

HM Inspectorate of Probation

**Independent serious further offence  
review of Jordan McSweeney**

January 2023

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## Acknowledgements

This independent review was led by Simi O'Neill, Head of Probation Inspection at HM Inspectorate of Probation and HM Inspector Lizzie Wright. We would like to thank all those who helped plan and took part in the review.

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### Published by:

HM Inspectorate of Probation  
1st Floor Civil Justice Centre  
1 Bridge Street West  
Manchester  
M3 3FX

Follow us on Twitter  
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ISBN: 978-1-915468-70-3

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# 1. Foreword

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On 14 December 2022, Jordan McSweeney was sentenced to life imprisonment, with a minimum term of 38 years, having pleaded guilty to the murder and sexual assault of Ms Zara Aleena. These offences occurred as Ms Aleena walked home, alone, with Mr McSweeney following her, before he subjected her to a sustained physical and sexual assault. This crime has devastated her family and shocked the local community and beyond.

Jordan McSweeney was subject to probation supervision when these offences occurred. The Probation Service typically conducts a Serious Further Offence (SFO) review when an individual on probation commits a serious violent or sexual offence. However, in this case, the Secretary of State for Justice asked me, as Chief Inspector of Probation, to conduct an independent SFO review into the Probation Service's management of Jordan McSweeney.

This report sets out the findings of that independent review. My inspectors found that the assessment of the level of risk posed by Jordan McSweeney was inaccurate given information that was known regarding past offending, behaviour in custody and patterns of behaviour. Subsequently this impacted on the way his case was managed and the level of oversight he was subject to.

Had the correct assessment of risk of harm been undertaken to identify that Jordan McSweeney posed a high risk of serious harm, actions taken in terms of pre-release planning, plans for accommodation on release and speed of response to non-attendance after release could have been significantly different and potentially more urgent.

Following his most recent sentence, in April 2022, there were significant delays in McSweeney's case being correctly allocated to a probation officer in the community. This impacted on the time available to update his risk assessment and plan effectively for his release on 17 June 2022.

Following his release, and successive probation appointments being missed, the Probation Service failed to take prompt action in respect of recalling him to custody. Once that decision was made there were also delays in signing the paperwork to initiate the recall. Had this been undertaken sooner, opportunities for the police to locate and arrest Jordan McSweeney would have been maximised.

The practice deficits in this case are set against a backdrop of excessive workloads and challenges in respect of staffing vacancies in the London region. I have commented on this in recent local probation inspections and the recommendations made in this report correspond to many of our findings in these. This is far from the first time we have made recommendations relating to the need to improve the assessment and management of the risks of serious harm to the public posed by some people on probation. The need for us to repeat them yet again raises questions as to whether HMPPS is learning the lessons of past mistakes. It is vital that they do so in the future.



**Justin Russell**

HM Chief Inspector of Probation

## 2. Background to the review

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On 26 June 2022, Ms Zara Aleena had been out socialising with a friend and was walking home in the early hours of Sunday morning in Ilford, Essex, when she was physically attacked and sexually assaulted. CCTV footage showed a white male, identified to be Jordan McSweeney (JM) following Ms Aleena and attacking her from behind. The victim suffered multiple injuries, including serious injuries to her head. She sadly passed away later in hospital. On 14 December 2022, JM was sentenced to life imprisonment with a minimum term of 38 years.

At the time the offence was committed, JM was supervised by the Probation Service – London region, having been released from custody on 17 June 2022. He had previously received a 16-month custodial sentence on 13 April 2022 for five counts of possession of an offensive weapon, three offences of criminal damage and one racially aggravated public order offence. All the index offences were committed whilst in custody serving a previous 32-month sentence for burglary.

JM's arrest for murder constituted a Serious Further Offence (SFO). SFOs are specific violent and sexual offences committed by people who are, or were very recently, under probation supervision at the time of the offence. They are committed by a small proportion of the probation caseload (fewer than 0.5 per cent)<sup>1</sup> however, while this percentage is small, for the victims and families involved, the impact and consequences are devastating and cannot be underestimated.

An SFO review is triggered when a person is charged and appears in court for a qualifying offence alleged to have been committed while they were under probation supervision or within 28 working days of the supervision period terminating. These reviews are normally internal management reports conducted by the Probation Service itself but, occasionally, the Secretary of State for Justice asks HM Inspectorate of Probation to review a particular case, or aspects of a case, as he did in this instance on 01 July 2022.

To inform this independent review, HM Inspectorate of Probation has reviewed the quality of the work undertaken by the Barking, Dagenham, and Havering (BDH) probation delivery unit (PDU), within the London Probation region (see annexe 1 for terms of reference). Current probation practice guidance, policy documents and relevant strategies have also been considered at a local, regional, and national level. Given JM had been released from custody 10 days prior to the SFO, practice and policy was also explored in HMP Belmarsh, by colleagues from His Majesty's Inspectorate of Prisons.

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1. Ministry of Justice and HM Prison and Probation Service. (2021). [Notification and Review Procedures for Serious Further Offences Policy Framework](#).

### 3. Chronology of events

This chronology outlines the significant events relating to JM's offending history and identifies any practice issues that emerged while he was subject to prison and probation supervision.

<b>1993</b>	JM is born.
<b>2005</b>	First reprimand received for two offences of common assault.
<b>2006</b>	First conviction for an offence of non-dwelling burglary which was his first involvement with youth offending services.
<b>2009</b>	First custodial sentence - Detention and Training Order (DTO), for offences of non-dwelling burglary, two counts of taking vehicle without consent and theft.
<b>2010</b>	First violent offence was ABH in 2010 and Battery committed in 2010 for which he received a detention and training order (DTO).
<b>2012</b>	First adult custodial sentence for offences of two dwelling burglaries, possession of cannabis, theft, and breach of suspended sentence order.
<b>2014</b>	Sentenced to three years in custody for six dwelling burglaries, three counts of theft of vehicle and making off without payment.
<b>2015-2018</b>	Three further periods of custody imposed - for burglary non-dwelling (two years), failing to surrender (14 days served) and his first offence of being in possession of an offensive weapon (eight weeks).
<b>March 2019</b>	Sentenced to 32 months in custody for burglary and driving offences.
<b>September 2020</b>	JM released on licence on 28 September 2020 to run until 06 October 2021.
<b>November 2020</b>	JM charged with offences committed whilst previously in custody; offences of carrying offensive weapons, criminal damage, and racially aggravated public order, all committed whilst in HMP Isis and HMP Belmarsh.
<b>January 2021</b>	JM due to appear in Court on 27 January 2021 for the above matters, however adjourned as JM could not attend owing to medical reasons and lack of funds to travel. The case was adjourned until 17 February 2021.
<b>02 February 2021</b>	JM appeared in court having been held in police custody, for offences of Section 18 Grievous Bodily Harm and Robbery, allegedly committed on 30 January 2021. Decision was made to recall by CRC1 following the new charges, initiated on 03 February. The alleged victim was a female friend of JM's mother. There was no assessment of his risk escalating or a new risk and needs analyses of the new matters.

<b>05 February 2021</b>	Recall paperwork sent and licence revoked on the same day.
<b>25 March 2021</b>	<p>JM appeared at Court in respect of the offences committed in custody. The case is adjourned, and remand extended. At this juncture there are three live events:</p> <ol style="list-style-type: none"> <li>1. Subject to recall on current sentence.</li> <li>2. Subject to remand for Section 18 GBH and Robbery.</li> <li>3. Subject to remand for offences committed in custody.</li> </ol>
<b>August 2021</b>	JM found not guilty of Section 18 GBH and Robbery following trial. Judge imposed three-year restraining order to protect complainant.
<b>06 October 2021</b>	Sentence for burglary expired and JM remained in custody on remand. JM remained registered with the Integrated Offender Management (IOM) scheme on the "black-list" <sup>2</sup> which ensured his case was reviewed pending sentence/release date.
<b>December 2021</b>	Case allocated by SPO1 to PO1 under remit of non-statutory IOM case.
<b>December 2021</b>	Case heard at IOM meeting. His upcoming court case was discussed but no other information was discussed about his case.
<b>February 2022</b>	PO1 met JM for the first time via video link to "gain basic information". regarding "childhood, family, ETE and his general behaviour since being in custody". No further details or analysis were recorded.
<b>February 2022</b>	JM's mother contacted PO1 advising JM could not live with her on release and concerns about him returning to the local area. This related to him "associating with negative peers and getting involved in crimes" as well as potential risks to him from others.
<b>February 2022</b>	PO1 requested JM's custody records for the past 12 months, which were not received.
<b>13 April 2022</b>	Sentenced to 16 months custody offensive weapon x 6, criminal damage and racially aggravated public order committed whilst in custody.
<b>April 2022</b>	Prison set the release date as 17 June 2022 taking account of the six months spent on remand since October 2021. This meant that JM should have been allocated a community offender manager (COM). This did not happen however until June 2022, leading to a two-month delay in formal allocation to a named probation officer.
<b>17 May 2022</b>	JM's case discussed at IOM case management meeting. JM had put forward his grandmothers address as his proposed release address. PO1 told the meeting JM's mother did not want him to reside with her. This meeting is not recorded on probation case management system, known as NDelius.

