Cumbria Partnership NHS Foundation Trust/Cumbria Constabulary/Cumbria Probation Trust/Cumbria County Council Adult Social Care

Multi-Agency Public Protection Arrangements/Multi-Agency Risk Evaluation (MAPPA/MARE) Pathway Policy

January 2017

CUMBRIA MAPPA/MARE PATHWAY DOCUMENT

Document Summary

To ensure that practitioners within Cumbria Partnership NHS Foundation Trust are aware of the Statutory arrangements, responsibilities and expectations of clinical/care staff in relation to MAPPA. The Policy also outlines the process for referral in to the Multi-Agency Risk Evaluation (MARE) to assist Multi-disciplinary teams in Cumbria to assess and manage Mentally Disordered Offenders who are a risk to the public and are either in the community or within hospital units.

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ACCOUNTABLE DIRECTOR	Director of Quality and Nursing
POLICY AUTHOR	Development Officer for Mentally Disordered Offenders (Cumbria Partnership NHS Foundation Trust MAPPA Co Coordinator (Cumbria Constabulary)

FREQUENTLY ASKED QUESTIONS IN RELATION TO MAPPA/MARE

- What does capacity and responsibility for actions mean? - In the context of this document it means that the Service User knows the difference between right and wrong and can make decisions about actions and/or behaviour that is, has or is likely to result in criminal offending.

- How do I refer in to MAPPA/MARE? – By completing the referral form at Appendix 1. (see page nos.13, 16 and 32)

- Who should complete the referral form? – The Care Coordinator, Key Worker or Clinical/Care Lead. (page no.16)

- Can a Service User be in the MAPPA/MARE process if not managed by a Clinical/Care Team? – A Service User may still meet the criteria for MAPPA but cannot be managed within MARE if he/she is not managed by a Clinical/Care Team i.e. not allocated or discharged from services. (page no.19)

- Who Chairs MAPPA/MARE meetings? – The Police or Probation Chair MAPPA meetings. MARE meetings will be chaired by the Single Point of Contact (The Development Officer for Mentally Disordered Offenders).

- Who records/documents the minutes for MAPPA/MARE? – The Police or Probation provides minute takers for MAPPA meetings. The referring team is responsible for providing minute takers for MARE meetings. (page no.13)

- Is there a set agenda for MAPPA/MARE? – There are agendas for both meetings. MARE meetings should follow the format outlined in the minute template at Appendix 7. (page no.52)

- Who should receive minutes of the meeting? – All attendees. The meeting may also agree to send minutes to other individuals within agencies if agreed at the meeting. The SPoC must receive minutes of all meetings. The minutes must be completed within 5 working days of the meeting and be accompanied by a completed Attendance Sheet (Appendix 5) and MARE Front Sheet (Appendix 6). (see page nos. 13, 18, 49 and 50)

- What about the Service Users Human Rights? – The Service User does have human rights, but victims and potential victims also have rights. Where there is a risk of serious harm to another, disclosure of those risks is appropriate (page no.20)

- Can I disclose information at MAPPA/MARE meetings? – Health (including Mental Health Services) is a 'Duty to Cooperate Agency' and can disclose information about a Service User provided it is lawful, necessary and proportionate to the risks posed (page no.22)

- Who should the referral be sent to? – MAPPA /MARE referrals should be sent to the SPoC. (page no.13)

- Will all Service Users that meet MAPPA criteria be managed through MAPPA meetings? – No. In some cases, where the lead agency is mental health and there is no active involvement of other agencies the case will be dealt with through MARE (page nos.9 and10)

- Who is responsible for arranging MAPPA/MARE meetings? – MAPPA meetings will be arranged by Police/Probation. MARE meetings will be convened by Team/Service Managers through the Care Coordinator, Key Worker or Clinical/Care Lead (page no.11)

- Who should be invited to MARE meetings? – All relevant parties responsible for the clinical/care needs of the Service User.

- Who informs the Police? – The SPoC informs the Police Single Point of Contact at Police HQ, who will arrange attendance all meetings. The Police will also update the SPoC of any new information they hold for a Service User.

