

**Investigation into the issues arising from the Serious Further
Offence Review:**

Dano Sonnex [DS] (d.o.b. 07.07.85, age 23)

***Liz Hill
Regional Offender Manager, South West
22 January 2009***

Investigation terms of reference.

1. Nick Pascoe, Director of Offender Management, London, commissioned me to undertake this investigation. The terms of reference, dated 24.10.2008 are:

You are directed to investigate the risk assessment and risk management by HM Prison Service and London Probation Area leading up to Mr Sonnex's release from custody. Specifically to:

[A] investigate the supervision of Dano Sonnex by London Probation Area, to ensure that the internal SFO Review has reviewed all the failings in the case and has identified appropriate and comprehensive improvement factors

[B] investigate the systems operated by London Probation Area to identify and allocate cases which need to be managed by experienced probation officers, including those cases that need to be managed through the Multi-Agency Public Protection Arrangements

[C] investigate the arrangements by which senior managers assure themselves that cases have been appropriately assessed, allocated and are being supervised to the right standard, in the light of information which is and ought to be held on offenders

[D] consider the issues concerning Mr Sonnex in light of the recommendations arising out of the Hanson and White and Chester Nash cases and to make recommendations.

2. Katie Price, Deputy Head of Young Adults at HMYOI Feltham assisted me in this investigation and our conclusions are set out below.

Headlines

3. Information from the HMPS file, the LPA file, the SFO Review and the LCJB report makes it clear that errors of judgement, failures of communication and practice which did not meet requirements were significant factors in the management of this case.
4. During the custodial period relevant information held in the medical file did not transfer to the general prison file and did not inform DS's management in custody. Communication between HMPS and LPA did not therefore include significant judgements made about DS prior to his release, and there was too little involvement of the LPA offender manager at the pre-release stage. Assessments of the risks DS presented fluctuated, and were over influenced by his eventual compliance in the latter part of his sentence and apparently while being supervised in the community.
5. Assessments varied unjustifiably, and he was incorrectly assessed to present a medium risk, which in turn was the basis for the decision to allocate his supervision to a standard offender management team, rather than a more skilled public protection team in LPA. Referrals to MAPPA were not followed through. Information about an alleged offence shortly after his release was not acted on by LPA managers as it should have been.
6. When DS was remanded in custody for further offences, he was subsequently released on bail, an action which appears to have been the result of confused communications between the field team and court staff. Recall action, when appropriately taken by the offender manager in the light of these further charges, was unaccountably delayed. When a warrant for his arrest was issued, questions arise about the speed with which this was executed.
7. Performance weaknesses took place within the LPA in a context of too little awareness at the most senior levels in the organisation about both locality capacity and competence factors.
8. All these events took place before the murders, and correct actions at any of these stages could have had a bearing on the eventual offence.
9. In addressing the current capacity of LPA to manage high risk cases safely, it is clear that significant steps were being taken during the period that this case was being supervised and have been taken since. The SFO Review addresses the weaknesses in the locality where primary responsibility for DS lay, and sets out appropriate actions. However, in the light of previous HM Inspectorate of Probation reports, questions remain about the degree to which proper levels of practice in relation to public protection are embedded across the organisation.
10. Wider issues that this investigation highlights are questions about the roles, responsibilities and expectations of the Board, especially when the

Chief Officer becomes accountable to the Board as probation areas move to trust status, and the role and function of the Director of Offender Management, in holding Boards and Trusts to account in failures of practice.

11. In undertaking this investigation we identified five main areas where we have recommended actions by NOMS, HMPS and LPA. Those recommendations appear in the report in sequence and are listed below. However, in addressing the main question concerning the safety of LPA as an organisation, our primary focus was on recommendation four:

Recommendation 4:

To ensure that improvements in the supervision of higher risk offenders are being both generalised and embedded, in the light of the learning points from the DS case, the Director of Offender Management for London should commission an independently validated examination of a random sample of tier three cases across 25% of LPA's boroughs, as chosen by the DOM.

This work should be completed before DS appears for his trial.

12. The remaining recommendations are as follows:

Recommendation 1:

HMPS should take steps to ensure that information relevant to the risk posed by a prisoner on release, no matter where such information originates from, should be shared with and used by staff responsible for the management of that offender throughout the course of his or her sentence.

Recommendation 2:

NOMS should issue instructions to HMPS and Probation staff to ensure that those who are responsible for managing offenders who may present a risk of harm are familiar with processes which enable timely transfer of ownership of OASys assessments from custody to the community and vice versa.

Recommendation 3:

Those responsible for new training arrangements for practitioners in NOMS should ensure that those who qualify are able to demonstrate appropriate awareness of relevant mental health issues, so that where necessary referrals are made to mental health specialists and then followed up to assist in the assessment and management of cases with the potential for causing serious harm.

Recommendation 5:

NOMS should design a mechanism by which the Chief Officer and the Board can assure the DOM that risks presented by higher risk offenders under supervision are being properly prioritised and managed to deliver as safe a level of public protection as is feasible.

This measure should be based on numerical factors such as caseloads, staffing levels, etc. and the judgement of the Chief Officer. Accountability for delivering against this measure should be through the Board/Trust to the Director of Offender Management on a quarterly basis.

The work to design this mechanism should be completed before 30 June 2009 to be implemented from Q2 2009.

Background.