<sup>2</sup> London Integrated Offender Management- managing persistent violent offenders, Updated Operating Framework V2.0 –October 2021

<b>27 May 2022</b>	IOM police visited JM's grandmother's home, who was not able to accommodate him owing to previous anti-social behaviour.
<b>07 June 2022</b>	Video link meeting held by PO1 and POL1 with JM to discuss release plans. There was no release address at this stage (only 10 days before release) and referrals were made for support with housing on release.
<b>08 June 2022</b>	After a two-month delay, JM's case is finally allocated formally to PO1 in Barking, Dagenham and Havering probation area – allowing only nine days before release for pre-release planning and assessment.
<b>09 June 2022</b>	PO1 returns the pre-discharge form to HMP Belmarsh. In addition to the standard licence conditions, PO1 requested the following: <ul style="list-style-type: none"> <li>• drug testing</li> <li>• attendance at "Catch 22", an organisation commissioned by the probation service to provide a personal well-being service.</li> </ul>
<b>17 June 2022</b>	JM released from custody with no clarity of his release address.
<b>17 June 2022</b>	JM failed to attend his initial appointment, PSO2 telephoned JM's mother. He was at her address, intoxicated and "passed out" under the influence of alcohol. PSO2 advised he should not attend under the influence and issued an appointment for 20 June 2022 with PO1. A first warning "compliance" letter was sent to his mother's address.
<b>20 June 2022</b>	JM failed to attend as instructed. PO1 contacts JM's mother who had not seen him since Friday (17 June). SPO5 advised PO1 to check with IOM police if there have been any arrests or contact with the police since release to inform next steps. PO1 issued a further appointment for 22 June 2022 by way of a further compliance letter to mother's address.
<b>21 June 2022</b>	PO1 received information from IOM police stating no contact with him, and no arrests are recorded. His whereabouts remain unknown.
<b>22 June 2022</b>	JM failed to attend again. PO1 discussed recall with local Head of Service (HoS1), described as an informal discussion. HoS1 advised recall should be considered, recall is initiated and sent to SPO1 for countersigning.
<b>24 June 2022</b>	SPO1 signs recall report 48 hours later (outside the 24-hour turnaround time set out in guidance), endorsed by HoS1 and sent to the central HMPPS public protection casework section (PPCS) at 15:01. This team finalises the recall and issue the licence revocation – the notification is issued by PPCS at 16:10, giving police powers to arrest and return to custody.
<b>26 June 2022</b>	JM murdered Ms Aleena in the early hours of 26 June 2022.

## 4. Summary of key findings:

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Our Inspectors have found that, overall, there were significant omissions and practice deficits which impacted on the management of this case, outlined in the summary below.

### **Risk of serious harm – inaccurate assessments and underestimation of risk**

JM was managed as a “medium risk of serious harm Integrated Offender Management (IOM) acquisitive individual” however his level of risk should have been escalated to “high” in February 2021, based on the range of information available on his past history of violence as well as acquisitive offending. There was information known about risks present in custody, such as possession of weapons, violent and threatening behaviour. In addition, he had carried weapons in the community, as well as the risks posed to known adults. The risk to the public, staff and other prisoners, should have been assessed as high risk of serious harm. The risk of serious harm to known adults should also have been high based on information related to offences against a known female received in 2021, which later resulted in a restraining order being imposed.

The risk should have been reviewed by the Community Rehabilitation Company (CRC) who were responsible for the case at that time. JM’s persistent poor behaviour in custody was seen in isolation and risk management in the community was not given sufficient consideration. The risk of harm posed was not viewed holistically in this case, with the focus being on acquisitive offending, and a thorough assessment of other presenting risk factors was missing.

The lack of effective information sharing between prisons and probation contributed to an incomplete picture of JM’s risks and potential for violence and disruptive behaviour. The fact he spent a significant proportion of his adult years in custody made it difficult to gather significant information about his circumstances and potential behaviour in the community. This strengthens the need for effective information sharing to ensure all known risk factors, behaviours and intelligence is gathered to produce effective risk management plans to use both whilst in custody and when in the community.

Had he been correctly assessed as high risk of serious harm – specifically in respect of other prisoners, staff, known adults and the public – the planning for release, licence conditions, reporting instructions, and action taken when he failed to attend on release could have been significantly different and potentially more urgent (for example following his failure to attend initial probation appointments on 17 and 20 June). He may also have been eligible for joint Multi Agency Public Protection<sup>3</sup> (MAPPA) management, and for consideration for an Approved Premises<sup>4</sup> (AP) placement, which would have afforded more monitoring of his risk in the community as well as opportunities for rehabilitation.

With the correct risk assessment, it is likely that the level of monitoring through the IOM arrangements would have been enhanced, allowing timely responses to non-compliance but more importantly, contributing towards a release plan appropriate to the risk posed.

A critical omission in the case was the failure to apply sufficient professional curiosity and management oversight to ensure all available information was analysed to assess the risk

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<sup>3</sup> MAPPA- Multi-agency public protection arrangements- The purpose of the Multi-Agency Public Protection Arrangements (MAPPA) framework is to reduce the risks posed by sexual and violent offenders in order to protect the public, including previous victims, from serious harm.

<sup>4</sup> Approved premises (APs) are residential units which offer an enhanced level of public protection in the community and are used primarily for high and very high risk of serious harm individuals released on licence.



posed by Jordan McSweeney. This review identifies that a significant amount of information became known regarding his circumstances confirming that he was in a relationship, had a stepchild and deteriorating family dynamics, particularly regarding his mother. While information was recorded, there was little evidence of this being explored in any detail or informing assessments undertaken by agencies. This led to risk factors being assessed in isolation and not building a picture of the overall risk posed.

The inaccurate classification of risk was a key theme in our recent PDU inspections in London. Of the 137 medium risk of serious harm cases that were inspected across six local probation areas, seven per cent were deemed to have had their risk underestimated and should have been rated as high risk of serious harm rather than medium<sup>5</sup>. Whilst this is only a sample, it does demonstrate the urgent need to ensure risk categorisations are accurate.

## **Case Allocation**

There were issues highlighted with the allocation of JM's case. Although JM received 16-months in custody, taking into account his time spent on remand, he only had two months left to serve in prison at the point of his sentence and so his case should have been allocated directly to a community practitioner. The processes for allocating cases when a custodial sentence is imposed is confusing and cumbersome, impacting significantly on pre-release planning. Had allocation taken place correctly and earlier, probation staff would have had more opportunity to consider the risks posed by this individual and to amend the risk of serious harm assessment. As outlined above, this would have allowed for the exploration of other release arrangements and restrictive conditions.

## **Enforcement decisions and recall process**

JM had a history of non-compliance. However, during his periods on licence, delayed decision-making by probation staff and ineffective management oversight resulted in non-compliance continuing without relevant action being taken. Following his release on 17 June, there were missed opportunities to recall JM following failed appointments and risk factors emerging. Recall should have been initiated following non-attendance on 20 June 2022, but management consultation did not consider recall and efforts made to locate JM were insufficient.

When the recall was initiated on 22 June, this occurred following an informal discussion and PO1's manager SPO1 was not fully included in the process. A delay to signing off the recall until 24 June, outside the 24-hour target specified in the related guidance<sup>6</sup>, meant the recall was not timely and ultimately delayed the opportunity for JM to be arrested by police.

Data indicates that the public protection casework section (PPCS), who process licence revocations in HMPPS, take an average of seven<sup>7</sup> hours to issue a licence revocation. National data on recalls also shows that the median time<sup>8</sup> between licence revocation and a return to prison custody is three days. Had a recall been initiated following the missed appointment on 20 June, or completed within the specified timescale on 23 June, the time for police to locate and arrest JM would have been maximised.

