sphere and that local accountability is important.

2.40 In terms of line-managing the Co-ordinator post, given the agreement about a rotating chair, it seems that continuity of employment terms would be best assured by having a consistent employer for the personnel including the Co-ordinator. There will be human resources issues to address no matter who employs the personnel, but these are not insurmountable. The DoJ

5 Ibid

already funds the posts and **we recommend PPANI personnel should be recruited and employed by the Department of Justice.**

Staffing

2.41 All of the Strategy and Policy Co-ordination Unit posts were recruited and employed by the PSNI at the time of this inspection. The Co-ordinator line-managed the others, and he in turn was line-managed by the PPANI chair. They were based at the PSNI's Seapark facility, adjacent to the Administration Unit and the PPT. This co-location was a helpful arrangement as the three teams worked closely together.

2.42 The former Co-ordinator was recognised as an expert in the field of sexual offending. He had done a significant amount of work to bring the public protection arrangements from their inception to implementation of the new legislation, and the arrangements were functioning well at operational level. Previous SMB chairs had relied heavily upon him. However, having given three months notice, he resigned in May 2010 to take up a another position. The PSNI provided a temporary replacement between July – November 2010, and an interim Strategy and Policy Co-ordinator commenced in December 2010.

2.43 An initial Head of Communications appointment was made in August 2007 for one year to help deal with controversial and difficult cases. The post was subsequently extended three times up to the final departure of the postholder in December 2009. The SMB minutes evidenced ongoing debate about grading and funding for both this and the Co-ordinator's post.

2.44 The impact of losing the Co-ordinator and the Head of Communications was amplified because it took place in the same time period as the PSNI's stated intention to withdraw from chairing the SMB. Most respondents suggested the Head of Communications post was particularly supportive when high profile cases were in the news. Managers reported that it helped staff and offenders if they were forewarned of pending publicity about their cases.

2.45 While the Co-ordinator was replaced, the Head of Communications was not. Since December 2009, the arrangement has been that PPANI communications was mainstreamed within the agencies, and the communications subgroup was chaired on a six month rotational basis by the PSNI, the PBNI and the NIPS. There were differing views about this practice: some SMB members felt it was the right way to go, while others suggested the practice conflicted with a PPANI information-sharing protocol which required joint or shared press statements. There was a discernible nervousness about media liaison and Inspectors heard of disagreement when agencies did not adhere to agreed lines, or publicised their own perspective without considering a corporate PPANI position.

2.46 There were other aspects of staff roles and deployment that require attention if proper governance is to be exercised. They included the following issues:

- Not all SMB members agreed with the staff mix and post gradings. Job evaluation analyses of the Co-ordinator and Head of Communications posts were undertaken in June 2009. This led to both posts being placed on a par

with each other and further delayed a decision by the SMB about proper structuring of the staff group;

- Throughout their tenure the Co-ordinator and Head of Communications were full members of the SMB. This was also inappropriate as it was in conflict with their status as officials who were accountable to the SMB.

We recommend a fundamental review of PPANI staff roles and grades should be undertaken. The outcome should ensure the PPANI media strategy aim of 'increasing public confidence in the arrangements' is delivered; and should provide clearer role boundaries and line management structure.

2.47 The Co-ordinator and PPANI agencies had worked hard to raise awareness of their role. They had made presentations to councillors, politicians, local community groups and other interested parties, though these efforts had not always been rewarded with high levels of interest. There may be benefit in considering the response of the Essex MAPPA to similar indifference: its agencies presented a mock panel meeting at a public event which was reported as very useful for educational and media purposes.

Business planning and Annual Reports

2.48 Inspectors received copies of SMB and subgroup business plans for 2010–11. The SMB plan had a total of six objectives, but it contained nothing to reflect a ministerial request for better data which was expressed at the end of 2009. An objective to enhance public understanding was to be achieved by *"providing opportunities for multi-agency training"* - which did not seem relevant. Three of the six objectives were identical in relation to sexual, violent offenders and PDPs. All of this gave the impression that business planning was a formality to be completed to a standard template rather than a meaningful aid to effective delivery of business and better public understanding.

2.49 Most subcommittee business plans were more specific, although the communications subcommittee contained the vague action: *"to put in place mechanisms for regular update and also rapid, targeted release of information."* Greater clarity is essential in this respect, especially in light of the significance of public communications about the PPANI. **We recommend the SMB and its subgroups should refocus their business planning processes to ensure the plans deliver clearer business outcomes.**

2.50 The agencies had begun to prepare Annual Reports on the arrangements since the last inspection. This was a positive development, placing information about a sensitive topic in the public domain. The format was developing and presentation of the statistical data was aimed at showing how the agencies, although assessing the risk posed by all sex offenders and certain violent offenders, focussed resources on managing cases where there was a clear risk of serious harm. The data contained in Annual Reports had changed, which was understandable given the major developments that took place since October 2008. The revised Manual of Practice set out data requirements for forthcoming Annual Reports - for example, the number of

offenders who breached their notification requirements and numbers recalled to custody. This can be expected to improve consistency of reporting and should also enable comparisons between years and with other public protection arrangements such as the MAPPA.

CHAPTER 3:

Delivery of the PPANI strategy

3.1 Operational delivery of public protection was co-ordinated via Local Area Public Protection Panels (LAPPPs). The LAPPPs covered the whole of Northern Ireland and their purpose was to:

- carry out a multi-agency assessment of the risk posed in the case of every offender who was referred. This assessment was based on all available information and focussed on identifying the factors which evidenced a risk of serious harm to the public;
- confirm a risk of serious harm category in all cases;
- develop risk management action plans to address the risks;
- appoint a Designated Risk Manager (DRM) for all Category 2 and Category 3 cases;
- regularly review all risk management plans; and
- refer those categorised as Category 1 risk of serious harm to the appropriate lead agency for risk management purposes.

Each agency then delivered those areas of the plan for which they had statutory authority by appointing a DRM. The MAPPA did not have DRMs, and this was another area where PPANI practice was considered better than the MAPPA because the DRM role made clear who held lead responsibility for a case.

