TAYSIDE MULTI-AGENCY PUBLIC PROTECTION ARRANGEMENTS (MAPPA)

SIGNIFICANT CASE REVIEW

PRISONER Z

EXECUTIVE SUMMARY

This Executive Summary is prepared to offer a brief overview of the findings of the Tayside MAPPA Significant Case Review (SCR) in respect of Prisoner Z, conducted on behalf of Tayside MAPPA Strategic Oversight Group (Tayside SOG) by Independent Reviewer Mr Mark Cooper. This summary should be read with reference to the full report 'Prisoner Z' which can be accessed at **www.angus.gov.uk/SCRPrisonerZ**

Background

In 2002 Prisoner Z was sentenced to life imprisonment, with a minimum punishment part of 15 years (backdated to 2001), for the Murder of Person A. Person A, who was unknown to Prisoner Z, had been attacked, head butted, repeatedly stabbed with a sharp instrument and stamped upon by Prisoner Z at the murder scene close to where Prisoner Z and Person A both lived.

In 2017, while on Unescorted Home Leave and three days before his second Life Prisoner Parole Tribunal, Prisoner Z attacked Person B with a blunt instrument as she walked her dog close to her home. Person B was unknown to Prisoner Z. Person B suffered life changing head injuries. Prisoner Z subsequently pled guilty to Assault to Severe Injury, Permanent Disfigurement and Danger to Life and Attempted Murder and was sentenced to an Order of Lifelong Restriction with a punishment part of five years.

Multi-agency Public Protection Arrangements (MAPPA) are a set of statutory partnership working arrangements introduced in 2007 by virtue of Sections 10 and 11 of The Management of Offenders etc. (Scotland) Act 2005. The Act places a statutory duty on the Responsible Authorities in a local authority area to jointly establish arrangements for assessing and managing the risk posed by certain categories of offenders. The Tayside MAPPA SOG oversees MAPPA across Tayside.

There are three different categories of people managed under MAPPA. Category 3 includes those offenders who, by reason of their conviction, are assessed as posing a risk of serious harm to the public. In December 2016, whilst at HMP Castle Huntly, and following social work assessment, Prisoner Z was confirmed as posing a High Risk of Serious Harm and met the threshold to be considered for management as a Category 3 offender under MAPPA.

Significant Case Review

There is a requirement in MAPPA National Guidance (2016) for Significant Case Reviews to be carried out in specific circumstances. Although Prisoner Z was a serving prisoner at the time of the offence, and therefore the responsibility of the Scottish Prison Service (SPS), representatives of the Tayside SOG formed the view that the circumstances of Prisoner Z's offence should be considered through a SCR; the circumstances of the offence having meet the criteria in National Guidance that "an

offender managed under MAPPA at any level, is charged with an offence that has resulted in the death or serious harm to another person".

Following agreement at the Tayside MAPPA SOG that the criteria for an SCR had been met and endorsement of this decision from the Angus Chief Officers Group, arrangements were made by Angus Council to commission an external review. Mr Mark Cooper, a retired Police Detective Superintendent, was appointed in June 2018 to carry out the review. Mr Cooper has significant experience in the management of high risk offenders, having had involvement in this area of policing from 2006 until his retirement in 2015.

The SCR aimed to examine the single agency and multi-agency involvement in the management of Prisoner Z, with particular focus on risk assessment and risk management prior to and during periods of Unescorted Home Leave. The review aimed to identify where systems worked appropriately and where improvements could be made in systems, processes and practice. In particular the SCR sought to examine:

- Whether the attack should have been anticipated and/or prevented and, if so, what are the implications for multi-agency practice?
- To identify key professional and organisational learning regarding how single and/or multi-agency working could have improved the management of Prisoner Z prior to and during Home Leave and better protected Victim B and any other person who may have been at risk in the community and any opportunities for improvement.
- Areas of good practice and practice/or processes that should be strengthened and replicated in managing prisoners on transition to Home Leave/or release.
- The extent and quality of multi-agency risk assessment and risk management planning for offenders prior to Home Leave/on Home Leave/in the community and any opportunities for improvement.
- The extent to which agencies involved worked together, shared relevant information and used information to influence decision making in respect of Prisoner Z.