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<sup>5</sup> HM Inspectorate of Probation data aggregated from London PDU inspections 2022

<sup>6</sup> Recall, Review and Re-Release of Recalled Prisoners Policy Framework April 2019 reissued July 2022

<sup>7</sup> Data provided the HMPPS Public Protection Casework Section (PPCS)

<sup>8</sup> The "median" is the midpoint in the data set for recalls, half will take up to three days to be returned to custody, half will take longer than this, with some taking much longer.

### **Diverse needs**

Throughout the records relating to JM, differing needs are highlighted. At different junctures records stated JM had Attention Deficit Hyperactivity Disorder (ADHD), Personality Disorder (PD) and had suffered from depression. He was stated to be medicated at various times for ADHD, but little analysis was undertaken of how this affected his day-to-day cognitive functioning and learning styles, and if there were links with offending behaviour.

## 5. Recommendations

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Between July and October 2022 HM Inspectorate of Probation inspected six PDUs in the London Region. Barking, Dagenham and Havering PDU was one of those inspected, many of the findings from this independent review mirror those from the London PDU inspections<sup>9</sup>. They focus on critical concerns such as the quality of work to assess and manage risk of serious harm, the delivery of interventions, information sharing between agencies, quality assurance processes and management oversight, staff training and development, and resourcing and retention of staff. These recommendations are relevant to the practice observed in the case of JM. It is crucial that the service deals with these broader issues to address the practice deficits, and wider systemic issues identified in this independent review.

Notably, some recommendations in this report mirror what has previously been recommended by His Majesty's Inspectorate of probation, particularly in the independent review of Joseph McCann<sup>10</sup>. **It is therefore imperative that these are actioned urgently given they have been highlighted previously as recommendations.**

This independent review makes a further nine recommendations specific to the case of JM.

### **HMPPS should:**

1. conduct a thorough, senior led review of the processes its staff use to assess the risks of harm that people on probation may pose to others, to ensure that all staff understand and apply the correct criteria for identifying high risk of serious harm cases and that this then informs robust and appropriate risk management plans and regular reviews. **This action should be conducted urgently**
2. implement effective arrangements to ensure all risk of harm assessments, including at pre-sentence stage, are quality assured for accuracy until regular and appropriate management oversight arrangements are established, given the national staffing resource shortage and middle management oversight limitations
3. develop processes to ensure all known information on past behaviour or current risks in prison or the community is available to probation practitioners and is properly analysed when formulating risk assessments pre and post sentence
4. create robust processes to record and analyse on probation case files when a person on probation is acquitted of offence(s) and where information remains relevant to inform risk of harm assessment and management
5. while cases are in custody ensure timely and accurate allocation of each case to probation practitioners in the community for supervision before and after release and a mechanism for checking this process
6. **undertake an urgent review** of processes for information and intelligence sharing between prisons and the probation service to be completed by June 2023. (A recommendation from the independent review of McCann, this should be given urgent attention given issues are still apparent).
7. develop processes to ensure that all recall decisions are signed off and submitted by Senior Probation Officers within the 24-hour target period – with compliance against this target monitored in every Probation Delivery Unit on at least a monthly basis

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<sup>9</sup> An inspection of probation services in: Barking, Dagenham and Havering PDU ([justiceinspectorates.gov.uk](https://justiceinspectorates.gov.uk))

<sup>10</sup> Independent review of Joseph McCann- HMIP 2020

8. ensure that data on the time from licence revocation by HMPPS Public Protection Casework Section to an individual being received into prison custody is monitored on a regular basis by HMPPS jointly with the National Police Chiefs Council (NPCC) and that joint probation and police plans are agreed for maximising performance against this metric
9. ensure the EPF2 tool is used when determining licence conditions and develop a mechanism for effective management oversight of this process to ensure that all appropriate licence conditions, including GPS tagging, are applied after release
10. develop a London wide initiative on neurodiversity and invest in trauma informed training for staff.

### **History of offending behaviour, analysis of probation supervision and period in custody.**

The following sections analyse practice during JM's most recent custodial sentence and the period following his release leading up to the SFO. There is also analysis of the previous custodial sentence imposed in 2019, as well as a summary and consideration of key themes from 2012 to 2018 when he was subject to various prison sentences.

## 6. Period of supervision prior to the SFO

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### Pre-release period April 2022-June 2022

JM was sentenced to 16 months in custody on 13 April 2022. As his remand into custody period started in October 2021, this resulted in him having only two months to serve on this sentence, meaning he would be released on 17 June 2022.

The process of allocating cases, like JM's, to a probation officer in custody (a Prison Offender Manager – POM) and in the community (a Community Offender Manager – COM) is complicated and unclear. London Probation Service region have their own additional bespoke process for case allocation of people subject to a custodial sentence<sup>11</sup>. The case allocation depends on the length of custody and the level of risk of serious harm. For JM, the process of allocation was delayed. The process states that only cases with eight-months custody or more, and a minimum of 16 weeks left to serve, should be allocated to the Offender Management in Custody (OMiC) process. Although JM received a custodial sentence of more than eight months, he did not have 16 weeks left to serve, owing to time spent on remand. This information was not available to the service centre, the probation administrative hub in London who were undertaking the allocation, nor was it known by probation court staff.

JM's case should have been allocated directly to a Community Offender Manager (COM) from the outset, but this only happened when the prison sent out a form to ask for relevant licence conditions to be returned and noted he had no practitioner assigned by the PDU. This didn't happen in JM's case until 08 June 2022, which was nearly two months after sentence. Therefore, time for formal release planning was minimal and very limited. This was significant as information regarding the restraining order, weapons, and behaviour in custody (referred to in the chronology above) was not assessed, and the opportunity to undertake domestic abuse and safeguarding enquiries was missed.

JM was allocated a prison offender manager (POM1) who undertook a basic custody screening tool (BCST)<sup>12</sup>, however this did not contain information known about JM in other records. For example, the document said he had five children, when probation records stated he had one stepchild. We discussed the process for BCSTs with prison colleagues. It was ascertained that information contained in BCSTs was often taken at face value and not verified by any means other than self-report. Whilst it is acknowledged the BCST document is not classed as an assessment, it is important that information is accurate as it is shared via the probation case management system, NDelius, with probation staff. If there is no mechanism for ensuring information is accurate, this calls into question the reliability and sufficiency of these screening tools.

There was limited communication between the prison offender manager (POM1) and the community probation officer (PO1), prior to release. POM1 was not invited to join a video link meeting with JM, PO1 and the IOM police officer (PLO1) on 07 June 2022. PO1 attributed the limited contact, with POM1, to their excessive workload and the limited time available given the late allocation. There was limited evidence of other exchanges of information and PO1 did not review the BCST completed by POM1.

Once the prison had contacted Barking, Dagenham, and Havering (BDH) Probation delivery unit (PDU) regarding the licence conditions and the lack of assigned community probation officer, SPO2 allocated the case to PO1. SPO2 has the lead for allocating cases in BDH,

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<sup>11</sup> Allocation screening process map

<sup>12</sup> Basic custody screening tool – a basic version of OASys completed in custody.

undertaking between seven to 10 allocations per day. This was described as challenging, given their additional responsibilities of managing a team within BDH.

SPO2 allocated the case to PO1 owing to their previous and ongoing involvement with JM as an IOM case, since December 2021. SPO2 would usually send a detailed email to the receiving practitioner with details of the case, relevant dates, and actions to be taken. However, this information was not included in the email to PO1. SPO2 stated that, as JM's case was already known to PO1, less time would have been spent on that allocation as new cases required more time. It was acknowledged that little information was shared, and risk was not reviewed. This should have occurred, especially given PO1 was a newly qualified officer (NQO) and should have benefitted from additional support. SPO2 was not aware of the restraining order that had been imposed. Given their workload, SPO2 stated it was not possible in such cases to review all the information for known cases.

The lateness of allocation to a community offender manager (POM), the lack of detail included in the allocation and the subsequent lack of review of risk, meant that a clear picture of the risks posed by JM were not gained prior to his release.

The request for licence conditions was returned to the prison by PO1 on 09 June 2022, requesting two additional conditions be added to the licence; drug testing, and attendance at "Catch 22", an organisation commissioned by the probation service to provide a personal wellbeing service. The purpose of this was to address offending behaviour. Both these conditions were appropriate, however further conditions should have been considered to enhance monitoring and engagement on release, such as a condition to engage with IOM, which we would have expected to see and secondly, a curfew or GPS tagging to have been considered. In addition, on the basis that inspectors deemed JM to pose a high risk of serious harm, a referral for an approved premise should have been undertaken.

