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The National MAPPA Research:

Serious Case Review Report

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Dedication

This research is dedicated to the memory of Saskia Jones (12.02.96 – 29.11.19), our former Criminology student who was determined to make the world a better and safer place through her studies. We hope that our findings may, in some way, contribute to that ambition..

PIER

The Policing Institute for the Eastern Region (PIER) is a research institute within ARU. Since its formation in 2016, PIER has been committed to delivering high-quality collaborative research for the improvement of policing practice, particularly in relation to public protection and the prevention of sexual and violent offending.

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Executive Summary

The National MAPPA Research was a 26-month study conducted by the Policing Institute for the Eastern Region to examine the effectiveness of the Multi-Agency Public Protection Arrangements (MAPPA) in England and Wales.

The research was made up of three components, 1) proven reoffending analysis (Lundrigan, Mann & Specht, 2023); 2) process effectiveness analysis (Mann & Lundrigan, 2023) and 3) serious case review analysis (current report).

MAPPA was placed on a statutory footing in 2003, under the Criminal Justice Act, with the aim of strengthening the monitoring of community-based individuals convicted of sexual and violent offences. Under the MAPPA structure, the Police, the Probation Service, and the Prison Service, along with other agencies who have a 'duty to cooperate', are legally required to work together to monitor and manage the risk posed by such individuals (Ministry of Justice, 2021).

Aim and method

The aim of this phase of the National MAPPA Research was to examine MAPPA Serious Case Reviews (SCRs) in order to identify learning relating to gaps in multi-agency operational and strategic practice. To do this, we:

- Collated all available SCRs conducted between 2012 and 2021, from five sample areas
- Thematically analysed SCRs with a focus on the review sections relating to 'Conclusions, Learning Points and Best Practice identified'

Five MAPPA areas participated. Together, they represented a wide geographical spread, with both rural and urban areas, and small and large numbers of MAPPA-managed individuals. In total, 19 SCRs were analysed. The findings provide learning relating to gaps in multi-agency operational and strategic practice.

Findings

Multi-agency operational and strategic practice gaps

The research identified a number of multi-agency operational practice gaps which reoccurred within MAPPA SCRs. The majority of these related directly to the risk management of individuals. Practice here was hindered by poor identification of risk, outdated risk management plans (RMPs) and the omission to risk assess in a robust way. In support of the findings of the process effectiveness report (Mann & Lundrigan, 2023), further operational practice gaps were identified in relation to information sharing between MAPPA agencies and disclosure of risk to third parties, the representation of certain agencies at panel meetings, the sufficiency of policy and practice when an individual transfers from one MAPPA region to another, and the administration of MAPPA in some areas.

A number of multi-agency strategic practice gaps were also identified and again, these supported findings from the process effectiveness report (Mann & Lundrigan, 2023). Gaps here stemmed from a lack of understanding regarding agencies' own roles and responsibilities within MAPPA, the under-resourcing of agencies and MAPPA as a whole, the insufficiency of policy and practice governing the transfer of young people from child to adult supervision, poor collaborative working and a lack of professional curiosity.

It should be noted that the gaps in practice identified in the SCRs mirror those found in analyses of other statutory framework reviews such as Domestic Homicide Reviews (DHRs, e.g., Home Office, 2016 & 2022; Standing Together, 2016 & 2019), Child Safeguarding Practice Reviews (CSPRs, Department for Education, 2020), and Adult Safeguarding Reviews (SARs, Local Government Association, 2020), and are not necessarily specific to MAPPA. It should also be noted that analysis also identified a number of examples of good practice within the SCRs.

Multi-agency learning

Multi-agency learning can be obtained from the SCRs and utilised to inform future MAPPA policy and practice. The majority of identified operational learning related to risk management, information sharing and disclosure. These gaps stem from longstanding challenges with multi-agency practice and their resolution would require a quality assurance approach, whereby practice is monitored for adherence to the requirements set out in the MAPPA guidance (2021[1]).

Strategic learning can also be obtained and utilised to inform policy and practice. The main strategic learning identified was around the transfer of management from the Youth Offending Service (YOS) to the Probation Service when a young person transitioned from child to adult supervision. Learning should focus on the insufficiency of MAPPA practice at this key point, as supported by the process effectiveness report (Mann & Lundrigan, 2023), and the need for closer and more collaborative working between agencies within MAPPA. Outdated funding models, also identified in the process effectiveness report (Mann & Lundrigan, 2023) contributed to a number of gaps in practice. Learning here should seek to reassess MAPPA funding in light of the increasing number of individuals being managed and the continued cuts to budget which MAPPA agencies have suffered since national austerity in 2010. Training is central to the transformation of learning into practice, particularly in relation to the need for a greater understanding of MAPPA and an increase in the professional curiosity exercised by MAPPA practitioners. Learning can also be obtained in relation to the quality of SCRs and the information included on the MAPPA managed individual and the victim. At present, opportunities to gather data which is essential to a greater understanding of those who commit serious further offending and those who are subject to that offending, are not currently being utilised.

Recommendations

This research makes five recommendations:

1. The national MAPPA team should hold copies of all SCRs in a central repository, which can be used to disseminate learning more effectively and provide a searchable learning resource for MAPPA practitioners.
2. Statutory guidance on SCRs should be updated and should draw on the adult safeguarding serious case review (ASCR) and domestic homicide review (DHR) guidance.
3. Reporting of all demographic and vulnerability data (including protected characteristics) on both the victim and the perpetrator should become mandatory in SCRs. Reporting should, however, exclude any identifiable data on serious further offences.
4. Cross-region information sharing agreements in each MAPPA area should be developed.
5. Quality assurance processes should be developed in each MAPPA area. These should include the screening (through dip sampling) of risk assessments and risk management plans

[1] This report refers to the 2021 MAPPA guidance which governed MAPPA at the time of the national research. The guidance was, however, updated in May 2022.

1 Introduction

This report presents the findings from the serious case review component of the National MAPPA Research. The National MAPPA Research was a 26-month study conducted by the Policing Institute for the Eastern Region (PIER) to examine the effectiveness of MAPPA in England and Wales.

The research was made up of three components,

1) proven reoffending analysis (Lundrigan, Mann & Specht, 2023);
2) process effectiveness analysis (Mann & Lundrigan, 2023) and
3) serious case review analysis (current report)[2].

MAPPA was placed on a statutory footing in 2003, under the Criminal Justice Act, with the aim of strengthening the monitoring of community-based individuals convicted of sexual and violent offences. Under the MAPPA structure, the Police, the Probation Service[3] and the Prison Service, along with other agencies who have a 'duty to cooperate'[4], are legally required to work together to monitor and manage the risk posed by such individuals (Ministry of Justice, 2021). There are three categories of MAPPA management, as shown in Table 1

Category 1	Offenders Subject to Notification Requirements: Sexual Offenders
Category 2	Violent Offenders sentenced to 12 months or more in custody (immediate or suspended) or detained under a hospital order and Other Sexual Offenders (non-registered)
Category 3	Other Dangerous Offenders who pose a high risk of serious harm (RoSH) but do not qualify for Category 1 or 2

Table 1: MAPPA Categories. Note: in April 2022 a fourth MAPPA category was introduced for terrorist or terrorist risk individuals

Under MAPPA, individuals are managed at one of three levels, which reflects the level of multi-agency cooperation required to implement their risk management plan effectively. Individuals may move between the levels, reflecting changes in the level of risk they are deemed to present.

