PROBATION SERIOUS FURTHER OFFENCE REVIEW

in the case of

JOSEPH McCANN

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Serious Further Offence Review in the case of Joseph McCann

Introduction

1. The National Probation Service completed a **Serious Further Offence** (SFO) Review as a result of Joseph McCann (JMc) being charged with multiple offences of kidnap and rape committed between 21 April and 5 May 2019.
2. The nature of these offences was horrific. JMc abducted, raped, digitally penetrated and sexually assaulted a number of victims ranging in age between 11 and 71 years across a number of counties in April and May 2019.
3. When an offender who is being supervised by the National Probation Service is charged with a serious offence, an internal management review, known as an SFO review, is undertaken. The purpose of this review is to investigate how the offender was managed by the Probation Service, identify areas of good practice and any improvements which need to be made in the future, along with timescales for action to be taken and what will be expected to improve as a result.
4. SFO reviews are not written for publication, although in cases where an offender is eventually convicted of an SFO, the review is disclosed to the victim(s), and redacted as necessary to safeguard the data protection rights of parties mentioned in the review. Exceptionally, the Ministry of Justice has produced this version of the SFO review for publication, given the nature of the practice failings identified and the need for wider public reassurance that the case has been thoroughly reviewed. This published review is thus distinct from the redacted review shared with those of McCann's victims who requested it but is nonetheless a faithful record of all the key findings in the SFO review.
5. We have included at Annex A a list of **acronyms** and **terminology** to serve as a guide to some of the technical language and processes used in this summary.

Chronology

6. JMc was convicted in his youth of a number of acquisitive offences, as well as later convictions for possession of a bladed article, escape from lawful imprisonment, affray, robbery and dangerous driving. He had a connection to a number of areas, including Norfolk/Suffolk, Hertfordshire, Buckinghamshire and Manchester.
7. In September 2007, JMc committed an aggravated burglary of the property of an 85-year-old male, threatening him with a knife, and was sentenced a year later (in September 2008) to an **Indeterminate Sentence of Imprisonment for Public Protection (IPP)** with a 30 month tariff, reflecting the seriousness of the offence. When an offender received an IPP sentence (the sentence was abolished for offences committed on or after 4 December 2012), the Judge imposed a minimum period in custody (tariff) after which the **Parole Board** may direct the prisoner's release, only if they consider the prisoner's risk can be safely managed in the community. Any offender sentenced to an IPP will be supervised in the community after release by the National Probation Service (NPS). JMc's case was allocated to a probation office in Hertfordshire. His offender manager, OM1, assessed him as posing a high risk of serious harm to the public and known adults, medium risk to children, staff and prisoners. It was not until March 2017 that the Parole Board directed the release of JMc on an IPP licence.
8. At a **Multi-Agency Public Protection Arrangements (MAPPA)**[1] meeting in 2011, the Police shared information which dated back to 2003 suggesting JMc might pose a risk of sexual harm and exploitation to teenage girls. The prison holding JMc had also intercepted

[1] See Glossary entry on MAPPA for an explanation of purpose.

two sets of letters from JMc with disturbing contents and one of the letters was addressed to his offender manager, OM1. Some of this content indicated he posed a risk of sexual harm. As a result, a number of psychological assessments were undertaken, and JMc spent a period residing in a Psychologically Informed Planned Environment (PIPE) in custody for part of his sentence. JMc was managed by a number of offender managers between May 2010 and August 2016 – OM2, OM3 and OM4 – with the case ultimately being transferred to OM5, an offender manager based in a Hertfordshire probation office. OM5 supported JMc's release in a report to the Parole Board in January 2017.

9. The **Parole Board** directed his release on 28 March 2017 to an **Approved Premises (AP)** in Norfolk/Suffolk for a 12 week placement. After an unplanned visit to the Norfolk/Suffolk probation office the day after his release (Norfolk/Suffolk had caretaking responsibility for the case whilst JMc was resident there), JMc was not seen again by his offender managers until 25 April 2017, despite being a high-risk offender who should have been seen more frequently. He was seen weekly by his allocated worker at the AP during this period and staff interacted with him on a daily basis.

10. Having completed the AP placement, JMc moved to a family address in Buckinghamshire. As this was a temporary arrangement a caretaking offender manager from Buckinghamshire, OM7, was allocated to work on his case alongside OM5 in Hertfordshire, who retained formal responsibility for the case. On 25 July 2017, JMc notified OM7 that he had gone to Manchester to visit family. As a condition of his licence JMc was expected to seek advance approval for staying even one night away from his approved address. OM7 had scheduled a home visit for the following day which JMc seemed unlikely to attend. OM7 advised OM5 to decide on enforcement action for breach of licence conditions. OM5 responded that, provided JMc kept in contact with OM7, no enforcement action would be taken.

11. On 26 July 2017, OM7 tried to make a home visit but was unable to contact JMc. He called later to confirm he was still in Manchester. Several days later on 31 July 2017, JMc reported that he would return to his family address in Buckinghamshire, but when OM7 attempted to complete a home visit on 2 August, they were again unable to contact JMc who had now gone to Hertfordshire. During this period, offender managers did not have a face-to-face meeting with JMc because he repeatedly moved addresses between family members and re-arranged his appointments.