The Mayor's office for policing and crime (MOPAC)<sup>13</sup> have funded an initiative in London that those convicted of knife crime are considered for GPS tagging on release, as part of their licence. PO1 had not considered this and recognised it would have been an added measure to manage JM on release, particularly given his history of non-compliance. Although it was not clear prior to release where JM would be living which would make a curfew difficult to impose, it was planned for him to have an emergency housing assessment on release so was still an option. With regards to the IOM condition, PO1 stated this was an oversight and should have been included.

PO1 confirmed there was no liaison with SPO1 regarding licence conditions and they did not utilise the Effective Proposal Framework (EPF)<sup>14</sup> tool to identify conditions to include. SPO1 explained management oversight would not routinely be involved; only if "there were concerns or if the person on probation was questioning why conditions had been put on" and that there is an expectation that practitioners utilise the EPF. There was no mechanism to provide oversight.

Information during this period suggests JM was medicated for attention deficit hyperactivity disorder (ADHD) which was confirmed by HMP Belmarsh. PO1 was also aware of this diagnosis prior to release in June 2022. There was no evidence to suggest this was discussed with JM, how it affected him, and any specific adaptations which were needed to ensure effective engagement.

### **Key findings:**

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<sup>13</sup> GPS Knife Crime Tagging Interim Evaluation Report February 2020 Valerie Forrester and Tim Read MOPAC Evidence and Insight

<sup>14</sup> The EPF tool is designed to assist practitioners when making decisions regarding interventions and licence conditions to ensure all relevant options have been considered.

- The case was not formally allocated to a probation officer in the community until 08 June – nine days before JM’s release from prison, delaying assessment and planning for release.
- All relevant information was not sufficiently analysed to inform the assessment of risk posed.
- Effective and appropriate licence conditions were not considered, despite there being tools in place to support such decisions.
- Management oversight was ineffective and failed to provide the necessary support for newly qualified staff, making assumptions about their knowledge of the case.
- Pre-release assessments were not reviewed, or cross referenced with information known to the probation service, impacting on the release plans, and keeping people safe.
- JM’s ADHD was not fully assessed or considered in the management of his case.



## **7. Release from custody – 17 June 2022 to commission of SFO – 26 June 2022.**

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JM failed to attend his initial planned appointment on the day of release. He was due to see PSO2, as PO1 was not in the office that day. After he failed to attend, PSO2 contacted JM's mother by telephone. She advised that JM was at her house but was intoxicated and "passed out" under the influence of alcohol. PSO2 advised that he should not attend the office under the influence and gave a verbal instruction to his mother for him to attend on Monday 20 June with PO1. A first warning "compliance" letter was sent to his mother's address.

Inspectors were unable to speak with PSO2 due to being away from work, however it became evident there was no discussion with SPO1, in the absence of PO1, regarding this failure to attend. When discussed with managers, the consensus was that it was usual to offer medium risk of serious harm cases who were managed via IOM, further chances to attend, to account for complexities and likelihood of non-compliance. A term used was that cases such as JM would usually "rock up" at some stage. This was indicative of using a generic approach to the management of the IOM cohort, rather than assessing a case on its own merits. Additionally, there were issues linked with the risk that JM posed, such as a lack of stable accommodation and use of alcohol, which should have been considered. Given previous concerns raised by JM's mother regarding him being at her address, this should have also been considered.

JM failed to attend the second appointment with PO1 on Monday 20 June. PO1 telephoned JM's mother, who stated he was no longer at her address and she had not seen him since Friday. PO1 consulted with SPO5 on what steps to take and whether recall should be initiated. SPO1, who was the line manager for PO1, was unavailable. SPO5 advised PO1 to undertake intelligence enquiries with the IOM police, then on receipt of the results, to consult again regarding further action the following day.

SPO5 had limited knowledge of the case, and used the information presented by PO1 to inform the advice. SPO5 did not consult HoS1 regarding the non-compliance, advising that SPOs have "discretion" when to consult and did not feel this was necessary until the results of enquiries and all known avenues had been explored. HoS1 had expected to be consulted when the recall threshold had been met, as this was the usual practice within the PDU. A limited amount of time was dedicated to the case by SPO5 due to their own work pressures. PO1 duly undertook the enquiries with IOM police, and in addition, issued a letter to JM, via his mother's address, with an appointment to attend on Wednesday 22 June. This was another compliance letter, indicating recall was not being considered. Guidance<sup>15</sup> suggests that given recall had been considered as part of the discussion with SPO5, the "decision not to recall" letter should have been issued instead. Furthermore, whilst sending a letter is good practice, HM inspectors questioned the likelihood of this being received or read by JM, given that a) his mother had stated he was not at her address, and b) the two-day window for it to arrive through the post.

On Tuesday 21 June, PLO1 (IOM police officer) sent information to PO1 confirming JM had not been arrested or had any contact with police since release. No further action was taken in respect of this information until the following day, when JM failed to attend the appointment communicated in the compliance letter.

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<sup>15</sup> Compliance and Engagement on licence guidance- EPSIG and PPCS November 2021

Following JM's failure to attend on Wednesday 22 June, PO1 had an informal discussion with HoS1 whilst both were on a break. PO1 took the opportunity to mention JM's case to HoS1 to seek advice. HoS1 suggested JM should be recalled, following which PO1 completed a recall report and sent to SPO1 for countersigning on the afternoon of 22 June. Inspectors were informed by HoS1 that this was an informal conversation, and they expected that PO1 would discuss it further with SPO1 so the usual process could be followed. However, PO1 considered this an instruction to recall, and started the process for recall.

It was an omission by PO1 not to consult with SPO1, who was not consulted about the case on either JM's release date of 17 June, or the 20 June when he failed to attend for a second time, and only mentioned in passing the recall had been agreed on the 22 June after the third failure. SPO1 received the recall report following the third failure to attend. At that time, SPO1 was faced with significant staffing issues, as six staff were off work, four on long-term planned leave and two on short-term unplanned leave. In the absence of one staff member who held a high risk of serious harm caseload, SPO1 was managing that caseload themselves owing to lack of options to reallocate. SPO1 commented "I was an SPO and a PO at the same time, so I was doing the work and having to manage at the same time" which indicated her excessive workload.

SPO1 did not sign the recall report until Friday 24 June. The recall process<sup>16</sup> states a licence recall should be actioned, endorsed and submitted to the public protection casework section (PPCS)<sup>17</sup> within 24 hours of initiation. In this case, that should have taken place on 23 June 2022. SPO1 confirmed it was an oversight not to sign it on 23 June, which was linked to their excessive workload. Furthermore, they had not been involved in formal discussion regarding the recall. SPO1 commented: "It wasn't at the top of my head as it was only discussed in passing". In addition, there is no process in place to remind SPOs that recalls are due to be received and signed.

The report was eventually signed on 24 June and endorsed by HoS1, then submitted to the PPCS in HMPPS headquarters. The licence was revoked at 16.01 on the same day. If the recall report had been signed and submitted on 23 June, this would have maximised the opportunities for JM to be located and arrested. Data suggests PPCS take an average of seven<sup>18</sup> hours to issue a licence revocation. National data on recalls also shows that the median time<sup>19</sup> between licence revocation and a return to prison custody is three days. Had a recall been initiated following the missed appointment on 20 June, or completed within the specified timescale on 23 June, the time for police to locate and arrest JM would have been maximised.

### **Key findings and missed opportunities:**

- There was a lack of consultation with an SPO following JM's first failure to attend.
- Recall should have been initiated on 20 June 2022 to increase opportunities to arrest JM and return to custody.
- An incorrect letter was sent to JM following his failure to attend on 20 June setting a new appointment date of 22 June. There was no evidence of this being communicated to JM via any other means.

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<sup>16</sup> Recall, Review and Re-Release of Recalled Prisoners Policy Framework April 2019 reissued July 2022

<sup>17</sup> The public protection casework section (PPCS) who are responsible for licence revocation.

<sup>18</sup> Data provided the HMPPS Public Protection Casework Section (PPCS)

<sup>19</sup> The "median" is the midpoint in the data set for recalls, half will take up to three days to be returned to custody, half will take longer than this, with some taking much longer.

- No home visit by the police was requested or carried out by probation services or the police, which could have been initiated through his IOM management.
- SPO1 was not included in discussions regarding non-compliance on Monday 20 June or Wednesday 22 June.
- The recall was initiated after an informal discussion with HoS1 and therefore the correct process was not followed.
- The recall was signed off by SPO1 two days after it was initiated, which is outside of the specified timescales in the recall process.