Level 1	Multi-agency support for Lead Agency risk management with information sharing
Level 2	Formal multi-agency meetings, including active involvement of more than one agency to manage the individual
Level 3	Formal multi-agency meetings and extra resources, the **'Critical Few'** including Critical Public Protection Cases (CPPC)

Table 2: MAPPA Levels

As of 31st March 2021, the number of individuals subject to MAPPA management in England and Wales, stood at 87,657 (64,325 were Category 1, 22,944 were Category 2 and 388 were Category 3). This represents a 2% increase from 2020 and a 70% increase from 2011 (Ministry of Justice, 2021).

[2] The National MAPPA Research was distinct but complementary to other work being undertaken between 2020 and 2022, including the Independent Review of Statutory Multi-Agency Public Protection Arrangements (Hall, 2022), the HMPPS Review of MAPPA Level 1, VKPP's analysis of MAPPA Serious Case Reviews and the Criminal Justice Joint Thematic Inspection of MAPPA (2022).

[3] The research was conducted prior to the unification of the Probation Service in June 2021

[4] These duty-to-cooperate agencies include youth offending teams, health and social care, housing, victim support and the Home Office.

1.1. MAPPA organisation

There are 42 MAPPA areas in England and Wales[5]. The largest MAPPA area is London, which is subdivided into 32 separate MAPPA areas across the 32 London boroughs. The Police, the Prison Service and the Probation Service make up the MAPPA responsible authority in each area and work in conjunction with the DTC agencies that are involved in an individual's management. The frequency of meetings and attendance is dependent on the complexities involved in implementing the risk management plan. Each MAPPA area has several roles central to the coordination and maintenance of the arrangements. These include:

- A coordinator or a manager, drawn from either Probation or police. They are the single point of contact for MAPPA and have responsibility for the oversight of MAPPA arrangements in their area
- Panel meeting chairs, whose role it is to chair the MAPPA level 2 and 3 meetings. MAPPA guidance (2022) states that chairs must be drawn from the Police or Probation Service
- The MAPPA Strategic Management Board (SMB) is made up of representatives from responsible-authority and DTC agencies. Their role is to manage MAPPA activity in the area, including the ongoing review of quality and effectiveness and the accommodation of any changes in legislation, national guidance or wider criminal justice policy. A chair sits as head of the SMB
- Lay advisors who sit on the SMB and represent the public in the monitoring and evaluation of MAPPA

MAPPA is overseen on a national level by the Responsible Authority National Steering Group (RANSG) at the Ministry of Justice.

1.2. MAPPA Serious Case Reviews

Serious further offence (SFOs) charges stood at 168 for 2020/21, representing the lowest number of SFOs in eight years (MAPPA, 2021a). Convictions for SFOs were even lower at 85, however, this may in part be attributed to the reduced operation of courts during the COVID-19 pandemic (MAPPA, 2021a). Once an individual has been charged with a SFO. MAPPA SCRs are undertaken to examine whether the MAPP arrangements were applied effectively to the individual under review and whether responsible authority and DTC agencies worked together to do all they reasonably could to manage the risk posed. Any lessons to be learned are identified within the review, as are any recommended developments of MAPPA policies and practice (MAPPA, 2022). SCRs are undertaken on a mandatory basis when an individual being managed at level 2 or 3 commits a serious further offence of murder, attempted murder, manslaughter, rape, or attempted rape. SCRs may also be conducted on a discretionary basis where the individual committed one of the above offences whilst being managed at level 1; committed a serious further offence included in the PI 10/2011 (see Appendix 6 of MAPPA Guidance, 2022); or it is in the public's interest. The SMB has responsibility for deciding whether to commission a discretionary SCR (MAPPA, 2022).

1.3. Previous research

A small body of work has examined the efficacy of MAPPA (Kemshall et al., 2005; Maguire et al., 2001; Wood et al., 2007; Bryant et al., 2015; Peck, 2011) as have two HM inspection reports (HM Inspectorate of Probation and Constabulary, 2011; 2015), an Independent Inquiry into the Multi-agency Management of individuals convicted of Terrorism Offences (Hall, 2020) and most recently a Joint Thematic Inspection of MAPPA (Criminal Justice Joint Inspection, 2022). However, to date, no examination of MAPPA SCRs has been conducted. SCRs contain sensitive information and as such, these documents are not available to the public. Accessing them from individual SMBs is a complex and time-consuming process.

Prior analyses of statutory review frameworks other than MAPPA SCRs, such as Domestic Homicide Reviews (DHRs, Home Office, 2016 & 2022), Safeguarding Adult Reviews (SARs, Local Government Association, 2020) and Child Serious Case Reviews (SCRs, now CSPRs, Department for Education, 2020), have attempted to capture key themes impacting practice. As expected, the themes arising from these analyses are not

[5] The MAPPA areas align with the 42 police services in England and Wales except for the City of London which is amalgamated with the London Metropolitan Police Service area.

analogous with the current MAPPA research findings (due to variations in statutory review guidance and/or analysis methodology) but do highlight some similar issues regarding practice gaps. In 2016 a Home Office analysis of 50 randomly sampled DHRs found that agency recording issues were the most frequently identified gaps in practice, followed by risk assessment and information sharing between agencies. Further research in 2022, which employed the same sample size and methodology, identified victim contact with agencies and risk assessment as key issues; although recording issues were still evident (Home Office, 2022).

The most recent Local Government Association (LGA) analysis of SARs (2020), based on the findings of 231 SARs completed over a 2-year period, identified 25 thematic practice gaps. The most frequent of which was attention to client mental capacity, followed by risk assessment and safeguarding activities. The analysis also identified ten thematic practice gaps in relation to inter-agency work, of which the most frequent were coordination of practice, information sharing, and safeguarding activities. The Vulnerability, Knowledge and Practice Programme (VKPP) (2021) analysed 21 SARs in order to identify police learning. They found that the identification and management of risk and collaborative working were key gaps in relation to police practice.

The Department for Education's analysis of SCRs (2020) examined a total of 368 SCRs published over a 3-year period and conducted a survey of practitioners to establish their findings. The key learning for practice arising from the practitioner survey related most commonly to the theme of 'working together' (including information sharing and communication, professional curiosity, professional challenge and escalation). Similarly, in their analysis of 64 unique CSPRs/CPRs/SCRs (Darling, 2021) the VKPP found that collaborative working, and information sharing between police and external agencies were the most frequently cited gaps in practice.