Risk assessment and planning

3.2 We sought evidence that risk assessment adhered to the criteria set out in the PPANI Manual of Practice including defensibility, robust and evidence-based outcomes which were individually tailored in each case.

3.3 The "Stable and Acute Assessment 2007" was the standard method of risk assessment for sex offenders. It took account of all relevant factors such as accommodation, relationships, employment and offending behaviour. "Stable" assessments were completed annually, while "Acute" assessments were updated at each encounter with the offender in recognition of the fact that risks changed in different circumstances. Other forms of assessment such as mental health and housing could be shared within the PPANI arrangements. All of this information provided a comprehensive understanding of the offender that was constantly updated.

3.4 The Manual of Practice was the main reference point for operational PPANI personnel. It informed every aspect of their work including assessment. The manual had been substantially revised to support the introduction of the Criminal Justice Order in October 2008. The

revision was widely consulted among operational staff and managers. This led to 90 amendments, confirming that staff had ownership of the final product, and the revised manual has been in use since December 2010.

Local Area Public Protection Panels (LAPPPs)

3.5 Each LAPPP was chaired by a PBNI Area Manager and core composition also included a Principal Social Worker and local PSNI personnel, usually from the PPU. Thereafter most attendees came along for specific cases. They normally included the DRM and might also include community social workers, NIPS governors and psychologists, and offender hostel representatives. The LAPPPs had to address some complex situations, an example of which is outlined below.

A brain injured man who committed domestic violence against his elderly father posed a conundrum because Social Services elderly team wanted him removed from the family home to protect the father; yet the mental health team preferred him to remain at home as he could not survive alone.

3.6 The risk classification process was based on three categories, with Category 1 posing the lowest risks and Category 3 the highest risks. The agencies felt that categorisation was important for identifying the levels of intervention required in each case, resource targeting and statistical analysis. The definitions in use were as follows:

Category 1 *"Someone whose previous offending (or current alleged offending in the case of potentially dangerous persons), current behaviour and current circumstances present little evidence that they will cause serious harm through carrying out a contact sexual or violent offence."*

Category 2 *"Someone whose previous offending (or current alleged offending in the case of potentially dangerous persons), current behaviour and current circumstances present clear and identifiable evidence that they could cause serious harm through carrying out a contact sexual or violent offence."*

Category 3 *"Someone whose previous offending (or current alleged offending in the case of potentially dangerous persons), current behaviour and current circumstances present compelling evidence that they are highly likely to cause serious harm through carrying out a contact sexual or violent offence."*

3.7 The PPANI risk management structure was based on the principle that cases should be managed at the lowest level consistent with providing a defensible risk management plan. This could cause anxiety among operational personnel when the formal assessment resulted in a lower category than the DRM's instinct suggested.

3.8 Inspectors observed 14 LAPPP meetings, in urban, rural and prison settings. Each case discussion followed a consistent format that included:

- an overview of case history - including a review of actions undertaken since the last meeting and any fresh developments;
- updated risk assessment discussion and seeking consensus on the risk categorisation of each offender;
- attention to victim issues; and

- summary of discussion, and responsibilities for actions to be undertaken before the next review.

3.9 Inspectors drew several conclusions from observations and minutes of LAPPP meetings. These were as follows:

- attendance levels were good;
- Chairs worked hard to keep LAPPP meetings on track in relation to purposeful outcomes and scheduling. They challenged appropriately and maintained a balance between public protection and maintenance of offenders' rights;
- the dynamic of LAPPP meetings was better than in the last inspection. Social Services were well-engaged and made useful contributions, even in cases they did not know. The legal basis for the arrangements meant that police were more confident in their dealings with offenders, while Administration Unit staff kept the meetings focussed on the need for clear criteria and evidence. Most core members were able to offer opinions supported by analysis;
- the standardised format for case presentation represented a major improvement since the last inspection;
- there was extensive sharing of available information between agencies which facilitated a holistic understanding of the case. The benefits of triangulated evidence were enhanced when agency representatives came along with background checks completed;
- some good police intelligence was available, although it could be difficult to determine how much weight to lend to such intelligence when charges had been reduced or dropped;
- there was a strong victim focus and clear concern was shown for the protection of the public with whom offenders were having contact;
- police DRM reports had improved, with greater detail now recorded;
- the Administration Unit were working with less paper and administration was taking less time than previously; and
- good data was being accrued for ongoing research which was centrally collated and fed into an all-Ireland forum.

3.10 While everyone agreed the current LAPPP process represented a major improvement on the past, cultural differences between organisations were occasionally evident. Some meetings were prolonged, which was considered by police to be a result of unduly democratic chairs spending too much time on cases that did not require it. Police characterised this as *"Trying to manage lifestyle rather than risk, and attempting to cover all possible areas of risk."* The contrary view was that risk had to be managed through lifestyle and full compliance with the guidance was essential in order to protect the integrity of the arrangements. These differing perspectives were equally valid, and prevailed within a context of positive working relationships. They were addressed by police attending quarterly meetings with the LAPPP chairs. All in all, this was a healthy tension which should be used productively. Audit data was generated in relation to timing of meetings. **We recommend the Local Area Public Protection Panel audit data should be analysed and fed back at a joint session of the core agencies to optimise all aspects of the Local**

Area Public Protection Panel process.

3.11 Inspectors noted a number of other procedural aspects of the LAPPPs that could be refined such as:

- verbal presentation of factual summaries and DRM reports seemed unnecessary when they were already available in written format;
- two Administration Unit staff attended each LAPPP – one to update forms and the other to record a minute of the meeting. Progress has been good on reducing documentation, but there was scope to collapse these roles; and
- some LAPPP participants wasted a lot of time travelling long distances to discuss cases with whom they were not well-acquainted.

3.12 It had been agreed that Category 3 offenders would be given an opportunity to attend LAPPPs that dealt with their cases. This arrangement was piloted for three years and was found to be unproductive. Very few of the offenders accepted the offer to attend; and some of those who did attend created public order situations. It was therefore concluded that Category 3 offenders views will continue to be sought, but they will not be invited to attend henceforth.