By considering the above, the review was asked to determine whether agencies appropriately assessed and managed risk to the public and in doing so, identify learning on a local, regional and national basis to improve public protection.

Findings

The Independent Reviewer concludes that Prisoner Z alone was responsible for the attack on Victim B and this could not have been predicted.

There is evidence that Prisoner Z did only what he needed to do in order to progress through the prison system to the point where it might be considered that he manipulated the system through a 'grudging compliance'. His positive behaviour in prison and on community leave did constitute relevant evidence that supported the decisions to increase his community access. However, the Independent Reviewer found that there were flaws within the balance of information that was shared to assess risk, particularly from the SPS to Scottish Ministers when applying for approval for Home Leave. There were subsequent flaws in the meeting structure that divided tasks between the SPS Risk Management Team and MAPPA and resulted in neither the single or multi-agency forum being enabled to take full responsibility for compiling a

structured and fully defensible risk management plan, on the basis of all available information and the respective views of all partners.

The dual process of Risk Management Team meetings and separate multi-agency MAPPA meetings created a context in which neither meeting compiled a Risk Management Plan that addressed the most up-to-date risk assessments, including risks outlined in Prisoner Z's Risk of Serious Harm (RoSH) assessment. Even when his initial assessment was reviewed and a RoSH indicated that he was a high risk of causing serious harm, this increase in risk did not alter his path towards Unescorted Home Leave when it can be reasonably argued that it should have. The Independent Reviewer questioned whether Prisoner Z had been set on an irreversible and inevitable pathway towards release and whether the SPS had missed opportunities to assess and take appropriate action in respect of Prisoner Z to protect the public.

The lack of balance in presenting evidence led to a dominant narrative that emphasised the many years of positive behaviour by Prisoner Z in custody and on leave, without giving equal weight to the assessments (particularly the 2012 Psychological Risk Assessment and 2016 RoSH) that highlighted underlying concerns that may have required more in-depth monitoring. The flaws in the dual meeting process also meant that workers were supporting increased community access without a robust risk management plan. Prisoner Z was subject to a number of standard and additional Licence Conditions but the absence of a proper balance in the presenting evidence meant the level of monitoring and checking for adherence of these conditions was less than what might be considered reasonable. There appears to have been minimal structured support/input to Prisoner Z's time spent in the community to enhance his integration and the protection of the public.

The lack of balance in assessing Prisoner Z's readiness to access the community started as early as the partial information supplied by the SPS to Scottish Ministers prior to his First Grant of temporary release. The Independent Reviewer concludes that similar decisions might have been made but that they would have been made on the basis of fuller information. If there had been a more balanced consideration of risk and a single fully agreed multi-agency risk management plan there may have been more opportunities to observe whether Prisoner Z was breaching his Licence Conditions. He may not have been breaching his Licence conditions and an even more robust regime of monitoring may not have uncovered any wrongdoing but the flaws in the risk assessment and in the risk management plan meant that the optimal conditions to prevent an offence like that which occurred, were not in place.

Overall the findings of the Independent Reviewer highlight a number of key areas for improvement for consideration by the Tayside MAPPA SOG and the range of organisations across Scotland involved in MAPPA arrangements:

- The effectiveness of the process of risk assessment and resulting Risk Management Plan for all MAPPA clients accessing the community on Unescorted Home Leave.
- Sharing of key information, including past key events, assessments and details of license conditions, in order to ensure that risk assessment, risk management and key decisions are based on all of the information available at the time.
- Ensuring robust arrangements are in place for the organisation of multi-agency meetings, including meeting invitations, circulation of information prior to meetings and recording of minutes.

- Accurate recording of decisions and agreed actions at both single and multi-agency meetings, including clear rationale.
- The effectiveness of arrangements for the SPS to notify community partners of specific instances of Unescorted Home Leave and of multi-agency arrangements to monitor adherence with Licence Conditions and identify new or emerging risk.
- Adherence to ViSOR recording standards.
- Arrangements for escalation of information to senior managers within partner organisations and involvement of senior managers in MAPPA Level 3 meetings.
- Ensuring robust communication arrangements between the MAPPA Co-ordinator, Local Policing and the Police Offender Management Unit.
- Developing a consistent process across all 8 MAPPA co-ordination areas for managing prisoners on community access from the SPS Castle Huntly.
- Reviewing the range of technological tactical options available to effectively manage high risk offenders who are being considered for Unescorted Home Leave.

