Edinburgh Offender Management Committee Response to Kevin Rooney Significant Case Review

1 Introduction

1.1 In response to the circumstances surrounding the death of Mrs Rosina Sutherland on 30 October 2011 and the complexities in the management of Kevin Rooney, the Edinburgh Offender Management Committee requested an initial case review into the multi-agency public protection arrangements (MAPPA) for Kevin Rooney's case. On receipt of the initial report, the Committee commissioned a significant case review in December 2012, on behalf of the Edinburgh Chief Officers' Group – Public Protection and the Edinburgh, Lothian and Borders Executive Group (now the Edinburgh, Lothian and Borders Strategic Oversight Group).

1.2 Local partner agencies are committed to learning from analysis of this review and to implement its recommendations to ensure best practice is promoted in the future. The Committee recognises the importance of this review to the responsible authorities, and in particular to Mrs Sutherland's family.

1.3 The two year interval between the commissioning of the review and receipt of the final report has seen changes and improvements implemented by the responsible authorities, based on the Committee's own analysis of the circumstances of the case.

1.4 Some of the recommendations in the report relate to the Scottish Government, and these have been passed on.

1.5 A first draft of the significant case review report was presented to the Offender Management Committee in October 2013. The Committee is appreciative of the time, effort and commitment of the review team in producing the final report, which was received on 6 March 2014. The report includes important learning points, and in so far as these apply to the responsible authorities, all were identified by the Committee's member agencies and acted upon prior to the conclusion of the review.

1.6 Section 2 below sets out the partner agencies' response to each of the recommendations in the report.

1.7 It is critical that the details of the report are accurate, and that the analysis of the circumstances is based on fact and evidence, to ensure maximum learning opportunities and relevant improvement action. Several concerns relating to factual inaccuracy and the need to reflect the agreed terms of reference for the review were highlighted to the authors of the report by the Committee. Section 3 below sets out the Committee's perspective on these issues.

2 Recommendations

2.1 Despite the Committee's concerns regarding some of the analysis and language of the report, most of the recommendations, in so far as they apply to the responsible authorities, are accepted in full. The exception is Recommendation 13. Following careful consideration, Police Scotland, whilst accepting the principle

of this recommendation, believes that the intended outcome can be achieved by different means.

2.2 Because of the delay between the commissioning of the review and the receipt of the final report, improvement action has been underway for some time, and in some areas, is complete. This will now be considered again in the light of the report, to ensure no required action has been overlooked.

Recommendation 1

"City of Edinburgh Council to consider introducing a procedure to provide dedicated support, such as the Neighbourhood Support Service, to support homeless sex offenders managed under MAPPA, prior to their release from prison, to ensure that suitable accommodation and appropriate support is in place at an early stage to provide stability as part of the risk management plan."

This recommendation is accepted and is being implemented.

A new through care service for prisoners (the Offender Recovery Service) will begin on 1 April 2014. It will engage prisoners in effective planning in advance of their release, including the identification of accommodation needs. Council housing officers will work closely with this service. Any person assessed as homeless will be offered a housing support assessment.

Recommendation 2

"The City of Edinburgh Council to consider updating its Housing Information System with a mandatory notification tab that requires to be completed with details of the name and time that an agency representative is informed before the booking-in process can be finalised."

This recommendation is accepted and is being implemented.

Work to scope and develop the system requirements is underway. When the new mandatory tab is ready, guidance will be produced and briefing sessions delivered to all relevant housing staff.

Recommendation 3

"The Scottish Prison Service should ensure that all key events relating to a sex offender under MAPPA while in custody are fully recorded on ViSOR."

This recommendation is accepted.

The Scottish Prison Service (SPS) already has procedures in place to ensure that key events during a registered sex offender's time in custody are recorded on ViSOR, but recognises that there is a gap in relation to episodes of suicidal ideation, particularly where the offender is on remand. SPS is in the process of recruiting an additional ViSOR operator and scoping additional methods of interrogating the prisoner records database to capture such episodes and record them on ViSOR.

Recommendation 4

"The Scottish Government to consider issuing guidance within the MAPPA National Guidance document that risk management levels should only be reduced following discussion at appropriate MAPPA Level 2 or 3 meetings (i.e. the management level of MAPPA 2 and 3 cases should only be reduced following review at Level 2 and 3 meetings respectively)."