Prison Local Area Public Protection Panels

3.13 There were an average of three prison LAPPPs each month, one at each of Northern Ireland's prison establishments. The NIPS had delegated most of its PPANI functions, including risk assessment and the DRM role to the PBNI. Prison governors however took greater responsibility than at the time of last inspection, particularly for providing intelligence about prisoners who were within the PPANI.

3.14 Prison LAPPPs had the same core attendance as community LAPPPs. In addition, there was also governor and psychologist representation from the NIPS in each case, which was a better than we found during the 2005 inspection. Further progress was evident in detailed 'Custody Profile' dossiers which were available in relation to most prisoners. These dossiers contained useful information about matters such as the prisoners' conduct, visitors, phone contacts, programme participation and drug tests.

3.15 In the prison LAPPPs observed by Inspectors, several NIPS representatives still lacked confidence in their ability to contribute to the PPANI. Some were uncertain of their competence to comment or conformed to others' views when asked about categorisation: *"I will defer to the others as I am not adequately trained…;"* or described themselves as *"standing in for someone else and not briefed,"* or *"I am just here to learn."* This was the level at which several police personnel functioned when CJI conducted the 2005 public protection inspection, and there is clear potential for operational NIPS personnel to further develop their contribution to the PPANI.

3.16 The NIPS improvements were also offset by several examples of prisoners being released without either being assessed or undertaking offending behaviour programmes, even after lengthy periods in custody. In one case that Inspectors observed where a man

had been in custody for four and a half years, a NIPS representative asserted: *"Due to time constraints it was not possible for him to complete the Sex Offender Treatment Programme …although he was willing to undertake this work."* While prisoners could not be compelled to undertake offending behaviour programmes, more could be done. In situations like this, the PBNI had to ensure the conditions of court orders would be fulfilled in the community, representing a missed opportunity while in prison, where the logistics of completing programmes should have been more manageable.

Multi-agency Risk Assessment Conference (MARAC) interface

3.17 MARACs were established as a joint initiative between the PSNI, Health and Social Care Trusts and the DoJ to reduce risks to victims of domestic violence. They were piloted in Larne, Carrickfergus and Ballymena, and had been accredited to operate throughout Northern Ireland since January 2010. The process was convened and chaired by police, and had wide inter-agency participation that was almost identical to the PPANI.

3.18 The PPANI and MARAC processes were complementary but different. Whereas the PPANI managed the risks posed by offenders, MARACs focussed on managing risks to victims. MARACs convened more quickly than PPANI and all actions were expected to be completed within 48 hours, so their action plans should usually have been implemented by the time an offender's case came into the PPANI. This raised the question of whether there was duplication of effort and whether some PPANI cases might not be better managed via MARAC and vice versa, with the option to refer to either as is the case in England and Wales. The PPANI should continue to work closely with the MARAC process with the aim of reducing duplication and maximising resources.

Potentially Dangerous Persons (PDPs)

3.19 PDPs were brought into the former MASRAM process. The initial intention was to manage risks posed by alleged high risk sexual and violent offenders - sometimes referred to as the 'critical few' - through identification and intervention at the earliest opportunity. In this respect, Northern Ireland was ahead of other UK jurisdictions as the MAPPA did not include PDPs. The initiative was well-intentioned but had become increasingly problematic. This was because:

- too many mainstream violent offenders were being brought into the PDP system. For example Inspectors heard discussion at a LAPPP about a mother's domestic dispute with her daughter which was highly unlikely to be followed through to prosecution. These were not people who merited multi-agency attention from the criminal justice system;
- the police who managed virtually all the PDPs reported that their numbers were swamping the system and deflecting resources away from core PPANI work. A total of 132 PDPs were removed from the PPANI between October 2008 – September 2010 after their cases were dropped due to insufficient evidence, or they were found not guilty. This represented more than one case

removed each week, after having been within the PPANI for up to 18 months, and therefore a large amount of nugatory work;

- the number of LAPPP meetings had increased to cope with fresh PDP assessments and many LAPPP agendas were routinely full due to PDP inclusion. Yet much information pertaining to PDPs was unavailable when LAPPPs convened because the majority were not previously known to the police. The consequence was that many PDPs could not be categorised at their first LAPPP;
- the Stable and Acute assessment method was unsuitable for PDPs, and assessment posed a legal risk as any information gleaned could compromise pending prosecutions;
- unlike convicted offenders, PDPs were not subject to notification requirements. Consequently, there were no powers to manage those who refused to engage with police, and any LAPPP recommendations for risk management were unenforceable; and
- PDPs were eligible to be managed by the normal range of individual bail, child protection and vulnerable adult measures that applied to all alleged offenders. With hindsight, all the agencies acknowledged that this seemed a much more suitable model for dealing with them.

An example of the problems is illustrated below.

Two PSNI Constables from a busy district spent a day undertaking 15 home visits, mostly to PDPs over a large rural area, yet only found two offenders at home. This meant they had little information for the next LAPPP and was a considerable waste of time.

3.20 Everyone agreed that the principle of involving PDPs in the PPANI process seemed to make sense at the time they were being introduced. However, by the time of this inspection it was unanimously accepted that the criteria were much too wide. They included everyone who had been interviewed by police or were in the process of being reported with a view to prosecution and posed significant concerns that were supported by evidence. Many who were not 'critical few' PDPs were therefore becoming unnecessarily involved in the arrangements. **We recommend the PPANI should amend the criteria for including PDPs within the arrangements to ensure only the 'critical few' alleged offenders remain. For example, they might only be brought into the arrangements when the PPS has decided to prosecute and they meet other relevant, stringent criteria relating to previous offending history and the current index offence.**

Staff training

3.21 Considerable effort was invested in providing training and support in the PPANI roles for staff from all the agencies. Everyone recognised the importance of proper training, particularly in securing adherence to the Manual of Practice so that the integrity of the arrangements was protected. The benefits of different professions training together were also acknowledged.

3.22 So far 120 staff had been trained in the Stable and Acute assessment process. This required considerable investment of time and money. All of these staff had

to undertake an annual refresher course plus a test, and had to complete two Stable and two Acute assessments per annum to maintain accreditation. The PPANI had three trainers to provide local validation for Stable and Acute assessments. The NIPS was the only core agency that did not participate in this training as the PBNI undertook their assessments for them.