12. JMc was due to report to OM7 on 18 August 2017, but the police called to inform the NPS that he was in custody for car theft and domestic burglary. A senior probation officer from the Hertfordshire office, SPO5, decided not to recall him unless he was remanded in custody, but when JMc was remanded in custody, managers, including Assistant Chief Officer (ACO), decided not to recall JMc before conviction because it would be more difficult for an indeterminate sentence prisoner to be re-released in the event of his acquittal. Later that month another senior probation officer from the Hertfordshire office, SPO4, recorded a decision not to recall JMc at this stage. During his period of remand, JMc admitted to OM7 that he had commenced a new relationship with a woman, in breach of his licence conditions. No action was taken by offender managers to address this.

13. In September 2017, JMc was again denied bail. On the date of the trial in January 2018, the probation officer in court left a message for SPO3 (a senior probation officer at the Hertfordshire office) asking for recall to be considered. Later that day, JMc was sentenced to three years for burglary plus four months for conveyance of a motor vehicle without consent. It appears that it was the court's understanding that JMc would be recalled, as the Judge remarked during sentencing that the recall should run concurrent with the existing IPP sentence.

14. Throughout JMc's sentence in 2018 and early 2019, there were numerous further discussions about the possibility of recall. Immediately after sentencing, SPO3 and a duty probation officer appear to have discussed the issue and decided not to recall him. In

February 2018 there is evidence of further discussion in communications between JMc's offender supervisor in the prison and OM 5 which referred to a decision by ACO1 (the Head of Service for NPS in Hertfordshire) not to recall him, although these discussions were not recorded. OM5 also appeared to believe that JMc would go through the parole process before release in the same way as any other IPP prisoner. This was incorrect as he had not been recalled on his IPP sentence. JMc was serving his sentence as a determinate sentence prisoner not an IPP so it was not for the Parole Board to consider release.

15. In August 2018, JMc's prison offender supervisor raised concerns with the Hertfordshire office that he had not yet been recalled. SPO3 said that they then consulted the **Public Protection Casework Section (PPCS)** and made a decision to recall JMc. There are no records of these discussions and despite the decision JMc was not recalled. The prison continued to question the decision not to recall JMc but no action was taken by probation.

16. In December 2018 and early January 2019, prison staff called the Hertfordshire probation office to express further concern that JMc has not yet been recalled. Shortly afterwards, management of the case formally transferred to OM8 (Hertfordshire office), who prompted SPO5 (a senior probation officer who had taken over line management of JMc's offender managers from SPO3) twice about the need for recall. SPO6, another senior probation officer in the Hertfordshire office, emailed SPO5 and ACO1 expressing concern that JMc had not been recalled. SPO5 responded to say that the decision had been made not to recall by SPO3, and that plans were being made for release. Following discussion with SPO5, ACO1 decided that it was too late to recall JMc and there was a risk of legal challenge. In late January the case formally transferred to OM9 (Hertfordshire office). At a multi-agency MAPPA Level 2 meeting on 30 January 2019 an action was set for SPO5 to explore recall with PPCS, but this action was never completed. OM9 attempted unsuccessfully to secure a place at an AP for JMc and instead, plans were made to place JMc with family in Buckinghamshire again on his release.

17. On 15 February 2019 JMc reported for his first appointment post-release at the Buckinghamshire probation office. His licence contained an additional condition to disclose to his probation officer any relationships with women. Later in the month, JMc's case was discussed at a MAPPA Level 2 meeting and a decision was taken to manage his case at level 1[2], with probation as the lead agency. OM10, the offender manager from Buckinghamshire with caretaking responsibilities for JMc's case, visited him at home and raised no concerns. JMc continued to report weekly to OM10 in Buckinghamshire, but attended the Hertfordshire office in March for OM9 to complete a risk review and update his sentence plan as they retained formal responsibility for the case.

18. In early April, OM10 took a call from a housing officer at a council in Buckinghamshire who had interviewed JMc and a female partner. JMc claimed he had been asked to leave his family home address after an argument. The council were not able to accommodate JMc and his partner, and he had become very irate and rude with staff. OM10 notified OM9 immediately, and saw JMc later that day. He had not told his offender managers about his new relationship and was therefore in breach of his licence. ACO1 agreed to write a warning letter which OM10 issued to JMc when he reported to the office on 10 April. On 18 April OM9 saw JMc again in person in Hertfordshire to discuss the breach and reinforce the warning.

19. On 23 April, OM9, SPO5 and ACO1 instigated an emergency recall, following information from the Police that JMc was wanted for an offence of kidnap and rape committed on 21 April. The effect of such a recall is that within hours a warrant is issued allowing the Police to arrest and return the offender directly to prison. JMc went on the run and committed a

[2] See Glossary for explanation of MAPPA levels.

number of serious sexual offences before police officers apprehended and arrested him on 6 May 2019.

Key Findings

Assessment of risk:

20. *At the start of supervision, there should be a detailed assessment of the likelihood of reoffending and the risk of harm posed to others. This should include relevant information, including past offending and behaviour, as well as the impact on victims. Assessment is a dynamic process with significant new events and information leading to a further assessment.*

21. Overall the assessment of risk in this case was deficient.

22. Earlier assessments whilst JMc was serving his IPP sentence were adequate, largely assessing the offender need and risk factors appropriately. In 2009, OM1 completed the start custody assessment and this covered all the relevant areas of risk including past behaviours that were indicative of serious harm. Whilst the risk assessments from 2010 were strongly informed by the disturbing content of the intercepted letters, neither OM1 nor OM2 linked emotional wellbeing to serious harm, despite recognising the need for forensic assessment of JMc. A review in 2012 reflected an appropriate level of risk, but there were no further meaningful updates to the assessment until 2014. Following interventions JMc had undertaken in custody which appeared to be having a positive impact, in 2014 OM3 significantly revised the risk assessment of JMc, assessing him as posing a medium risk of serious harm to the public and a high risk of serious harm to a known adult. At this stage, the assessment failed to link risk to emotional well-being but did reflect the significance of the disturbing letters and the various psychological assessments.