13. Dano Sonnex (DS), now aged 23, was sentenced to 8 years imprisonment on 14 March 2003 for offences of assault with intent to resist arrest, having an imitation firearm with intent, attempted robbery, robbery x 4 and wounding with intent. He was 17 at the time of being sentenced, with no previous convictions but with a history of difficulties, including exclusion from school. His Pre-Sentence Report, prepared by the Youth Offending Team, assessed his risk at that time to be low to medium. Risk assessments in 2006 and 2007 while he was in custody suggested that he presented a high risk of harm to the public, but by the time he was released this had been reduced to medium, based predominantly, it appears, on DS's transformed compliance and improved behaviour.
14. DS is charged with the murders, on 29 June 2008, of Laurent Bonomo and Gabriel Ferez, in New Cross. He was arrested on 11 July 2008 and first appeared in court on these charges on 14 July 2008. At the time of the murders he was subject to supervision by London Probation Area (LPA) on a post-release licence, having been released on the latest date possible (8 February 2008) from a sentence of eight years imprisonment. His supervision was due to end on 11 October 2008. The LPA had twice opposed his release on parole. On the first occasion this opposition was based on the fact that he had attracted over 40 adjudications for a range of matters, including violence, drug offences, disobedience and 1 for setting light to items in his cell, and that he had failed to engage with offending behaviour programmes. On the second parole was opposed because of further concern about the risk presented by DS in the accommodation he proposed to return to with his family.
15. At the time of the murders DS was subject to a warrant for his arrest to be recalled to prison, a process which commenced on 3 May 2008 and concluded on 11 July 2008 when he was arrested. This period consisted of three distinct phases: the time from 3 May 2008 to 12 June 2008 when LPA was preparing the papers. On 12 June 2008 these were submitted to the Release and Recall Section of NOMS who notified the Metropolitan Police on 13 June 2008. The police attempted to execute the warrant on 29 June 2008, the day of the murders, and DS was arrested on 11 July 2008.
16. DS is due to stand trial on 21 April 2009 at the Central Criminal Court, with a co-defendant (not subject to supervision).
17. There are two other investigations into this case and its handling:
 - i) A multi-agency case review by the CEO of the London Criminal Justice Board, supported by the MAPPA signatories group, which is in draft at this stage and due to be finalised by 31 January 2009.
 - ii) A review undertaken by the Independent Police Complaints Commission, which will be published after the case has been through the court processes.

[A] Investigate the supervision of Dano Sonnex by London Probation Area, to ensure that the internal SFO Review has reviewed all the failings in the case and has identified appropriate and comprehensive improvement factors.

The supervision of Dano Sonnex.

18. At the point of sentence on 14 March 2003, DS was managed by Lewisham YOT and he was transferred to the probation service in August 2003. LPA's SFO Review contains a chronology from the date of sentence, highlighting key events in the LPA management of the case. In addition, there is material contained in the prison file which illuminates the progress of DS through the system. In investigating the risk assessment and risk management of this case by both HMPS and LPA, it was necessary to draw on both sources and a more detailed custodial history is included below.

The pre-release / custodial period

19. During the early part of his sentence, DS was transferred several times to different establishments in the young people's estate including HMPs Portland, Reading and Feltham, due to his continued poor behaviour. This behaviour resulted in more than 40 adjudications for various offences against Prison Rules, including taking drugs, disobeying orders, threatening behaviour and serious violence against both staff and prisoners. He also set a fire in the Segregation Unit at one of the establishments. However, at the time of the incident, it was considered to be an act of self harm and was dealt with accordingly.

20. In both the period he spent on remand and the first period of his custodial sentence, DS was considered to be a challenging prisoner to manage and he spent many periods in separation as a result of his poor behaviour and attitude. The record shows that DS was referred to see a psychiatrist to deal with his paranoia and anger management issues while he was at HMYOI Feltham and for a short while undertook weekly one to one Anger Management sessions until his transfer to HMYOI Portland, where he was referred to the Mental Health In-Reach Team.

21. He was seen in May 2004 by a doctor at HMYOI Aylesbury, who made a diagnosis that DS had a conduct disorder. Later that month DS was assessed by the Medical Officer at HMYOI Portland. The Medical Officer was a registered General Practitioner who held a Diploma in Prison Medicine and had extensive knowledge of prison medicine specialities. Following this meeting, the Medical Officer wrote to his colleagues in the Community Mental Health Team (CMHT) highlighting various issues with regard to DS and the risks he presented.

22. The Medical Officer wrote, "I have strong feelings that this fellow will come under the orbit of psychology to explore levels of dangerousness (which I already predict are high), given his record of violence, lack of remorse or pity, latent aggression, number of adjudications and pre-conviction record". The Medical

Officer ended the memo with: "The forensic dimension is the greatest concern, especially as he admits that his reactions could kill".

23. Shortly after this assessment DS was transferred from HMYOI Portland and he was seen by the In-Reach Team at HMYOI Aylesbury in September 2004. The report of their assessment questioned whether DS had Aspergers Syndrome and gave some details of his family circumstances but it is not clear that the Medical Officer's assessment was available or considered. DS did not attend the next appointment made for him and there is no further evidence of contact with the In-Reach Team in Aylesbury. The record states that DS had many subsequent opportunities to use the services of the Mental Health Teams at various establishments, which he declined.
24. The memo from the Medical Officer at HMYOI Portland highlights a clear issue of risk to others, including DS's own view that his 'reactions could kill'. The documentation was present in his Inmate Medical Record (IMR), and made available to this investigation from HMP Elmley from where he was released in February 2008. The remaining record was provided from HMP Belmarsh where he is remanded in custody in relation to his current charges. It is not clear whether both sections of the record followed DS's progress through his sentence or whether information in the medical record was available to, or used by, those whose routine access would have been to the main record. However, there was no reference to the judgements made by the Medical Officer at HMYOI Portland in any subsequent assessments of DS's risk. It appears that the information contained in the Medical Officer's note was not used by or was not available to other staff with responsibility for assessing and managing the risk DS presented to others.
25. Throughout DS's prison file, there is mention of paranoia, mood swings and changes in behaviour until his OASys review in July 2007 which stated that he no longer had issues with paranoia and depression due to giving up taking drugs for a year. It went on to state "since abstaining from taking drugs, Mr Sonnex's behaviour has greatly improved. He is much better behaved and is not a control problem". This change noted in DS's behaviour was supported by the fact that most of his adjudications took place between 2002 and 2004, and that 10 of these had been for Mandatory Drugs Test (MDT) failures during custody. His final three MDT's were all negative.
26. The record suggests that a combination of DS giving up substance abuse and being transferred to HMP Elmley, an adult establishment, resulted in generally improved behaviour and attitude although he continued to display short bursts of negative behaviour. Despite this improvement, neither of his parole applications was supported by his Offender Manager and he was released on his Non-Parole Date, the latest date he could be released from custody.