- Do all Service Users who present a risk of harm to others go through the MARE process? – No. Service Users who present a low or medium risk of harm to others will still be managed within CPA/MDT. Only cases where the Service User present high risk of serious harm to others should be referred in to MAPPA/MARE. (page no.12)

- Who completes Form I? – This is an admin form and only designated health professionals complete this form. (page nos.15 and 16)

- Who completes Form A? – The SPoC is responsible for liaising with the MAPPA Coordinator and completes this form. (page no.17)

- Does the Service User or Representative (relative, advocate, solicitor) attend MAPPA/MARE meetings? – No. In order to ensure the free flow of relevant information and to formulate Risk Management Action Plans the service User or Representative must not attend. (page no.28)

- Should the Service User be informed they are in the MAPPA/MARE process? – Not prior to the initial MAPPA/MARE meeting (page no.28)

- What about safeguarding victims? – All MAPPA/MARE referrals will be notified to the Cumbria County Lead for Safeguarding. All MAPPA/MARE referrals involving a child as an offender or victim will be notified to the Trust's Child Protection Lead. Risk Management Action Plans within MAPPA/MARE meetings must address risks to all (see also Victims of Mentally Disordered Offenders at Para 24; page number 29)

- Can the minutes of a MAPPA meeting be sent to a third party? – The minutes cannot be shared or copied without the prior approval of the Chair of the MAPPA meeting.

- Can the minutes of a MARE meeting be sent to a third party? – The minutes cannot be sent to a third party unless the delegates within a meeting agree, or, outside of the meeting, the Chair of the meeting agrees. In any other case the Trust Policy in relation to third party disclosure of information must be strictly applied. (page nos.13 and18)

Partnership NHS Foundation Trust MAPPA/Multi-Agency Risk Evaluation Pathway Policy

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1 INTRODUCTION

1.1 Risk assessment and risk management in conjunction with the Criminal Justice System already takes place within Mental Health Services as an integral part of the Assessment and Care Planning process.

1.2 The Probation Service, Police Service and Prison Service have a statutory responsibility in relation to the management of offenders who are identified as posing a danger to the community.

1.3 Dangerous offenders include those who have committed, are suspected of having committed, or assessed as very likely to commit, offences that would cause immediate and serious harm.

1.4 The development of Multi-Agency Public Protection Arrangements (MAPPA) has given rise to a need for clarity and consistency within the Cumbria Partnership NHS Foundation Trust (the Trust) in order for MAPPA obligations for Health and Adult Services to be implemented. This policy sets out the responsibilities and expectations of clinical/care staff in relation to MAPPA. The Policy also outlines the process for referral in to the Multi Agency Risk Evaluation (MARE) (see para 6).

1.5 This document should be read in conjunction with the

- "Multi-Agency Public Protection Arrangements – Cumbria – Protocol for the Sharing and Disclosure of Information"
- "Multi-Agency Public Protection Arrangements – Cumbria Memorandum of Understanding between Cumbria Responsible Authority (Probation, Police and North West Prison Service) and the Duty to Co-operate Agencies"

2 POLICY STATEMENT

2.1 MAPPA is intended to create a multi-agency framework in which rigorous risk assessment and risk management can take place, providing a foundation for defensible decision making in cases where there are public protection concerns.

2.2 MAPPA has a statutory basis in the Criminal Justice and Court Services Act 2000 and the Criminal Justice Act 2003. The Acts established the Police, Probation and Prison Services as leads or "Responsible Authorities" under MAPPA. The legislation comes with guidance detailing how the system is recommended to operate.

2.3 The Criminal Justice Act 2003 also created the "Duty to Co-operate Agencies", which include Health, Social Services, and a wide range of other agencies such as Education, Job Centre Plus, Housing, and Registered Landlords. Cumbria Partnership NHS Foundation Trust (The Trust) is a "Duty to Cooperate Agency" (as defined under S.325 (6) of the Criminal Justice Act 2003.

3 MAPPA ORGANISATIONAL BODIES

3.1 Strategic Management Board (SMB)
The Strategic Management Board (SMB) is the means by which the Responsible Authority (RA) fulfils its duties under the Criminal Justice Act (2003). The legislation requires the RA to:

> **'Keep the arrangements (i.e. MAPPA) under review with a view to monitoring their effectiveness and making any changes to them that appear necessary or expedient'.**

3.2 The SMB has responsibility for shaping MAPPA activity in its area. This involves agreeing the role and representation of the different agencies within the SMB and brokering the protocols and memoranda of understanding which formalise these.