Most recently, in their analysis of the 'Quality of reviews of serious cases' (VKPP, 2021) briefing, the VKPP revisited the 126 child and adult statutory reviews of death and harm studied in their meta-analysis (Allnock, 2020) and found significant variations in the quality and methodology employed in the undertaking of such reviews. Missing data on protected characteristics, the paucity of police-specific 'space' in the reviews, the length of time between review and publication, police input/analysis, a lack of focus on single agency practice, the absence of effective systems analysis, and the absence of formal recommendations for police were all identified as practice gaps arising from the analysis sample.

1.4. Aims and objectives

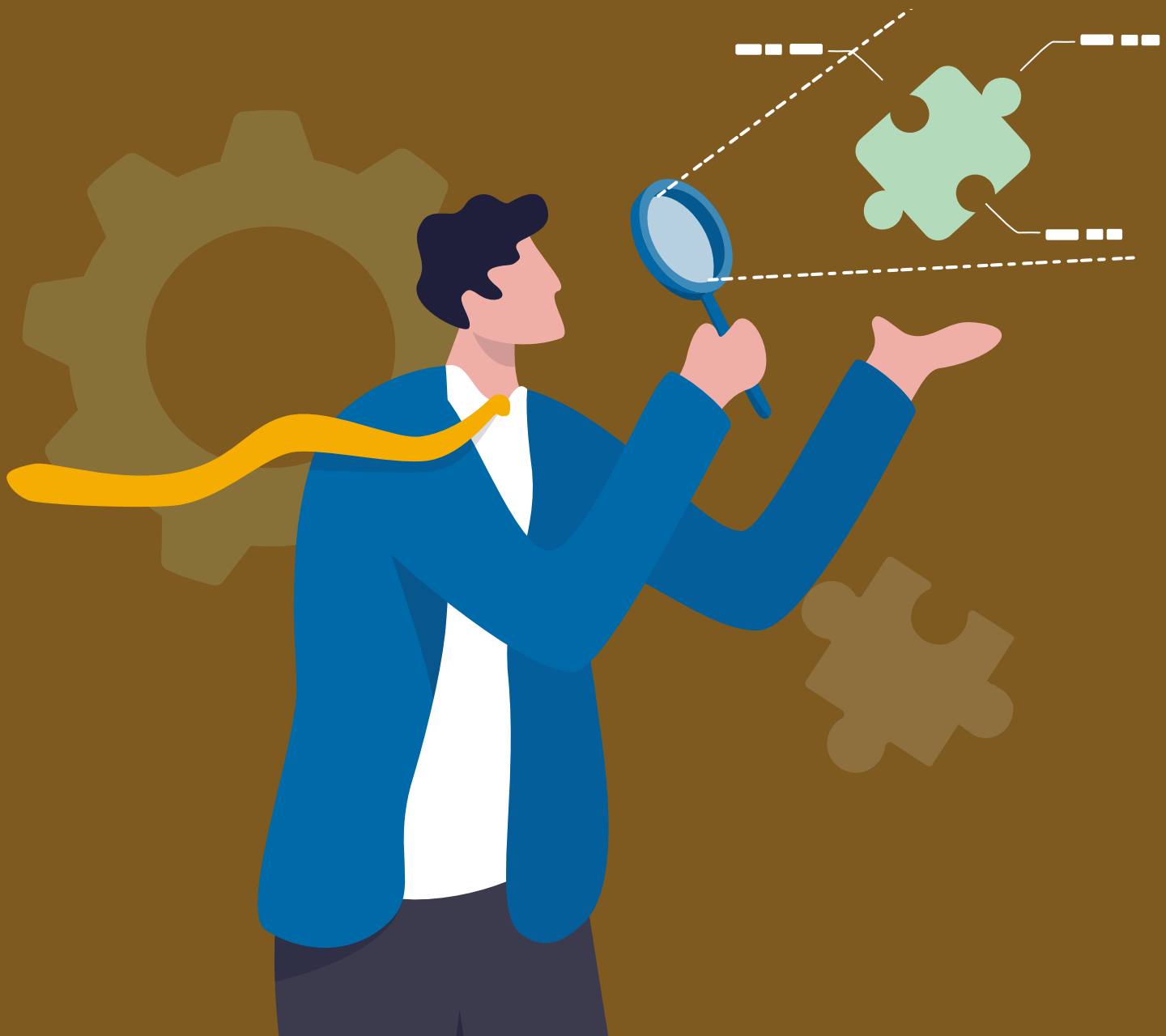
The aim of this phase of the National MAPPA Research was to examine MAPPA SCRs in order to identify learning relating to gaps in multi-agency operational and strategic practice. To do this, we:

- Collated all available SCRs conducted between 2012 and 2021, from the five sample areas
- Thematically analysed the SCRs with a focus on the review sections relating to 'Conclusions, Learning Points and Best Practice identified'

2 Methodology

2.1. Ethics

Full approval from both the Anglia Ruskin University Faculty Research Ethics Panel and the HMPPS National Research Committee was secured (Ref: 2020-102). Separate permission was also provided by the Parole Board. All ethical issues pertinent to this study, such as informed consent and confidentiality, were identified and managed accordingly. Throughout the report, any information regarding the identity of the MAPPA areas who took part in the study has been removed.



2.2. Data collection

Five MAPPA areas from the 42 regions across England and Wales participated in the National MAPPA Research. Together, they represented a wide geographical spread, with both rural and urban areas, and small and large numbers of MAPPA-managed individuals. In total 19 SCRs were analysed.

2.3 Method

The SCR analysis was conducted in collaboration with the Vulnerability, Knowledge and Practice Programme (VKPP) at Norfolk Constabulary. Hosted by the National Police Chief's Council (NPCC), the VKPP works with police violence and public protection leads to identify current interventions and approaches to vulnerability and serious violence across England and Wales. The MAPPA SCR analysis built on the VKPP's existing research which identified police specific learning from different types of case reviews, including Domestic Homicide Reviews and Child Safeguarding Practice Reviews.

Due to their sensitive content, MAPPA SCRs are not available in the public domain. As such, the SMB chairs in all 42 MAPPA areas were contacted by the National MAPPA Research team and asked to complete an information sharing agreement (ISA) which was produced in collaboration with the Ministry of Justice and the VKPP. Once the ISA was signed by the MAPPA SMB representatives for each agency, they were asked to provide all SCR reports between 2012 and 2021. The year 2012 was selected as it represents a time when the SCR template changed, and reviews became more standardised and comprehensive. It also allowed the analysis and recommendations to be relatively contemporary and based on SCRs which had been completed in the most recent 10-year time frame. Thirty-six areas returned completed ISAs and of these 23 areas had conducted SCRs within the time frame. In total, 93 SCRs were submitted and passed onto the VKPP for the police related analysis phase. After cleaning the sample and eradicating duplicated reviews, 81 SCRs were examined by the VKPP, and the findings written up in a separate report.