23. In February 2016 OM4 conducted a significant review as part of the parole process, which assessed an increase of risk to the public to high, but reduced the risk to a known adult to medium and the risk to children as low. It is unclear what triggered the increase in the risk to the public, and the reduction in other categories given the content of the police intelligence. This intelligence from 2003 and the content of the letters in 2009 suggested that this assessment should have incorporated sexual harm.

24. OM5 reviewed JMc's risk again in January 2017, but it does not appear that much new information was added to this assessment. Indeed, some sections were identical to the previous assessment by OM4, suggesting they had not been reviewed at all. There was no consideration of risk to children in the context of the potential for domestic abuse or of sexual harm more generally. Supervisors at the time recognised the overall poor quality of OM5's assessments. SPO3 was OM5's line manager at the time, and noted that OM5 was originally a temporary member of staff, and had an extremely high workload, as well as inheriting some particularly challenging cases. OM5 did not have experience of working with high risk offenders and this also impacted on the standard of their work.

25. OM8's assessments in January 2019 were inadequate. They removed useful information on the psychological reports and the potential to manage JMc through the Personality Disorder pathway, which had been flagged by previous offender managers. There was also no consideration of the police intelligence. Whilst it was noted that release should involve stay at an AP, OM8 took no action to progress the referral.

26. OM9's assessment in March 2019 was an improvement on previous reviews, with a broad consideration of risk factors linked to serious harm – again with the exception of emotional wellbeing. However this review preserved the failure by OM8 to consider the relevant

psychological and psychiatric reports, the need to manage the case through the Personality Disorder pathway, or sexual harm.

27. Offender managers are expected to review the risk assessment when there is a change of circumstances to ensure that the plan to manage an offender is up-to-date and robust. There were a number of missed opportunities where they should have reviewed the risk JMc posed. These coincided with the periods when management of JMc's case was formally with Hertfordshire, but JMc was residing in Buckinghamshire or travelling to Manchester, and caretaking arrangements were in place:

    - JMc moved out of the AP Norfolk/Suffolk in 2017 to reside with his family in Buckinghamshire;
    - He frequently travelled to Manchester and thwarted contact with his supervisors;
    - He commenced a new relationship with a woman during his IPP licence;
    - He was arrested for the new offences of burglary and vehicle thefts in 2017, and subsequently sentenced in 2018; and
    - He commenced a new relationship with another woman in April 2019 and was issued a warning letter.

28. The most significant omission was the failure to review risk when JMc was arrested for further offences in 2017. OM5 did not revise the risk assessment to reflect the new offences and the impact on his risk to others. A revised risk assessment was not completed for over a year until shortly prior to release in 2019. Critically, the lack of an up-to-date assessment meant that OM9, who took over the case at short notice before JMc's release in 2019, did not have the benefit of easy access to all the relevant information when they had to make decisions at speed about arrangements for release.

<u>Planning:</u>

29. *The assessment should lead to clear plans for delivering the sentence in order to reduce the likelihood of further offending. Additionally, where a risk of harm to other people is identified, there should be a plan for managing the risk. Plans should be reviewed regularly to ensure they are up to date.*

30. Similarly, planning for risk in this case was deficient.

31. Early sentence planning for JMc during his IPP sentence was broadly positive, despite initially challenging behaviour from JMc making this more difficult. Plans recognised the need for psychological and psychiatric assessments, and were actively reviewed throughout.

32. After JMc went back to prison on the determinate sentence for burglary, planning was poorer. Indeed, JMc spent a full year in custody before a sentence plan was completed by OM8 in January 2019. This appears to have been the result of severe challenges facing the Hertfordshire probation office, and the poor performance of OM5, who had held JMc's case since before his release by the Parole Board and was responsible for managing the majority of JMc's determinate sentence in 2018. Supervisors noted that OM5 faced particular difficulties as a new temporary member of staff with a number of challenging cases inherited from previous colleagues who had handed them over at short notice. OM5 was also absent for periods during 2018. More widely, SPO3 reported that at the time, all staff caseloads were very high, with significant staff turnover and many temporary staff unfamiliar with the standards of practice expected. Managers were aware of these issues, and concerted efforts were made to tackle the poor standards of work.

33. SPO5 became responsible for the management of the whole office in late 2018, when SPO3 took absence. The office was placed into a performance management plan after significant performance issues emerged. Disciplinary action was taken against a number of individuals and SPO5 urgently audited much of the caseload of the office. However,

they did not become aware of JMc's case until November 2018, when OM5 was also absent from work. OM5 did not return to work before they were dismissed in January 2019 – between November and January their custody cases were not reallocated, and there does not appear to have been a handover process for this case. JMc's case was briefly transferred to OM8 in January until SPO5 and SPO4 identified their poor practice and OM8 left the probation service. OM9 was then transferred the case just two weeks before JMc's release in February. Whilst ACO1 reported that there were improvements in performance in the Hertfordshire office as a result of the disciplinary procedures taken against individual staff, this rapid turnover of staff managing the case and their lack of planning made picking up the case and planning for release a difficult task for OM9.