3.23 Inspectors sat in on two training seminars, one led by PBNI and the other by the PPANI Co-ordinator. The focus was on learning from internal audits and external scrutiny of how agencies throughout the UK managed high risk offenders and high profile cases. These had good levels of turnout from the PSNI, the PBNI and Social Services, but very little representation from the NIPS – a missed opportunity, especially for governor grades to develop their understanding and confidence in an important area of public service. **We recommend the NIPS should commit to greater engagement with PPANI training provision.**

3.24 A detailed training programme for chairs and practitioners began in October 2010 in relation to the new Manual of Practice. There was also good agency-specific training which was relevant to the PPANI. For example, PSNI officers were training to use technology - funded by assets recovery proceeds - which could monitor offenders' computer usage. The PBNI placed considerable emphasis on professional training throughout a probation officer's career, and a considerable amount of their training programme contributed to PPANI responsibilities.

Managerial oversight

3.25 Management checks were very important to ensure the quality of work undertaken was of a high standard. They had improved significantly within the PPANI since the last inspection.

3.26 The former Co-ordinator had initiated a programme of quarterly case audits. The samples comprised 100% of Category 3 cases, 10% of Category 2s plus all cases that had been reduced from Category 2 to Category 1 during the previous quarter. The audits were jointly undertaken by the Co-ordinator and the Public Protection Team leaders. Their detailed analyses and action steps to achieve improvement were fed back in written reports to managers and practitioners.

3.27 Inspectors reviewed all the audit reports. They were frank and helpful for example, in highlighting poor initial compliance with stable and acute assessments, leading to marked improvement in this area by June 2009. They showed a drift from focus on public protection to peripheral issues that needed to be addressed by specific agencies; and raised concerns about reclassification of some offenders.

3.28 Category 3 case management plans were found to be invariably very good when audited. The June 2009 audit reported *"The records in all eight of the Category 3 cases contained compelling evidence that the subject is likely to cause serious harm. All three of the audit team are convinced that focus on the Category 3 cases has achieved the objective of identifying evidence to support and justify interventions with the subjects, particularly with the PPT."*

3.29 This auditing process was much more sophisticated than anything that preceded it. In addition to the audits, there had been four case reviews since the last inspection. Although none of the individual circumstances actually met the criteria for a serious case review, they were initiated to ascertain if there was anything to be learned, and they led to amendments in the Manual of Practice.

3.30 There were other forms of oversight. The PPANI Administration Unit had an important gatekeeping role to ensure the threshold criteria were met at point of referral into the arrangements. This applied to all cases including PDPs, re-referral of Category 1 cases and new referrals. A PSNI Superintendent quality-assured data protection and Violent Offender and Sex Offender Register (ViSOR) entries in relation to all PDPs, in order to ensure PSNI criteria were met. The PBNI routinely applied sophisticated line management monitoring to all their cases, especially those who were considered a risk to public protection.

Communication and documentation

3.31 Much PPANI recording had progressed from manual to electronic copy since the last inspection. This process was not yet complete, but the development had simplified case management and information sharing. Whereas there were formerly 10 forms for the LAPPP process, this was reduced to five. Operational staff reported that recording was better than in the past and LAPPP minutes were available more promptly.

3.32 Nonetheless, there were cumbersome aspects to the process and scope for further improvement. The October 2009 management audit found that *"the present PPANI forms tend to drive practice in the direction of being process rather than assessment driven..."* Large amounts of data were still required for each case to generate the comprehensive database which provided management information. The notification process was due to become fully computerised, but will still require close attention as recent inspection[6] has shown that even a sophisticated administrative system, such as that of the Northern Ireland Courts and Tribunals Service, can lead to errors caused by human frailty. Police voiced concern about risks of early termination or of people being retained within the arrangements beyond their proper date if information was not communicated accurately from commencement of an offenders notification.
We recommend the PPANI registration and deregistration processes should be subject to regular quality assurance to ensure timeliness and accuracy.

3.33 Inspectors heard examples of poor communication, particularly in the larger organisations. Internal communication breakdowns have had serious ramifications in the past and we cannot stress enough the importance of basic communication and intelligence checks in the public protection arena (see examples opposite).

6 An inspection of the handling of sexual offence cases by the justice system in Northern Ireland: Donagh sexual abuse cases inspection, CJI November 2010 http://www.cjini.org/CJNI/files/a8/a88eb7d6-ef11-4fb0-9292-f5b6e644ed1d.pdf

- *A police response unit attended a domestic dispute without checking background details. Unaware that the man was a sex offender - which PPU colleagues could have told them - they missed cues that may have aroused wider concerns about his pattern of behaviour.*
- *Internal communication failure within the NIPS meant that a sex offender against children was not known as such to Visits staff. Consequently he was permitted a child visitor. The visit was interrupted when a social worker phoned the prison because she suspected the child would be brought along to visit the man.*

3.34 Co-ordination of information exchange between agencies was logistically challenging given the numbers of people involved, the sensitivity of the information and a variety of recording systems in use. The Violent and Sexual Offender Register (ViSOR) was a comprehensive UK-wide database which was particularly helpful for the PPANI process. However, sharing beyond the PSNI remained difficult as National Intelligence Model (NIM) grading was required for data inputters, and there were training and security implications if other agencies were to have ViSOR terminals.

3.35 There was concern about bail being granted in some cases without Social Services being notified. This seldom happened in sex offending cases, but was reported to be a regular occurrence in domestic violence cases, and offenders could be granted bail to live in houses of multiple occupancy where it was difficult to establish possible risks to other residents. These difficulties were recognised and were being addressed.

For example, a recent arrangement for police to notify social workers of Investigating Officers contact details will assist with background checks in advance of LAPPP meetings.

CHAPTER 4:

PPANI outcomes

Outcomes for Victims

4.1 Inspectors found that victims needs were accorded higher priority than at the time of the 2005 public protection inspection. The PPANI website had a page that dealt with victim issues and representations. The Manual of Practice explicitly required victim concerns to be identified and addressed at LAPPPs and by DRMs. Nonetheless, the victim's voice had been reduced at strategic level following termination of the SMB victims subgroup (along with three other subgroups) in October 2008, on the basis that its work was complete. Inspectors were told the group was stood down on the basis that in future issues relating to sexual offence victims were to be considered by the Victim and Witness Steering Group - this aimed to avoid duplication. However, CJI's current thematic inspection of victims and witnesses suggests this development has not taken place.

