



SERIOUS CASE REVIEW

TREVOR HAMILTON

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Introduction



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Management of Sex Offenders

Since 1997 convicted sex offenders have been subject to legislation, which provides for their management within the community.

This includes provisions such as 'Notification Requirements', commonly referred to as the 'Sex Offenders Register'. Where an offender is convicted, he can be required to be subject to Notification Requirements for a specified or indefinite period of time. This requires, for example, the offender to provide details of their identity and location to the police and to advise the police of any changes.

Where an offender who is so registered is released from prison or otherwise comes into the community, they will be subject to a management system, which involves members from Police, Probation and Social Services along with other agencies such as NIHE.

This system is known as MASRAM (*M*ulti *A*gency *S*ex offender *R*isk *A*ssessment and *M*anagement)

MASRAM involves these agencies that meet regularly in Area Sex Offender Risk Management Committees (ASORMC) to collaborate in the management of registered sex offenders. Each Sex Offender will be allocated to a Designated Risk Manager (DRM) who leads within the multi agency framework on the management of the offender and reports to the chair of the ASORMC. The DRM could be from any of the agencies involved. The DRM will be appointed by the ASORMC.

The ASORMC will develop an Action Plan to monitor and manage the offender during his time in the MASRAM scheme.

Risk Management

The key principle within this structure is the concept of risk management. This determines how the individual is managed and, for example the frequency of ASORMC Meetings.

There are five main elements to risk management:

- a) To assess and coordinate actions required to reduce risk and dangerousness
- b) To identify strategies which will reduce the risk by identifying necessary safeguards for potential victims
- c) To monitor the sex offender's behaviour and attitudes
- d) To act immediately if it is likely that serious harm to others may be caused
- e) To share relevant information between agencies

Risk Assessment

All sex offenders coming to police notice are subject to initial screening using a psychological process known as the MATRIX 2000 or Structured Anchored Clinical Judgement (SACJ) risk assessment scale. This process is in use throughout the UK and is based on a substantial piece of research carried out by David Thornton a criminal psychologist.

The Thornton matrix develops a profile of the risk, which an individual poses, based on what are described as Static Factors.

Static factors are unchanging facts around the individual; for example they look at an offenders offending history (type of offences, age at commission etc) and provide a screening view of the offenders risk. The purpose of this screening is to target resources rapidly at the most dangerous sex offenders.

Those cases that are identified as Category 3, (high risk) or 2, (medium risk) using the SACJ scale will be subject to a multi-agency risk assessment which will critically examine the dynamic factors impacting on each particular case.

The dynamic factors are changeable and relate to internal and external factors attaching to the specific individual. They will include Offender Specific Hazards (for example the offenders attitude to his crimes) and Situational Hazards (for example the support network around an offender to prevent re-offending). This dynamic assessment will also include examination of current internal and situational strengths (such as attending a Sex Offender Treatment Programme) and current dangers (such as opportunity to offend).

By its very nature dynamic risk assessment relies on all agencies involved gathering and sharing timely and relevant information to facilitate the formulation and implementation of an appropriate risk management plan peculiar to any particular offender.

Trevor Hamilton

Trevor Hamilton was assessed as a High Risk (Category 3) sex offender on his release from prison in August 2003. A Risk Management plan was produced, and he was subject to the management of the local ASORMC, with a Designated Risk Manager (DRM) drawn from the Probation Service.

Whilst under this management regime, Hamilton abducted and murdered Mrs Attracta Harron.

**Report of Independent Serious Case
Review**

Trevor Hamilton

Report on Serious Case Review: Trevor Hamilton

Introduction

1. Hamilton was sentenced to a Custody Probation Order on 19 September 2001 for offences of rape, indecent assault of a female, assault with intent to commit buggery and threats to kill. This was increased on appeal by the DPP to 7 years custody, followed by one years probation, including a requirement to participate in a Sex Offenders Treatment Programme. (Two years earlier Hamilton had been found guilty on five counts of indecent behaviour committed on four different occasions when he had been 15 and 16 years of age, and sentenced to two years probation.) He was released from Hydebank Wood Prison on 18 August 2003, having served 3 ½ years of his determinate sentence, and on release was subject to supervision by the Probation Board.
2. During his period of supervision in the community Hamilton was charged relating to the abduction and murder of a 65-year-old woman and remanded in custody, where he currently awaits trial. Since he had been subject to multi-agency procedures (assessed at category 3, the highest level of risk) for the assessment and management of sex offenders (MASRAM) when this alleged offence took place, NISOSMC commissioned a review of the handling of the case from his release from prison to his arrest and remand in custody.

Methodology

3. The review was conducted by analogy to the case management review process set out in DHSSPS's guidance 'Co-operating to Safeguard Children', notably the concept and procedures described in chapter 10. This puts the accent on assessing the effectiveness of multi-agency working and on drawing out constructive lessons: 'The review should be conducted in such a way that the process is a learning exercise'.

4. Each of the three agencies involved - the police (PSNI), Prison Service (NIPS) and Probation Board (PBNI) - nominated a senior member of staff, none of who had been involved in the Hamilton case, to a panel that I chaired. The police and PBNI provided internal reviews they had already conducted; the NIPS commissioned one for the panel. All three agencies put papers and personnel at our disposal and co-operated fully and constructively with the review throughout.

5. After an initial planning meeting the panel met three times to draw up its conclusions as expressed in this report, which is unanimous. At the second of these we had a full discussion with the authors of the three internal agency reports, based on a lengthy set of questions that the panel had previously prepared. It has been reassuring for the panel to rely on rigorous internal reviews, themselves independent of the handling of the case. (NISOSMC has access to the three reviews as each of the agencies is represented on it, and there is much to be said for the Committee to consider them for itself.)

Assessment

6. The MASRAM system for risk assessment and management of sex offenders is built upon the principle that effective work with sex offenders requires a multi-disciplinary approach and recognition that inter-agency working is vital. Overall, the panel did not identify anything to cast doubt on the validity of the MASRAM concept or procedures themselves, although we make suggestions for some relatively minor adjustments. The thread that runs through our conclusions relates instead to the **execution** of the steps and actions identified as necessary for Hamilton's safe management. It became clear to us that **mechanisms to ensure that agreed actions are in fact taken are as important as the specification and quality of the procedures themselves.** The following paragraphs seek to expand on that.

Custody

7. Although our terms of reference invite us to review the handling of the case from the point of Hamilton's release from custody, the panel believes that a number of lessons can usefully be learnt from his period in prison, and we have accordingly taken the liberty of recording those.
8. First, Hamilton did not undergo the Sex Offenders Treatment Programme while in gaol (although he did attend a Programme for the Prevention of Sexual Abuse after release). This was because he continued to deny the index offence and, as he was considering appeal (though this was not in the event lodged), on advice from his solicitor he seems to have been unwilling to take a step, which might have been construed as compromising his position. Although this is a complex area bearing on the individual's rights, **it does seem questionable whether, particularly given the terms of the Custody Probation Order, such refusal should be permitted in light of the risk to the public which might ensue, especially in cases already assessed at category 3, and which might be mitigated by attendance at such a course. We recommend that this be reviewed.**
9. Second, in practice there is no accredited course for sex offender treatment at Hydebank Wood Prison. Programmes are available at other prison establishments, and an experimental course was run at Alderwood at one stage but not continued. There are undoubtedly questions of suitability of wider courses to younger prisoners and of safe transportation as well as cost, **but we recommend that this issue be revisited by the NIPS and PBNI.**
10. Third, it is clear that both the Hydebank Wood Head of Custody and Prison Psychologist developed a set of useful insights into Hamilton's personality while in gaol and so were well positioned to point to particular risks on his release, but it is a good deal less clear that arrangements encouraged these to be effectively passed on to the PSNI and PBNI at that point. For example, although the Head of Custody attended all the ASORMC meetings on Hamilton save two (although arguably those were particularly important); the Psychologist attended only one and was not invited to the others.