## 8. Prison findings – HMP Belmarsh

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HM Prison inspectors visited HMP Belmarsh to review this case and spoke to staff at HMP Isis where some of the index offences occurred. The areas of review included:

- information sharing
- thresholds of behaviour in custody
- case allocation.

### Information sharing

There were processes in place in HMP Belmarsh to manage specific risks whilst in custody, including several pathways and forums which could be utilised for sharing information. An Interdepartmental Risk Management Meeting (IRMT) was the primary vehicle of management and discussion of MAPPA<sup>20</sup> nominals with partner organisations. However, JM did not meet the criteria as he was not eligible for MAPPA management due to his medium-risk assessment and the offences for which he was sentenced. Additionally, HMP Belmarsh stated that there was no reason, at the time of custody in 2022, for JM to have been referred for any specific risk management pathways and there was no direct or specific intelligence or identified risk. However, had his risk of serious harm been deemed to be high, he may have met the threshold to be included in these meetings.

Notably, during JM's period in custody, between February 2021 and June 2022, there were ten submitted intelligence logs at HMP Pentonville and a further five at HMP Belmarsh. Intelligence was primarily in relation to weapon-making and use of illicit drugs. While probation staff had knowledge of poor behaviour in custody, there was no reference to these incidents specifically on probation systems or further exploration of them, which should have been shared to inform ongoing reviews of the risk posed. This may also have triggered inclusion at the prison risk management meetings, however given the detail of the intelligence is not known, this is difficult to ascertain. It is noted that PO1 emailed the offender management unit (OMU) in HMP Pentonville to request records from the preceding 12 months in preparation for potential release. However, no response was recorded to this or followed up. Unless information on prison intelligence is added directly onto the probation case management system (NDelius), there is no way of probation practitioners in the community being aware of it, unless it is shared in a meeting or directly by the prison.

Information sharing was poor in this case, which may have been hindered by JM's movement between prisons and the lack of formal allocation to a probation officer following sentence. However, both PO1 and POM1 were aware of each other's involvement and therefore there were opportunities for them to share information between sentencing in April 2022 and release in June. Further, POM1 was not invited to the video link meeting held in June prior to release. This was a missed opportunity to ensure all information was gathered to inform JM's release plans.

Whilst JM was assessed as posing a medium risk of serious harm to prisoners, there was no in-depth consideration of his behaviour in custody, and this does not appear to have been taken into account in relation to potential risks in the community. This behaviour was seen in isolation, whereas he had an entrenched pattern of poor behaviour in custody. Additionally, given the significant amount of time JM had spent in custody, there had been

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<sup>20</sup> MAPPA- Multi-agency public protection arrangements- The purpose of the Multi-Agency Public Protection Arrangements (MAPPA) framework is to reduce the risks posed by sexual and violent offenders in order to protect the public, including previous victims, from serious harm.

limited opportunity to test his behaviour in the community, meaning this was largely unknown.

Had the potential risks JM posed been considered holistically, a different risk assessment would have been formulated, given there were weapons offences in both custody and the community, as well as previous violence and disruptive behaviour evident in both settings.

### **Thresholds for behaviour**

Given JM's poor history of behaviour in custody, inspectors were interested to know why prosecution occurred in November 2021 – in respect of the index offences of weapons in custody, criminal damage, and racially aggravated public order – when previous incidents in prison had not progressed beyond internal processes. This question was put to senior prison leads as to what led to this threshold being met for these charges. There were no direct or confirmed answers as to why referral for prosecution was made, so this remains unclear. Leaders agreed that it was unusual for such a case to progress but did comment that where alleged incidents are of a racial nature, the victim is routinely asked if they would like police involvement. This may have been the trigger to this progressing to prosecution, but this was not confirmed.

### **Case allocation**

Evidence shows JM arrived at HMP Belmarsh on 08 April 2022 from HMP Pentonville and was sentenced on 13 April 2022. The prison confirmed that JM should have been "immediately a COM (community offender manager) responsible case with support of POM (prison offender manager) and pre-release staff".

It is noted that for case allocation an automated email would have been received by the Barking, Dagenham and Havering Probation Delivery Unit (PDU), following sentence calculations, which should have prompted immediate allocation to a COM. However, the PDU did not complete this allocation when calculations were completed on 20 April 2022. We found the allocation process to be complicated and unclear.

There was no evidence that the OMU staff in HMP Belmarsh prompted Barking, Dagenham and Havering Probation Delivery Unit (PDU) that a COM was needed following his reception at that prison in April 2022. We were told that, as OMU staff could see on NDelius that PO1 was undertaking some pre-release activity, it was perhaps not deemed necessary or a priority. The acting SPO (PO3) was new in post at the time of JM's sentencing and, although was au fait with the processes, was acclimatising to the role at a time when resources were stretched across the prison estate.

Issues of allocation both in the community and in custody had an impact on the management of JM's case, as well as limited information sharing and the fact his risk was not viewed holistically, with poor behaviour in custody being considered in isolation.

## **9. Relevant background information 2012 to 2018**

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**Between 2012 and 2018 JM was subject to the following sentences:**

- September 2012: 24-months custody imposed for offences of two dwelling burglaries, possession of cannabis, theft, and breach of suspended sentence order.
- April 2014: three-years custody imposed for six dwelling burglaries, three counts of vehicle theft and making off without payment.
- November 2015: two-years custody imposed for non-dwelling burglary.
- June 2017: 14 days for failing to surrender to court (time served).
- February 2018: eight-weeks custody for possession of an offensive weapon.

**Throughout these sentences, a number of key areas were identified by inspectors that should have been considered:**

### **Substance misuse**

Assessments, from 2012, indicated JM was committing offences to fund drug addiction and reported weekly use of cannabis and cocaine. Alcohol was also highlighted as an issue, with initial reporting of occasional drinking, increasing to daily excessive use within a six-month period in 2012. Alcohol and drug misuse remained a feature of offending through his early adulthood, where it was stated he was offending to fund the use of both substances. Associated health problems are later reported because of excessive use. Although JM reported a reduction in substance misuse, there was evidence to suggest his use of alcohol continued to be problematic, both in custody and in the community. Whilst in the community, there was little information pertaining to him engaging with substance misuse services during this period.

### **Offences of violence**

During this period, earlier offences of ABH, assaulting a police officer and racially aggravated public order were not explored in sufficient detail. Details relating to these offences were missing from the case files inspected and the focus of assessments were on his acquisitive offending. Whilst a medium risk of serious harm assessment was reached from his first assessments in 2012, it was repeatedly unclear and unspecific regarding who was at risk, the nature of the risk and any risk management arrangements.

In 2018, JM received a custodial sentence for possession of an offensive weapon. Crown Prosecution Service (CPS) records, and JM's own account indicate he was carrying this weapon for his own protection. A report was completed for his court hearing which highlighted gang involvement, and the author assessed JM should be escalated to high risk of serious harm if any further similar offending occurred. However, this was not followed through in later assessments.

We found a significant comment contained within OASys – the system used to undertake assessments and develop risk management plans and sentence plans – in 2016 stating the following: "He (JM) stated that it scares him sometimes how angry he gets and that he does not know how to control it. He stated that he feels it is very likely that he will offend in the future". Despite this, there was little evidence to suggest a focus on anger management, or on exploring the underpinning causes of this with JM during probation's contact with him.

## **Domestic abuse**

There was limited evidence of enquiries being made in respect of domestic abuse, except for enquiries made relating to home detention curfew (HDC) applications, which were related to addresses rather than individuals. Concerns in respect of violence towards a partner were noted from early assessments, but these were not explored or analysed. JM was assessed as posing a medium risk of serious harm to a known adult from 2012, however this was relating to a neighbour of whom no details are given. In 2016, an assessment stated a domestic abuse incident occurred between him and his then partner, again there are no further details of this. Separately, it was recorded that they miscarried a baby but again the impact of this or any accompanying risks are not explored.

This was key information that was held within probation records and should have been analysed when later assessments were being made. To inform future risk reviews, the gaps in evidence should have been followed up with the police.

## **Family dynamics**

Within early assessments, it was noted that JM revealed he was sexually abused as a child by a family member when he was five years old approximately, which continued over a prolonged period. He revealed this to his mother, aged 12 or 13, which coincided with him becoming increasingly involved in offending. Issues with other family members were raised during this period. JM's grandmother shared previously problematic behaviour, including offending against family members with probation staff and felt reluctant to provide support at various stages. This should have been explored further. In 2015, information was recorded to suggest he had been "kicked out of his mum's home after a family fight". The relationship breakdown with his mother also features on a later release in 2020. Again, there is little analysis of this, and of the potential risks posed.