4.2 The SMB minutes of January 2009 noted that there was *"…no representation of victims at strategic level as there had been in the past."* There was also a view that victims' expectations could not be met and there was no process to support them beyond distributing information leaflets. No action was proposed to deal with this deficit, partly because the appointment of the lay advisors was considered to represent a community perspective. Inspectors would urge the SMB to always afford high priority to victims' perspectives and needs. Other CJI inspections have illustrated how far apart victims' perspectives could be from those of the criminal justice agencies, even when the agencies were doing all that was required of them. There is always a risk of personnel becoming too focussed on the process and missing the point of why they are engaged with the PPANI. **We recommend the PPANI SMB should re-establish a Victims subgroup with the aim of ensuring that victim issues remain a priority for all those who participate in the arrangements.**

4.3 The policy of issuing information leaflets to victims was an improvement on the past. However, the policy was not consistently implemented as agencies were often uncertain about who should deliver the leaflets. Victims reported that calls to phone numbers provided on the leaflets were often routed to voicemail systems; and felt frustrated that they could not be informed of offender's level of risk or conditions of offenders' court orders and licenses.

4.4 There was considerable debate about the extent to which the criminal justice

system - whose staff were more used to focussing on offender risk assessment and management - was able to look after victims of crime. Other CJI inspections have demonstrated the major gaps that could exist between their perspective and the official view. This important theme is currently being explored more widely by CJI in a thematic inspection of the treatment of victims and witnesses in the criminal justice system.

4.5 Both the PBNI and the NIPS had victim information schemes. The PBNI estimated that 70% (170 new cases per annum) of referrals to their scheme were victims of serious sexual offences or violence, and therefore the offenders were likely to be involved with the PPANI process. Each scheme was valuable in providing victim information to DRMs and to LAPPPs.

4.6 The NIPS scheme also provided for victims' written representations to be shared at home leave boards and LAPPPs. Prisoners were entitled to view these representations so that they could rebut any material they considered might be prejudicial to their case. This seemed a potentially risky practice if a prisoner were to take exception to adverse representations; and it could be a deterrent for victims. However, the NIPS had received clear legal advice that removing this entitlement would render them non-compliant with the European Convention on Human Rights. Inspectors recognise the importance of observing prisoners' human rights, but suggest this needs to be continuously balanced against protection of the victim.

Management of Risk of Harm

4.7 We sought evidence that the risk of harm was being properly managed by adherence to PPANI standards in the application of restrictive and constructive interventions. These standards required defensible decisions, risk management plans that matched the identified risk factors and evaluation of performance to improve delivery.

4.8 Inspectors found that risk management practice had improved since the last public protection inspection. Oversight of inter-agency risk management plans was carried out by the LAPPPs. When the public protection arrangements were placed on a statutory footing in October 2008, revisions were made to the criteria for each risk category. There was a subsequent decrease in the number of those classified as Category 2, an increase in those classified as Category 1, while the proportion of Category 3 cases remained broadly similar.

4.9 In an important development from earlier practice, offenders who were assessed as Category 1 level were no longer reviewed within the inter-agency arrangements. Instead, they were managed by a single agency, with the proviso that they could be re-referred to a LAPPP if the DRM suggested there had been an increase in risk. Category 2 cases were managed within the inter-agency arrangements; and Category 3 cases in the community were managed by the co-located Public Protection Team.

Violent Offenders

4.10 An extension of the arrangements to include certain violent offenders had taken place in October 2008; and a further extension to incorporate hate crime offenders was planned for April 2011. At the time of this inspection, the operational agencies were frustrated because, irrespective of the risk category allocated, no notification requirements, additional court orders nor enforcement applied to violent (including domestic violence) offenders. Sex offender notification had been a requirement since September 1997 under conditions laid out in the Sex Offenders Act 1997 and the Sexual Offences Act 2003. This required everyone cautioned or convicted of a sexual offence to notify police of their name and aliases, all addresses regularly used, their date of birth and National Insurance Number.

4.11 In contrast, the only implication for violent offenders who were managed within the PPANI was that they would be discussed on an inter-agency basis if they were managed at Category 2 or 3 level. However, Inspectors saw benefits in LAPPPs where violent offenders were discussed and risk management plans agreed, even though they were unenforceable. Table 3 shows that a low proportion of violent offenders had come within the arrangements up until March 2010, but these numbers can be expected to increase as the rollout of violent offender inclusion continues.

4.12 Some operational agencies understood the reason for violent offenders not being required to notify was that, whereas sexual offenders were considered compliant, violent offenders were considered less likely to comply.

Table 3 New PPANI cases October 2008 – March 2010

	Sexual offenders	Violent offenders	Total
Number assessed	261	46	307
Requiring multiagency risk management	129	19	148
Managed by co-located team	19	2	21
Current PPANI cases at 31/3/10	133	14	147

Legislation had been in place since 2009 in England and Wales to provide for violent offender notification and the lessons from this were being considered by the DoJ and PPANI agencies to determine the best way forward for Northern Ireland.

4.13 Inspectors examined 30 probation and police files that were maintained on notifiable offenders at each category level. These were a mixture of hard copy and electronic files. They contained relevant statutory documents such as bail conditions, licences and Sexual Offences Prevention Orders (SOPOs), and provided a clear picture of case progression. The plans were individually-specific and it was apparent that information was being shared between the appropriate agencies.

4.14 Probation files showed a particularly detailed level of recording in relation to risk assessment and risk management. Individualised action plans were prepared, risk management plans were linked to assessments and contained a balance of constructive and restrictive

interventions. Planned and unannounced visits were evident; there were regular reviews and managerial oversight was apparent. Offender input was evidenced in several files by signatures on hardcopy documents.