Areas of Good Practice

Alongside the key areas for improvement the Independent Reviewer also identified five areas of good practice:

1. The Integrated Case Management approach including the Risk Management Team (RMT) meetings is a strong framework to manage risk and determine whether a prisoner is progressed towards community access and release. Although these systems and processes were deemed not to be particularly effective in this case the underpinning framework, if well implemented, has the basis and structure to allow RMTs to function moving forward.

2. Recognition by wider Community Justice partners of the need to meet to discuss the potential media issues surrounding Prisoner Z's community access and release.

3. Although there were some flaws in the process, at practitioner level, the handover of responsibility between Dundee City Council and Angus Council was effective.

4. The involvement of Prisoner Z's Community Based Criminal Justice Social Work in attending ICM meetings is seen as good practice. It was also good practice that both Social Workers from Dundee City and Angus Council met with Prisoner Z during every period of Home Leave.

5. The appropriate challenge of community partners by the Offender Management Unit supervisor at a multi-agency meeting held in January 2017 meeting showed good awareness and leadership. Organising the compilation of a Special Intelligence Bulletin in February 2017 is also seen as good practice.

Recommendations

The Independent Reviewer made 10 recommendations, all of which have been accepted by the Tayside MAPPA Strategic Oversight Group.

Recommendation 1 - The **Scottish Prison Service** should review the information provided to Scottish Ministers when submitting reports that recommend First Grants of Temporary Release to ensure that the report gives a balanced reflection of a prisoner's period of imprisonment and the assessed risk.

Recommendation 2 - The **Scottish Prison Service** should review what information is available and considered during the Risk Management Team meetings when considering a prisoner's progression. The full LS/CMI risk assessment, together with any other risk assessments carried out, should be considered in full.

Recommendation 3 - At the point where a prisoner is considered for progression to the Open Estate, the chair of the Risk Management Team within the **Scottish Prison Service** must ensure that the LS/CMI and any Risk of Serious Harm (RoSH) assessment have been fully completed, endorsed by a Senior Prison Based Social Worker and that all documentation is forwarded to the Open Estate for their consideration within seven days before the date of the proposed transfer.

Recommendation 4 - The **Scottish Government** should work with partners to undertake a review of National MAPPA guidance and improve consistency of application across the country. Guidance should specifically lay out how the Home Leave and release decision making processes; Scottish Prison Service Risk Management Team meetings; community based multi-agency meetings; and MAPPA arrangements interfaces with MAPPA risk management arrangements in practice.

Recommendation 5 - The **Tayside MAPPA Strategic Oversight Group** should ensure that concise and accurate pre read material for MAPPA and multi-agency meetings is sent to attendees in advance of all meetings. This should include formal meeting invitations for all attendees. Meeting minutes should be concise, accurate, ensure tasks are detailed and clear in terms of ownership with updates and outcomes captured. Minutes should clearly reflect the rationale for decision making.

Recommendation 6 - The **Scottish Prison Service** should develop how risk is assessed and mitigated within Risk Management Team meetings. Risk requires to be the main consideration and decisions made should serve to mitigate and manage risk rather, than trigger progression.

Recommendation 7 - The **National MAPPA Strategic Oversight Group** should ensure that ViSOR Standard documents are adhered to by all partner agencies.

Recommendation 8 - Police Scotland should review and improve lines of communication between Offender Management Units and Local Policing in cases involving MAPPA, particularly in cases where there are crossovers of ownership and accountability.

Recommendation 9 - The **Scottish Government** and **Scottish Prison Service** should consider what technological options are available to assist with the management and monitoring of high risk prisoners who are being granted Home Leave - specifically evaluating the viability of GPS tagging solutions.

Recommendation 10 – The **Scottish Prison Service** should review the start to end process of how information regarding individual prisoners' unsupervised community access is consistently reported to and received by Police Scotland and Criminal Justice Social Work in a way that facilitates the identification and management of individuals who may pose a risk in the community.

Executive Summary prepared by Tayside MAPPA Strategic Oversight Group with agreement of Independent Reviewer, Mr Mark Cooper

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