## **Behaviour in custody**

Information from 2013 highlighted poor behaviour in custody, namely threatening a prison officer and damaging property, indicative of later behaviour but not explored in detail. In 2015, records indicated an ongoing investigation into GBH and arson, committed whilst in custody. The CPS documentation indicated a significant level of involvement; however, JM was later acquitted of these crimes in 2017. Despite having this information, it was not included in subsequent risk assessments. This was indicative of future assessments whereby the risks posed in custody, and how this may translate to the community, were not fully assessed, or incorporated into risk management plans.

Self-harm in custody was also recorded for the first time, as well as a suicide attempt and concerns he had raised regarding control of his anger. None of this information was explored further. An assessment highlighted JM used poor behaviour in custody to enforce a move to a different establishment – behaviour which was repeated later. There was no evidence to suggest he was challenged regarding this.

Further evidence of disruptive behaviour in custody was also noted in an assessment in 2015, stating "he [JM] resorted to a dirty protest, he has been on the netting of a wing, set off fire alarms, caused cell damage, been heard to use racist language and threatened to stab cell-mates and take them hostage". The assessment included the risk to prisoners, but the risk of serious harm remained as medium. This evidence should have led to the risk of serious harm being re-assessed and consideration of high risk to staff and prisoners, owing to the catalogue of poor behaviour recorded and the seriousness of the threats made. This was not considered.

## **Poor compliance**

JM demonstrated poor compliance and engagement with probation throughout this period. There was a cycle of custodial sentences, recall to custody and further offending. For example, there were two instances of recall in 2013, with him not being seen for a month prior to one recall. During this period, he committed further offences for which he later received a custodial sentence. His lack of engagement was indicative of non-compliance, which was the start of an entrenched pattern of failing to engage with services. Indeed, JM stated to probation staff that he would not comply on more than one occasion. Practitioners commented in assessments that the lack of detail available was owing to the fact he was rarely seen to be interviewed.

Also, in 2015, there are further instances of non-compliance and chaotic behaviour. JM was again recalled for non-attendance. He committed further offences again prior to recall. Two further recalls occurred in 2016 and breach action in 2018. It is noteworthy that during this period, and subsequent releases, there was confusion over where JM was being managed and this contributed to his non-compliance. He had connections with both Kent and London, with records showing him moving between the two areas, often without informing probation services of where he intended to be. The contact between the two areas was inconsistent which at times led to a delay in taking enforcement action.

## **Neurodiversity and mental health**

There was no evidence that JM's mental health and neurodiverse needs were explored sufficiently, resulting in these not being fully understood. There was reference during this period to JM having Attention Deficit Hyperactivity disorder (ADHD), personality disorder (PD) and depression. The impact of these conditions was not explored, and were not consistently mentioned, leaving it unclear if these were formal diagnoses and what the impact was on JM. He was stated to be medicated at various times for ADHD, but little analysis was undertaken of how this affected his day-to-day cognitive functioning and learning styles, and if there were links with offending behaviour.

## **Key findings:**

- Information, particularly from custody, was not consistently reviewed or incorporated into updated assessments.
- Violent offences and behaviour were not sufficiently analysed to understand what triggered the behaviours and therefore how to manage the risks posed.
- Insufficient application of professional curiosity, resulting in a lack of detail regarding JM's circumstances and offending.
- Delays in actioning failures to attend resulting in prolonged periods in the community with no oversight.
- Confusion over where JM was residing and inconsistent communication between Kent and London probation services.
- Failure to act on emerging information from custody regarding poor behaviour and possession of weapons.
- Lack of analysis of diagnosis of ADHD and any links to offending behaviour.



## 10. Case management: 2019-2021

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In March 2019, JM was sentenced to 32 months for burglary. As highlighted earlier, this followed a pattern of repeated acquisitive offending and was his fourth prison sentence in as many years.

JM was allocated to the London CRC<sup>21</sup>. During his time in custody, there was a repeated pattern of poor behaviour which resulted in a period in segregation. Weapons were also found in his cell. There were charges brought regarding behaviour in custody, explored in this report.

JM was released at the half-way point of his sentence, on 28 September 2020, to reside with his mother. Her address had been assessed as unsuitable for release on Home Detention Curfew, however he was released to live there with no curfew restrictions, which was deemed to be inappropriate. During his supervision, JM informed the practitioner that he was involved in gang activity, however, when checked with police, they had no information to corroborate these claims. After JM provided details of having a partner and child, safeguarding referrals were made through Barking and Dagenham Borough Council, and JM was assessed as posing a medium risk of serious harm to children – not via a direct risk, but due to his stated gang affiliations and the potential impact of the associated lifestyle.

In November 2020, JM was arrested for theft of a mobile phone and bank card belonging to his mother. There are further incidents of arguments noted between JM and his mother during this period on licence. Additionally, probation records indicated his relationship with his partner broke down which he was struggling to deal with. Concerns were raised about his presenting behaviours, specifically being in an agitated and anxious state, and his appearance being indicative of having taken substances. This is not explored, in depth, with JM to consider if risk was increasing or any additional conditions were required to manage his risk.

Further, in November 2020, information was received by probation regarding the offences of weapons, criminal damage, and public order whilst he had been serving the custodial part of the sentence for burglary. There is no evidence of any further exploration of the circumstances behind this offending and the impact on his risk assessment. Whilst JM was assessed as posing a medium risk of serious harm to prisoners, there is no in-depth consideration of his behaviour in custody, and this was not translated into potential risks in the community. This behaviour was seen in isolation, whereas there was an entrenched pattern of poor behaviour in custody. Additionally, given the significant amount of time spent in custody, there had been limited opportunity to test his behaviour in the community, meaning the potential risks outside prison were largely unknown. JM cited the offences from custody were “hanging over him” and were contributing to him feeling stressed and being unable to cope.

Whilst information was recorded and available during this period, we found a lack of professional curiosity, which meant that information was often not followed up, or explored in detail, to fully understand the risks he posed. Given previous known concerns regarding drug and alcohol misuse, we would have expected that this to have been explored, and referrals made to the relevant services. Additionally, no work was undertaken to investigate his family relationships or discuss tensions between JM and other family members. No additional risk management measures were considered when information was received

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<sup>21</sup> formerly known as the London Probation Trust and on 1 February 2015 ownership transferred to MTCNovo under the governments *Transforming Rehabilitation* agenda.

regarding alleged thefts from his mother. It was documented much earlier in his records that there were previous domestic abuse concerns, however these were not considered even though he was in a relationship. There were no domestic abuse enquiries undertaken during the release period and no professional curiosity demonstrated to explore the stated difficulties in the relationship.

JM's case continued to be managed under IOM arrangements, however, there are few records relating to this, and therefore how this added to the management of the case was unclear. We would expect to see multi-agency oversight of the case, specifically between the police and probation, with opportunities to share information and undertake additional monitoring, however this was not evident.

It is notable that JM spent five months on licence for this sentence from September 2020 to February 2021, which was the longest period spent in the community for some years. We found there was ample opportunity to gain further understanding of his lifestyle and potential risk factors whilst he was readily engaging with the probation practitioner. This was the last period he had in the community prior to his release in June 2022 before the SFO occurred.

Key findings:

- Lack of professional curiosity when new information was reported by JM.
- An absence of domestic abuse enquiries and insufficient consideration of previous domestic abuse incidents.
- No measures considered to manage the risk posed to his mother.
- Lack of holistic risk assessment and failure to acknowledge or act on emerging risks, resulting in an underestimation of the risks posed.
- No exploration of new charges; the circumstances or JM's account.

## 11. Recall: February 2021

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Information was shared by the court team, on 01 February 2021, that JM was due to appear for offences of Section 18 GBH and Robbery. The alleged victim was a female friend of his mother. A decision was taken, on 03 February 2021, to recall JM based on these new charges. However, although these offences were mentioned in the recall report, there was an absence of sufficient detail regarding the offences. There was a lack of prompt management oversight, with entries only recorded two days later, which contained little detail other than he was being recalled for new offences. We would have expected to see sufficient information about the offences, the victims, and the impact on the risk of serious harm he posed and a decision detailing why recall was agreed, including arrangements to ensure actual and potential victims were kept safe.