Category 3 cases and the co-located Public Protection Team

4.15 Category 3 cases were by definition the most serious offenders. Adjudicated offenders and PDPs who were assessed as presenting this level of risk were subject to multi-agency risk management plans. These were frequently supplemented by SOPOs which would normally include a range of restrictive conditions that aimed to eliminate undesirable behaviour and discourage them from crime. Typical conditions might include refraining from contact with specified people or from frequenting certain places, not being allowed to own computers or cars, and avoiding alcohol and drugs.

4.16 The Category 3 cases were managed in the community by the co-located Public Protection Team (PPT). Its staff were experienced personnel who had volunteered to work in the PPT. Their monitoring of detailed risk management plans required close inter-agency co-operation, with unannounced home visits and planned contacts to assess compliance.

4.17 The PPT managed a caseload throughout Northern Ireland. Small caseload figures - there were never more than 12 Category 3 cases in the community at any point in time - disguised the significant levels of input that they required. Each case was co-worked by a police officer and a probation officer. The low numbers in the community was partly a consequence of high enforcement levels which meant offenders were frequently being returned to prison for failures to comply with court orders and license conditions. Spare PPT capacity was used to undertake risk assessments and home visits for lower risk cases.

4.18 The PPT model provided reassurance that did not previously exist in relation to the supervision of high risk offenders. Probation officers found they had access to better intelligence, and co-location with police meant resources could be mobilised much more quickly for arrests if offenders were in breach. Category 3 offenders were becoming aware of the significant role the PPT played in regulating their lifestyles and behaviours.

4.19 The April 2010 PPANI audit commented: *"The cases being risk managed by the co-located PPT present a high standard of both recorded information and active intervention."* This was in keeping with CJI's and other inspection findings which showed that work with offenders who were assessed as posing an increased risk of harm to others, was generally of a higher standard than that with other offenders. Therefore it was not surprising to find many examples of good practice in the PPT files.

Category 1 and 2 offenders

4.20 The PBNI managed 30% (357) of Category 1 and 2 cases in the community at the time of this inspection. They applied both Probation and PPANI standards in their supervision of every case. Probation standards were detailed and prescriptive, from frequency and expectations of supervisory contact

through to enforcement and managerial monitoring arrangements. The PBNI files evidenced good balance between care and control, and in particular, there was good use of home visits to monitor risk of harm. Category 2 offenders received regular home visits (including unannounced visits) from PBNI DRMs.

4.21 Because legislation prescribed lengthy periods of notification, the vast majority of notifiable offenders would transfer to the PSNI after they had completed any prison or probation term that was imposed by the courts. Transfers appeared to be handled in a timely manner and were often undertaken at a joint meeting with the offender. The most obvious consequence of transfer for an offender was that the frequency of supervisory contact would reduce considerably, although this could be increased if concerns arose.

PSNI Public Protection Units (PPUs)

4.22 The Public Protection Units (PPUs) were established in 2007 by the PSNI to carry out a range of tasks at local level under the umbrella of public protection. This included providing DRMs for all Category 1 and 2 cases where the PSNI was the lead agency. Their other responsibilities included missing persons and child abuse. Most PPUs were led by an Inspector and usually comprised a Sergeant and three Constables. District Commanders were reported as generally responsive in terms of resource allocation to the PPUs, recognising that public protection was often the greatest concern on their risk register.

4.23 Senior management support was important because resourcing difficulties mounted as numbers and complexity increased. Whereas DRMs were originally only responsible for notifiable sexual offender cases, by the time of this inspection, their responsibilities had extended to include:

- PDPs and violent offenders;
- a wider range of court orders to enforce;
- a higher rate of ongoing breaches; and
- a new, more detailed assessment process.

We have highlighted elsewhere the problems associated with PDP cases and made a recommendation. Their reduction within the PPANI process would greatly increase manageability of the PPUs.

4.24 While an Inspector or Sergeant generally fulfilled the DRM role, it was mainly Constables or neighbourhood officers who undertook home visits to offenders and PDPs. They were also required to deliver letters to victims which explained assistance that was available. They found this difficult as it often led to requests for information about the offender which police were not able to share. They then felt unhelpful, which went against the grain when they instinctively sympathised with victims. However, it represented progress that at least somebody was attempting to provide information to victims.

4.25 The Stable and Acute assessment model had assisted police in their offender management because it provided a tangible reason for them to enter an offender's house - to conduct the assessments - plus a set of offence-related questions. While probation officers used the Stable and Acute

assessment method with all categories of offender, the PSNI only used it with Category 2 and 3 offenders due to the high and growing numbers of Category 1 offenders on their caseloads.

4.26 Inspectors heard anxiety from police about the robustness of processes for classifying Category 1 cases and about the high proportion that were being managed by them alone without any form of multi-agency oversight. There was some concern that Stable and Acute scores did not always reflect the reality of offenders' risks: *"Drastic changes took place in October 2008, yet the risks did not change."* Although a few felt the standards were too rigid and mechanistic, this was a consequence of managers insisting on strict adherence to their own detailed guidance, both because it was best practice and also to avoid successful court challenges. In any event, there were safeguards: several PPUs conducted internal reviews more frequently than specified in the manual of practice; and when concerns arose about Category 1 cases, they could be re-referred for LAPPP consideration.

4.27 Despite concerns, establishment of PPUs was undoubtedly a beneficial step. Most personnel were experienced police officers who had volunteered to work in the PPU, factors which helped considerably. They were able to form productive working relationships with the offenders. One officer commented *"Many of the sex offenders have learning difficulties, are marginalised or have no friends, so they actually welcome police visits…"*

4.28 Good relationships and communication were reported between the PPUs and their partner agencies, particularly the PBNI. Everyone with whom we spoke believed in the value of the arrangements and regarded them as a real improvement on the previous MASRAM process. There were somewhat mixed views about the offender management role which was not a traditional policing task. While police officers continued to use their powers of investigation and were involved in preparing prosecution files, one suggested that public protection work was *"…very intensive and stressful, unending and frustrating for a police officer…there's not enough police work in it for me but it is good experience…"*

4.29 Training and support for PPU and PPT personnel were good, though the pressure of societal expectation and victim awareness added to stress of the job. Attention was being paid by the agencies to career development and the duration of secondments to these specialist teams.