Although this recommendation is for the Scottish Government, the principle is accepted by the Offender Management Committee and the recommendation will be implemented in Edinburgh, pending a decision from the Scottish Government.

Edinburgh partners will ensure that no Level 2 or 3 cases will be reduced in level without a formal review. Policies and practice to support this are under review, and a staff training and awareness programme is being put in place. This action will be monitored by the Offender Management Committee via the performance management report, which is considered on a monthly basis.

Recommendation 5

"The Scottish Government to consider issuing clearer guidance to Responsible Authorities within the MAPPA National Guidance document on the screening of referrals to ensure that the process withstands scrutiny and decisions are defensible."

This recommendation is for consideration by the Scottish Government.

Recommendation 6

"The Scottish Government to consider amending national MAPPA Guidance to include examples of characteristics of Level 2 and 3 MAPPA cases to assist practitioners when deciding on risk management levels."

This recommendation is for consideration by the Scottish Government.

Recommendation 7

"Police Scotland, in conjunction with Social Work partners, to consider developing a national MAPPA Level 1 Risk Management Review process that will withstand scrutiny and provide consistency of approach across all Police Divisions and Local Authority areas."

This recommendation is accepted and is being implemented.

The work will include all relevant local authority services, health and other involved parties, and will not be limited to social work partners, as suggested in the recommendation.

The Council has undertaken a comprehensive audit of all active Level 1 MAPPA cases, where criminal justice social work is recorded as the responsible authority (a total of 83 cases at the time of the audit). 14 trained case file readers undertook the audit over a period of one week. It was completed using an amended version

of the Social Work Inspection Agency (now the Care Inspectorate) High Risk Offenders case file audit tool. All findings were recorded using Survey Monkey software.

In addition to responding to the specific questions in the template, the auditors' comments included: low levels of reoffending; strong partnership working, with some excellent examples cited; good engagement with group work programmes; and many positive outcomes recorded, which demonstrated that workers were not taking a narrow approach to risk management, but were helping people to address issues that contribute to a more stable and safe lifestyle.

Police Scotland is currently undertaking a review of all Level 1 very high and high risk registered sex offenders in Edinburgh for whom Police Scotland is the responsible authority.

Recommendation 8

"Responsible Authorities to consider introducing compulsory joint refresher training for risk assessors and line managers to ensure that risk assessment tools are applied properly and consistently and that high standards of competency are maintained."

This recommendation is accepted and is being implemented.

Training in the application of risk assessment tools is developed and co-ordinated nationally to maintain a consistent approach. This includes refresher training.

New scoring guidance for Stable and Acute 2007 and Risk Matrix 2000 was issued in October 2013. This is being disseminated by the SA07/RM2K Training Co-ordination Group and is targeted at accredited assessors and their line managers, across social work, police and the Scottish Prison Service. Refresher training is being developed and will be tested to ensure consistency across the country. Once this training has been finalised, a series of one day, joint training events will be scheduled across the Lothian and Borders Community Justice Authority.

Level of Service Case Management Inventory (LSCMI) is the risk assessment and case management tool applied across the offending population by criminal justice social work. Following a recent self-evaluation on the implementation of LSCMI, led by the Care Inspectorate and Risk Management Authority, each Scottish local authority produced an improvement action plan. For Edinburgh, this included the drafting of updated guidance, which is being issued along with refresher training for staff and line managers.

Recommendation 9

"Police Scotland to consider implementing regular reviews of the suitability of officers to continue managing certain offenders after an extended period of time, especially offenders that are particularly demanding and difficult to manage."

This recommendation is accepted and is being implemented.

It was agreed that all agencies delivering MAPPA should, through line managers, consider the continued suitability of staff managing offenders. This is achieved via formal supervision and performance review procedures, established in each agency.

Recommendation 10

"The Responsible Authorities to consider introducing a process to ensure that reports by health professionals relating specifically to the risk management of offenders are shared with senior managers."

This recommendation is accepted and is being implemented, in so far as the responsible authorities are interpreting reference to "reports by health professionals" as reports by psychologists and psychiatrists relating to the management of offenders.