Recommendation 1:

HMPS should take steps to ensure that information relevant to the risk posed by a prisoner on release, no matter where such information originates from, should be shared with and used by staff responsible for the management of that offender throughout the course of his or her sentence.

OASys and Risk Assessments

27. DS had his first Start Custody OASys report completed in August 2006 in HMYOI Aylesbury. This assessment identified that DS had some risk of imprisonment for a violent offence within 2 years, but low risk of imprisonment for other offences. It also described him as presenting a high risk to the public in the community. It identified the issues that he had with alcohol and crack cocaine and the fact that he had learning difficulties, having been excluded from school in year 8 for disruptive behaviour and loss of temper. There is also information that DS witnessed domestic violence and had childhood behavioural problems. DS had, by the time of the report, also failed a mandatory drugs test for cannabis use in custody.
28. Although risk of harm to others was identified as being an issue, it would appear that by the time of this assessment (August 2006) DS had started to make efforts to change his behaviour and he was then employed as a wing cleaner, a job given to trusted prisoners.
29. His risk of reoffending was still noted as very high and his OASys score was 111 out of 168 as a result. A referral to MAPPA at level 3 was suggested prior to release.
30. DS's first Parole application was not supported and parole was refused.
31. A separate assessment took place in July 2006 by a PO in the Lewisham OM Unit, which stated that there were no physical or mental health conditions identified. While the Medical Officer at HMYOI Portland's note did not identify a specific mental health condition, it is hard to believe such a statement would have been made had the judgements it contained been available to the PO.
32. DS was transferred to HMP Elmley in December 2006 and he completed an Enhanced Thinking Skills (ETS) course there in June 2007. A second parole assessment was completed in June 2007 by a seconded Probation Officer at HMP Elmley. This report stated that DS had applied to do the Prisons-Addressing Substance Related Offending (PASRO) course which was due to start in August 2007. There was also a reference to the risk that DS may be prepared to resort to violence using a weapon, and that this was still a risk. It was noted that whilst at HMYOI Feltham DS did undergo some sessions with a member of staff in dealing with anger issues, but had not completed an Anger Management Course.

33. The parole assessment also noted that DS had stated that he no longer used drugs and avoided being in the company of those who used drugs. There was a mention of DS being referred again to In-Reach, Community Mental Health Team (CMHT); however there was no evidence of a referral at that stage or a report to show what work was done with him.
34. With regard to risk, the report stated that DS was considered to be high risk for reconviction for any offence within two years, a high risk of harm to the public and the risk of harm was likely to increase if he returned to drugs. The report did not recommend his early release on parole.
35. A further OASys assessment was completed in July 2007 which indicated that when he was transferred to HMP Elmley and completed the ETS course, his behaviour changed, and his previous poor behaviour stopped reasonably suddenly. The report from the ETS tutors at the end of the course stated that DS had fully engaged in the process and had taken on board his need to change his behaviour.
36. The OASys assessment stated that DS no longer had any psychological or psychiatric issues since giving up drugs and completing the ETS course. His interpersonal skills were reported as good and he was no longer considered to be a control problem. This was supported by the fact that he had no further adjudications from December 2006 and on his self assessment form he noted that he had learned his lesson and wanted to lead a 'normal' life.
37. While this sudden change in behaviour may have been reasonable to accept in a young man apparently being assisted to grow up through attendance at programmes designed to achieve that effect, had the assessment made by the Medical Officer at HMYOI Portland been available or considered the change may not have been so readily taken at face value. This change in behaviour seems to have had a significant influence on later risk assessments.
38. DS completed his PASRO course in December 07 and his tutor report stated that he was polite, respectful and punctual throughout the course. Although a MAPPa referral was made on 26 September 2007, which was due to be discussed at the October 2007 meeting, the record shows that there was a computer or printer error which resulted in the offence details not being shown on the printed form and therefore the referral was not considered. This printer error was recorded by the Offender Manager in the OASys file, which had a note that a hard copy was available.
39. This first referral was discussed at the pre-MAPPa meeting in October and the MAPPa SPO requested a re-referral to include the missing information. A second referral to MAPPa in January 2008 was prepared by the OM but not sent. The record shows a discrepancy at that point between the OASys assessment (High risk) and the assessment on the LPA IT system, Delius, (medium risk). In addition the OM was unable to gain control at that stage of the OASys assessment which was held in the prison during the custodial part of DS's sentence. This is a known issue both with Offender Managers in the Probation Service and Offender Supervisors in custody who have difficulty transferring assessments which they

share because historically the system was built on two different IT platforms. Information from the Offender Assessment and Management Group suggests that there are ways to address this problem.

Recommendation 2:

NOMS should issue instructions to HMPS and Probation staff to ensure that those who are responsible for managing offenders who may present a risk of harm are familiar with processes which enable timely transfer of ownership of OASys assessments from custody to the community and vice versa.

40. DS was released from custody on Discretionary Conditional Release (Non Parole Date) on 8 February 2008 and his risk of causing harm at that time was assessed as medium risk of harm. Supervision was to be from 8 February 2008 to 11 October 2008.