Arrangements should be made to facilitate the structured input of the NIPS into subsequent case management, including by Prisons psychologists where appropriate. This should include attendance at ASORMCs and input to the risk management plan at all stages as it develops through the life of the case so as to help identify particular risks, which might have become apparent in prison. This is linked to the wider question of consistency of representation and attendance, which is touched on later.

Area Sex Offender Risk Management Committees (ASORMC)

11. We now turn to the working of ASORMCs, and in many ways the most important part of our findings. It is through ASORMCs that the essential co-ordination of inter-agency procedures is achieved in specific cases, and so these committees are in many respects the lynchpin of MASRAM. Their task of effecting inter-agency co-operation is easily stated, but is, in my experience in Government service, far from easy to implement. Public bodies, and especially uniformed organisations under discipline, have a natural tendency to pursue their own organisational objectives as a priority - often an indispensable strength - and subordinating these to wider goals, not to mention wider authority, can prove very difficult, particularly if cross-agency working is a new venture in the field in question. Deficiencies should be seen in that perspective, and arrangements need to be put in place to ensure that common goals and joint working are achieved in practice.
12. Against that background, these are our observations in the Hamilton case.
13. There was a constant churn in attendance at ASORMC: with an average attendance of 6-7 people, 22 different people in total attended the meetings. No one person attended all the meetings. There were 7 different people from PBNI, 9 from PSNI, 3 from social services and 2 from NIPS. The practical difficulties of consistency of attendance by the same personnel do not need restating, but it is an important principle that has much in its favour if ASORMCs are to work effectively. If the ASORMC had been consistently attended in the Hamilton case, several of the weaknesses identified in the internal reviews, particular the PSNI report, might well not have arisen. MASRAM was of course fairly new at that time, and this issue may since have resolved itself – this would be worth

checking. But, unless it has righted itself, **the principle of consistent attendance should be re-emphasised to both key ASORMC personnel (i.e. chairs, DRMs, MASRAM sergeants) and all those likely to attend meetings. Moreover, there should always be a specified alternate for each member, so that briefing and updating is simplified in cases of enforced absence. The opportunity should also be taken to re-emphasise the central importance of ASORMCs to successful case management.**

14. There is a case for greater clarity in the roles of ASORMC chairs and DRMs, to the benefit of both those office-holders and other Committee members too. It seems clear that neither the chair nor the DRM in the Hamilton case were confident that they had authority to check that agreed action had actually been taken, specifically by those outside their organisation. **The roles and authority of ASORMC chairs and DRMs should be further clarified and re-emphasised.** In the current guidelines it is the DRM whose responsibility is ‘to co-ordinate all elements of the risk management action plan and ensure it is delivered when and as agreed’; it is less clear that the chair has any role in ensuring, in a way appropriate to his/her level, that agreed action is executed – the role as currently described seems a little too hands-off in terms of ‘managing’ the DRM. This can be delicate territory, but **there is scope for an expanded role to be articulated in the guidelines.**
15. That clarification of roles will be as important for those likely to participate in the MASRAM process as for the ASORMC chairs and DRMs, because the notion of cross-agency working and authority bears frequent repetition until it becomes natural. Again, the PSNI report provides ample justification. But, to take a simple instance, although the reason why ASORMCs are chaired by PBNI personnel, the DRM is drawn from any of the core agencies and the secretariat is provided by the police can be readily understood, that itself requires a degree of flexibility and cross-boundary working that needs clarity and real effort to sustain and make really effective. **We recommend that the clarification of roles, with particular emphasis on the need for cross-boundary working and acceptance of legitimate external authority in the MASRAM process, be re-emphasised to all those who potentially participate in the MASRAM process.**

16. It is clearly important not only, as already argued, that agencies be consistently represented at ASORMCs but that they also be represented by the right person(s). We were struck by this aspect in particular of the PSNI report, and wish to **endorse strongly its finding (second recommendation, paragraph 3.3) that ‘each DCU must identify the officer responsible for MASRAM matters. A suitable deputy must also be identified’**. That review amply justifies the need for this recommendation, but it is worth underlining the need, particularly in a specialised area such as this and where there is normally more than one DCU in an ASORMC area, for the police representative to be thoroughly familiar with MASRAM requirements and to be in a position to ensure actions are taken in various parts of the DCU. **In a word, he/she should be seen as the central point in the DCU who ensures that the agreed action is taken.** Greater clarity on this point might, for example, have prompted the PSNI to undertake its agreed programme of visits to Hamilton.

17. The PSNI review also identified the need for co-ordination not just among normal ‘MASRAM players’ in the DCU, but also among wider policing units in the area and beyond – in this case traffic. There were clear breakdowns within the PSNI and the ICIS system in not passing on relevant information after sightings of Hamilton to others in the police who needed to know. The introduction of ViSOR should help here, **provided it is not seen as a panacea on its own for such problems in future.** But neither NIPS nor PBNI will have access to ViSOR for some time, and in the meantime there may be some risk that police will naturally be tempted to think that ViSOR absolves them from keeping NIPS and PBNI appropriately informed. **This should be borne in mind in training officers in the use of ViSOR.**

18. We were struck by the crucial need for the prescribed process to incorporate checking that agreed steps have been executed in fact, reflecting the overall need for firmness in managing the work of the Committee. **This should be an explicit element of the role of ASORMCs as prescribed in guidelines, which should also make clear the weight of the chair’s responsibility and the need for commensurate firmness in approach.** There is no doubt that a risk management plan for Hamilton was properly prepared by ASORMC, specifying steps prescribed by ASORMC on a rolling basis to guard against the high risk he represented. There is every reason to believe that it should have been

effective (although it is the case that such plans set out to manage risk – it cannot be wholly eliminated). But all three internal reviews identify steps that were either not taken or not completely so, and we suggest some steps to promote verification of steps in future plans.

18.1. First, **the risk management action plan should always clearly identify the following:**

- **specific actions to be taken**
- **the agency and person to be tasked with taking them or ensuring they are taken**
- **the date by which action should be taken.**

18.2. Paragraph 4.13 of the Manual provides for this, but it would be further strengthened if the MASRAM action plan forms could include columns specifically to record these points, plus one for the ASORMC chair to confirm that they have been taken. The ASORMC meeting after the current plan has been agreed should then review action and the chair should then initial that column to confirm that each action has been taken. If it has not, then the discussion and revised plan should take appropriate account of that. **So, second, we recommend that those amendments be made and ASORMCs planned accordingly.**

18.3. Third, **there should be tightening-up in the clarity and distribution of the minutes of ASORMC meetings.** It is the action plan that must clearly state agreed actions, but the minutes have an important role to play in recording reasons for variations, expression of reservations that might have an important bearing on future case-handling discussions, etc. So minutes should be more than a bare record but impart the essential flavour as well as outcome of meetings. At the same time, if they are to fulfil this role, minutes need to be timely and distributed to those whose business they affect. There is reason to believe this latter did not occur as it might have done in Hamilton. This point again underlines the need for regular co-ordination and understanding between the chair, DRM and secretary.