Assessments and reports from the Serious Offender Liaison Service (SOLS) are commissioned by supervising social workers and police offender management officers seeking advice and support to inform the management of risk. The reports are provided and discussed with these staff, and will be shared with managers, as appropriate. Where the reports relate to registered sex offenders, they will be shared with the MAPPA coordinator, and via the coordinator to all representatives, where there is multi-agency management of the case. The SOLS team has been evaluating the outcomes of the assessments, and this evaluation will continue.

Recommendation 11

"The Responsible Authorities to review how best to integrate adult protection services and training with the MAPPA process to ensure links are made across all strands of public protection in relevant cases."

This recommendation is accepted and is being implemented.

Set out below are the developments and work streams underway in Edinburgh over the past 2 years, which reflect a collaborative and integrated approach to the identification and management of risk in Edinburgh:

Escalating Concerns Group
This group is being piloted across Edinburgh. It provides a multi-agency platform to consider those individuals who are at risk to themselves and/or their community, but who are unwilling or unable to engage with services. The cases discussed will typically present extraordinary challenges to agencies who may have exhausted their own range of options and which would benefit from a multi-agency risk management approach.

Frequent Attenders' Process
Patients who attend an emergency department more than 5 times in 3 months, or 10 times in 12 months, will trigger a review of their situation. Their GP will be notified, and if appropriate, a care plan will be developed. Social work professionals provide input to the 'frequent attenders' review meetings at the Royal Infirmary of Edinburgh.

Adult Support and Protection Duties and Training

Criminal justice social work staff are involved in adult support and protection activity, and work alongside other health and social care colleagues to undertake 'council officer' duties and functions under the Adult Support and Protection (Scotland) Act 2007. Training and guidance are in place to support this development. The findings of significant case reviews are disseminated to practice staff at multi-agency adult protection training. Workers from across the public protection spectrum are reminded of their duty to identify and respond to the multiple needs and challenges facing and posed by individuals, who can be subject to a number of simultaneous risk management processes.

Joint Quality Assurance Sub-committees
Both the Offender Management Committee and the Adult Protection Committee had an established Quality Assurance Sub-committee. These 2 sub-committees have now been merged, in recognition of a shared agenda and purpose, and an acknowledgement that individuals who place their families and their communities at risk often need support and protection themselves. These two multi-agency groups have been aligned to facilitate an integrated approach to the management of risk, critical evaluation and practice improvement.

'Inclusive Edinburgh'
This is an inter-agency coordinated approach to scope the needs of people who often fall outwith effective statutory interventions. The complexity of their needs and the chaotic circumstances in which they find themselves can make it difficult to manage the risks they present to themselves and to other people effectively. Inclusive Edinburgh is an extensive review and redesign to create an integrated approach, assertive engagement strategies and the application of effective evidence-based interventions. This will provide effective support and recovery opportunities for people with extremely complex and challenging needs.

Recommendation 12

"The Responsible Authorities to consider attendance of Senior Social Workers, experienced in Adult Support and Protection matters, at MAPPA Level 2 and 3 meetings in relevant cases."

This recommendation is accepted and is being implemented.

Community care sector managers are standing members of the MAPPA Level 2 panel, and are active participants. This has been common practice for some time, rather than a response to this case. All have adult support and protection 'council officer' training. One of the managers, who is also a member of the Level 3 panel, has particular experience in this area of work; is a member of the joint Offender Management and Adult Protection Quality Assurance Sub-committee; and is involved in the development of adult protection procedures.

Recommendation 13

"Police Scotland to consider introducing dedicated Adult Protection Co-coordinators or single points of contact within all Public Protection Units to provide enhanced levels of expertise in support of operational officers, act as single points of contact for partner agencies on all issues concerning adult support and protection and to represent Police Scotland at relevant multi-agency meetings."

This recommendation has been considered. Currently in Edinburgh, every member of the Public Protection Unit has completed adult, child, domestic abuse and MAPPA training to the required level. Managers have completed training to Level 3, and are now responsible for contributing to adult and child protection training. There are links between all frontline offender management staff and the Inter-agency Referral Discussion hub, which deals with adult protection on a daily basis. Moving to coordinators or a single point of contact could dilute, rather than enhance the effective management of public protection. Edinburgh proposes to continue the current practice as the most effective form of management.