41. Issues emerging from the custodial period include:

- Failed transfer of information from the medical file to the general prison file to assist management of DS;
- Fluctuating risk assessments ranging from high to medium;
- Too little input by the Offender Manager prior to release;
- Technical problems with transfer of the OASys assessment;
- Ready acceptance of DS's apparent behaviour changes.

The community period

42. At the point of release DS was assessed as presenting a medium risk on Delius, LPA's IT system. The OM based this assessment on information from the prison that DS was one of their most improved prisoners, having become drug free and settled down during his sentence. The judgement was confirmed for her by his polite compliant behaviour on release and the fact that he reported regularly, frequently turning up for appointments early.

43. The judgment that DS presented a medium risk meant that a referral to an Approved Premise was not feasible. No referral appears in the record but the OM indicated that a conversation with the SPO at the local hostel confirmed that a referral would not be successful, as there were already insufficient places for those considered high risk. The protective opportunities of accommodation in an Approved Premise which would include among other things oversight and drug testing were therefore not available and DS remained in family accommodation which was considered unsuitable.

44. The OASys assessment which had proved difficult to transfer from custody to the OM was then not updated following DS's release. The Start Licence OASys was not prepared until 25 May 2008 and no sentence plan for the period of post release supervision was prepared.

45. Within days of release, DS was involved in an alleged offence of kidnap of a pregnant cousin and her partner. While prosecution of the case did not proceed, as the allegations were withdrawn, sufficient information existed from social services, the police and from DS himself to require, at a minimum, a revised risk assessment. The OM took advice from her SPO whose judgment was that a warning would be sufficient but that was delivered inappropriately by the OM rather than the ACO. A recall on the basis of this information may have been challenged by DS but would have provided an appropriate opportunity to re-assess the level of risk he presented.
46. The requirement in DS's licence to attend further interventions and testing for his drug use, subject to the discretion of the OM, was not implemented as the OM did not consider it necessary. He was also not referred by the OM to attend the Cognitive Skills Booster programme as required in his licence. The OM focused instead on pressing accommodation and employment issues.
47. The MAPPA referral which had failed in October 2007 and been revised but not sent in January 2008 should have been re-activated, particularly in light of the alleged kidnap attempt.
48. On 24 April 2008 DS was remanded in custody for an offence of handling stolen goods. The OM was made aware of this on 30 April and initiated recall appropriately as a result but the recall was not progressed. DS was then released on bail on 16 May despite a conversation which the OM reported having on that day with the legal advisor at the court to clarify that the recall had not yet been implemented. The LCJB report suggests that the decision to release was understood by the court to be a 'technical' release, as they may have understood DS to be a serving prisoner.
49. Recall was initiated by the OM on 3 May 2008 although information from the court concerning the detail of the charge was limited. The SPO's judgment that there was not enough at that stage to justify recall meant that she did not forward the papers to the ACO until 11 June 2008 when she felt they contained sufficient information about the offence. On 12 June 2008 papers were sent to the Release and Recall Section of the Ministry of Justice who notified the Metropolitan Police on 13 June 2008.
50. It is clear that the OM tried to track what was happening, and the SFO Review highlights both the capacity and experience weaknesses in this operational cluster, which compounded and probably contributed to DS's supervision weaknesses and poor judgements, especially by the manager.
51. In particular, the OM had been qualified for 9 months at the time of the SFO; on appointment to Lewisham she took on a full caseload from an officer on sick leave and a full resettlement caseload; she described feeling overwhelmed, with little prospect of relief; supervision became less regular than the initial monthly meetings; the SPO was acting temporarily in the role, and also described feeling overwhelmed; the ACO confirmed this, and also felt stretched in dealing with workload and staffing pressures.

52. Also, up to the point of arrest for the offences of handling stolen goods, DS had complied with the reporting requirements of his supervision, and thereby reduced any concerns.

Organisational changes

53. During 2007 LPA undertook substantial organisational changes which resulted in four quadrants being re-aligned into two operational divisions under the management of the Chief Operating Officer. She is responsible directly to the Chief Officer. At senior management level this led to a significant reduction in the number of ACOs managing operational staff in the boroughs which were clustered together, generally with two or three boroughs in a cluster, although there are some with more. In practice, this rationalised an inherited structure and since all ACOs underwent a re-appointment process, was designed to ensure that the right skills and experience were held by ACOs in these posts.

54. The Lewisham staff are clustered with staff in Greenwich and the new ACO came into post in September 2007. A core model exists for each cluster which includes case administrators and a business support unit. This model was in the process of implementation in Lewisham during the period following September 2007 and is now fully functional. In addition, vacancy and sickness levels have been reduced in that cluster.

55. Part of the rationale for the organisational changes was to ensure that staff were operating consistently across the area with proper levels of skill and judgement. In Lewisham, the ACO described inheriting a borough where bad behaviour was rife and many areas of practice were in need of repair. He was concerned to improve a range of practice and management issues; relevant to this case was the need which he had identified to improve recall activity, in particular to secure an appropriate level of detail in recall papers on first submission.

56. Inadequate staffing levels were a key feature of this case, including at SPO level. LPA have since introduced a rolling programme of recruitment for SPOs who are required to pass an assessment to demonstrate that they have sufficient levels of skill and judgement to operate in the role. In addition, a Capacity Model was to be implemented in January 2009, which tracks staffing levels across the area on a system which is accessible to the Chief Operating Officer at her desk.

The Serious Further Offence Review.

57. LPA conducted the required Serious Further Offence Review within the standard timescales. The initial review stages 1 and 2 were completed by 18 July 2008, stage 3 by 30 July 2008 and stages 4 and 5 by 8 October 2008. The learning points from that review were identified, with needs to improve:

- Timely completion of OASys, quality of Risk Management Plans;

- Early planning for prisoners' release from prison, timeliness of recall in high risk cases;
- The attention given to static factors (e.g. previous violence) in risk assessment;
- Implementation of all licence requirements;
- Communication from Court Teams;
- Staffing levels in the borough.