3.3 **Single Point of Contact (SPOC) within the Trust**

MAPPA process requires each "Duty to Cooperate" Agency to identify a Single Point of Contact (SPoC).The Development Officer for Mentally Disordered Offenders acts as a SPoC for Mental Health Agencies regarding MAPPA issues, including:

- MAPPA and MARE referrals, which are processed in conjunction with the Trust's Mental Health Act Administration Manager's (MHAAM) office. The office is located at the Carleton Clinic, Cumbria Partnership NHS Foundation Trust site.
- Ensuring the MHAAM maintain a database for all MAPPA cases within their areas that includes:
  - -Identifying service users who are subject to sex offender notification requirement upon discharge from hospital (Category 1 Offenders)
  - -Identifying service users who meet the criteria for MAPPA Management under Category 2 of the legislation
  - -Identifying service users who meet the criteria for MAPPA Management under Category 3 of the legislation
  - -Identifying other MAPPA eligible Service users

4 WHO SHOULD BE INCLUDED IN MAPPA?

4.1 The Pathway Policy will apply to any individual managed within the Trust's Mental Health and Learning Disability Services. The Youth Offending Service has a MAPPA referral process for Child & Adolescent cases.

4.2 MAPPA referrals will only apply to service users who have been convicted of a "relevant" violent or sexual offence. Relevant offences are extensive and are detailed in the MAPPA guidance issued by the Home Office. The offences are grouped into the following three categories;

4.3 **Category 1**

Registered Sex Offenders

- This Category includes offenders required to comply with the notification requirements set out in Part 2 of the Sexual Offences Act 2003 ("SOA 2003").
- A person convicted of, cautioned for, or found to be under a disability and to have done the act charged, or found not guilty by reason of insanity for an offence listed in Schedule 3 (list of offences) to the SOA 2003 will become subject to the notification requirements of Part 2 of the Act.
- **These offenders are often referred to as being on the "Sexual Offenders' Register."**

4.4 **Category 2**

Violent offenders and other sex offenders

Those offenders convicted of a relevant violent or sex offence (not requiring sex offender registration). To clarify, it is the following offenders who should be included in category 2:

A. Those convicted of a relevant offence (murder or any of the offences in schedule 15 to the Criminal Justice Act (2003)) who receive the following sentences: It is important to note that a conviction for an offence specified in Schedule 15 to the CJA 2003 does not make the offender subject to MAPPA unless he or she receives one of the sentences listed below in respect of that conviction
   - Imprisonment for a term of 12 months or more (please note that this includes a sentence of an indeterminate term and cases where the sentence is suspended);
   - Detention in Youth detention accommodation for a term of 12 months or more (please note that this includes a sentence of an indeterminate term & cases where the sentence is suspended);
   - A Hospital Order (with or without restrictions) or Guardianship Order.

B. Those found not guilty of a relevant offence (murder or any of the offences in schedule 15 to the CJA 2003) by reason of insanity or to be under a disability (unfit to stand trial) and to have done the act charged who receive a Hospital Order (with or without restrictions).

C. Those subject to a Disqualification Order (DO) imposed under sections 28-29A of the Criminal Justice and Court Service Act (2000) the order disqualifies the offender from working with children. The Courts' power to impose DO's was repealed by the Safeguarding Vulnerable Groups Act (SVGA) 2006 and no new ones can be imposed as of June 2013. They have been replaced by a barring scheme run by the Disclosure & Barring service. Those subject to existing DO's did not have them revoked and they continue to be included in Category 2.

4.5 **Category 3**

Other Dangerous Offenders

This category is contains offenders, who do not meet the criteria for either Category 1 or 2 but who are considered by the Responsible Authority to pose a risk of serious harm to the Public which requires active multi-agency management. For example, it could include offenders under the supervision of Probation services or Youth Offending Services on a Community sentence or order.

To register a Category 3 offender, it must be established that the person has either:

- A conviction for any offence (current or historic within the UK or abroad); Or
- Received a formal caution (adult or young person) or reprimand/warning (young person) for any offence; Or
- Been found not guilty of any offence by reason of insanity; Or
- Been found to be under a disability (unfit to stand trial) and to have done any act charged against him/her;
- AND
- The offence for which they received the disposal (Above) indicates that the person may be capable of causing serious harm to the public.