- 18.4. Fourth, **DRMs (and indeed others members as necessary) should have an explicit right to raise with ASORMC chairs, either at or between ASORMC meetings, any concerns he/she might develop that any of the agencies is not undertaking an action as agreed, so that the chair can seek to remedy it.**
- 18.5. Fifth, we gained the impression that the culture of ASORMCs is not to challenge the actions of others, and of other agencies in particular. This is especially understandable where the practice of multi-agency working is bedding in, and certainly a culture of excessive criticism is to be avoided. A greater sense of collective responsibility should not dilute each agency's obligation to discharge its statutory responsibilities – in relation to Hamilton, to supervise in the case of the PBNI, to visit the offender in the case of the PSNI. In fact greater collective responsibility properly developed should provide a stronger guarantee of action by individual agencies. Greater consistency of representation at ASORMCs should help improve the sense of corporacy. **But ASORMC chairs should also be encouraged to develop a greater sense of collective responsibility in their Committees and show a lead, for example, by ensuring collective discussions of actions taken to date on each individual case on the agenda and an opportunity for appropriate cross-questioning of one agency by another. And each Committee member should be encouraged to critique, constructively and sensitively, the actions of other members and agencies, as well as to respond positively to such critiques.**
19. **We think the clarity of guidance on frequency of ASORMC meetings should be revisited.** Paragraph 2.17 of the Manual says that ASORMCs should be held 'as required by the workload but not less than once a month'. Paragraph 3.13 states that the risk category of all category 2 or category 3 offenders 'will be subject to quarterly review unless they are serving a custodial sentence in which case they may be reviewed every 6 months with the agreement of the meeting'. While this guidance is not necessarily inconsistent, chairs, secretaries and members might be helped by some greater clarity, perhaps in the form of illustrated examples.

NI Sex Offenders Strategic Management Committee (NISOSMC)

20. Some points affecting NISOSMC flow from this analysis.
21. First, since our main finding has not raised concerns about the quality of the risk management plan in respect of Hamilton but about verifying its execution, we suggest that NISOSMC should consider if it should have some long-stop checking role on this point. Paragraph 2.21 of the Manual assigns a range of tasks to NISOSMC, including:
 - quality assurance of risk management plans
 - ensuring that the multi-agency risk assessment and risk management policy and procedure is implemented, and
 - taking direct oversight of category 3 cases (though this seems to be mainly with resourcing and support in mind).
22. **Responsibility for monitoring execution of risk management plans should be made a more explicit responsibility of NISOSMC.** Its High-Risk Sub-group may be the best vehicle for undertaking a suitable level of monitoring, perhaps in liaison with ASORMC chairs and building on the verifying role of chairs recommended in paragraphs 14 and 18.2. **But** there is a delicate balance to be struck here, in that NISOSMC will not want to obtrude too much into the business and responsibilities of ASORMCs, while ensuring that the procedures for which it is responsible are operated in practice and to the proper quality. So we think it best if a monitoring role for NISOSMC of the kind suggested is designed primarily by the Committee and its constituent agencies themselves. We have provided some pointers.
23. Second, we noted from the PBNI internal review that there may have been some breakdown in liaison between the Committee and ASORMC over Hamilton. His case was referred to NISOSMC in January 2002 as indicating a category 3 risk. NISOSMC sought an update report nearer to his release from custody. In the event this seems not to have been forwarded nor a renewed request made by NISOSMC. **This suggests that liaison arrangements between NISOSMC and ASORMCs should be revisited to ensure that clearing mechanisms are in place to chase progress, etc.**

24. Third, we welcome the fact that there is continuing assessment and adjustment of MASRAM guidelines on an annual basis through the Policy and Practice Sub-group of NISOSMC. This makes good sense, not because we have concerns about the quality of the guidelines themselves but because capacity for running adjustment is always useful in systems and procedures that continue to bed down. And indeed the panel came across versions of MASRAM guidance that were incorrect.

Overall conclusions

25. The panel would like to offer some more generalised observations and recommendations.
26. First, there are questions to be considered about the basis and timing of Hamilton's release (particularly, but not only, if he did in fact commit the subsequent murder as alleged). His was a determinate sentence, leaving the NIPS no option or discretion over time of release of an offender who continued to refuse to acknowledge his offending and to do anything to address his behaviour during custody. Yet at that point, and for some time before it, all the professionals involved in his case remained concerned that he represented a material risk to society, as reflected in the Hydebank Head of Custody's refusals to a number of applications for home leave. Clearly there are complex and wider considerations at play here. **But we understand that the NIO is reviewing the law bearing on this at present and suggest that, if NISOSMC shares our concern about the level of protection afforded to society by the criminal justice system in circumstances of this kind, this broader matter might be brought to their attention for consideration in that review.**
27. Second, **we suggest that, to the extent that it accepts our findings and recommendations, NISOSMC should put in hand a review of the implementation of both these recommendations and those made by the internal reviews directed at individual agencies.** (There is some limited overlap between the two.) This would be of a piece with NISOSMC's recommended role of monitoring compliance in actuality as well as good management practice. Summer 2006 may be about the right time.

28. Third, our findings tend to underline the need for continued training - indeed the PSNI review made recommendations on this for the police, and we understand those are now in hand. **NISOSMC may wish to refer this aspect of both this report and the underlying internal reviews to its Training Sub-group to consider the implications and draw up an appropriate training response.**
29. Fourth, the PBNI internal review raised some concerns about the availability of sufficient suitably trained PBNI specialists in this field, not least with the retirement of a particular expert early in 2007. We understand that this question seems to have been resolved, but these resources are so crucial to the success of MASRAM that **NISOSMC may wish to seek an update from the PBNI of its plans to ensure continued availability of adequate specialist expertise.**
30. Lastly as already noted, our principal finding has concerned implementation and execution, not the quality of the procedures themselves. We were struck by many very positive features of the system:
- internal reviews reflected, and sometimes explicitly noted, a widespread commitment to MASRAM on the part of agency staff
 - the professionalism and care of the agency staff whose work was involved in the case.
 - reports from reviewers that the professionals involved believed that MASRAM and the way it has worked had made a real difference by promoting inter-agency co-ordination, the increasing familiarity with and effectiveness of the work of ASORMCs and the valued input of the NISOSMC in its co-ordinating role, and
 - the high quality of the reviews themselves in their rigour and honesty.

31. The deficiencies we found in execution also need to be seen in perspective: what is needed is tightening-up of mainly administrative arrangements. But they are important. We noted that no consideration was given to using the option of community notification in Hamilton's case. This is a power sparingly and carefully used, and rightly so. We are not suggesting that it necessarily should have been used in relation to Hamilton, nor that the course of events would even probably have been different had it been so. But we wondered whether one of the reasons why it had not been considered was because all those involved in the case were, quite understandably, confident that the handling plan in respect of Hamilton was sufficient to manage the risk, based on the natural assumption that that plan would be fully executed as prescribed. If that hypothesis stands up, then the importance of verifying execution of risk management plans is apparent. All that said, however, we recognise that what we are dealing with here is a plan to manage risk, not to eliminate it entirely.

(Sgd) David Watkins

D J Watkins

Chair, Serious Case Review Panel (Hamilton)

30 January 2006

Internal Agency Review Report

Police Service of Northern Ireland



Review of PSNI Role in management of Hamilton

Following the arrest and charging of Hamilton, the PSNI commissioned a review of the police response to the case.

This review was carried out by an independent Senior Investigating Officer of D/Superintendent rank and an independent CARE D/Inspector who had particular knowledge around the management processes required in relation to sex offenders such as Hamilton.