58. The SFO Review also identified the need to improve the tiering of cases (the tiering includes as a significant factor the level of risk of harm an offender presents) and to review which Tier 4 (highest risk and needs) cases are held outside Public Protection Units. New tiering guidance for LPA was issued in June 2008. A key improvement from previous guidance is that this requires reconciliation of tiering between Delius and OASys, and identifies SPOs as being responsible for tiering decisions.

59. The SFO Review process is designed to review probation practice and ensure learning in cases where an offender under supervision commits a serious offence. Evidence from the LPA case file, the prison case file and the LCJB report from the MAPPA Signatories Group suggests that the SFO Review in the case of DS did cover all the failings in the probation management of this case. Action plans from the stage 3 initial review and the stage 5 follow up are comprehensive. It is clear that the shortcomings of practice in the assessment and management of risk which led to DS being tiered at level 3 and allocated to an Offender Management Unit rather than a Public Protection Unit have been identified and addressed within the cluster.

60. Remedial action was identified at stage 3 with the OM and the SPO identified in the case, together with procedural improvements and wider learning for staff in the cluster to be applied by the ACO. Further improvements aimed more widely in the cluster were identified at stage 5. These have all been delivered to the time set and further improvements to practice are continuing.

61. The SPO who was on temporary promotion to the role at the time of these events did not pass the assessment for permanent promotion and has been returned to the grade of PO.

62. One issue which emerged from the case during this investigation was the extent to which DS may or may not have a mental health diagnosis. Despite the analysis of the Medical Officer at HMYOI Portland the potential mental health aspects of this case were not prioritised by either HMPS or probation during their engagement with DS. The Medical Officer's analysis appears not to have been available to prison staff during the custodial period and was therefore not shared with LPA but there were features of DS's behaviour which could have provoked staff in the prisons or the OM to have raised questions about his mental health.

Recommendation 3:

Those responsible for new training arrangements for practitioners in NOMS should ensure that those who qualify are able to demonstrate appropriate awareness of relevant mental health issues, so that where necessary referrals are made to mental health specialists and then followed up to assist in the assessment and management of cases with the potential for causing serious harm.

63. Overall, the SFO Review was a thorough examination of DS's supervision in the community, and it established appropriate learning points, both systemic and individually focused for the locality. However, the learning points are directed at the locality ACO and cluster staff. In the light of previous examinations of LPA's management of higher risk offenders, and the HMI Probation Risk of Harm Inquiry Report 'On the right road' published in July 2008, it is important that the learning points of this review are checked and implemented as required across the LPA.

[B] Investigate the systems operated by London Probation Area to identify and allocate cases which need to be managed by experienced probation officers, including those cases that need to be managed through the Multi-Agency Public Protection Arrangements.

64. Allocation of cases in LPA is governed by a number of guidance tools. These include a position statement relating to whether cases should be supervised by POs or PSOs dated April 2007, guidance for SPOs relating to prioritising Offender Manager workloads dated September 2007 and Tiering Guidance dated June 2008. The latter replaced previous guidance following publication of nationally revised guidance in PC08/2008.

65. DS was wrongly assessed as Tier 3 and managed in a caseload where he was less likely to receive an appropriate level of attention. It is clear from the Tiering Guidance published in June 2008 that it is the responsibility of the SPO from that date to make decisions about the tiering of all orders and custody cases. LPA has also taken steps to ensure that SPOs making those decisions have the required level of competence to make them accurately.

66. DS should have been referred to a MAPPA panel and there is evidence that the OM recognised the need to do so. The initial referral could have generated a multi-agency response prior to DS being released but through a technical fault was insufficiently detailed. The second referral, of which there is evidence, was not sent, an apparent administrative casualty of the overwork experienced by an inexperienced OM. Administrative systems which have been introduced as part of LPA's restructuring are now robust enough to make it unlikely such a combination of failures would occur again.

67. Evidence suggests that the systems which are in place for offenders subject to MAPPA operate appropriately once referrals have been made.

68. One key weakness was the limited knowledge senior managers appeared to have of locality capacity and competence factors. The LPA capacity model, to be implemented from January 2009, will give senior managers a better overview of this organisational issue, supported by improved attention to SPO competence.

[C] Investigate the arrangements by which senior managers assure themselves that cases have been appropriately assessed, allocated and are being supervised to the right standard, in the light of information which is and ought to be held on offenders.

69. The key issue here is the revised responsibility for SPOs to undertake offender tiering, and this has been addressed. This is supported by changes to SPO recruitment, as set out above, designed to ensure proper levels of competence. Routine monitoring of performance is then the route to provide information to senior managers concerning standards of supervision, and the structural changes which brought about the cluster arrangements offer a better capacity for focus on performance.

70. The major re-structure programme undertaken by LPA during 2007 was prompted not just by overriding financial pressures but also by a recognition that a number of inherited senior and middle managers required training to raise their abilities both to support staff and hold them to account more effectively.

[D] Consider the issues concerning Mr Sonnex in light of the recommendations arising out of the Hanson and White and Chester Nash cases and to make recommendations.

71. In the HM Inspectorate of Probation report which followed the Chester Nash SFO, the Chief Inspector said in his foreword:

“We have discovered a mixed picture. Whilst there were encouraging signs of better practice with the highest Risk of Harm offenders, we were concerned that the base-line level of risk of harm practice across the caseload was not of sufficient quality.”

And one of the conclusions in the detail of the report said:

“There was a clear difference in the ability and knowledge of the specialist PPU staff in terms of dealing with assessment and sentence planning compared to those in OMUs. The performance for RoH assessment and planning in OMUs needed considerable improvement.”