4.30 There were also operational frustrations for PPUs, for example when some sex offenders did not understand they had to notify at their local police station within three days of being convicted or released from prison. Whereas police previously had discretion about how to deal with these cases, from August 2010 they had to refer everyone (there were 13 in the first month of the new policy) to the Public Prosecution Service to consider prosecution. This was characterised as *"taking the management out of offender management."* PPU officers reported that many of the failures to notify were often not inspired by deviance, but caused by misunderstanding of the court outcome, learning disability or genuine forgetfulness. Removal of police

discretion in these cases seemed a retrograde step and counter-productive when DRMs were trying to assist offenders to comply with their notification requirements. **We recommend the PSNI should reinstate operational discretion to decide whether or not prosecution is required in the event of offenders' failure to notify.**

4.31 The PSNI held bi-monthly middle management meetings which included all the PPU Inspectors. These provided links to subgroups of the SMB and were therefore a useful communication channel.

Restrictive interventions

4.32 A range of positive and restrictive interventions were available for the agencies to assist their risk management of offenders. Restrictive interventions included four civil court orders: SOPOs, Risk of Sexual Harm Orders (ROSHOs), Foreign Travel Orders and Disqualification Orders. Although civil orders, they had significant criminal penalties if breached – up to five years' imprisonment in the case of SOPOs.

4.33 There was greater usage of SOPOs than at time of the 2005 inspection when they had only been newly-introduced. That inspection reported *"...application [for SOPOs] was slow to the point of being of little value...we only saw evidence of one order actually being made....and it took 15 months to obtain...."*

4.34 In contrast 28 new SOPOs, two ROSHOs and six Notification Orders were made during April 2009 - March 2010. It had become established practice that SOPOs were sought at the point of conviction, when courts had relevant and up to date information, rather than waiting until a later date when an offender demonstrated risky behaviour. Probation officers worked closely with the PSNI by outlining suggested SOPO prohibitions in their pre-sentence reports.

4.35 It was apparent that courts were fulfilling their duty to protect offenders' rights as well as their public protection duty. Police told us of courts refusing to make SOPO prohibitions that appeared too intrusive. For example, a court refused a residence prohibition on the grounds that it would *"...give police power to make him homeless;"* while another court refused a police request for a SOPO condition to permit regular house searches, describing it as *"an open-ended search warrant."*

4.36 Electronic monitoring had commenced in April 2009 and up to 31 October 2010, a total of 1,139 monitoring requirements had been imposed. The data did not reveal how many of these orders related to PPANI offenders. However, it showed that 97% related to bail curfews imposed by courts, and only 3% (34 orders) were attached as conditions of community sentences or post-release licences. The agencies explained this was due to the fact that electronic monitoring was not necessary if other conditions were sufficiently robust. The operational agencies explained that electronic monitoring was most suitable for car crime and domestic burglary offenders, and was not appropriate for offenders who lived in offender hostels, had mental illness or a learning disability. Even so, the very low number of electronic monitoring requirements as an element of licenses

was surprisingly low, suggesting that this element of the legislation was less necessary than had been envisaged for PPANI purposes.

4.37 The PPANI risk management plans for each category of offender were stricter and more controlling than MAPPA plans. Two examples involved a DRM being instructed to check an offender's access to a computer even though his offences were not computer-related; and a LAPPP addressing the risk of contact offences via his job in an elderly care home in respect of an offender who allegedly offended against a prostitute while drunk at a party.

4.38 If necessary surveillance and other intrusions such as phone interceptions were used - with appropriate authority - to monitor offenders who posed particular concerns. Such resource-intensive measures were normally retained for, though not exclusive to Category 3 offenders.

Approved Premises

4.39 There were six approved premises (also known as offender hostels) in Northern Ireland, all run by voluntary sector organisations. They provided 87 accommodation places for offenders, of which 31 were occupied by PPANI offenders on 19 January 2011. These places were in effect, a mixture of restrictive and constructive interventions: they considerably curtailed the liberty of residents, though by contractual agreement rather than by the physical measures that a prison could provide. At the same time, they actively worked to help residents develop more responsible and crime-free lifestyles.

4.40 Most offenders with whom Inspectors spoke resented the restrictions that living in a hostel entailed. Several reported having been breached because of transgressions and indicated they were being tightly managed by the hostel in conjunction with supervising probation officers and local police. It was observed that a Northern Ireland hostel was more secure than an open prison in England.

4.41 There were several difficulties for the organisations that ran the hostels. Funding was an ongoing problem and their residents often presented complex behavioural and mental health needs. It was also difficult to move residents on, and many had to stay longer than the notional maximum of six months. The practice of these hostels has been inspected in its own right[7] and the conclusion was that they performed an important public safety service. This PPANI inspection, combined with annual unannounced inspection of each hostel suggested they continued to perform well, and Inspectors heard several examples of good public protection (see below).

- *Two schoolgirls in uniform called at a hostel to see an offender, then ran off when staff challenged them…their headmaster was called, viewed CCTV footage and identified the girls…police were notified, they called with the girls' families and warned them and their parents against visiting the hostel again.*
- *A decision at the hostel allocation panel ensured an offender was not placed near where his victim worked. He was also deemed unsuitable to live in a different hostel because his safety could be jeopardised in that area.*

7 Inspection of Approved Premises, CJI, July 2008, http://www.cjini.org/CJNI/files/4a/4a0c3240-f23b-42c8-8f62-2fbe86b098bb.pdf

4.42 The accommodation subgroup of the SMB considered that in view of the reduced number of Category 3 offenders in the community, the current approved accommodation had proved that, with careful risk assessment and appropriate risk management plans and external support, they had sufficient capacity to manage.

Enforcement

4.43 Overall levels of compliance with court orders and licence conditions by offenders within the PPANI were high. A total of 35 offenders (20 court orders and 15 licence conditions) who were subject to the arrangements failed to comply during April 2009 – March 2010. By comparison, the PBNI breached a total of 720 non-PPANI cases during the same period. The fact that PPANI breaches only represented 5% of their total, despite having a higher average number of additional requirements attached to their orders, suggested PPANI offenders were not failing to comply with supervision or reoffending disproportionately.