During this review, the officers identified a number of points where police performance did not fully meet all expectations and requirements.

In particular they identified the following:

- The police did not carry out the formal visits to Hamilton which the plan required.
- This failure was not detected by police management
- It appears that within the police the structure for the management of Hamilton was not properly understood. The attendance of local (Strabane) police at ASORMC meetings was lacking, with an Inspector attending an ASORMC meeting on 24th June 2003 prior to Hamilton's release from prison but no member attending a subsequent meeting in September 2003 while Hamilton was resident in the community.
- These failings were not identified by the ASORMC.
- There was a lack of communication within the police and between the police and the DRM in relation to the significance of Hamilton's access to a motor vehicle through his employment and the two sightings of Hamilton in a motor vehicle by police. It should be noted that none of these sightings involved Hamilton using the car in which he used in the crime.

- The police response to the Missing Person report was comprehensive and in compliance with service policy. For example, within a short period of Mrs Harron being reported missing the Garda had been advised and an army helicopter had been tasked. The local police immediately grasped the seriousness of the report and the D/Inspector responsible for the area commenced a rigorous and thorough investigation which subsequently led to the successful conviction of Hamilton.

- It should be noted that sadly there are no indications that there was any likelihood that Mrs Harron could have been located and rescued before Hamilton murdered her.

Conclusion

In conclusion, Hamilton's offending behaviour was classed by experts as impulsive. However, he was also clearly a calculating and callous criminal who identified a window of opportunity when he could offend and targeted his victim accordingly. He was remorseless and his determination to avoid capture is shown by his forensic awareness.

No Risk Management plan is failsafe; the risk which Hamilton posed could never have been completely negated other than under permanent incarceration. Nonetheless, it is clear that there were certain weaknesses in the management of Hamilton as a sex offender in the community. It is to be hoped that the implementation of the recommendations of this report (listed below) will go some way to addressing this.

Recommendations

1. PSNI should formulate and promulgate policy as a matter of priority regarding police responsibilities for the management of registered sex offenders in the community.
2. The management of sex offenders must be recognised as a policing priority for DCUs. DCU Commanders should be encouraged to take a proactive interest in this important area of community safety and should consider including it within their NIM strategies.
3. Each DCU must identify the officer responsible for MASRAM matters. A suitable deputy must also be identified. A record of these officers should be maintained by the MASRAM team and updated by DCUs as necessary. Training for MASRAM officers is referred to at recommendation 10.
4. These officers must be conversant with current service instructions, MASRAM guidance and procedures. They should be proactive in the dissemination of relevant information to and from ASORMC meetings.
5. Where ASORMC minutes are distributed, receipt should be acknowledged by the addressee.
6. Where a sex offender is subject of an ASORMC meeting, the relevant DCU MASRAM officer must attend (see recommendation 3).
7. It is accepted that officers responsible for MASRAM matters may require the assistance of other officers in the visiting of sex offenders. Where this is the case the MASRAM officer must ensure that these officers are aware of their powers and responsibilities. Additionally these should be pro actively supervised to ensure both that they are done but also to ensure that any information required for or generated by such visits is communicated from/to the MASRAM officer.
8. A short aide memoire should be produced for the benefit of officers visiting sex offenders under the MASRAM framework. This aide memoire should set out the requirements of such visits and their legal basis.

9. MASRAM practice guidelines should be amended to require the recording of all visits to registered sex offenders. These should be reported on at relevant ASORMC meetings.
10. The PSNI Missing Persons Risk Assessment Form should require the officer completing and all officers signing to time and date the form. This will ensure the continuity of Risk Assessments, as well as bringing integrity to the process.
11. When received, the MASRAM induction package should be made available to the whole service via PoliceNet.
12. The MASRAM induction package should form the basis of a distance-learning package supplied to all officers identified under recommendation 3. This package should address MASRAM roles and responsibilities but must also clarify the relevant legal considerations (e.g. Human Rights and Data Protection legislation) with regard to sharing of information. A record should be maintained of those officers supplied with this package and the date on which it was supplied.
13. Consideration should be given to the establishment of a mechanism to facilitate the exchange of information and best practice between the MASRAM Unit and other officers involved in the process. Active consideration should be given to use of PoliceNet in this regard.
14. Consideration should be given to raising awareness throughout all parts of the service of the MASRAM process. As in recommendation 13 it is suggested that use be made of PoliceNet. It may also be appropriate to utilise Callsign in this internal exercise.

Summary of how recommendations have been implemented

Recommendation 1

On 11/11/05 a General Order (37/2005) was published entitled 'Multi-Agency Procedures for the Assessment and Management of Sex Offenders'. The electronic version of this Order on 'PoliceNet' provides links to the Manual 'Multi-Agency Procedures for the Assessment and Management of Sex Offenders' and 'Multi-Agency Procedures for the Assessment and Management of Sex Offenders, Practical Guidelines 1/2004 (These guidelines have just been reviewed and have taken into consideration the 14 recommendations, were applicable, and are due to be re-published before the end of June 2006).

Recommendation 2

ACC Gillespie issued clear directions to all District Commanders on 12/8/05 covering all aspects of the 14 recommendations. These directions emphasised the duty upon DCU Commanders to take a proactive interest in this important area of community safety and to consider including it within their NIM strategies.

Recommendation 3

The D/Inspector in charge of the MASRAM Unit at North Queen Street now maintains a record of all Designated Risk Managers (DRMs).

Recommendation 4

Two sessions of training was provided by NISOSMC for all DRMs on an inter-agency basis between September and December 2005. PSNI provided training specifically for all PSNI DRMs on 27/2/06 and 27/3/06. These training events covered all current instructions and procedures. Senior detectives from Crime Operations have begun a series of 'dip sampling' of cases to ensure procedures in DCUs are being adhered to and pro-active supervision is taking place.

Recommendation 5

Minutes from MASRAM meetings are collated centrally at the MASRAM Unit, North Queen Street. The minutes are now forwarded to local DRMs by internal PSNI email. This provides an audit trail for sending and receipt of these.

Recommendation 6

This has been re-enforced by ACC Gillespie's directions dated 12/8/05. It has also been covered at the training events sponsored by NISOSMC and the recent PSNI training for DRMs.

Recommendation 7

On 17/1/06 PSNI formally launched the **Violent and Sex Offender Register** (ViSOR) computer system in N.Ireland – linking it to all United Kingdom Police Forces. ViSOR is used to ensure that clear instructions regarding required actions are properly managed and audited. ViSOR requires the DRM to update all relevant actions by their assisting officers. ViSOR alerts them when these have not been completed. The MASRAM Unit contains the 'Force Central Point of Contact' for other UK forces. They also have the capability to check on individual offenders to establish if relevant actions have been completed on them.

Recommendation 8

ViSOR contains the action plan regarding each offender and provides the visiting officer with details of what is required from the visit. Local Criminal Intelligence Officers are required to update ViSOR on notification of completed actions and any information noted.

Recommendation 9

This has been addressed through the NISOSMC Policy and Practices Sub-Committee. The recommendation has been accepted and incorporated into the revision of the Manual. All visits must also now also be recorded on ViSOR and are available for ASORMC meetings.

Recommendation 10

The 'Missing Persons Risk Assessment' has since been reviewed and the new print has included this recommendation.

Recommendation 11

The Induction Package was forwarded to all Police DRMs in June2005. The manual and guidelines are now on PoliceNet and there are links from the electronic version of General Order 37/2005 as referred at recommendation 1 ante.