For the current project, all SCRs submitted from the five sample areas that took part in the National MAPPA Research were included in the sample. A coding framework was developed that utilised terms replicated from the VKPP analysis. However, our analysis examined practice gaps and learning in relation to all MAPPA agencies involved in the SCRs, and not just the Police. Quantitative data was collected describing the frequency of operational and strategic multi-agency practice gaps. Qualitative data was drawn from the review sections of the SCRs ('Conclusions, Learning Points and Best Practice identified') which identified learning relating to the gaps in practice identified.

3 Findings

The characteristics of the 19 SCRs included in the sample are detailed below:

- 79% (n=15) of the SCRs were undertaken as a result of mandatory requirements. The remainder (n=4) were completed at the discretion of the respective SMB
- 37% (n=7) of the individuals under review were from Category 1. 27% (n=5) were from Category 2 and 27% (n=5) were from Category 3. The MAPPA category of the individual was not recorded in 10.5% of the SCRs (n=2)
- 63% (n=12) of the individuals under review were being managed at level 2. Twenty-one percent (n=4) were being managed at level 3 and 16% (n=3) were being managed at level 1 at the time the serious further offence was committed
- The Probation Service were the lead agency for the individual in 73% (n = 14) of the SCRs. The Police were lead agency for 21% of individuals (n = 4) and YOS were the lead agency for 5% of individuals (n = 1).
- 23 total serious further offending types were identified across the sample (some SCRs included multiple offences). Rape made up 39% of all offence types featured in the SCRs. Murder made up 26% of all offence types (n = 6, or 26%). Attempted rape made up 8% (n = 2). Attempted murder made up 8% also (n = 2). Battery, sexual assault, robbery, and incitement to religious hatred all made up 4% of the total offences respectively (n = 1).

The characteristics of the 19 MAPPA managed individuals reviewed in the SCRs are detailed below:

Sex. All individuals in the sample were male.

Age. The youngest individual was 17 years of age, and the oldest was 60 years of age. The mean age of sample was 34 years. The age of the perpetrator was not stated or could not be calculated in 31% (n=6) of the SCRs analysed.

Ethnicity. Only 16% (n=3) of the SCRs recorded the ethnicity of the MAPPA managed individual under review. Where ethnicity was stated, the findings show that 1 individual was White British, 1 was from a Gypsy / Roma background, and 1 was Portuguese.

Vulnerabilities. Issues impacting the individual under review were recorded a total of 25 times across the 19 SCRs. Of these, the most frequently cited vulnerability related to acute accommodation needs which featured in 47% (n=9) of the SCRs. The second most frequent vulnerability related to poor mental health of the individual under review which featured in 31.5% of the SCRs (n=6). Substance misuse issues were cited in 26% (n=5) of the SCRs and other physical health issues were cited in 10.5% (n=2) of the SCRs. In 10.5% (n=2) of the SCRs the MAPPA managed individual had previously been supported by child safeguarding services immediately prior to the commission of the offence for which they were under review.

Victim Characteristics

Sex. 74% of the victims were female (14 in total; two SCRs featured two victims). Male victims were identified in 21% (n=4) of the SCRs. The sex of the victim was not documented in 16% (n=3) of the SCRs analysed.

Age. The age of the victim was documented in 21% (n=4) of the SCRs. The range was from 11 years to 49 years, with a mean age of 24 years.

Ethnicity. None of the reviews in the sample recorded the ethnicity of the victim(s).

Vulnerabilities. Only 10% (n=2) of SCRs analysed contained details regarding victim vulnerabilities. Of these, 10% (n=2) victims were identified as having physical health problems, and 5% (n=1) had a physical disability.

[6] These are warnings of death threat or high risk of murder that are issued by British police or legal authorities to the expected victim.

The substantive findings provided a range of learning relating to gaps in multi-agency operational and strategic practice and are discussed below.

Operational and strategic multi-agency practice gaps

Across the sample of 19 SCRs, a total of 118 discreet issues, or gaps in the operational and strategic practice of the responsible authority or duty to cooperate agency (excluding police as this was the focus of the VKPP research) were identified. This is an average of 6.2 practice gaps per SCR.

3.1.1 Operational practice gaps

A large number of the practice gaps identified within the SCRs related to MAPPA operational practice. For the purposes of this report, operational practice has been defined as any practice which all agencies engage in, and which allows MAPPA to function and achieve its objectives.

3.1.1.1 Risk Management

The primary aim of MAPPA is to effectively manage the risk posed by the individual and examples of good practice around MAPPA's management of risk were cited in most SCRs in the sample. A specific example of this related to the proactive management of risk posed by one individual via an Osman Warning to his new partner[6]. However, despite some examples of good practice, the most frequently occurring gaps in practice across the sample related to risk management. Issues ranged from insufficient consideration of risk when making accommodation placements, to the premature deregistering of a MAPPA managed individual. Issues with the overall approach to, and operation of, risk management by individual MAPPA areas was most frequently cited as being problematic, followed by the risk management practice of the Probation Service and then the Prison Service. Issues with the risk management practice of mental health services, approved premises, children's social care, and YOS were all also identified. In their analysis of police learning from 81 MAPPA SCRs, the VKPP research found that the key issues impacting the risk management of individuals were the overall content of risk management plans, inadequate safety planning, and issues with multi-agency cooperation and decision making.

For example, regarding issues with the management of risk, one SCR in our sample found:

> **'The most significant shortfalls in relation to the management of the subject were in the MAPPA process. Whilst the subject was appropriately identified for Level 2 management within MAPPA, there were clear deficiencies in relation to the agencies invited to attend the Level 2 meeting and review meeting, the lack of focus on risk management within those meetings, and the failure to share key information with MAPPA participants'**

The identification of risk

MAPPA guidance (2022) acknowledges that risk can never be completely eradicated. However, effective assessment of the individual and multi-agency collaboration and information sharing via MAPPA, means an adequate picture is achievable. Within the SCRs analysed, issues related to the failure to sufficiently probe the individual when gathering information which informed the assessment of risk. One example related to the insufficient consideration of dynamic risk factors. One review did, however, commend the activities of a local YOS in proactively identifying the ongoing risks posed by a young person, even though this individual was over the age of 19 and had completed his statutory order. Another example of good practice related to one area's hosting of a multi-agency level 1 meeting which was found to have added value to the subsequent risk assessment and risk management of the individual under review.

[6] These are warnings of death threat or high risk of murder that are issued by British police or legal authorities to the expected victim.

To illustrate issues in relation to the identification of risk, one review found that:

> 'The overall conclusion of the panel is that professionals managing high risk sex offenders should be more circumspect when dealing with new information that suggests the risk is increasing; had this been the approach in [the offender's] case, he would have been identified as breaching his licence conditions and possibly offending'.