34. Consequently, OM9's release planning had some significant omissions, most critically finding an AP place for JMc. Whilst OM9 did attempt to secure a place, it was withdrawn at short notice due to operational issues. Given that the alternative was to release JMc to a family address, an environment considered to contribute to risk, an AP residency would have been a key element of risk management. The urgent need for a place should have been escalated to a senior level so action could be taken to try to secure a short notice place in an AP.

35. It appears that the pressure on the staff throughout 2018 and the chaotic transfer of the case between numerous offender managers also significantly impacted their ability to comprehensively review JMc's historical record, and therefore to identify the previous references to sexual violence. Had offender managers reviewed the historical records, including the police intelligence, they might have instigated one to one work with JMc to address sexual violence. However, aside from this historical intelligence from 2003 and the letters intercepted by the prison in 2009, there were no more recent indicators of concerning sexual behaviour, and this failure should be viewed in this context.

<u>Implementation and Reviewing:</u>

36. *The risk management plan should be implemented as intended, ensuring all required actions are undertaken to protect the public. The sentence plan should lead to the delivery of high quality, well-focused and individualised services which engage the service user. There should be a regular review of progress and an effective response to changes in the offender's circumstances, behaviour and compliance.*

37. Implementation and reviewing of risk management in this case were also deficient.

38. Early management of this case by OM1-4 was good, with offender managers responding appropriately to challenging behaviour by JMc. OM2 dealt robustly with JMc after the two sets of letters were intercepted in 2009, and the request for psychological and psychiatric assessment demonstrated an appreciation of the potential risk.

39. However, as well as the deficient risk assessment and planning, OM5's management of the case was frequently inadequate. In the run up to JMc's release from his IPP sentence, they did not review the required management under MAPPA. OM5's management of JMc's licence period after his release was also poor. OM5 did not establish clear boundaries and there were several instances where OM5 was too lenient in their approach to compliance with the licence conditions. This included the occasions that JMc left his approved address in Buckinghamshire to visit family in other parts of the country, which OM5 did not enforce. OM5 also failed to investigate or act on the information that JMc had commenced a new relationship with a woman without informing his offender manager, contrary to his licence conditions. There was an unacceptable lack of grip retained on the case by OM5 whilst JMc was residing in Buckinghamshire or travelling to Manchester, and their approach to risk management was poor.

40. Manager oversight also varied across the management of this case. In particular, there were a number of notable omissions by SPO3 in their management oversight of OM5

which suggest they did not have a proper grasp of JMc's case. SPO3 did not instruct OM5 to consider a MAPPA referral into Level 2 prior to the parole review, and failed to document their enquiries about recall. SPO3, SPO5 and SPO4 also all endorsed a number of risk assessments by OM5, OM8 and OM9 that were of insufficient quality. Despite this, overall, SPO5 made great progress to improve performance in the wider probation office, moving it from an environment in significant turmoil to a functioning office.

41. The most significant omission in the management of this case is the failure to recall JMc to custody after he was charged with and remanded in custody for further offences following his release on IPP licence. There is evidence of missed opportunities, failures to act and misapplications of the guidance on recall.

42. Guidance on recall states that when recalling an IPP offender on licence, there must be:

- evidence that there is an increased risk of harm to the public; or
- behaviour that presents an increased risk of sexual or violent harm to others, regardless of the original offence; or
- behaviour that presents a clear causal link to the behaviour shown in the original offence.

43. It also states that '*recall to prison does not depend upon a prosecution and conviction for a fresh offence...Consideration must be given to 1) if the suspected behaviour is similar to previous offending; 2) if the suspected behaviour reflects a pattern of entrenched offending; 3) if the suspected behaviour constitutes an increase in risk of serious harm'.*

44. At the first point of JMc's arrest in 2017, SPO4 supported by ACO1 decided not to recall JMc. This was on the basis of their judgment that, whilst there was an offence paralleling previous behaviour (i.e. burglary), there was no evident escalation in risk, in that this offence was less serious than the last, and that a recall decision should be made only upon conviction.

45. ACO1 reported that at the time there had been focus on the particular impact of recall on those subject to IPP sentences, as recall often resulted in lengthy returns to custody requiring review by the Parole Board prior to release. Given the guidance on recall, this concern was <u>not</u> a defensible reason not to recall JMc, particularly given the strength of the evidence, and the fact that the alleged new acquisitive offences mirrored JMc's aggravated burglary offence.

46. Further, on JMc's appearance at court in August 2017, there was a failure to communicate effectively with the court, which appeared to believe that JMc would be recalled if remanded in custody, despite ACO1 and SPO4's earlier decision not to recall until conviction. Even after JMc's sentencing in January 2018, when the Judge remarked on their expectation that the sentence would be served concurrent with recall, no action was taken to recall JMc. Both SPO4 and ACO1 acknowledged in an interview for the SFO review that JMc should have been recalled at this stage.