Recommendation 12

As per Recommendation 11 above, this is now covered by General Order 37/2005. The Manual and Guidelines were covered at the training given on 27/2/06 and 27/3/06. This training is to now be given on an annual basis.

Recommendation 13

The introduction of ViSOR provided a mechanism for the exchange of information and actions to and from the MASRAM Unit. ACC Gillespie issued a direction on 11/11/05 to all DCU Commanders to make full use of PoliceNet briefing pages to ensure all officers are acquainted with their local high risk sex offenders and are actively gathering intelligence on them.

Recommendation 14

Please see recommendation 13 ante. The Police magazine CallSign has included articles on MASRAM/ViSOR – ACC Gillespie also carried out a media launch for the public launch of ViSOR on 17/1/06.

Internal Agency Review Report
Probation Board for Northern Ireland



Review of PBNI role in the management of Hamilton

Introduction

- 1.1 In July 2004 I was asked to carry out an independent review of the management, by PBNI staff, of the Trevor Hamilton case.
- 1.2 During early 2001 Trevor Hamilton was sentenced to a Custody Probation Order for offences of: abduction, rape and threat to kill. His victim was a twenty seven year old female from his home area. Subsequently the Court of Appeal varied his sentence upwards to one of seven years imprisonment followed by one-year probation supervision. After serving three and a half years, including remand time, he was released from the Young Offenders Centre at Hydebank Wood, Belfast on 18 August 2003. Probation supervision took effect from the day of his release.
- 1.3 In the course of reviewing the case I read and familiarised myself with MASRAM policy and procedure as well as scrutinising the probation supervision record. I also had meetings with ten PBNI employees who had either direct or indirect dealings with the case during the four years prior to 28th March 2004 when Trevor Hamilton was remanded in custody for offences related to the disappearance and death of Attracta Harron for which he is now awaiting trial. The PBNI employees who met with me and provided information about their contact and dealings with the case were:

ACO – PBNI representative on the MASRAM Strategy Group
ACO – Line management responsibilities
Area Manager/Chair of MASRAM local area committee
Area Manager – YOC
Area Manager – ISU
2nd supervising probation officer
Back up supervising officer
1st supervising officer
1st probation officer - YOC
2nd probation officer – YOC

- 1.4 In making judgements about the management of this case I applied the interim CPO Standards which were introduced on 1 November 2000 and which are still applicable. In addition I took account of MASRAM risk management plans as related to the case.

Main findings

- 2.1 None of the PBNI employees with whom I discussed the case were in any doubt that Trevor Hamilton poses a serious threat to the safety of others. This unanimous opinion of PBNI staff involved with the case was supported by independent psychiatric and psychology reports as well as the recorded opinion of the therapist connected with the Prevention of Sexual Abuse Programme at Tyrone and Fermanagh Hospital. The RA1 rates him as being a high risk of harm to others and within the MASRAM process he was graded at the highest level, risk Level 3. This high level of assessed risk of harm to others was maintained throughout the time he was under supervision.

- 2.2 From the records and from my conversations with PBNI staff I formed the opinion that on the surface Trevor Hamilton presented as being quite amiable and cooperative but in many ways a shallow personality. He is reported as consistently denying all of his previous offences even in the face of overwhelming evidence. When, more than three years after the offences, he accepted responsibility for his earlier convictions he displayed no remorse and no regard for his victims. For a long time his parents refused to accept his guilt and at times appear to have been quite hostile to the PBNI and NIPS staff involved with the case.

The case record

- 3.1 The case record showed that contact between the supervising probation officers and Trevor Hamilton exceeded the frequency required by the Standards. With the exception of one week at Christmas 2003 he had face-to-face contact with a probation officer at least once per week during the period that he was under supervision in the community. The requirement for unannounced home visits was fulfilled. In accord with the additional requirement of the court to attend a sex offender treatment programme, he was referred to the Prevention of Sexual Abuse Programme (PSAP) which is delivered at Tyrone and Fermanagh hospital. Initially he attended individual sessions with a therapist there and subsequently participated in the group work programme.
- 3.2 The Enforcement Record reveals that Trevor Hamilton complied with his supervising officer's instructions on every occasion but one. He failed to attend a joint appointment with his supervising officer and the PSAP therapist on 13th January 2004. His failure to attend that interview was followed up with an immediate home visit. His explanation that he had misunderstood the instructions was accepted and fresh instructions were given. He complied with the new instruction.
- 3.3 The case record contains a set of documents relating to each occasion that the Hamilton case was listed for consideration by the area MASRAM panel. These records comprise a collection of completed risk management review forms. There is no other form of record such as minutes of the deliberations of the panel. I was informed that general minutes are not taken.

The supervising probation officer, who was also designated as the risk management officer (DRO), reported back to the area panel on each occasion that the Hamilton case was listed. Within 24 hours of each review the DRO visited the Hamilton home to feed back the panel's findings.

The therapist responsible for Hamilton's participation in the PSAP has been a regular attendee at, and participant, in MASRAM reviews of the case.

The case was referred to the Strategic Group of MASRAM in January 2002 indicating that Hamilton was a Level 3 risk. At that time the Strategy Group required an update report nearer to Hamilton's release from custody. There is no evidence that an update report was forwarded or that a renewed request was made by the Strategy Group.

- 3.4 Supervising officers whom I met in the course of this review said that they felt adequately supported in their work with sex offenders. Primarily they derived their support from the colleague designated as back up supervisor and other colleagues who have undergone sex offender training. They reported having open access to consultation and guidance from Area Managers. They also value the opportunity to attend “Care Call” as a means of professional support. Officers have valued the professional support provided by _____ but as her role and responsibilities have expanded in other areas this valued service has diminished.
- 3.5 _____ is the most experienced PBNI employee in the field of working with sex offenders. Since the introduction of the CSOG Programme, much of her time and energy is taken up:
- in managing the CSOGP in terms of both programme management and treatment management;
 - servicing six MASRAM panels;
 - servicing two Area Child Protection Committees;
 - making joint monitoring visits with representatives of other agencies in none statutory cases; and
 - as a training resource for both in-service and interagency training events.

Practice development needs

- 4.1 None of the following observed weaknesses in practice and process could be said to have contributed in any way to Trevor Hamilton re-offending. However, in my judgement, the areas identified fall short of practice requirements and therefore need closer attention in supervising future cases.
- 4.2 All persons involved with this case consistently acted in accord with the high level of assessed risk of harm posed by Trevor Hamilton. However, scrutiny of the ACE document revealed weaknesses as follows:
- (i) inaccurate totalling of the offending related scores on the initial summary;
 - (ii) insufficient evidence provided in support of amended likelihood of re-offending scores at later reviews.
- 4.3 When measured against the criteria set out in the Service Requirements for formulating plans for the supervision of sex offenders, the plans in this case fall short of meeting requirements. The main weaknesses are that they do not:
- clearly state the intended outcomes of supervision;
 - contain clearly articulated and time bounded targets;
 - *contain an integrated relapse strategy.

* A handwritten outline of a relapse strategy was found on file but this had not been integrated into the supervision plan.

- 4.4 A further weakness in planning practice was the delay in carrying out the required four monthly reviews of plans.
- 4.5 Standards require that, where an offender is attending an approved programme, progress reports from the programme provider be entered into the record at four monthly intervals. I found no formal progress reports from the PSAP although it was evident from the supervising officer's notes that there had been dialogue between him and the therapist at the PSAP. The therapist also attended and contributed to MASRAM reviews of the Hamilton case.