In relation to the identification of risk, an issue with onward referral was also discussed. In this case an individual was discharged from MAPPA but was not referred on to Multi-Agency Risk Assessment Conferences (MARAC). The review found:

> 'The incident was not recognised as a domestic incident and so no referrals to MARAC and no subsequent referral to MAPPA were made, this was clearly a missed opportunity'.

Risk Management Plans (RMPs)

An essential aspect of risk management is the MAPPA RMP which all individuals managed at level 2 and 3 require. An RMP identifies all areas of risk of serious harm and includes the single and multi-agency actions agreed at panel meetings which are required to manage those risks. All agencies contribute to the RMP and it is reviewed and monitored on a regular basis to ensure its effectiveness (MAPPA, 2022). However, findings from the analysis show that gaps in practice relating to MAPPA RMPs were the second most frequently identified and included the failing of one MAPPA area to adequately update an RMP of an individual, and a further omission by another area to ensure that RMPs were updated and that actions were SMART (Specific, Measurable, Achievable, Relevant, and Timely). Interestingly, the VKPP SCR analysis found that RMPs frequently failed to adequately address the four pillars[7] required, as per MAPPA guidance (2022).

For example, issues with Risk Management Plans are illustrated by the following SCR conducted in 2017:

> 'The MAPPA Risk Management Plan was a repeat of the one submitted by the Police in the referral...It made no reference to the community order and its contribution to [the offender]'.

[7] The Four Pillars of risk management is a model developed by Professor Hazel Kemshall, in response to the recommendations of the 2011 joint inspection of MAPPA (HM Inspectorate of Probation and Constabulary, 2011). Originally this model was adopted by a small number of MAPPA areas across the country but more recently, the Four Pillars RMP template has been utilised by all 42 MAPPAs. The Four Pillars approach prioritises risk management by addressing four essential elements that are detailed in the RMP of MAPPA managed individuals: 1) Supervision; 2) Monitoring and Control; 3) Interventions and Treatment; and 4) Victim Safety Planning.

Individual compliance with Risk Management Plans and Licence Conditions

A significant part of MAPPA management involves the monitoring of individual's compliance with the RMP and this requires active and timely multi-agency information sharing. One SCR in the sample identified good practice in relation to an individual's compliance with RMPs and licence conditions. In this instance, staff at an Approved Premises notified police at the earliest opportunity that an individual had failed to return to the accommodation and had kept the individual occupied when he did finally return whilst waiting for police to attend and undertake an arrest. Within the analysis, issues with compliance were most frequently related to Probation Service supervision; something which is unsurprising given the prevalence of Probation involvement with MAPPA managed individuals. The VKPP SCR analysis found that perpetrator dishonesty was a significant risk factor in non-compliance, but also that the Police -partner-agency approach to ensuring an individual's compliance, was inconsistent across MAPPA areas.

For example, issues with compliance are demonstrated from the following:

> **It is now known this person was deliberate and calculated with the aim of instilling confidence in professionals that he was compliant; in brief he manipulated people around him including his victims'.**

Risk Assessment tools

The identification of risk is supported by a number of risk assessment tools which are utilised by MAPPA agencies. These include HMPPS' Offender Assessment System (OASys) which provides a risk of serious harm level and the Police's OASys Sexual Reoffending Predictor (OSP) and Active Risk Management System (ARMS), both of which are used with adult males convicted of sexual offences, and which provide a risk of reoffending level and a management level respectively. Practice gaps in relation to risk assessment tools primarily related to their robustness and included the failure of a Probation Community Rehabilitation Company to complete a risk assessment, and the absence of a robust risk assessment in relation to the brother of a MAPPA managed individual, who may have had access to the explicit images collected by the individual. Similarly, the VKPP found examples of poor and inadequate police risk assessment, in their analysis of 81 SCRs.

To illustrate, one SCR from the sample stated:

> **'The MAPP meetings focused on the risk of harm to members of the public and known adults and there was consideration of the risks to particular known females. There was though little consideration of his potential risk to other females or whether he was a risk to his daughter – including by his being a target for violence when with her'.**

3.1.1.2 Information Sharing and Disclosure

MAPPA is the conduit through which effective multi-agency information sharing occurs. This information sharing is vital to the effective risk assessment of the individual and essential to the effective management of that risk. This research has found that the second most frequently occurring gap in practice identified within the SCRs related to issues of information sharing (between agencies) or disclosure (to relevant third parties). Incidences included the absence of information sharing between a MAPP panel and a local GP, and a failure to disclose relevant risks to the family of a MAPPA managed individual. The Probation Service, substance misuse services, Children's Social Care, the Prison Service, YOS, a disability team and health agencies were all identified in relation to omissions or delays in information sharing and disclosure. This was also evident in the SCR analysis completed by the VKPP, who identified that police information sharing, and disclosure practice was problematic at times.

Despite this, information sharing and disclosure were the most commonly cited examples of good practice across the SCRs. One review found that information sharing between MAPPA and a local GP was particularly effective in managing the risk posed to a partner by the individual.

To illustrate issues with disclosure, one review stated that:

> **'What is clear is that there was available information to allow the relationship between [the offender] and [his new partner] to be assessed and potential for [new partner] and her family to be given disclosure, which would have allowed them to make informed decisions on continuing the relationship or not. This did not happen, and this has to be seen as a failing in the MAPPA process'.**

3.1.1.3 Attendance at panel meetings

MAPPA guidance (2021) states that agency representation at level 2 and 3 panel meetings must be of sufficient seniority, and should be consistent, in order to allow for the development of good working relationships. The issue of attendance at panel meetings was identified as problematic within a number of the SCRs and most frequently related to poor attendance by certain agencies, including housing, Social Care, YOS and the Prison Service. This is supported by the VKPP findings; their analysis of 81 SCRs also highlighted that meeting attendance was an issue which affected MAPPA effectiveness.

To evidence the impact of non-attendance at MAPPA, one SCR stated:

> **'The accommodation issue was undoubtedly exacerbated by the absence of a housing representative at the MAPPA meetings. Despite repeated invitation a representative did not attend. There needs to be a commitment to this important area of offender management and a joint understanding of how accommodation can be achieved in circumstances.'**

Good practice in relation to attendance at panel meetings was, however, only cited in a single SCR. In this case, the panel found that attendance was reflective of good local buy-in to the MAPPA framework, arising from effective strategic links across agencies.

3.1.1.4 Transfer and cross region management

One aspect of MAPPA management is the effective transfer of an individual from one MAPPA region to another. MAPPA managed individuals move for many different reasons but the process effectiveness analysis (Mann & Lundrigan, 2023), found that this was frequently in relation to accommodation needs and a lack of appropriate housing in some MAPPA areas. One SCR from the sample identified good practice in relation to the management of an individual transitioning from one region to another. In this example, agencies from each area were present at relevant meetings and substantial information was consequently shared.

Multiple issues with managing individuals across MAPPA areas were identified within the reviews and these ranged from the failure of one MAPPA area to ensure that adequate enquiries were made with relevant agencies in different localities, through to the absence of a formal agreement between two police forces; something which affected MAPPA's ability to appropriately manage an individual convicted of sexual offences.