72. This conclusion from the HM Inspectorate of Probation report highlighted the greatest weaknesses in the more general Offender Management Units, rather

than the more specialised PPU teams. It was an Offender Management Unit that carried responsibility for DS.

73. Risk of Harm training has been undertaken across LPA and structures have been improved to minimise the possibility of the procedural breakdowns which were apparent in this case. It remains a question whether Risk of Harm assessment and planning improvements have been embedded in OMUs across the area and to test that I would make the following recommendation:

Recommendation 4:

To ensure that improvements in the supervision of higher risk offenders are being both generalised and embedded, in the light of the learning points from the DS case, the Director of Offender Management for London should commission an independently validated examination of a random sample of tier three cases across 25% of LPA's boroughs, as chosen by the DOM.

This work should be completed before DS appears for his trial.

74. With regard to the Hanson and White case there are both striking similarities between the offenders (long custodial sentence at 17, instrumental violence, age at release) and in terms of a number of the weaknesses and failures identified. Many of the practice recommendations in the HMI Probation report of February 2006 remain relevant in this case. LPA has taken a number of steps which are likely to have addressed these concerns in the intervening period and the recommendation above is designed to test whether those actions have been effective across the organisation.

75. Set out below is a summary of issues that remain relevant from the Hanson and White inquiry, with a predominant focus on Damien Hanson (released on parole to LPA), and with links to the HMI Probation report (paragraph numbers):

- Hanson was convicted of robbery at the age of 17 and sentenced to 12 years imprisonment, (9.1.1)
- He was subject to a number of adjudications including for assault (9.1.6)
- He was moved between establishments and became compliant later in his sentence (9.1.6)

There was:

- Over reliance on dynamic risk factors to the detriment of static factors, coupled with an over-estimation of progress in custody (9.1.28)
- Lack of attention to instrumental violence (9.1.29)
- Failure to set out an adequate release plan (9.1.33)
- Discontinuity of offender management (9.2.1)
- Sporadic contact with Hanson by the LPA during his sentence (11.4.3)
- Incorrect risk assessment and subsequent allocation (9.2.7)
- No referral to MAPPA (9.2.9)
- Staff shortage linked to weaknesses (9.2.10)

- Unsatisfactory risk of harm assessment and management (11.5.1)
- Poor liaison between offender managers and administrators (11.6.1)

76. The failures in the Hanson case led HMI Probation to conclude that “there was an overall collective failure within LPA both to identify the nature of risk to others and to act to keep his (Hanson’s) risk of harm to a minimum”. (9.2.21)

77. Steps taken by LPA between 2006 and July 2008 included significant improvement of performance in Public Protection Teams as identified in the Chester Nash Report. That DS was supervised in a standard Offender Management Unit was a consequence of an error in tiering and a failure to refer him to the right level of MAPPA management. However, all SPOs supervising practitioners should have sufficient competence to give correct advice about issues such as those presented by DS. The assessment process now in place for applicants to the SPO grade in LPA is designed to address this.

78. Many of the HMI Probation recommendations in relation to Hanson remained pertinent in the light of this case, namely (in short);

- Continuity of offender management (10.1)
- Quality of OASys and risk assessments to be a management priority (10.18)
- Improved use of OASys (12.2)
- Improved supervision of staff (12.5)
- Improved administrative arrangements (12.7)

79. Paragraph 11.2.2 refers to levels of experience of the middle manager and the breadth of their work, coupled with a “dysfunctional management group in the borough together with high sickness rates.” The ACO’s description of the borough he took over when he moved to Lewisham in September 2007 matched this description.

80. It is clear that LPA has taken steps to re-structure the organisation to make it more robust and to improve levels of competence, at the SPO grade in particular. However, it is important to establish that the learning has been embedded across the organisation.

Wider issues

81. In the light of this case and that of other cases being addressed by Local Authority departments for services to children, this investigation raises some wider issues, not least as probation areas move from board to trust status, with the freedoms to be associated with such a transformation. In addition, the reporting structures of Chief Officers will change, from direct accountability via the DOM to the centre to being accountable to their Trust Boards as Chief Executives.

82. These are transition issues which may be resolved through the Board to Trust Programme, but as a basic requirement DOMs must be satisfied that the probation trusts with which they contract are ‘safe’. While there are currently a

number of processes designed to assure managers of the operating safety of prison establishments (e.g. Operating Capacity, minimum staffing levels, stability certification) no similar processes exist for probation areas. It may be difficult to achieve a direct equivalent in a community setting, but such an assurance process needs to be developed. Its focus would be to establish a range of measures (e.g. staffing levels, sickness levels, caseloads with tiering levels) which, taken together with the judgement of the Chief Officer, would ensure that the organisation is operating appropriately to ensure risk assessment and risk management are properly prioritised to reflect the priority of safety and public protection.

Recommendation 5:

NOMS should design a mechanism by which the Chief Officer and the Board can assure the DOM that risks presented by higher risk offenders under supervision are being properly prioritised and managed to deliver as safe a level of public protection as is feasible. This measure should be based on numerical factors such as caseloads, staffing levels, etc. and the judgement of the Chief Officer. Accountability for delivering against this measure should be through the Board/Trust to the Director of Offender Management on a quarterly basis.

The work to design this mechanism should be completed before 30 June 2009 to be implemented from Q2 2009.