4.6 Offenders should not be registered as Category 3 unless a multi-agency approach at Level 2 or 3 is necessary to manage the risks they present. The current risks do not always have to relate directly to the offence above. Offenders convicted abroad could qualify for Category 3 on this basis.

4.7 In most cases the offence above will be of a clearly sexual or violent nature, although it need not be listed in Schedule 15 to the CJA 2003. There may, though, be some cases where only an examination of the circumstances surrounding the offence will indicate that the offender may cause serious harm. This may show, for example, a pattern of offending behaviour indicating serious harm or an escalation in risk of serious harm e.g. deterioration in Mental Health that was not reflected in the charge on which the offender was actually convicted.

5 MAPPA LEVELS OF RISK MANAGEMENT

5.1 For each category of MAPPA there are three levels of risk management that are decided upon on a case by case basis.

5.2 **Level 1 Ordinary Agency Management**

Level 1 management is the level used in cases where the risks posed by the offender can be managed by the agency responsible for supervision/case management of the offender. This does not mean that other agencies will not be involved, only that it is not considered necessary to refer the case to a level 2 or 3 MAPPA meeting.

5.3 It is the responsibility of either the Police or Probation to convene and chair these meetings. However, when the individual is already involved with an

agency, such as health and adult social care services, then the meeting will usually take place within care co-ordination arrangements, with other agencies being invited where appropriate. Particularly where a single agency identifies a risk of harm or sexual offending and has the facilities, expertise and structure to contain and manage that risk within its own agency. Such cases would be expected to be chaired by Team Managers or above. Please note that there will be cases managed within the Trust's processes that meet the criteria for MAPPA, but are being managed at Level 1 within the Trust's MARE, CPA or MDT processes.

5.4 **Level 2**

Cases should be managed at MAPPA Level 2 where the offender:

- Is assessed as posing a high or very high risk of causing serious harm but does not mean all cases assessed as high or very high risk will automatically require Level 2 management. OR
- The risk level is lower but the case requires the active involvement and co-ordination of interventions from other agencies to manage the presenting risk of serious harm. OR
- The case has been previously managed at Level 3 but no longer meets the criteria for Level 3. OR
- Multi-agency management adds value to the lead agency's management of the risk of serious harm posed.
- Police or Probation Service representatives Chair Level 2 meetings.

5.5 **Level 3**

Level 3 management should be used for cases that meet the criteria for Level 2 but where it is determined that the management issues require senior representation from the Responsible Authority and the Duty to Co-operate agencies. This may be when there is a perceived need to commit significant resources at short notice or where, although not assessed as High or Very High risk of serious harm, there is a high likelihood of media scrutiny or public interest in the management of the case and there is a need to ensure that Public confidence in the Criminal Justice is maintained.

5.6 The guidance stresses that managers "senior enough to make resource decisions" should attend along with the relevant clinicians.

5.7 A central MAPPA question in determining the correct MAPPA level is:
"What is the lowest level of case management that provides a defensible Risk Management Plan?"

6 MULTI-AGENCY RISK EVALUATION (MARE) FRAMEWORK

6.1 In addition to the three categories of MAPPA the Cumbria area operates a Multi-Agency Risk Evaluation (MARE) framework in relation to service users with a mental disorder. This only applies to those service users who do not meet the criteria for MAPPA Level 2 and 3, but are assessed as posing a high risk of serious harm to the public. Please note that there will be cases

managed within the Trust's processes that meet the criteria for MAPPA, but are being managed at Level 1 within the Trust processes.

6.2 Identification as a MAPPA/MARE case is based on the judgment of the clinical/care team that the service user represents a high risk of serious harm to others, and the risk is current (that is, it is not a theoretical risk in the long term).

6.3 **Serious harm means 'An event which is life threatening and/or traumatic, from which recovery, whether physical or psychological, can be expected to be difficult or impossible. (MAPPA Guidance Section 11.7)**

6.4 When deciding to refer a service user into the MAPPA/MARE process the following points should be considered before making the referral.