47. A further opportunity to recall was missed when SPO3 and a duty offender manager discussed the case in January 2018. They reviewed the guidelines around recall and SPO3 decided to take no further action. However, another discussion took place in August 2018, where SPO3 contacted PPCS for guidance, given that by this stage JMc was already half way into his sentence for the burglary and car theft. Following discussion with PPCS, SPO3 said in interview for the SFO review that a decision was made to recall JMc even though it was not actioned. None of these decisions were recorded formally. Due to the aforementioned workload pressures in the Hertfordshire office, the management of JMc's case was not prioritised, with a focus instead on offenders in the community. SPO3 was absent from duty shortly after the discussion with PPCS and no one else followed this up the decision to recall. Indeed, there was a lack of clarity about the advice between those

involved, as ACO1 believed that SPO3 had made the decision not to recall after speaking to PPCS.

48. SPO5 took over management of the office from SPO3, but as mentioned above, did not become aware of JMc's case until November 2018. SPO5 alerted ACO1 to JMc's case on discovery of it, but ultimately ACO 1 decided that it was too late to recall, as they believed that recall action taken less than 8 weeks prior to the expected release date would be subject to successful legal challenge. Due to this, the repeated requests by the prison to consider recall were dismissed, and the focus shifted to preparing for release.

49. It should be noted there that there is no reference in the guidance on recall to any scenarios where recall to protect the public should be avoided due to legal challenge. Whilst there may have been the potential of a legal challenge from JMc, this was not a defensible reason not to recall especially given there was not an adequate risk management plan in place. Concerns about the legality of the recall should have been discussed with PPCS.

50. After JMc's release from his second sentence in February 2019, there was a final missed opportunity to recall him. JMc's failure to disclose a new relationship with a woman, his 2 week period of staying with her, his loss of accommodation due to the dispute with his family members, his abusive behaviour to the staff at the council all constituted clear breaches of his licence conditions

51. Relevant resettlement guidance also suggests that offender managers should, in response to poor compliance at the very least, consider a range of additional restrictive or supportive measures to manage an offender in the community, such as placement in an AP, or increased reporting and home visits. However, the guidance is clear that alternatives to recall should be implemented only if the risk can be safely managed in the community. Attempts were made to secure an AP placement without success, and the ACO warning letter focused on JMc's failure to disclose his relationship, without attention to the other breaches mentioned above – and risks arising from them. The Divisional Director for South East and Eastern considered that 'an ACO warning was not an unreasonable decision'. However, the SFO review found that, whilst the approach to enforcement improved during the second release in 2019 leading to the ACO warning letter being issued, given the escalating risk, recall should have been actioned.

52. The failure to correctly apply recall and resettlement guidance in this case is notable throughout the management of this case from August 2017. Senior management confirmed that briefing and guidance on recall was available to staff. NPS were delivering national workshops in respect of high risk offenders and enforcement/recall practice over the winter of 2018, although no workshop had been held at the Hertfordshire office. A separate learning event was held at the office which covered recall procedures but both SPO5 and SPO3 were absent from the office at the time. This training did not, therefore, impact positively on practice and decisions in this case.

53. The wider challenging environment of the Hertfordshire probation office had a further deleterious effect on the management of risk. Frequent changes in offender managers with insufficient handover processes, both between staff in the Hertfordshire office and between caretaking staff appear to have undermined effective risk management. As a result, the historical background of the case became diluted as it was transferred between offender managers. Further, due to the high staff turnover, a newer offender manager in Hertfordshire managing the case from 2016 onwards did not benefit from an experienced team with whom to discuss this complex case. This may have contributed to that failure to adequately consider the need to review this case under the Personality Disorder pathway, or to explore concerns around sexual harm.

Conclusion

54. The NPS SEE Division did not manage JMc effectively or in line with the policies and procedures which set out the expectations for managing offenders who pose a high risk of harm. The standard of practice did vary significantly over time and between individuals. Whilst there were ultimately clear inadequacies in all areas, early offender managers laid strong foundations for the management of this case in their proactive liaison with prison colleagues and key partners, and in their responsiveness to risk during the early years of the IPP sentence. All of these practitioners encouraged JMc to shift his negative approach to his sentence, and engage meaningfully in a number of targeted interventions to address his violence, conflict resolution and management of intimate relationships.

55. However, early good practice was critically undermined by the repeated and various failures in assessment, planning and management. The pertinent risk concerns of the case were lost in the numerous handovers between offender managers, as well as failures to comprehensively consider historical intelligence. As a result, assessments were inadequate and did not incorporate the potential risk of sexual harm or of suitability for the PD pathway. Sentence planning was frequently inadequate or incomplete.

56. Later offender management immediately before JMc's release by the Parole Board in 2019 and afterwards by OM9 and OM10 demonstrated efforts to restore appropriate practice. This included the attempts to refer JMc to an AP. Whilst this work was an improvement, it was not sufficient to compensate for the previous failure in planning and was let down by some poor managerial oversight, problematic case transfers and the lack of further interventions through the PD pathway and exploration of sexual deviance.

57. The most significant practice failing was the repeated failure to recall JMc or to reflect critically on earlier decisions not to recall him, in the face of both court and prison staff communicating their concerns. From the point where JMc was arrested for burglary in 2017 to the point of his release, there were eight occasions where recall was considered or the recall decision was questioned. These all represented opportunities to recall. If the probation service had recalled JMc he would not have been released until the Parole Board was satisfied his release could be managed in the community. It will always be a matter of conjecture whether JMc would have been re-released at or shortly after the end of his determinate sentence, but this would not have happened without the Parole Board fully reviewing all the known risk factors and being satisfied a comprehensive plan to manage him on release was in place. The indecision about recall also appears to have contributed to poor release planning during JMc's second sentence. There was then a final missed opportunity to recall when there were further breaches of his licence following release including when it transpired that he had formed a new relationship without disclosing it.