4.44 It was not known how many offenders had breached their notification requirements during 2009-10. This is an important piece of information for management purposes that we expect to be addressed by the more detailed data specification contained in the new Manual of Practice.

4.45 The PBNI reported that they had difficulties when trying to enforce Article 26 (of the Criminal Justice (Northern Ireland) Order 1996) licences if an offender moved out of the Northern Ireland jurisdiction. Recent legislation had improved the situation in that offenders could now be ordered to serve the remainder of sentence that was outstanding for breaches of Article 26 licences (the previous maximum sentence for Article 26 breach was six months); and they could now be summonsed directly to the Crown Court. However, these licences were 'territorially restricted' which meant Article 26 offenders could not be returned to Northern Ireland - even from within the UK - if they left without permission; and any offences committed elsewhere could not be deemed as breach of their licence. As there were 147 Article 26 licences at the time of this inspection, the issue remained live. The DoJ told Inspectors that the matter was in hand, though those with operational responsibility for managing the risks reported they were unclear about the rate of progress.

4.46 The matter of requirements for sex offenders visiting Northern Ireland to notify was being addressed by European Union legislation on the application of mutual recognition of probation conditions which is scheduled to commence in December 2011.

Constructive interventions

4.47 Inspections and research evidence all demonstrate that the most effective management of offenders is achieved by an individually-tailored mix of restrictive and constructive interventions. Whereas restrictive interventions aimed to limit offenders' opportunities to commit crimes, constructive interventions aimed to help them with matters such as education, training and employment, obtaining stable accommodation, developing positive relationships and reducing dependence on alcohol and drugs.

4.48 Between October 2008 - June 2010 probation-supervised offenders who were subject to the PPANI had an average 0.81 additional requirements per person attached to their orders. This compared to 0.39 additional requirements for those not subject to the PPANI, thus demonstrating higher levels of intervention for the PPANI offenders.

4.49 A range of offending behaviour programmes had been designed to engage offenders in addressing their criminal misconduct, both in custody and in the community. The community-based programmes were delivered by PBNI. The main offending behaviour programmes for PPANI offenders in the community were:

- the Integrated Domestic Abuse Programme (IDAP) which commenced in February 2010. In 2006 the NIPS had committed to delivering a similar programme in the prisons, but as yet this had not been done. For now, the PBNI had sufficient capacity in the community to meet all requirements - there were 139 such additional requirements at the end of July 2010;
- the Community Sex Offender Groupwork programme (CSOGP) – on 31 July 2010 there were 161 offenders whose probation orders contained an additional requirement to complete the CSOGP and the PBNI was able to provide places for all these offenders on a programme;
- Safer Lives - a programme for 18-21 year old male sex offenders;
- the Internet Sex Offender Treatment Programme; and
- the Adapted Sex Offender Treatment Programme - for learning disabled offenders.

4.50 204 people who were sentenced to orders supervised by PBNI during April 2008 - March 2010 were also made subject to PPANI arrangements. A total of 53% of these had additional requirements attached to their court orders, mainly for the CSOGP. A total of 75 such requirements (58 CSOGP) were completed between October 2008 - December 2010.

4.51 Prison-based programmes for PPANI offenders included anger management, Sex Offender Treatment Programme (SOTP), Cognitive Self Change (CSC), Enhanced Thinking Skills and a Motivational Enhancement Group. Most of these programmes were the responsibility of NIPS psychologists, and they were sometimes supported by uniformed staff and PBNI personnel. The introduction of new sentences under the 2008 Criminal Justice Order was expected to increase demand for programmes in prisons, as prisoners with these new sentences would now have to demonstrate to the Parole Commissioners that they had undertaken work to reduce their risks.

4.52 However, there were ongoing difficulties in providing some of the Offending Behaviour Programmes (OBPs) in prisons. These have been well-rehearsed in previous CJI inspection reports.[8] The difficulties centred on two issues: a shortage of facilitators and prisoner ineligibility. The NIPS database was also inadequate, and as in previous

8 A Review of transition to community arrangements for life sentence prisoners in Northern Ireland (March 2009) http://www.cjini.org/CJNI/files/35/35b32bff-abe2-411a-867b-e26624a76ae9.pdf and An inspection of the Northern Ireland Prisoner Resettlement Strategy (June 2007) http://www.cjini.org/CJNI/files/5c/5ccaff46-66ac-4add-a705-db5d5ac4ce67.pdf

inspections it again proved impossible for Inspectors to obtain hard data on referral, participation or completion rates for offenders on most of the prison OBPs. The available data showed:

- Sex Offender Treatment Programme (SOTP) - 24 Magilligan prisoners had completed the Rolling SOTP during between October 2008 – September 2010. However, the Core SOTP had not been delivered at Maghaberry since 2007. The NIPS explained that not enough sex offenders there met the programme criteria. Out of 108 sex offenders assessed at Maghaberry in 2009, only 27% were sentenced and therefore eligible for the SOTP. However, most of these were precluded by having a release date which was too soon to undertake the programme, awaiting trial for further charges, too low a risk, unwilling to participate, too low an IQ or having mental health difficulties. There was a particular difficulty with engaging the high number of prisoners who continued to deny their offences: 40% of sexual offenders in Magilligan in March 2010 fell into this category.
- Safer Lives had been introduced to Hydebank Wood Young Offenders Centre in February 2010 and 15 prisoners had 'engaged with' the programme since then.

4.53 Previous inspection recommendations that the NIPS should strengthen its OBP delivery structure, develop programmes for deniers and develop an effective database had been accepted. The NIPS Offender Management Unit which was set up to plan for the new sentences had made progress in several areas, but the OBP situation still showed scope for improvement. Offenders might reasonably challenge agency failure to help them reduce their risks if they were not provided with relevant assistance to do so. **We again recommend the NIPS should strengthen its Offender Behaviour Programme delivery structure, develop programmes for deniers and improve its Offender Behaviour Programme database.**

4.54 Despite the difficulties with OBPs, there were personal development opportunities and programmes that were more easily-delivered and were more attractive to prisoners. These included parenting programmes, alcohol and drug awareness, bereavement care, and education. The value of these and other programmes in helping to reduce risk, albeit indirectly, should not be underestimated.

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