- Evidence of increasing risk and or patterns of behaviour (e.g. the use or presence of weapons etc) and/or a known victim (named) as 'at risk'
- Offending behaviour linked to dangerousness and/or increased contact with the police (e.g. threats, possession of weapons, assault, sexual offending etc)
- Regular reporting of dangerous incidents from the community.
- History of non-compliance with treatment/services and/or difficulty in engaging service users leading to increasing dangerousness.
- Child Protection issues.
- Hospital Orders (e.g. Sections 37, 37/41, 47, 48, 45a Mental Health Act 1983 (as amended 2007) moving into the local community.
- Restraining or injunction orders involving staff, other service user, partners, or Trust property.
- Adverse Incidents involving dangerous behaviour.
- Ex High Secure, Regional Secure and Low Secure service users
- New to services from prison with knowledge of index offence of dangerousness.

See **Appendix 10** for factors that increase the risks of criminal offending

6.5 Risk assessment is an integral part of the management of mentally disordered offenders both in hospital and within the community. The majority of mentally disordered offenders will be subject to post-discharge supervision within the community by the health and adult social care services. In determining the risk a mentally disordered offender poses it is recommended that a more comprehensive risk assessment tool (e.g. HCR 20) is used in conjunction with current generic risk assessment tools to enhance the decision making process and management action plans. Risk assessment tools should be used to support decisions rather than predict outcomes

6.6 It is the responsibility of Team/Service Managers in collaboration with the SPoC to convene and chair "MARE" meetings within the framework of care co-ordination and invite to those meetings relevant other agencies who may be required to assist in managing the risk (e.g. Police, Probation, Housing, 3rd Sector Providers etc). Unless a more urgent meeting is necessary a "MARE"

must be held within the 20 working days after the date the clinical/care team receive the decision that a "MARE" meeting is appropriate.

6.7 It is the SPOC's responsibility to inform the Police of the date of all MARE meetings, when these have been decided.

6.8 The SPoC will Chair all MARE meetings.

6.9 The MARE meetings will develop a risk profile of the service user, assess the level of risk to individuals, the public and other groups and formulate a risk management action plan.

6.10 All MARE meetings must be minuted, using the MARE minute template at **Appendix 7**. MARE meeting minutes must be sent to the SPoC from all meetings within 5 working days.

6.11 The SPoC will liaise with partner agencies to determine whether the actions from the MARE meeting have been completed and update the action plan as necessary

6.12 Service users assessed as being of low or medium risk of harm to the public will continue to be managed within the normal CPA process. This does not preclude the clinical/care team from inviting other agencies to participate in case discussions as appropriate without invoking the more formal MARE process.

6.13 The following documents have been developed in order to have a consistent approach towards risk management and to assist practitioners and senior managers. **Please ensure this document set is used within the MARE process**.

- **Appendix 1** Referral Form into MAPPA/MARE
- **Appendix 2** Chair's Guide - MARE Meetings
- **Appendix 3** Chair's Guide - Risk Assessment Matrix
- **Appendix 4** Chair's Guide - Frequently used Management Actions
- **Appendix 5** MARE Attendance Sheet
- **Appendix 6** Front Sheet
- **Appendix 7** MARE minute template
- **Appendix 8** Information Sharing – Legal Grounds**)**
- **Appendix 9** MAPPA/MARE Flowchart
- **Appendix 10** Factors that Increase Risk of Criminal Behaviour
- **Appendix 11** MAPPA Form I (Designated parties only)
- **Appendix 12** Glossary and Definition of Terms
- **Appendix 13** MAPPA Notification Form A (SPoC only)

7 REFERRALS, MINUTES AND MEETING FORMATS

7.1 All referrals into MAPPA/MARE must be made to the SPoC on the referral form at **Appendix 1**.

7.2 It is the responsibility of the referring clinical/care team to provide a minute taker for each MARE meeting.

7.3 In order to maintain a consistent approach the MARE meeting and minutes must follow the MARE minute template at **Appendix 7** of this document.

7.4 Attendees of the MARE meetings will receive a copy of the minutes of the meeting and a copy of the meeting minutes must be sent to the SPoC within 5 working days of the date of the meeting.