Upon sharing that new offences had been committed, the risk and needs assessment was reviewed, and the assessment updated to include his mother's friend as being at risk of serious harm. However, the level of risk of serious harm continued to be assessed as medium. There was no evidence of discussion taking place regarding a potential risk escalation at this stage. Given the severity of the new charges, and information now known regarding weapon-related offending in custody, we would have expected to see a discussion to consider increasing the assessed level of risk, and review of whether the risk assessment should be increased to high risk of serious harm.

At this time, CRCs managed cases assessed as posing a low or medium risk of serious harm. When risk was perceived to have increased, there was a process in place to undertake a risk escalation to the then National Probation Service (NPS). If agreed, arrangements were made to transfer the case to the NPS and put in place appropriate risk management arrangements.

We spoke to SPO1, the manager of CRC1 at the time, regarding this, but they had limited recollection of what occurred. However, they indicated it was likely that a conversation would have taken place regarding an increase in risk and that a decision on risk escalation would usually wait until either a charge was brought, or the outcome of the court case was known. SPO1 advised this was often the case when considering risk escalation at that time. Given that a charge had been brought, we would have expected the risk escalation to proceed. We found, however, that no conversation was recorded to indicate that either an increase in risk, or an escalation to NPS, had been considered. This was a missed opportunity, and the lack of detailed information regarding these new offences impacted future views and assessments on the level of risk he posed.

### **Key findings and missed opportunities:**

- The risk of serious harm was not reassessed in February 2021 following JM's arrest for offences of Section 18 GBH and Robbery.
- Risk escalation was not considered and therefore he continued to be managed by the wrong probation service provider.
- Management oversight was ineffective and did not detail the nature of the offences and reasons for recall.

## 12. Custodial period and case management Feb 2021-October 2021

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On 25 March 2021, JM was remanded into custody (while already a serving prisoner) for the offences committed in custody in 2020/2021. Therefore, at this point there were three live court/sentenced events that JM was subject to.

JM stood trial, in August 2021, for the offences of GBH and Robbery and was acquitted on 31 August 2021. The judge, however, imposed a three-year restraining order (RO) to protect the female friend of JM's mother. A court officer uploaded the RO onto NDelius on 01 September 2021, however there are no corresponding entries or alerts added to ensure staff were aware that an active RO was in place. In addition, no risk "globes" (also known as risk registrations<sup>22</sup>) were "lit" on NDelius to alert anyone checking the record that this had been imposed, which is expected practice to ensure key information about a case is clearly identifiable.

We were unable to interview the court officer who uploaded the RO, or the practitioner managing the case at this time, however a discussion took place with SPO1. They could not recall the PDU being notified of the acquittal, stating information may have gone to CRC1 but not shared further. There was no evidence to indicate the PDU were aware. Indeed, a management oversight entry on 22 September 2021 states: "currently in custody on remand/recall awaiting trial for GBH and Robbery", indicating they were not aware the trial had concluded the month before. Additionally, SPO1 did not recall this being discussed at IOM meetings or presented as new information by the police. Notably, PO1, who went on to manage the case, was not aware of the RO until after the commission of the SFO.

The fact that information either wasn't shared effectively, or recorded sufficiently, was a significant omission in this case. It meant that the circumstances regarding the RO were not included in any risk assessments or considered later when the case was allocated. There was also no evidence to suggest the RO was discussed at IOM meetings, which was another missed opportunity to discuss the implications of this on his level and type of management, and to assist with release planning.

### **Missed opportunities:**

- Information was not shared effectively by PSO1 regarding the imposition of the restraining order (RO).
- Risk information was not clearly flagged on probation case management systems to highlight the imposition of the RO to those viewing the record.
- Information was not shared regarding the RO at IOM meetings.

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<sup>22</sup> National Delius Case recording instructions December 2019 – updated August 2022

## 13. Period on remand: October 2021- April 2022

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The 32-month sentence for Burglary expired on 06 October 2021. However, JM remained remanded in prison for the offences committed whilst in custody.

It was good practice that JM's case was informally allocated to PO1 on 07 December 2021, in recognition of the fact he could be sentenced, and therefore potentially released, at any time, in the coming months and therefore needed oversight. He was not subject to any formal supervision therefore there was no formal allocation. A formal handover was not provided to PO1, who instead undertook a self-familiarisation of the case and was confident that SPO1 had a thorough knowledge of JM as the lead for IOM.

PO1 contacted the prison offender manager in custody on, 13 December 2021, requesting an update on JM's outstanding court case and was advised that JM had appeared the previous day and pleaded guilty to one matter, with a date to be fixed for the other matters. No other information was shared during this exchange.

JM's case was discussed at an IOM case panel meeting on 23 December 2021. The meeting was advised that JM had changed his plea to guilty on 15 December 2021 regarding the offences committed in custody and was awaiting sentence. It was also noted that PO1 had not yet met JM but was planning to arrange a video link meeting.

PO1 sent two separate requests for a video link meeting to be arranged in January and February, with no response recorded. However, they subsequently held a video link meeting with JM on 22 February to gain initial information, which was recorded on NDelius as covering "his childhood, family, ETE and his general behaviour since being in custody". JM also informed PO1 that his court hearing was due in April.

On 24 February JM's mother contacted PO1 to advise the court date would be 11 April 2022. She also stated he could not reside with her on release, as well as concerns regarding him returning to reside in the Barking, Dagenham and Havering area, owing to the negative influence of peers and the potential risks to JM himself. There was no further detail included to advise what the risks were and from whom at this stage.

PO1 requested records from custody relating to JM on 24 February 2022 citing the reason for request as the possibility of immediate release on 11 April. There was no response to this recorded on the system and no evidence of this being followed up. PO1 arranged a further video link for 29 March 2022 alongside PLO1, however JM refused to attend.

It was notable that during this time PO1 was undertaking these tasks whilst JM was not subject to statutory supervision, which was good practice to try and prepare for eventual sentencing. However, there was no evidence of in-depth exploration of any of his past offending or potential risk factors, which would have been beneficial given the known offences relating to weapons and the imposition of the RO during his last sentence. The lack of exploration of these issues has led to underestimation of the risks posed by JM.

### **Key findings:**

- It was good practice that JM's case was managed on a non-statutory basis and PO1 attempted to engage with him via video link.
- No information was shared regarding his acquittal from August 2021, at the IOM meetings.
- Attempts to prepare for release were not supported by prison staff.

## 14. 'Early Look' and onward actions

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Following JM's arrest for murder, an 'early look' SFO review was completed by the Probation Service – London region in June 2022 in line with HMPPS expected practice. The purpose of an 'early look' is to quickly review the practice in the case and promptly identify, to senior leaders within HMPPS, any practice and training deficits that require immediate attention and to begin appropriate actions, and human resource (HR) processes if assessed as being necessary. Inspectors found the quality of the 'early look' to be mostly of a sufficient standard. However, on further exploration, some information contained within it, and therefore subsequent actions, were inaccurate. This related specifically to the following:

*The assessment undertaken at Court as part of the allocation process was inaccurate as it pulled through information from historic assessments that required updating. Whilst PO2 was limited by the fact that he did not have the opportunity to meet with JM, the offence analysis did not relate to the index offences and I would have expected this to have been updated.*

Having spoken with PO2 and the line manager, and considered the guidance in place, PO2 was required to undertake an "RSR<sup>23</sup> only" OASys which does not require a full review. The process requires an OASys assessment to be generated solely for this calculation, to determine allocation. There is no expectation of court officers to undertake a review of risk. We found that although the correct process was followed here, the process led to inaccurate information being contained within assessments but in line with guidance, should have been updated by the receiving COM or POM.

The 'early look' also indicated that the inclusion of a licence condition to engage with Catch 22 was not appropriate as their remit was to support people to build emotional resilience. We disagreed with this, as it was clear this would be of benefit to JM. However, we did agree other conditions were omitted which would have been beneficial to risk management, such as the imposition of a curfew/GPS tagging.

When considering the recall prior to the SFO, the 'early look' states SPO1 was included in the discussion on 22 June, however on further investigation we know this did not occur, with them only being informed by PO1 a recall was being completed. Actions relating to management oversight and recall processes which were highlighted in the 'early look' have already been progressed.

Following this, HR investigations procedures were initiated in respect of two staff members. These have now concluded, with no further action taken in either case.