Conclusion

83. While there are similarities between this case and the Hanson and White case, there are some differences, and a number of steps have been taken which are designed and likely to improve performance.
84. DS did undertake programmes designed to address his offending behaviour while in custody and on the two occasions when he applied for parole his applications were not supported. DS was not released from prison until the latest date possible when it would have been illegal to hold him for longer.
85. The Offender Manager, though inexperienced and under substantial pressure, sought advice appropriately at key points in the supervision of DS on licence. She took steps to refer him to MAPPA and to recall him when he was charged with a further offence.
86. However, there were several significant points in the management of this case when practice should have been better.
- The mental health assessment made in 2004 should have been made available to/made use of by staff responsible for managing the case
 - DS should have been more accurately and consistently assessed and managed as a high risk offender
 - The referral to MAPPA should have been progressed so that multi agency attention would have been paid to the case

- At the point of the alleged kidnap the judgement that DS should not be returned to prison was wrong
- Communication between the OM and staff at the court should have been better, so that having been arrested in April, he would have been kept in custody when he appeared at court in May
- Once the recall had been initiated by the OM, the delay in progressing it suggests the SPO was more concerned with process at the expense of a judgement that speed was required, not least as required by standards
- It is not clear why there was a delay in arresting DS once the recall had been implemented.

GLOSSARY

ACO	Assistant Chief Officer
HMIP	Her Majesty's Inspectorate of Probation
HMP	Her Majesty's Prison
HMPS	Her Majesty's Prison Service
HMYOI	Her Majesty's Young Offender Institution
LCJB	Local Criminal Justice Board
LPA	London Probation Area
MAPPA	Multi Agency Public Protection Arrangements
OS	Offender Supervisor
OM	Offender Manager
OMU	Offender Management Unit
PO	Probation Officer
PSO	Probation Service Officer
PPU	Public Protection Unit
RoH	Risk of Harm
SPO	Senior Probation Officer

THE SUPERVISION OF DS			
<i>The pre-release / custodial period</i>			
Issue	Systemic or individual failings	Solution	Responsibility
Failed transfer of information as DS moved between institutions, and weaknesses with transfer and use of information from health professionals	Probably systemic	Better implementation of the OM model; better liaison with and between offender supervisors; improved clarity concerning the integration of health information with other HMPS documentation	NOMS / HMPS
Too little input by the Offender Manager, who took over the case in July 2007, leading to loss of continuity of supervision	Systemic (OM over-loaded) and individual	Better implementation of the OM model; improved LPA guidance to staff (done)	LPA
Transfer of information from custodial settings to the OM	Systemic, compounded by problems with transfer of OASys	Better implementation of OM model; improved understanding of systems for transfer of OASys between custody and community	NOMS
Ready acceptance of DS's apparent behaviour changes in custody, which influenced subsequent judgements	Systemic and individual	Better understanding of importance of static risk factors in HMPS and probation staff; recognition that a good/compliant prisoner may behave differently in the community	NOMS
<i>Assessments - OASys and risk assessments</i>			
Loss of, or non-action with regard to, crucial risk information following a mental health assessment in 2004 (custodial)	Systemic and individual	Clarification of importance of including medical assessments in the management of offenders; implementation of the OM model; better awareness of mental health indicators among HMPS and probation staff	NOMS / HMPS
Fluctuating risk assessments ranging from high to medium, with questionable justifications, especially in the light of the two refusals for parole (custodial)	Systemic and individual	Employers of OM staff must ensure they are sufficiently skilled to do high quality risk assessment which needs to be challenging, and retain a predominant focus on the post release period	LPA / NOMS / HMPS
Failed MAPPA referrals	Systemic and individual	Address discrepancies between OASys and Delius risk ratings; improve middle manager role; address capacity and competence issues	LPA

No sentence plan at point of release, nor new OASys assessment	Systemic and Individual	Systemic, in so far as OM had too large a workload, was inexperienced, and had limited supervision	LPA
Incorrect tiering – this failure was absolutely critical to the allocation of the case – DS tiered as ‘3’, should have been ‘4’	Systemic and Individual	Systemic, in so far as OASys and Delius included different risk ratings. New tiering guidance issued - SPO role in tiering decisions revised	LPA
<i>Post-release period</i>			
The requirement in DS’s licence to attend further interventions and testing for his drug use, subject to the discretion of the OM, was not implemented as the OM did not consider it necessary. He was also not referred by the OM to attend the Cognitive Skills Booster programme as required in his licence, the OM focusing on accommodation and employment issues. DS was released to his family’s accommodation that had been deemed unsuitable at the second parole application	Individual	In higher risk cases OMs must be alert to the static risk factors, i.e. the original offences	LPA
Failure to react effectively to information from the social services and self reported by DS about an alleged offence of attempt by DS to kidnap his cousin. This alleged offence took place 2 days after his release.	Systemic and individual	All SPOs supervising practitioners should have sufficient understanding of risk and public protection to give better advice	LPA
No re-activation of the MAPPAs referral	Systemic and individual	Better co-working between OMs and case administrators, to support OMs with process follow up; OMs to guard against false security of compliance with reporting requirements	LPA
Communication confusions between the field and court teams when DS was first remanded in custody (24 April) for an offence of handling stolen goods and then released on bail (on 16 May, probably technical	Systemic and individual	Improve communication and co-working between OMs and case administrators, between OMUs and court staff – the OM did try to advise the court staff to remand DS in custody, and that a recall was pending	LPA