5. **General observations**

- PBNI invests a very significant amount of management time in the operation of MASRAM. As the smallest organisation involved PBNI seems to maintain a consistently high commitment compared with the *reported* variability of commitment from some other organisations.
- It became evident to me that a large proportion of probation officers have elected not to work with sex offenders. This leaves the burden of supervising many of the highest risk cases to a very small proportion of more willing staff, some of whom have specialised wholly or partly in this high stress area of work for extended periods of time. This seems to be more problematic in rural areas of the service.

6. **Conclusion**

All PBNI staff who have been involved with the Trevor Hamilton case have had a clear appreciation of the threat he poses to the safety of others and have carried out these duties accordingly.

Whilst reviewing the case I identified some areas of practice which need to be strengthened. However, these weaknesses in process cannot, in my judgement, be construed as having contributed in any way to him having re-offended. Unrelated to this case, the service has already undertaken a major revision of its standards of practice which, over time, will progressively improve the quality of service delivery in all areas of work of the service.

INTERNAL PBNI CASE REVIEW ON HAMILTON

ACTION PLAN

- | | | |
|----|--|---|
| 1. | Replacement of specialist expertise | Recruitment for Programmes Manager underway, June 2006 |
| 2. | Standards – practice development needs | Staff have completed new standards training in April and May 2006 |
| 3. | ACE (Assessment, Case Management and Evaluation) for all Probation Officers and Managers | This is currently underway and will be completed in September 2006

- Renewed Training on ACE for Probation Officers and Managers |

Internal Agency Review Report Northern Ireland Prison Service



Review of NIPS role in the management of Hamilton

An assessment of the application of MASRAM standards and procedures by the Northern Ireland Prison Service in the case of Trevor Hamilton.

Introduction

I was asked on 15 December by the Northern Ireland Prison Service to undertake an internal independent review of the case of Trevor Hamilton.

- 1.1 Trevor Hamilton was sentenced to a Custody Probation Order on 19 September 2001 at Enniskillen Crown Court for offences of rape, indecent assault of a female, assault with intent to commit buggery and threats to kill. His victim was a 27-year-old woman from his home area. Mr. Hamilton's sentence was increased, on appeal by the DPP, at the Northern Ireland Court of Criminal Appeal, to 7 years custody followed by one years probation. The sentence included a requirement for Hamilton to participate in a Sex Offenders Treatment Programme. Two years earlier Hamilton had been found guilty at Strabane Youth Court of offences of indecent behaviour (5 counts) committed on 4 different occasions when he was 15 and 16 years of age and had been sentenced to 2 years probation at that time.
- 1.2 Mr. Hamilton was subject to the multi-agency procedures for the assessment and management of sex offenders. Having already been on remand for 19 months prior to sentence he was released from Hydebank Wood Young Offenders Centre on 18 August 2003, having served three and a half years. From the date of his release he was subject to supervision by the Probation Board. During his period of supervision in the community he was arrested in connection with charges relating to the abduction and murder of a 65-year-old woman and remanded in custody at HMP Maghaberry, where he currently remains pending trial.
- 1.3. This report assesses the extent to which the Prison Service applied MASRAM standards and procedures in the Hamilton case and seeks to highlight any lessons to be learnt, which may be helpful to the Prison Service for future cases.

Methodology

- 2.1 I read MASRAM Practice Guidelines 1/2004 and the Multi-Agency Procedures for the Assessment and Management of Sex Offenders. I also examined the prison records relating to the case. I obtained from the MASRAM unit the Multi-Agency Sex Offender Assessment and Management form (MASRAM 1) and the review forms (MASRAM 2) relating to the time Hamilton was in custody. These were not available from the Prison Service as their copies had been shredded after Hamilton was released and the relevant Head of Custody left the YOC. I also interviewed key staff who had been involved with the case during the custodial part of his sentence. The persons to whom I spoke in connection with the case were:

The Head of Custody at YOC at the time;
The PBNI Area Manager, YOC;
The Principal Psychologist, NI Prison Service
The Director of Operations, PBNI.
The MASRAM Unit, PSNI
Criminal Justice Department, PSNI
NISOSMC Strategy and Policy Coordinator

Multi Agency Procedures for the Assessment and Management of Sex Offenders

- 3.1 “The primary aim of risk assessment and risk management of sex offenders is to help protect the public from harm by reducing the offender’s opportunity and/or propensity to re-offend.” (taken from the MASRAM Manual of Procedures)
The MASRAM system for risk assessment and management of sex offenders is built upon the principle that effective work with sex offenders requires a multi-disciplinary approach and a recognition that inter-agency working is vital. It has developed protocols relating to the exchange of information and the development of effective information systems. MASRAM provides a structure under which the risk presented by serious sex offenders can be assessed and managed by a committee of persons drawn from the relevant agencies concerned with them.
- 3.2 The Northern Ireland Prison Service is one of the key agencies involved in the operation of MASRAM. It has agreed arrangements with the other key agencies for the co-ordination of how each agency fulfils its respective responsibilities. The co-ordination of procedures is achieved through the development and co-operation of Area Sex Offender Risk Management Committees (ASORMC). Each agency carries certain responsibilities in contributing to the effective and efficient operation of these risk management committees. The Northern Ireland Prison Service has an important role to play in the assessment and management of sex offenders who are serving prison sentences or who are due to be released from prison. The extent to which the Prison service has fulfilled its roles and responsibilities in connection with the operation of the MASRAM system in the case of Trevor Hamilton is the basis of this report.

Findings

- 4.1 One of the principles underpinning MASRAM is that the same people should attend regional risk assessment and management committee meetings as often as possible to build up good communication channels and relationships of trust. It was noted from the MASRAM papers that there had been an initial classification meeting on 12.10.01 and 6 further review meetings of the Area Sex Offenders Risk Management Committee (ASORMC) during the custodial part of Hamilton’s sentence. These meetings were held in the North West of the Province. While the average attendance per meeting was 6-7 people, the meetings were attended by 22 different people in total. No one person attended all the meetings and there was quite a lot of changes in personnel representing different agencies from meeting to meeting. There were 7 different people from the Probation Service, 9 from PSNI, 3 from Social Services and 2 from the Prison Service. The therapist from the Programme for Prevention of Sexual Abuse was represented by the same person, although PPSA was not represented at 3 of the 6 meetings. This pattern of attendance suggests that the principle of attendance by the same people at meetings has not been adhered to. It was noted, however, that the Prison Service was represented consistently by the Head of Custody at all of the meetings until the last two meetings when there was no prison representative present at either of these. The prison psychologist was only in attendance at one meeting. I understand that she was not invited to attend any of the other meetings.