Response to the SFO

58. When the NPS became aware of the first of JMc's serious further offences, it took emergency recall action, and his licence was revoked within hours.

59. As soon as the Chief Probation Officer for England and Wales became aware of the extent and seriousness of JMc's offending whilst subject to licence, she worked with senior managers who took decisive action to immediately review practice and identify the failings in this case. This included disciplinary investigation into the individual practice failings – specifically relating to ACO1, SPO3, SPO4 and SPO5. All four faced a disciplinary hearing against a charge of gross misconduct. In three cases, the hearing officer (independent of NPS SEE Division) found the charge of gross misconduct not proven, whilst in one case the hearing officer found the charge proven and demoted them. Whilst a number of significant deficiencies were identified for OM5 and OM8, neither individual was still

employed by NPS at that stage, as they had both been dismissed for the general deficiency of their work, so no further action was taken in relation to them.

60. In line with the SFO Review Procedures a robust review and comprehensive action plan was also completed. The SFO review was quality assured by experienced staff at HMPPS HQ.

61. A summary of the recommendations for the division and probation offices responsible for managing JMc has been set out below:

62. Recall

- Managers will reflect on recall decisions and alternatives to recall at an upcoming forum. All managers will record enforcement decisions relating to recall. The South East and Eastern Divisional Director will lead a benchmarking exercise with Heads of Service to audit recall decisions.
- A weekly newsletter will continue to share messaging on recall decisions to all South East and Eastern staff. Managers will revisit principles of recall, including recall of IPP cases, and alternatives with staff at team meetings to ensure all staff adhere to the Recall Policy Framework. Managers will discuss in regular supervision with offender managers to ensure recall guidance is properly adhered to.

63. MAPPA and Risk Management

- Offender managers must refer into MAPPA six months prior to a parole review or potential release to ensure timely release planning. Managers in Hertfordshire will remind offender managers in regular supervision of the importance of thresholding MAPPA cases in a timely manner to ensure release planning begins for all custody cases within 3 of months release.
- The MAPPA Chair will also ensure that they obtain evidence of completed MAPPA actions and this will be backed up by managers dip sampling individual cases.
- MAPPA meetings in the relevant counties must incorporate the use of police intelligence. Senior manager will dip sample meeting minutes to confirm.
- Managers will identify all IPP cases and refer them to the IPP panel to coordinate risk management plans.
- All offender managers will screen and refer all relevant cases to the PD pathway. This will be reinforced through regular coaching and monitoring as part of supervision and senior leaders monitoring PD screening reports on a monthly basis.
- Managers will escalate the requirement for an AP bed space to senior management in all relevant cases.
- Offender managers should explore all indicators of risk in every case, including sexual harm. Managers will undertake reflective case discussion with offender managers to ensure all aspects of risk have been explored and are being managed appropriately. Cases reviewed in supervision and quality assurance processes should be used to check all aspects of risk are being addressed.

64. Case Management

- Managers will facilitate sessions on ensuring contact is maintained when a service user is out of area, and the importance of case transfer between offender managers working across different areas. Managers will dip sample to ensure learning has been embedded.

- Managers will ensure that comprehensive handovers take place between offender managers, with a case summary entry of the key aspects of the case and relevant actions being made available.
- Managers will ensure the workload of staff is reviewed and monitored. Managers will seek authorisation from the Head of Service where staff are over capacity to implement the Demand Management approach to prioritise areas of business. Senior Leadership Team meetings chaired by the Divisional Director will monitor resources across the South East and Eastern regions and undertake reasonable action to address the staffing shortages, with concerns escalated to senior HMPPS officials.

ANNEX A

A LIST OF ACRONYMS AND TERMINOLOGY

Action plan The list of actions identified within the SFO review as being required to address all areas of deficient practice observed. This may include the highlighting and sharing of positive aspects of practice, as well as addressing all appropriate areas of deficient practice.
ACCT Assessment, Care in Custody and Teamwork – *Any prisoner identified as at risk of suicide or self-harm must be managed using the Assessment, Care in Custody and Teamwork (ACCT) procedures.* ACCT is a prisoner-centred, flexible care-planning system which, when used effectively, can reduce risk. The ACCT process is necessarily prescriptive and it is vital that all stages are followed in the timescales prescribed.
ACO A senior probation manager with operational knowledge who manages a local delivery unit in a specific area within a Division.
Acute risk factors Those that change quickly, perhaps over days or hours and whose emergence indicates a period of critical risk for an individual where the potential for inflicting serious harm on others already exists. Examples might be: Increased levels of substance misuse or destabilisation of socio- economic factors such as loss of accommodation. While alcohol may be a dynamic risk factor, intoxication would be the acute risk factor
Approved Premises (AP) A residential unit providing intensive supervision for offenders who present a high or very high risk of serious harm. Most will have been released from prison on licence or have a requirement imposing AP residency on them. Residents at APs are subject to national rules with a number of restrictions, including a minimum curfew of 11pm-6am.
CAS Case Allocation System. The NPS is responsible for the allocation of cases through the Case Allocation System to the NPS or CRC.
Chronic (or stable) risk factor A dynamic risk factor that tends to be persistently present.
Clinical risk assessment Based on professional judgement through interview and observation, knowledge of case history and current circumstances. The aim is to increase the understanding of how relevant dynamic risk factors interact for this individual and thus be able to work more effectively with them to construct a workable plan to address the risks.