By way of illustration relating to issues with regional transitions, one review stated:

> **'Where a nominal is accepted by MAPPA who has moved between a number of areas, the meeting should ensure that enquiries are made with relevant agencies in those areas to ensure that the meeting has the fullest and most current information to access risk'.**

The VKPP's SCR analysis also found cross border management to be a problematic issue. They identified that a lack of notification of an individual's transfer and a lack of communication between home and host police forces led to insufficient management of risk, something also highlighted by practitioners in the report which examined their perceptions of the effectiveness of MAPPA (Mann & Lundrigan, 2023).

3.1.1.5 MAPPA Administration

Effective administration is essential to the smooth running of MAPPA and so it is unsurprising that problems occur when that administration support is insufficient. Issues in relation to administration ranged from poor communication between a screening panel and a MAPPA panel, through to a MAPPA administrator's failure to identify and invite a Community Rehabilitation Company to relevant meetings. Similarly, the VKPP's SCR analysis found practice gaps relating to MAPPA administration, and the report on practitioner perceptions of the effectiveness of MAPPA (Mann & Lundrigan, 2023), identified practitioner concerns regarding insufficient administration support which affected the efficiency of the arrangements. By way of illustration, one review stated:

> **'It is concerning that erroneous information was included both in the referral to the MAPPA Level 2 meeting (MAPPA A) and in its minutes (MAPPA B). It is understood that the accuracy of these documents is stressed to MAPPA Administrators and Chairs, but the findings of this Review indicate that a further reminder would be appropriate and that it will be important for there to be an audit process for such documents'.**

Inadequate Record Keeping

A significant part of the MAPPA administrator role is to take minutes and make sure these are available to MAPPA practitioners in a timely manner. Gaps in practice relating to inadequate record keeping were identified on numerous occasions and ranged from the inadequate taking of panel meeting minutes which negatively impacted on the subsequent risk management of an individual, through to poor minute-taking which resulted in a failure to record key decisions which were taken at a panel meeting. The VKPP analysis of 81 SCRs also found that inadequate record keeping directly contributed to issues with risk identification. They noted that the majority of these inadequacies were down to human error, however, some were due to the use of incorrect terminology utilised to record information. There were no examples of good practice in relation to this area within the SCRs.

To illustrate issues with record keeping, one review stated:

> **'Information sharing was generally good and there were particularly good practices with the information held and shared with the GP. Unfortunately, this information sharing did not extend across the health services and not within the accident and emergency department. Even with support and a willingness to ensure records are identified for those with MAPPA or MARAC involvement, the sheer scale and complexity of systems would prove problematic'.**

3.1.2 Strategic practice gaps

Strategic practice has been defined as any practice which is less tangible, and which is fundamental to achieving MAPPA's purpose and overarching objectives. Issues relating to strategic MAPPA practice were less evident within the SCRs; those which were identified are discussed below:

3.1.2.1 Understanding of the MAPPA framework

MAPP arrangements are complex, comprehensive and, as identified elsewhere in the National MAPPA Research, practitioners require training in order to make best use of them. Within the SCR analysis an inadequate understanding of the MAPPA processes and policies were identified as a key issue. Practice gaps in this area highlighted the need for Probation Service Offender Managers to be trained in how to prepare for MAPPA meetings and the need for enhanced training on MAPPA processes for those working in adult community disability teams (CDLT). The VKPP, in their SCR analysis, also found that a poor understanding of MAPPA had a negative impact on the effective management of individuals; they pointed to recommendations made by reviewers that police and partner agencies ensured sufficient knowledge via mandatory training, with a focus on key processes such as making referrals.

Relating to the understanding of the MAPPA framework, one SCR stated:

> **'Speaking to the 3 workers, there was a lack of knowledge about their responsibilities, what information should be brought to MAPPA meetings, CLDT responsibility at such meetings, who is the lead agency and what lead agency means in terms of responsibilities. The view of CLDT was MAPPA concentrates on forensic mental health as this area has more cases but for community mental health who have a lot fewer the training in MAPPA has passed them by'.**

No examples of best practice in relation to this issue were identified within the SCRs.

3.1.2.2 Under-resourcing

MAPPA funding differs from region to region and is calculated using funding models which were identified as being outdated in the report on practitioner perceptions of the effectiveness of MAPPA. In conjunction with inadequate funding models, since the introduction of public sector austerity in 2010, MAPPA responsible authority and DTC agencies have faced financial challenges which have been exacerbated by an increase in the number of individuals being managed under MAPPA. It is therefore unsurprising that under-resourcing was identified as an issue within the SCRs. Issues in relation to this area included a delay in Probation staff being able to provide an individual with a supervision appointment, and a MAPPA area having inadequate time to fully discuss cases. The VKPP SCR analysis also found that the under-resourcing of MAPPA had led to a higher workload for staff, and an increase in the number of cases being heard at individual panel meetings.

Issues with resourcing are illustrated via the following quote from one SCR, which found:

> **'A specialist residential setting delivering interventions for sexual harmful behaviour at an early stage may have been more beneficial for [the offender] managed risk more effectively and in the long term offered a more cost-effective management regime'.**

Despite a number of identified issues, an example of good practice relating to resourcing was identified within the SCRs. The panel in this case were impressed by the range of programmes an individual had accessed whilst serving a term of imprisonment.

3.1.2.3 The transition from child to adult services

As a DTC agency, the YOS is essential to the success of MAPPA for individuals who are under 18, or those who are transitioning from child to adult supervision at 18 years of age. The SCRs identified gaps in practice in relation to the transitional planning of young peoples' management and these predominately related to insufficient practice when individuals transitioned between YOS and Probation Service supervision. This was an issue which many YOS practitioners raised elsewhere in the National MAPPA Research (see Mann & Lundrigan, 2023). They felt that the young people transitioning to Probation Service supervision were essentially being set up to fail due to a lack of understanding of 'the child' and a lack of sufficient support and supervision.

To highlight issues around transitional planning, one review found:

> **'There were also weaknesses in the planning for [the offenders'] transition to adult services, and in particular no discussion between YOS and the Probation Trust or at a MAPP meeting before the Youth Rehabilitation Order was made'.**

The VKPP also identified transitional planning as a significant practice gap when managing the risk of potential future harm, in their SCR analysis. A lack of MAPPA oversight and professional and strategic leadership of the transition of young people, was considered detrimental to child/young person safeguarding at this time. No examples of good practice relating to transitional planning were evident in the SCRs.

3.1.2.4 Collaborative Working

Collaborative working is key to the effective management of individuals and the main aim of the MAPP arrangements is to provide the framework through which this collaboration can most effectively be realised. Within the SCRs an example of good practice was identified in relation to collaborative working across child protection services, domestic abuse services, alcohol and accommodation services, and mental health services, highlighting the multi-agency nature of MAPPA management. The VKPP analysis also found strong evidence of collaborative working across all MAPPA areas. Where practice gaps relating to collaborative working were identified, these most often related to ineffective collaboration between agencies, most notably the Prison Service.