In respect of other areas which have been highlighted as significant in this review, we discussed work that is underway to address some of the deficits. We were told there are significant changes being made to IOM case management in London, in particular work is underway to improve liaison between prisons and IOM colleagues. With regards to neurodiversity, the Head of Operations for north east London boroughs (HOOP) told us

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<sup>23</sup> The Risk of Serious Recidivism (RSR) is an actuarial risk assessment instrument used by His Majesty's Prison and Probation Service (HMPPS) and the Ministry of Justice (MoJ). It was implemented in 2014, and its calculations were incorporated into the Offender Assessment System (OASys) in 2019. It predicts proven reoffending for most seriously harmful offences.

there are aims to embed a trauma-informed approach<sup>24</sup> to practice, and projects are already set up in some areas of London focussing on specific needs particularly in respect of young adults.

Although not eligible for OMiC management, the effectiveness of this process is under review by HM Inspectorate of probation with a number of recommendations to review the process which aim for improvements across the OMiC spectrum<sup>25</sup>.

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<sup>24</sup> A trauma-informed approach is promoted which seeks not to re-traumatise with blame and sanction, but to recognise individual strengths and skills, build confidence and re-educate. HM Inspectorate of Probation Academic Insights 2020/05

<sup>25</sup> A thematic inspection of Offender Management in Custody – pre-release ([justiceinspectorates.gov.uk](https://justiceinspectorates.gov.uk))

## 15. Conclusion

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Inspectors found that overall, there were significant omissions and practice deficits which impacted on the management of this case.

JM was managed as a “medium risk of serious harm IOM acquisitive individual,” however, his level of risk should have been escalated to high risk of serious harm in February 2021, based on the range of information available had it have been sufficiently analysed and considered.

The risks present when he was recalled, in February 2021, were not sufficiently considered for a potential escalation to high risk of serious harm and management by the then National Probation Service. When a restraining order (RO) was imposed in 2021, the PDU were not sufficiently aware which was another missed opportunity to reassess the risk posed. Furthermore, JM’s persistent poor behaviour in custody was seen in isolation and not given sufficient consideration in terms of his risk management in the community.

Issues were found with sharing of information between prison and probation and assessments were completed in isolation. This led to agencies managing the individual without thorough consideration of the impact on the risks posed, and how they should be managed, both in a custodial and community setting.

A lack of professional curiosity coupled with a failure to consider information known about JM holistically, led to inaccurate and insufficient risk assessments. There was a significant amount of information known about JM which should have been analysed and explored more fully.

The delay in JM’s case being allocated to a probation officer meant his case was not formally allocated for two months following sentencing. Positively, PO1 continued to work with JM and did undertake some pre-release planning. However, given the delay in allocation, a pre-release assessment was not completed prior to release. This was a missed opportunity to review all the available information and inform pre-release planning and the risk of serious harm assessment. Tools such as the EPF tool which was developed by the probation service to determine relevant licence conditions was not utilised and therefore not all relevant conditions were included.

On release, the PDU missed opportunities to recall following failed appointments and evidence of risk factors emerging, such as significant use of alcohol. A recall should have been initiated following the missed appointment on 20 June 2022. However, relevant senior leader consultations did not take place, and insufficient efforts were made to locate JM. When the recall was initiated, this was because of an informal discussion and PO1’s line manager was not included formally in the process. A delay to signing off the recall, 24 hours later than the specified timescale, meant the recall was not timely and ultimately delayed the opportunity for JM to be arrested by police.

The findings from this review mirror findings from the recent HM Inspectorate of probation inspections of London PDUs, including Barking, Dagenham and Havering (BDH) PDU where the overall quality of work delivered to manage people on probation was insufficient and we rated the PDU as ‘Requires improvement’.



## 16. Annexe 1 - terms of reference.

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On 01 July 2022, the Secretary of State for Justice wrote to the Chief Inspector of Probation to ask him to undertake an independent review of the case of Jordan McSweeney.

The lines of enquiry to inform the review were:

- assessment of risk posed and risk management arrangements
- involvement of the Integrated Offender Management Team (IOM)
- quality of management oversight and exploration of enforcement and of decision making and timeliness in relation to recall
- review of period in custody – exploring security intelligence, behaviour in custody and communication with community offender manager
- exploration of preparation for release from custody and resettlement plans
- staff training, learning and development and application of professional curiosity
- identify findings and learning at national, regional and local levels.

JM was released from custody prior to the SFO, to support this review, HM Inspectorate of Prisons reviewed the significant events that took place in custody, specifically HMP Belmarsh.

### **The following probation staff were interviewed with direct knowledge of the case:**

- PO1: probation officer case manager from December 2021.
- PO2: court probation officer who completed Risk of Serious Recidivism<sup>26</sup> (RSR) assessment following JM's sentencing in April 2022.
- SPO1: PO1's line manager.
- SPO2: the SPO who allocated the case to PO1 on 08 June 2022.
- SPO3: line manager of the Probation Service Officer (PSO1) who uploaded a restraining order following a court appearance in August 2021.
- SPO4: PO2's line manager.
- SPO5: the SPO who had a professional discussion with PO1 on 20 June 2022 regarding JM's non-compliance.
- HOS (Head of Service) for Barking, Dagenham, and Havering (BDH) Probation Delivery Unit (PDU).
- DH1: interim deputy head for prisons and OMiC (Offender management in custody) in the London region.

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<sup>26</sup> The Risk of Serious Recidivism (RSR) is an actuarial risk assessment instrument used by His Majesty's Prison and Probation Service (HMPPS) and the Ministry of Justice (MoJ). It was implemented in 2014, and its calculations were incorporated into the Offender Assessment System (OASys) in 2019. It predicts proven reoffending for most seriously harmful offences.

- SOSM1: Senior operational support manager- Integrated Offender Management (IOM) lead for London region.
- HOPP1: Head of Public Protection with gangs lead for London region.
- HOPP2: Head of Public Protection with prisons and OMiC lead for London region.
- HOOP: Head of Operations for North East London boroughs.
- HOSC1: Head of Service Centres for London region, regarding processes of allocation.
- SAO1: Senior Administration Officer who manages a team who undertake allocations in Bromley Service Centre in London.

**Prison Inspectorate colleagues interviewed the following prison staff:**

- Senior leaders at HMP Belmarsh (security and offending management unit)
- Senior leader at HMP Isis
- PO3: Probation officer HMP Belmarsh (acting SPO at time JM was in custody between April 2022 and his release).

Given JM's case was managed under the IOM Framework, the following members of police staff were also interviewed:

- POL1: IOM police officer involved in the management of JM's case.
- POL2: IOM Lead and senior ranking officer to POL1.

**We were unable to interview:**

- POM1: the Prison Offender Manager (prison employee) who was assigned to JM on 22 April 2022 (no longer in the service).
- CRC1: the CRC probation practitioner who completed the recall of JM on 05 February 2021 (long term unavailability).
- CRC2: the CRC probation practitioner who completed OMNIA assessments following JM's recall on 05 February 2021 (no longer in the service).
- PSO1: probation court officer who uploaded a restraining order in August 2021 (no longer in the service).
- PSO2: Probation Practitioner due to see JM on release on 17 June 2022 (long term unavailability).

**Inspectors also read the following documents to assist with the review:**

- probation case records, NDelius - case management system where information is stored) and OASys – system used to undertake assessments and develop risk management plans and sentence plans
- staff supervision notes
- integrated offender management guidance (IOM) – national framework and London IOM framework
- London newly qualified officer (NQO) induction programme
- HMPPS Recording recall decision making and issuing letters guidance
- HMPPS case allocation framework

- OMiC strategy and allocation guidance
- Crown Prosecution Service (CPS) documents relating to the SFO
- CPS documents relating to the acquittal for GBH and Robbery
- Recall report and OASys assessment following the SFO offence
- HM Inspectorate of Probation's thematic on SFOs (2020)
- HM Inspectorate of Probation's thematic review of probation recall culture and practice (November 2020)
- HM Inspectorate of Probation's thematic on OMiC in custody (2022)
- HM Inspectorate of Probation's Independent review of Joseph McCann (2020<sup>27</sup>)
- OMNIA<sup>28</sup> guidance (integrated case management and risk and needs assessment tool)
- CRC/NPS risk escalation process discussion
- London case allocation process
- the Mayor's Office for Policing and Crime's (MOPAC) GPS Knife crime tagging interim evaluation report (2020).

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<sup>27</sup> [Independent review of the case of Joseph McCann \(justiceinspectorates.gov.uk\)](https://www.justiceinspectorates.gov.uk/hmip/independent-review-of-the-case-of-joseph-mccann/)

<sup>28</sup> The risk and needs assessment tool used by London CRC, no longer used since unification in June 2021.