3 Accuracy and interpretation

3.1 Despite accepting the learning points of the review, it is disappointing that many of the concerns brought to the attention of the review team remain in the final report. Examples of these are set out below.

3.2 The report comments on Kevin Rooney's troubled past and demonstrates the challenges involved in supporting him and in trying to reduce the threat he posed. The report refers to Kevin Rooney's overwhelming problems, clearly indicating the need for a multi-agency response. Kevin Rooney was an extremely complex and difficult case, and the limitations of the legal interventions available to the responsible authorities were particularly unhelpful.

3.3 The report does not reflect accurately the level of contact, support and management provided to and for Kevin Rooney; or the frequent, sometimes daily, discussions among staff from a range of agencies; or the consistency of attempts at engagement from those tasked with his supervision. Kevin Rooney did present significant challenges to those seeking to manage the risk he presented and to provide him with appropriate support and supervision. His behaviour was chaotic and out of control. This had a negative impact on the ability of services to reduce the risk he posed, but it did not divert them from attempting to do so. Case records evidence this commitment, and it is disappointing that this is not reflected in the balance of the report.

3.4 Kevin Rooney's community accommodation was predominantly provided in Council-funded bed and breakfast provision. This is a matter for repeated criticism in the report. The Council block purchases all of the capacity in these units, which do not accept tourists or other members of the public. This form of temporary accommodation can have a stabilising effect, as it provides a curfew, which can be a protective factor. This mechanism acts as an early indication if someone is not conforming to the rules.

3.5 Kevin Rooney was considered for his own tenancy on two occasions, however, the consequences of his repeated offending or self-harming meant that plans to secure permanent accommodation were always disrupted. In addition, managing a tenancy would have been challenging for Kevin Rooney, and would have made monitoring of his actions and movement much more difficult than the relatively controlled use of temporary accommodation.

3.6 The report indicates that there was no ongoing risk management review in the management of Kevin Rooney. This is incorrect. However, it is acknowledged – and it is a matter for regret and for improvement action – that reviews were not formally recorded on ViSOR. In addition, the review states that the recording of

risk assessments was inaccurate. This is not correct, there were no factual inaccuracies; however, it is accepted that recording was inadequate.

3.7 The responsible authorities have considered the level of contact between the police officer and Kevin Rooney, the level of supervision from the officer's line manager (whose experience included his role as a MAPPA Level 2 chair) and the level of risk management case conference discussion, and have found no evidence to suggest this was inappropriate. Recommendation 9 is based on the view that the long-term involvement of the police officer may have made it more difficult for him to manage the case. An equally valid premise, and one supported by evidence, is that the consistency and resilience of the relationship between supervisor and individual can have a more successful impact on behaviour than frequent changes of worker.

3.8 Adult protection practice has developed significantly since the Adult Support and Protection (Scotland) Act 2007 was implemented. Initially, inter-agency responses were based on the "three point test" described in the review report. Adults who did not meet these criteria were often deemed to have capacity to make choices, and opportunities to provide support were limited accordingly. Inter-agency adult protection practice has changed, and now extends beyond these narrow criteria to all individuals whose vulnerability or risk requires support and management.

3.9 In Kevin Rooney's case, each risk management case conference at Level 2 included discussion of Kevin Rooney's vulnerabilities. Experienced representatives from adult protection services were present at these meetings, and in addition, consideration was given to the extensive medical and psychiatric assessments.

4 Conclusions

4.1 This significant case review has examined the circumstances leading up to the death of Mrs Sutherland, and the long-term effect this has had on her family. The Edinburgh Offender Management Committee members would like to express their sincere condolences and sympathy for Mrs Sutherland's family, and to restate the responsible agencies' full commitment to addressing the areas for improvement highlighted both by the review report and the Committee's own analysis of the circumstances of this case.

4.2 Although the Offender Management Committee continues to have concerns regarding a number of inaccuracies, and some of the opinions and language of the report, the recommendations, in so far as they apply to the responsible authorities are accepted. In many cases, the work to improve our responses is well progressed. An action plan outlining all the improvements is being drawn up and its implementation will be scrutinised by the Committee on a regular basis.

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