With regards to the Prison Service, one SCR found:

> **'The circumstances of [the offender's] release from custody were unusual in that he was a high risk of serious harm offender who was released from closed conditions..There should have been detailed contingency planning, including a pre-release Level 1, information sharing meeting, in the six months leading to [the offender's] parole hearing, to address the possibility that the Parole Board would opt to release him into the community or to an AP'.**

3.1.2.5 Lack of Professional Curiosity

Issues relating to a lack of professional curiosity were identified within the SCRs. These ranged from the failure of MAPPA agencies to take an investigative approach to

risk identification, through to an overreliance on the individual's explanation for breaches of licence. This is supported by the work of the VKPP, who also found that an absence of professional curiosity hindered effective practice in the management of individuals. This was aggravated by an inability to recognise risk factors and dynamic changes of risk, which together resulted in ineffective risk identification and risk assessment.

To illustrate this factor, one review found that:

'An area of particular concern is the lack of investigative approach and professional curiosity. There was an accepted risk to those associated with [the offender] but several opportunities were presented where this could have, and should have, been followed up. This investigative approach should have been driven by MAPPA'.

No examples of good practice were identified in relation to professional curiosity with the SCRs.

3.2. Multi-agency learning

It should be noted that the issues arising from the identification of practice gaps in this research mirror those found in analyses of other statutory framework reviews such as Domestic Homicide Reviews (DHRs, e.g. Home Office, 2016 & 2022; Standing Together, 2016 & 2019), Child Safeguarding Practice Reviews (CSPRs, Department for Education, 2020), and Adult Safeguarding Reviews (SARs, Local Government Association, 2020), and so should not be considered as distinct to MAPPA. They do, however, offer points of potential learning. Where issues have also been identified across the National MAPPA Research, consideration should be given to the implementation of changes in practice which would address these issues.

3.2.1 Operational learning

The majority of practice gaps, and subsequent operational learning, identified in the current research relate to risk management, information sharing and disclosure and risk identification. These gaps appear to be historically entrenched in multi-agency practice, as reflected in the analyses of other statutory reviews cited above. To address these key gaps, considerable efforts are needed to embed quality assurance processes (dip sampling of risk assessments and risk management plans) within MAPPA practice and in the greater utilisation of information-sharing agreements across agencies and the development of those for use across geographical areas. Both activities have previously been recommended in relation to learning from analyses of DHRs (Home Office, 2016 & 2022), and the Government has published relevant information sharing advice for safeguarding practitioners which could be adapted for MAPPA practitioners. Learning and examples of good practice in relation to information sharing can also be found at the Centre of Excellence for Information Sharing.

Frequent gaps in practice in relation to meeting attendance, inadequate record-keeping, and risk management plans were also identified. In relation to inadequate record keeping, difficulties with agencies access to ViSOR, were most commonly cited. ViSOR access was identified as a problematic issue elsewhere in the National MAPPA Research and despite this being raised in the Independent Inquiry (Hall, 2020); the National ARMS Evaluation (Mann and Lundrigan, 2020), and most recently, in the Criminal Justice joint thematic inspection of MAPPA (CJJI, 2022), it is clear this remains a crucial problem that continues to negatively affect the management of individuals.

Cross border management, when an individual transferred from one area to another, was also identified as an issue both here and elsewhere in the National MAPPA Research. Practitioners raised concerns around the policies in place when an individual transfers from one lead agency to another, particularly between YOS and the Probation Service, and when transferring between MAPPA areas. It was felt that the processes in place to manage risk at this point were insufficient.

3.2.2 Strategic learning

Strategic practice gaps relating to resourcing and transitional planning were identified. Issues regarding transitional planning predominately related to those SCRs involving younger individuals, especially those moving between YOS and the Probation Service during their MAPPA management. Again, the processes in place were considered insufficient, with communication and an overstretched Probation Service adding to practitioner concerns. A joint protocol for the transition of children from YOS to the Probation Service was published in 2021, and it should be noted that the majority of these SCRs predate this guidance. However, issues with the transfer of management from YOS to Probation have been identified within the process effectiveness analysis (Mann & Lundrigan, 2023). The proven reoffending analysis (Lundrigan, Mann & Specht, 2023) also found that the peak age of offending for MAPPA managed individuals was 17 years; it is therefore even more important that the youth to adult transition is managed effectively to reduce the risk posed by those who are near the peak of their offending careers.

The process effectiveness report (Mann & Lundrigan, 2023) also identified under-resourcing as a key issue in relation to the effectiveness of MAPPA. This was an evident issue both in relation to individual agencies being overstretched, and also in relation to MAPPA funding in light of the increasing number of MAPPA managed individuals and the increasing complexity of their needs.

On occasions strategic practice gaps relating to an awareness of MAPPA processes and policies were identified. These gaps were in relation to practice by Probation and an NHS CTLD. A practice gap was also identified where a Children's Social Care service had failed to complete an assessment relevant to the management of an individual under MAPPA (this was in relation to an incomplete S.47 assessment). In the process effectiveness analysis (Mann & Lundrigan, 2023), practitioners raised concerns around the level of training received. A number of practitioners, particularly those from DTC agencies, felt they lacked a level of understanding necessary to make best use of MAPPA. It seems that these concerns may have been well founded and in order to avoid future occurrences, standardised training delivered via a national training package, as recommended elsewhere in the National MAPPA research, would be highly beneficial.

3.3 Quality of the Reviews

The reviews in the sample varied significantly in terms of content, detail, length and depth. Basic personal and potentially protected characteristics of individuals managed under MAPPA were lacking. Victim characteristics (personal and potentially protected) were almost totally absent. Interestingly, the most recent MAPPA Annual Report (2020 /21) has noted that the presence of such characteristics (as they relate to the MAPPA managed individual only) is desirable and have included an experimental data section on diversity in their annual report. This would suggest that the national MAPPA team has begun to understand the importance of such data, although at present there is no section on victim characteristics.

Whilst some of the reviews analysed were of good quality and contained a breadth of contextual and analytical information and learning, many were predominately descriptive and failed to capture the 'why' in relation to the practice gaps identified in their conclusions. This may be a consequence of practice guidance relating to the conduct of a SCR (MAPPA, 2022) which is considerably less prescriptive than guidance relating to the conduct of DHRs and SARs.