- 4.2 All meetings of ASORMC were chaired by Probation. I found the Procedures Manual ambiguous regarding frequency of ASORMC meetings. In one part of the Manual (paragraph 2.18) there is a statement that ASORMC meetings should be held as often as required by the workload but not less than once a month. Elsewhere at paragraph 3.17 it is stated that all offenders classified as category 2 or 3 are subject to risk management procedures and will be subject to quarterly review unless they are serving a lengthy custodial sentence in which case they may be reviewed every 6 months with the agreement of the meeting. The responsibility for convening ASORMC meetings rests with the MASRAM sergeant (PSNI) in conjunction with the PBNI ASORMC chairperson. It was noted that the ASORMC meetings relating to Hamilton's case were held at intervals of 2, 6, 4, 2 and 5 months respectively. Hamilton would have been regarded as a long sentence prisoner (7 years) and therefore subject to 6 monthly reviews.
- 4.3 Hamilton's screening by PSNI, using the static elements of the Risk Matrix 2000 risk assessment scale, placed him as high risk. As such he was then subject to a joint police and probation service risk assessment using Part 1 of the MASRAM form. This also resulted in him being assessed as Level 3 (high risk). It was clear from the MASRAM forms completed for every ASORMC meeting during the time he was in custody that Hamilton was judged consistently by the committee as remaining at this level of risk. No-one was in disagreement with this assessment. He was assessed as presenting a danger to the public in general and to adult females in particular. His offence had been premeditated and he had targeted his victim. The assault had been violent and he had threatened to kill should the victim report him. The committee noted that he had consistently denied having committed the offences and was unwilling to participate in any work to address his offending behaviour.
- 4.4 Within the Young Offenders Centre Hamilton was reported to be a willing worker who presented no behaviour problems. He was described as respectful to staff and other inmates and responsive in doing what he was asked to do. He was therefore seen as compliant with the prison regime. This enabled him to progress through the YOC levels from 'Basic' to 'Standard' and on to 'Enhanced' in a reasonably short period of time. However, he did not make any effort to address his offending behaviour while in custody, using the justification that he was planning to lodge an appeal against his conviction and sentence and had been advised by his solicitor not to participate in any programmes that focused upon offending behaviour. Indeed correspondence on his file from his solicitor to the Head of Custody (8.5.02) indicated that Hamilton had been asked to discuss his offending behaviour. The letter went on to say that Hamilton had instructed his solicitor to consider the merits of an appeal against sentence and conviction. In light of the fact that Hamilton was considering an appeal his solicitor pointed out that he should not be asked to engage in any way with anyone in authority in addressing his "offending" behaviour and sought assurances that Hamilton would not be asked to do so. The Head of Custody's reply pointed out there were significant benefits for individuals addressing aspects of their risk thereby reducing the likelihood of re-conviction but emphasised that it was a choice for Hamilton to make. He emphasised that there was no compulsion to participate except where directed by a court and Hamilton would not be approached about it by prison staff.

It is interesting to note that there was a MASRAM form outlining the deliberations of an ASORMC meeting held on 30.7.2002 which inaccurately stated that a new Custody Probation Order had been made (on 25.2.02) with no additional requirements. It indicated that there was no longer a requirement for Hamilton to attend a sex offenders programme on release. This mistake was corrected at the next ASORMC meeting on 26.11.2002 but it is possible the Head of Custody was misled by the inaccurate statement on the MASRAM form about the requirement of the court.

- 4.5 This may have been academic in any event in view of Hamilton's persistence in denial of the offences for which he had been convicted and sentenced to custody and his unwillingness to participate in any programme which would address his offending behaviour. A further difficulty was that the YOC had a relatively small number of convicted sex offenders, and insufficient numbers to enable a sex offenders treatment group to be run. It is understood that there were no accredited sex offender treatment programmes available in the YOC (and there are still none). Most accredited sex offender programmes are focused on older sex offenders and even if Hamilton had been willing to address his offending behaviour it would probably have had to be done in another prison along with older men. It is understood that an experimental programme was run at Alderwood (a probation facility located close to the YOC) at one stage in the past but this has not been continued.
- 4.6 I noted in reading the initial MASRAM 1 form (15.11.01) that a full risk assessment was to be undertaken by a Consultant Psychiatrist. There was reference in the next MASRAM form (22.1.02) to the psychiatric assessment having been completed, indicating that it confirmed the "offender specific hazards" that had been identified in the initial risk assessment and highlighted violence and Hamilton's denial of the offences. In the next MASRAM form (20.7.02) there was a comment "(Hamilton) has been seen by the Consultant Psychiatrist - content of report not known". This suggests some weakness in the checking of previous MASRAM reports.
- 4.7 In the earlier list of "Offender Specific Hazards" there was a reference to 'Denial of offences until recently'. There is no further reference throughout the MASRAM papers to this having been further explored in light of Hamilton's subsequent total denials of the offences. It is suggested that discussion of this point with Hamilton might possibly have had a bearing on the position Hamilton subsequently took regarding his denial. While he denied any involvement in the offences throughout the period of his custodial sentence the psychologist told me that shortly before he was released he acknowledged that something had happened, although this was related in rather vague terms. As it was raised too late to allow the psychologist to engage in more detailed assessment he was advised to address the matter through probation on release. The psychologist reflected to him her concerns of what might happen if he continued to fail to address problem areas such as his sexual behaviour. In discussing his future plans post release she also expressed concerns about plans for opening a garage at his home where he would work alone as a mechanic, allowing the opportunity for possible further offending e.g. women coming to his garage with cars.

- 4.8 I formed the impression that the Head of Custody was committed to the MASRAM approach. He relied heavily on it for assessment of risk and was guided by the committee's advice regarding Hamilton's various applications for home leave. He was clearly influenced by the risk of danger posed by Hamilton to women and his responsibility to avoid putting the public at risk by releasing him for weekend leaves. He also made sensible use of the ASORMC's proposals for a phased programme of temporary release commencing with a structured hostel placement in an approved probation hostel when the time for Hamilton's release was imminent. The fact that Hamilton was not given home leaves earlier than he was (the last weekend before he was released) was related to the fact that Hamilton refused for some time to co-operate with the proposed plan for a phased programme of release initially to a Belfast based hostel, where he could be carefully monitored.
- 4.9 The prison case record was of limited assistance to me in ascertaining what the prison had done to address Hamilton's offending. I found no sentence plan for Hamilton on the file. Discussions with the former Head of Custody, who was at the YOC at the time, left me with the impression that the YOC relied heavily on probation and psychology departments for help in relation to risk assessment and management of risk. It was noted that the designated risk manager for Hamilton's case was always someone from the probation service, in spite of the statement in the MASRAM Procedures Manual that in all category 3 high-risk offenders the prison service will undertake the role of risk manager during the sentence. The Head of Custody regarded the YOC probation manager to be the appropriate person to carry this role. Within the YOC Hamilton presented few problems and the primary focus of risk management was related to how the risk he presented could be managed when he was released into the community. He was, however, encouraged to participate in both Anger Management and Enhanced Thinking Skills (ETS) programmes which were available in the YOC. The Anger Management programme was co-delivered by the YOC psychologist and an outside practitioner and the ETS programme was co-delivered by her along with two prison officers who had received specific training as facilitators. As more prison officer staff are trained to participate in relevant programmes this should enable the YOC to deliver a greater range of programmes in response to identified need in the future.
- 4.10 It has to be acknowledged that MASRAM did much to identify the risks that Hamilton presented and no one was in any doubt regarding the risk that Hamilton would pose on his return to the community after his discharge from custody. Efforts were made to engage him in a phased programme of temporary release as he neared the end of his sentence in an attempt to facilitate as safe a return home as possible. These were frustrated by Hamilton's unwillingness to co-operate with the proposed temporary release package until the very last stages of his custodial sentence. The Area Sex Offenders Risk Management Committee drew up plans for his regular supervision by probation from the day of his release and these were put into operation immediately. Plans were also made for work to be undertaken with Hamilton's parents and for monthly visits to the home by the police to monitor his behaviour. Hamilton was also required to attend a sex offenders programme which was run at Tyrone and Fermanagh Hospital. All of these measures were planned as part of the arrangements for the protection of the community. However, agencies cannot be held responsible for the criminal actions of sex offenders as long as they have exercised their best endeavours to co-operate in a professional way to ensure that the risks are properly assessed and plans are put in place to manage the risks identified.