Contingency plan An outline of intended contingency actions should essential elements of the risk management plan break down. The plan should identify what actions would be required in response to the emergence of specific risk factors or the breakdown of protective factors.
Defensible decisions Decisions that will stand up to 'hindsight scrutiny'. All probation staff should be able to demonstrate defensible decision making throughout the management of a case and that 'all reasonable steps' have been taken to minimise the risk of serious harm. Decisions should be appropriately recorded and explained in the case record.
Deficient practice Where the work undertaken is assessed to have fallen below the required standards.
Dynamic risk factor A factor that contributes to further offending, but is amenable to change. A dynamic risk factor may be stable or acute (see respective definitions in this glossary). Examples of dynamic risk factors might be: alcohol; substance misuse; mental ill health; suicidal ideation; threats to harm others; access to weapons; relationship problems; psychotic and manic behaviour; financial problems; unemployment.
Enforcement The term used to refer to action taken if an offender fails to comply with the requirements of their sentence/licence. Actions can include verbal and written warnings, additional restrictions, breach proceedings and potential recall to custody.
Harm Ill-treatment or the impairment of health or development including, for example, impairment suffered from seeing or hearing the ill-treatment of another. The threshold between non-harmful and harmful behaviour would be more easily met in the case of a child or vulnerable adult. 'Serious Harm' is a sub-category of this definition (see below).
High Profile SFOs which attract significant media attention or may have increased ministerial involvement.
HMPPS Her Majesty's Prison & Probation Service. A government organisation with responsibility for the management of offenders in prison and by both the NPS and CRCs.
Imminence Imminence relates to the timescale within with it is likely that an event will occur eg how soon will this offender do something harmful? Is the harmful offence likely today, tomorrow or in the foreseeable future? Professional judgement will need to determine such timescales in each individual case.
Imprisonment for Public Protection The sentence of imprisonment for public protection (IPP) were introduced in 2005 by the Criminal Justice Act (CJA) 2003. This sentence was designed to be imposed on those who had committed specified 'serious violent or sexual offences' and who were

deemed to pose a 'significant risk of serious harm' in the future. Under an IPP sentence high-risk individuals served a minimum term in prison (their tariff), during which time they would undertake work to reduce the risk they posed. At the point when sufficient risk reduction had been achieved, they would be released by the Parole Board. If at the end of their tariff their risk has not been reduced sufficiently, they continue to be detained until they satisfied the Parole Board that they had reduced the risk they posed and could be safely managed in the community. Those released from an IPP sentence are also subject to a life licence, which they can apply to have cancelled after 10 years in the community.

Key findings
These are the areas of positive and deficient practice that the SFO review identifies. These should be addressed with appropriate learning points in the action plan.

MAPPA
Multi-Agency Public Protection Arrangements. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other responsible authorities/agencies dealing with offenders to work together in partnership to devise and implement plans to manage risk.

MAPPA Levels
There are three levels of MAPPA management based upon the complexity of the case and level of multi-agency co-operation that is required to implement the offender's risk management plan effectively.
Level 1: The risk presented by these offenders requires all agencies involved to share all relevant information with each other but does not require formal MAPPA meetings to assess and manage offenders' risks. The lead agency will manage the offender in accordance with its usual arrangements. For offenders who are on licence, the lead agency is the National Probation Service.
Level 2: The combination of risk and complexity means that the risk management plans for these offenders require the active oversight of several agencies, at a more senior level, via regular MAPPA meetings. Partner agency action will add value to the lead agency's risk management plan which will be adopted as the MAPPA risk management plan.
Level 3: As with Level 2 offenders, the risk management plans for these offenders require the active involvement of several agencies via regular MAPPA meetings. These cases, however, require the involvement of senior leaders from the relevant agencies to authorise the use of special resources or to provide ongoing senior management oversight of the case.

MOJ
Ministry of Justice. The department of government with responsibility for criminal justice, including the management of offenders by HMPPS.

National Delius (NDelius)
The national case recording system for community based work with offenders.

NPS
National Probation Service. The public sector service with responsibility for managing high risk (and other) offenders released into the community.

Offender Assessment System (OASys)
The offender risk assessment and management tool.

Offender Manager (OM)
The officer responsible for managing the offender through their sentence. Also known as the Responsible Officer (RO) dependant on the organisation.

OGRS 4
Version 4 of the Offender Group Reconviction Scale, which is a validated risk predictor tool based on static risk factors.

OVP 2
Version 2 of the OASys Violence Predictor, which is a validated risk predictor tool for violent offending, based on both static and dynamic risk factors.

ORA (Offender Rehabilitation Act)
This refers to legislation governing sentences imposed from 1 February 2015. The biggest change was the requirement for any offender receiving a custodial sentence to be supervised in the community for a minimum period of 12 months. This meant the introduction of post sentence supervision (PSS) – see below.

Offender Personality Disorder Pathway
The joint NHS and HMPPS OPD pathway is a co-delivered and co-financed pathway of connected services for offenders who are high risk, and likely to satisfy a diagnosis of 'personality disorder'. The OPD Pathway programme commissions services in prisons, secure health and community settings that offer a range of interventions including early identification, consultation to staff, treatment and progression opportunities.