bail as the court may have believed, incorrectly, that DS was a serving prisoner)			
Appropriate recall initiated by the OM, but the paperwork was seriously delayed by the acting SPO, from 5 May to 11 June – this was a crucial failure	Systemic and individual	Systemic in that the SPO was more concerned about getting the paperwork right for the ACO who had complained to middle managers about poor quality information for recall decisions, individual in that the middle manager should not have been diverted from proper judgement by process concerns	LPA
Failed communication within the supervising team. No further appointments were made after DS's release on bail on 16 th May. The OM believed recall had been actioned	Systemic and individual	Strengthen role of case administrators	LPA
Delayed activation of the warrant for DS's arrest by the police.	IPCC investigating	Subject to IPCC recommendations	Police
<i>LPA Allocation and Senior Manager Roles / Staff Supervision</i>			
Lack of role clarity for SPOs in determining offender tiering	Systemic	Role clarification completed by LPA + competence requirements for SPOs set	LPA
Insufficient senior management awareness of locality capacity and competence factors	Systemic	Capacity model, to be implemented from January 2009; improved attention to SPO competence	LPA
<i>Issues related to Hanson / White and Chester Nash</i>			
Capability of the general offender management units to supervise higher risk cases	Systemic and individual	For DOM to check generalisation of learning points from SFO; fourth recommendation	DOM / LPA
There remains significant read-across to the failures as set out in the HMI Probation review of the Hanson and White SFO, published by HMI Probation in February 2006. A number of the failings identified then are	Systemic and individual	See above. Although HMI Probation reported improvements in LPA management of risk (Risk of Harm Inquiry Report – On the Right Road, July 2008) it also indicated that much remained to be done. This underpins the recommendation that the DOM	DOM / LPA

<p>echoed in this investigation</p>		<p>commissions a further 'inspection' of tier 3 work across LPA, to ascertain the degree to which lessons learned have generalised across the organisation.</p>	
<p><i>Wider Issues</i></p>			
<p>Clarification of roles and responsibilities of the Board and the DOM as probation areas move to trust status, and to ensure that the DOM is able to 'certify' any trust as 'safe', based on clear criteria, as applied by the provider</p>	<p>Systemic</p>	<p>Recommendation 5</p>	<p>NOMS</p>

**Investigation into the issues arising from the Serious Further
Offence Review:**

Dano Sonnex [DS] (d.o.b. 07.07.85, age 23)

Addendum covering

- A)** The circumstances of Mr Sonnex's release from custody on 8 February 2008, in particular when the Police were informed of this release.

- B)** The circumstances regarding Mr Sonnex's release on unconditional bail on 16 May 2008, in particular whether the court understood that he would not be immediately taken into custody.

***Liz Hill
Regional Offender Manager, South West
07 April 2009***

Background.

1. This addendum was requested by Nick Pascoe, Director of Offender Management, London, following receipt on 22 January 2009 of my investigation into the issues arising from the Serious Further Offence Review case of Dano Sonnex.

Findings.

A) The circumstances of Mr Sonnex's release from custody on 8 February 2008, in particular when the Police were informed of this release.

2. At the pre-MAPPA meeting in October 2007 at Catford Police Station, the police were informed that Dano Sonnex was going to be released on his non parole date.

3. Dano Sonnex's nominal non parole date for release was Sunday 10 February 2008. As the Prison Service does not release on a Saturday or Sunday, his actual release date was Friday 8 February 2008. This is normal Prison Service practice, of which both the Offender Manager and the Police should have been aware.

4. Dano Sonnex reported on release to London Probation on 8 February as required. Confirmation that Dano Sonnex had been released was sent to the police Borough Intelligence Unit by the Offender Manager on 11 February 2008. This was the first working day after Dano Sonnex was released.

5. The Joint National Protocol policy requirement is for a copy of the licence to be supplied to the police on the day of release, and the confirmation on 11 February therefore constituted a delay. However, it seems unlikely that this delay had any material impact on the management of the case.

6. Following up information received from Social Services on 4 March 2008 and on 7 March 2008 about the alleged incident on the Sunday following Dano Sonnex's release (10 February 2008), the Offender Manager tried to contact the Detective

Constable in the police Child Protection Unit who had been identified by the Social Services staff in relation to the alleged kidnap, without response. On 7 March 2008 she then spoke to the borough Jigsaw team in the police, who had no information about the allegation.

B) The circumstances regarding Mr Sonnex's release on unconditional bail on 16 May 2008, in particular whether the court understood that he would not be immediately taken into custody.

7. On 24 April 2008, Dano Sonnex appeared at Greenwich Magistrates' Court charged with handling stolen goods and was remanded into custody until 1 May 2008.

8. On 1 May 2008, a second hearing at Greenwich Magistrates' Court resulted in a trial being fixed for 16 May 2008. Dano Sonnex was again remanded into custody.

9. On 16 May 2008, the CPS requested that the trial be adjourned. The court granted the adjournment and then, upon application by the defence, found that there had been a change in circumstances which allowed them to hear a bail application. Dano Sonnex was subsequently granted bail and a new trial date was fixed for 7 August 2008.

10. It is not unusual for the defence to argue that the question of bail should be reopened if the prosecution is not ready to proceed with the trial on the date fixed and it is often the case that a court will agree to hear a further bail application in such circumstances.

11. Clearly the decision as to whether or not to grant bail was one for the court. There is however some uncertainty regarding the information available to the court in making this decision.

12. According to her file note, the HMCS legal adviser in court on 16 May called the Offender Manager to discuss Dano Sonnex's recall status. The Offender Manager confirmed Dano Sonnex's compliance with reporting requirements prior to being remanded in custody, and also clarified that Dano Sonnex had received a verbal warning in relation to allegations of kidnapping soon after his release. The Offender Manager stated that due to the handling stolen goods charge Dano Sonnex would definitely be recalled to custody, that a recall was in progress and that it was being done that day.

13. The Offender Manager's case notes confirm that she received a call from the legal adviser, who asked whether Dano Sonnex was being recalled. The Offender Manager replied that she was in the process of recalling Dano Sonnex and was doing a risk management plan, but did not state when the recall would be completed.

14. It was therefore clear to both parties that Dano Sonnex was being recalled, but the legal adviser understood that the recall process would be completed that day, while the Offender Manager did not record any indications regarding timings. This suggests that a misunderstanding over the timing of the recall arose during the conversation.

15. The legal adviser then informed the bench that the defendant was subject to a licence and was going to be recalled. It therefore appears that the bench, when granting bail, were under the impression that Dano Sonnex was likely to be rearrested and taken back into custody for breach of licence immediately or almost immediately.