4.11 This report has identified some areas where practice might have been better but I do not think that any of them can be taken as having in any way contributed to Hamilton's alleged re-offending.

5. **The Prison Service input to the Hamilton case**

5.1 The Head of Custody was a regular contributor to MASRAM meetings from the start of the sentence. There is no record as to why he did not attend either of the last two meetings before Hamilton's release and he was unable to recall the reason for his unavailability at these meetings when I met with him. He did, however, consider that the YOC probation manager was in a good position to represent the views of the Prison Service at these meetings.

5.2 The Head of Custody did make efforts to engage Hamilton in the MASRAM process by inviting him to contribute his views to the risk assessment and risk management process. It is clear from the records that Hamilton was informed of MASRAM arrangements and understood the purpose of MASRAM. Although it is understood he contributed little to MASRAM (other than in relation to his applications for home leave) he was kept informed by the Head of Custody and the probation manager of the risk assessments and action plans being put in place by the committee, as required by the MASRAM system.

5.3 The YOC psychologist had a good deal of contact with Hamilton during his custodial sentence. She was involved in risk assessment and in the delivery of cognitive programmes which provided insights into his thinking and offered the possibility of positive intervention had Hamilton been willing to co-operate fully. In her report to the MASRAM committee on Hamilton's progress in the programmes she considered that his motivation was more related to the expectation that attendance might help him to secure home leave paroles than to any genuine motivation to change. Given her knowledge of Hamilton, I consider that she would have been able to make a valuable contribution to the work of the ASORMC, but she was only invited to attend one meeting.

5.4 Regrettably little was done to address Hamilton's offending behaviour while he was in the YOC. This was unfortunate but given his total denial of his offending and his unwillingness to engage in any work that would address his offending behaviour there was relatively little that could be done. In any event, the lack of any available group programme within the YOC for sex offenders was a deficiency. It is suggested that the Prison Service should explore the possibility of accessing suitable sex offender treatment programmes which could be used for sex offenders from the YOC in the future.

5.5 Hamilton was able to achieve certain privileges within the YOC based on his compliance with the prison regime. Although he was not able to achieve the SP (special privileges) status because of his unwillingness to address his offending behaviour he would have been relatively comfortable and it appears that little was done to provide him with any real incentive to face up to the factors that had led to his sentence. The lack of encouragement from either his family or his solicitor to accept his offending behaviour and allow prison staff to address it with him would have made this difficult anyhow.

5.6 Hamilton was refused home leaves on several occasions because of the identified risk of danger that he was considered to present to the community, in light of the risk assessments that had been carried out throughout his period in custody. This was primarily out of a sense of duty to protect the community. The present arrangements for release of determinate sentenced prisoners at half sentence meant that Hamilton was released into the community in the full knowledge that he was likely to be a danger to women.

6. **Conclusion**

6.1 While there are some matters which have been identified in this report that could have been dealt with more professionally, it is unlikely that the tragedy which occurred could have been prevented by anything other than retaining him in custody for a longer period of time.

6.2 The main issue that arises from this review relates to the fact that a dangerous sex offender, who received a 7-year custodial sentence for serious sexual offences, who refused to acknowledge his offending and failed to do anything to address this behaviour during his sentence, was released into the community at half seems to me that it was a very risky thing to do. The Head of Custody had refused a number of applications for home leave on the grounds of the risk that he would present in the community, yet when he reached his earliest date of release he was discharged. It is suggested that the legislative position relating to discharge at half sentence needs to be reviewed if the public are to be adequately protected by the criminal justice system. Had there been a parole board in this jurisdiction for considering such cases it is extremely unlikely the board would have agreed to Hamilton's release at the stage he was released given all the indications of his dangerousness, which were known to the prison system through the MASRAM system. In my view automatic release at the half sentence stage for offenders who are assessed as dangerous and likely to cause serious harm in the community fails to give adequate protection to the public.

NORTHERN IRELAND PRISON SERVICE

There are four main recommendations arising out of the Prison Service Internal review, which are also contained in the Watkins report. The four recommendations are set out below together with the course of action agreed by the Prison Service to address them.

1. The need for regular and consistent attendance of prison representatives at ASORMC meetings.

Response

The Prison Service has revised its guidelines to Governors on the MASRAM process and their role of Designated Risk Manager (DRM) during custody. The guidance makes clear that the DRM has responsibility for monitoring the prisoner's progress throughout the period in custody and, to ensure consistency in approach and reporting, and to attend both Prison and Area ASORMC meetings when required. This includes having named alternates to attend meetings together with other professionals when required. These guidelines have been implemented.

2. It is recommended that accredited sex offender treatment programmes are available at Hydebank Wood for young offenders.

Response

The Prison Service accepts there is a need to provide an appropriate range of interventions, including programmes to address specific needs of this kind and to ensure that sufficient opportunities for engagement are available. The Prison Service in partnership with Probation Board for Northern Ireland will have an agreed strategy for the delivery of appropriate programmes for sex offenders at Hydebank Wood, by March 2007.

3. It is recommended that more prison staff be trained as programme facilitators.

Response

There is a need for more programme facilitators for programme delivery and prisoner support at all levels. A multi-disciplinary working group has been established to identify the overall extent of the need and how this can be met. The Working group will report to the Prison Service Senior Management Group by the end of 2006.

4. The legislative position on how someone considered high risk, who failed to do anything significant to address his offending behaviour, can be released from custody on 50% remission, should be reviewed.

Response

The legislative position on remission for prisoners is not a matter for the Prison Service.

Summary of Recommendations

WATKINS SERIOUS CASE REVIEW

Summary of Recommendations

		Recommendation	ACTION
1.	Para 6	Mechanisms to ensure that agreed action is taken	Completed in Guidelines Review 2006
2.	Para 8	Custody Probation Order and legal issue of attending programmes whilst in custody phase	Legal issue - NIO
3.	Para 9	Course for sex offender treatment at Hydebank Wood Prison	NIPS and PBNI taking forward at present
4.	Para 10	NIPS attendance at ASORMCs	NIPS and PBNI taking this forward currently
5.	Para 13	Principle of consistent attendance at ASORMCs	Completed in Guidelines Review 2006
6.	Para 14 + 15 + 18	Roles and authority of ASORMC chairs and DRMs further clarified and re-emphasised, including cross-boundary working	Completed in Guidelines Review 2006
7.	Para 16	PSNI representation at ASORMC	PSNI actioning
8.	Para 18.1 + 18.2	Risk Management plan details and format	Guidelines Review 2006 and Manual to be completed
9.	Para 18.3	Minutes of ASORMCs	Guidelines Review 2006

10.	Para 18.4	DRMs and other members' right to raise issues with ASORMC chair at or between meetings	Guidelines Review 2006
11.	Para 18.5	Collective responsibility at ASORMC – Chair + all members	Guidelines Review 2006
12.	Para 19	Guidance on frequency ASORMC meetings	Guidelines Review 2006 and Manual to be completed
13.	Para 22	Monitoring of risk management plan	High Risk Sub Group and development of P&P Audit team by Co-ordinator
14.	Para 23	Liaison between NISOSMC and ASORMC	Guidelines Review 2006 and Co-ordinator
15.	Para 26	Law and Determinate Sentencing and Release Mechanism	Legal and NIO
16.	Para 27	Implementation plan	Completed and will be overseen at NISOSMC
17.	Para 28	Training Needs	Ongoing internal to each agency and generally across MASRAM agencies
18.	Para 29	Specialist Expertise in PBNI	Currently recruiting Programmes Manager