The aims of the pathway are to manage or reduce the risk of future serious harm, increase psychological wellbeing and create a competent and confident workforce.

The OPD Pathway provides a network of connected services mainly located within prisons and probation

Progression Regime
A prison-based regime with three-stages of progression, each leading to an increasing set of freedoms and responsibilities. The stages of progression allow offenders to demonstrate an ability to manage their own risks, take responsibility for themselves and for carrying out required tasks and routines consistently. It is designed for indeterminate sentenced prisoners, and for those serving extended determinate sentences, who are finding it challenging to progress towards release via the usual routes. It tests residents' ability to respond appropriately to the trust placed in them, and enables them to actively pursue activities and community-ties which support rehabilitation.'

PIPE
Psychologically informed Planned Environments are specifically designed environments where staff members have additional training to develop an increased psychological understanding of their work. PIPE services are supported by additional prison/probation staff and a qualified psychological therapist. PIPEs focus on providing pro-social relationships and interactions and form part of a treatment pathway of services. PIPEs

are not a treatment programme in the traditional sense, instead they support progression and transition through a pathway operating in Prison and Probation settings.
Probation Officer (PO) Someone with responsibility for supervising/managing offenders. A PO will have achieved defined qualifications in order to obtain PO status. Also known as a Responsible Officer or Offender Manager
Protective factors Static or dynamic factors, whether external or internal, that make it less likely someone will re-offend.
Pre-Sentence Report (PSR) A report completed by the NPS with a view to assisting the court in determining the most suitable sentence for the offence/offender. Reports can be fast delivery (FDR) or standard delivery (SDR), the difference being the timescales for their completion. Some reports are delivered verbally to the Court.
Recall An offender subject to licence can be recalled to prison if they fail to comply with the conditions of their licence. They can be released again after 28 days if they meet certain criteria, if not, the parole board will decide if they can be re-released at any point prior to the end of their sentence. In some instances, the responsible officer can support executive release which allows the public protection casework section to decide whether an offender is suitable for re-release without a full parole board review.
Risk assessment The process of collecting, verifying and evaluating information to establish the nature and extent of risk, either of likelihood of re-offending or of the occurrence of serious harm. Risk assessment is often aided by the use of formal risk assessment tools. Good quality risk assessment builds on strengths as well as identifying difficulties; is grounded in evidence; is offender-centred; is a continuing process, not a single event.
Risk Management Refers to those strategies used to manage risk, either by reducing the likelihood that a harmful offence will occur, or in reducing the impact of the offence should it take place (e.g. victim protection). Strategies most usually restrict opportunities to offend, restrict access to or impact on potential victims, and target risky behaviours for change. The term tends to be used with reference to risk of harm rather than risk of re-offending. Risk management is more effective when the offender is committed to and supports the activities, which is made more likely by a clear focus on desistance principles and opportunities to change.
Risk Management Plan (RMP) A shared, actively monitored plan, for managing the identified risk of serious harm. Such a plan is required to be in place and documented for all offenders assessed as Medium, High or Very High RoSH.
ROR (LoR) Risk of Re-offending or Likelihood of Re-offending. Based on static and dynamic assessment tools, the likelihood that an offender will go on to commit a further offence. Expressed in terms of low, medium, high or very high.

Risk of serious recidivism (RSR) tool
A tool to identify a score for the probability that an offender will commit a seriously harmful offence within the next 12 or 24 months, based on a defined list of relevant offence types. The tool can be administered using static information only, or a combination of static and dynamic information.

Risk of Serious Harm (RoSH)
The assessed level of risk of harm that the service user is identified as presenting. Serious harm is defined below. This assessment is part of the OASys assessment tool. There are four levels of ROSH:
Low risk of serious harm (LRoSH): Current evidence does not indicate likelihood of causing serious harm.
Medium risk of serious harm (MRoSH): There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, and drug or alcohol misuse.
High risk of serious harm (HROSH): There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.
Very high risk of serious harm (VHROSH): There is an imminent risk of serious harm. The potential event is more likely than not to happen imminently and the impact would be serious. This assessment is likely to relate to a 'critical few'.

SAQ
Self-Assessment Questionnaire. Completed by the offender at each sentence plan review to identify any problematic areas linked to their offending.

PPG
Public Protection Group. The group within HMPPS in which the national SFO team sits.

Serious harm
An event which is life-threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible. As defined in the OASys risk assessment tool.

SFO
Serious Further Offence

SFO Notification
The document submitted to the national SFO team within 10 working days of the offender's first court appearance. Also known as the Annex D.

SFO review
The document submitted to the SCGGP SFO team within 3 months of receipt of the SFO notification. Also known as the Annex E.

SFO review period
The period under review will typically commence from the point of sentence and cease at the end date of the commission of the SFO. If less than six months is recorded, and the offender had an immediate previous sentence, then the review may explore the work undertaken in this previous sentence.

SPO Senior Probation Officer
Stable risk factors (also referred to as ‘chronic’ risk factors) Dynamic risk factors that tend to be persistently present.
Static risk factors Those elements of an offender’s identity or past behaviour and its consequences that are historical and/or factual such as gender, age, number and type of previous convictions. Unlike dynamic risk factors, static factors are not susceptible to fluctuation.