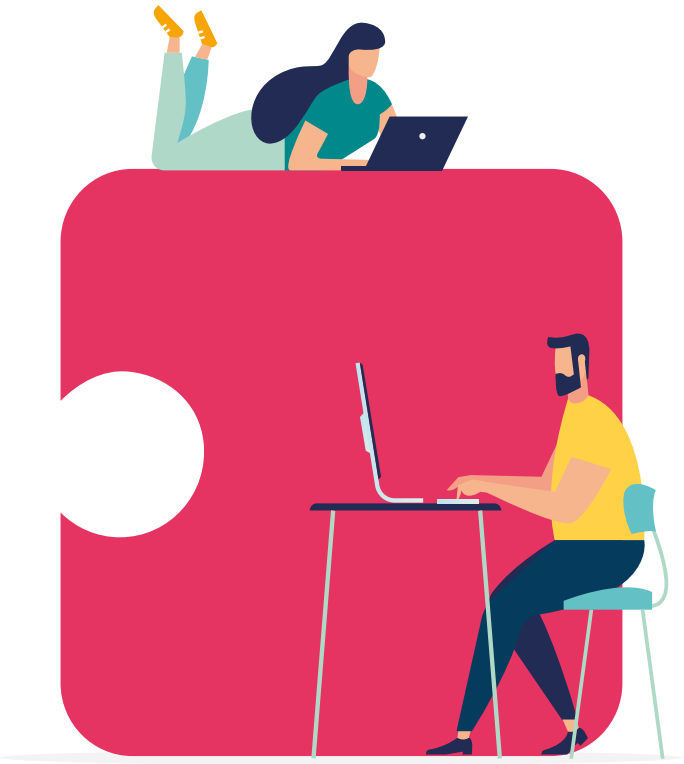
A further issue with regards to capturing the 'why' in relation to the quality of the reviews sampled, may be a consequence of the make-up of the SCR review team itself. Considering the prevalence of violence against women and girls (VAWG) crime types across the sample, it is somewhat surprising that none of the reviews invited specialist representation from the VAWG sector to inform learning. Again, this may be a consequence of the MAPPA SCR guidance, which does not specifically call for such representation.

3.3.1 Characteristics of perpetrators and victims

MAPPA guidance on SCRs leaves significant room for interpretation and the SCRs analysed in this research varied greatly in terms of the information recorded in relation to the perpetrator and the victim. The sex of the perpetrator was well recorded in all SCRs; they were all male and all were aged between 17 and 60 years (at the time of the offence leading to the SCR). Within the sample, age appeared to be a contributing factor to the practice gaps identified where the perpetrator was at the younger end of the range. The age of the perpetrator was not, however, provided in six of the SCRs analysed. Poor recording was replicated in relation the ethnicity of the perpetrator, which was recorded in just three of the 19 SCRs.

Information on perpetrator vulnerability were included in some of the SCRs. The most frequently recorded vulnerabilities related to accommodation needs, poor mental health, and substance misuse issues. Poor physical health was detailed twice, and a learning disability referred to once. In two of the SCRs, the perpetrator had been supported by child safeguarding services immediately prior to the offence which necessitated a SCR. Many of the SCRs within the sample contained scant information relating to the victim(s). Across the sample of 19 SCRs. Three contained no detail whatsoever. Where the SCR did contain details relevant to the victim, findings show that females were disproportionately affected (74% of the total number of victims). Two children, both female, were also identified as victims across the sample, and in three SCRs the victim's sex was not recorded. The ages of the victims, where identified, ranged from 11 to 49 years, however, the majority (15 of 19) of SCRs in the sample did not state the victim's age, and none recorded the ethnicity of the victim. Only two SCRs recorded any detail regarding victim vulnerabilities, and these were in relation to physical health problems and physical disability.

The lack of basic information, and that relating to potentially protected characteristics of the perpetrators and the victims within the SCRs, highlights an inadequacy of the current guidance. At present SCRs do not capture all the information available and as such, opportunities to gather data around issues which are central to understanding the increasingly complex needs of MAPPA managed individuals and their victims, are missed. As are the significant opportunities for learning which could stem from an interrogation of this data if it were collected.



Recommendations

- The National MAPPA Team should provide clear guidance on agencies' powers to share information under MAPPA, in light of the new legislation

4 Strengths and Limitations

The current research has several strengths:

The research:

- Is the first analysis of MAPPA SCRs conducted
- Examined all SCRs available in the five sample areas
- Examined multi agency learning across all responsible authority and DTC agencies featured in the reviews
- Presented findings relating to victim and perpetrator demographics as well as identifying gaps in multi-agency operational and strategic practice

It is also important to document the potential limitations of the study which may impact on the generalisability of the findings. Firstly, in comparison to the volume of SCRs analysed by the VKPP, the sample utilised for the current project was small. However, discussions with the VKPP throughout the analysis established that the practice gaps and learning identified in the SCRs from the five sample areas, was consistent with those being identified within the VKPP sample. Second, the reviews within the sample span a ten-year period, and whilst every effort has been made to include examples of more current practice, some of the practice identified within this report may be less common or less problematic today under revised guidance.

Third, we were not able to include all SCRs that took place in the five sample areas over the requested time period. Of the 31 SCRs undertaken, only 19 were submitted for analysis. The omitted SCRs were often unlocatable by the current SMB because staff had moved on and it was not known where older reviews were filed or stored. MAPPA guidance (2021) requests that SCRs are sent to the national MAPPA team for central storage, however, it seems that this does not always happen, particularly in the case of older SCRs.

5 Conclusion

As stated previously, the majority of practice gaps relating to the activities of the MAPPA responsible authority agencies and DTC agencies identified in the current research reflected those previously identified in published analyses of DHRs, SARs and CSPRs.

Subsequently, addressing these gaps requires a substantial, concerted and coordinated effort on behalf of the respective bodies charged with monitoring the learning arising from such reviews.

The quality of the SCRs in the sample, and consequently the quality of learning arising from them, was directly impacted by the MAPPA SCR statutory guidance, which in comparison with other statutory guidance frameworks, was not considered sufficiently prescriptive. In order to improve the overall quality of MAPPA SCRs, the statutory guidance should be updated and should draw on that used in cases of domestic homicide and adult safeguarding.

6 Recommendations

This component of the National MAPPA Research has examined all SCRs submitted from the five sample areas, since 2012.

It has demonstrated that despite examples of good practice, a number of multi-agency operational and strategic practices reoccur within SCRs. The findings from this research support those of the VKPP's analysis on police learning from MAPPA SCRs. Together these reports clearly identify the areas where MAPPA practice requires improvement. Five recommendations are made.

Recommendation
The national MAPPA team should hold copies of all SCRs in a central repository, which can be used to disseminate learning more effectively and provide a searchable learning resource for MAPPA practitioners.
Statutory guidance on SCRs should be updated and should draw on the adult safeguarding serious case review (ASCR) and domestic homicide review (DHR) guidance.
Reporting of all demographic and vulnerability data (including protected characteristics) on both the victim and the perpetrator should become mandatory in SCRs. Reporting should, however, exclude any identifiable data on serious further offences.
Cross-region information sharing agreements in each MAPPA area should be developed.
Quality assurance processes should be developed in each MAPPA area. These should include the screening (through dip sampling) of risk assessments and risk management plans.

Table 4: Recommendations

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