8 PATIENTS DETAINED UNDER PART III MENTAL HEALTH ACT 1983

8.1 Clinical/care teams **must** consider whether service users detained under Part III of the Mental Health Act 1983 (i.e. S37, S47, S48 etc) should be referred in to the MAPPA/MARE pathway. If referral into MAPPA/MARE is deemed inappropriate, the reasons for non-referral must be documented in the service user's case notes

8.2 MAPPA Guidance includes a number of requirements by Mental Health Services in relation to Mentally Disordered service users who are MAPPA eligible. A summary of the new requirements are as follows

- Relevant sexual and violent offenders who receive Hospital or Guardianship Orders qualify automatically for MAPPA under Categories 1 and 2
- Category 1 offenders qualify if they are subject of Sexual Offender Notification
- Category 2 offenders qualify if they have been convicted of an offence specified in Schedule 15 to the Criminal Justice Act 2003 and received a custodial sentence of 12 months or more, or are subject to a Hospital or Guardianship Order under the Mental Health Act 1983 (amended 2007)
- MAPPA eligibility remains throughout the period of the Hospital Order or Sexual Offender Notification period. When both are discharged MAPPA eligibility ceases
- Offenders charged with Murder or an offence specified in Schedule 15 to the Criminal Justice Act 2003, is found not guilty by a court by reason of insanity or to be under a disability but the court finds that the offender has done the act **and** as a result gives the offender a hospital order or a guardianship order under the MHA 1983.
- Category 3 offenders qualify under Section 325 (2)(b) where a mentally disordered offender may be subject to MAPPA if the Responsible Authority (Police/Prison/Probation) considers the offender, by reason of his/her offences, to present a risk of causing serious harm to the public. Paragraph 4.5 of this document contains guidance on the criteria to be applied in these cases. This group will include an offender who is given "notional section 37" of the MHA 1983 at the end of a Prison sentence, who has a past conviction for a violent or sexual offence, is still assessed as posing a risk of serious harm to the public which requires management at Level 2 or 3. These cases can only be classified as a

Category 3 case by completing the MAPPA/MARE referral form at **Appendix 1** which must be sent to the SPoC for consideration. It is for the MAPPA referral panel at Police HQ to determine whether the Offender meets the criteria.

- Relevant Sexual Offenders who receive an unrestricted Hospital Order (S.37) will be subject to Sexual Offender Notification for a period of 7 years
- Relevant Sexual Offenders who receive a restricted Hospital Order (S.37/41) will be subject to Sexual Offender Notification for life
- Where a convicted prisoner is transferred from prison under S.47 of the Mental Health Act the Offender Manager's (Probation) responsibility continues and they should attend Care Programme Approach (CPA), Multi-Disciplinary Team meetings (MDT's) or MARE meetings during the licence period
- The Mental Health Trust must identify all MAPPA eligible service users/offenders in hospital and within the community and notify them to the MAPPA Co-ordinator by completing Part 1 of form MAPPA I (See **Appendix 11**)
- The Mental Health Trust must complete Part 2 of form MAPPA I (See **Appendix 11**) when the patient is assessed as ready to take unescorted leave. This is the notification for discharge planning.
- Each "Duty to Co-operate" Agency must record MAPPA offenders on their internal case management systems, which should include category and level of management
- Identification of MAPPA eligible service users/offenders must be referred to the MAPPA co-ordinator within 3 days of sentence

8.3 Restriction Orders

8.4 A Restriction Order under S.41 can be enforced on a Hospital Order by the Crown Court at the time the Hospital Order is imposed. The Court can order this to protect the public from serious harm by considering the nature of the offence, the antecedents of the offender and the risk of him/her committing further offences, if set at large.

8.5 The Secretary of State within the Ministry of Justice is responsible for individuals subject to Restriction Orders and those subject to such orders are usually called "Restricted Patients".

8.6 In relation to all restricted patients the Secretary of State's consent is required for.

- Leave into the community
- Transfer between hospitals
- Discharge into the community (both conditionally and absolutely), except where directed by a Mental Health Tribunal
- The return to prison from hospital of a transferred prisoner

8.7 Conditionally Discharged Restricted Patients

8.8 The majority of patients subject to a S.37/41 are discharged into the community when they leave hospital and the requirements of both the S.37 and 41 are discharged absolutely.

8.9 Some patients who are subject to S.37/41 may, when discharged back into the community, be subject to a Conditional Discharge, which can be imposed by the Secretary of State or a Mental Health Tribunal. In such cases the S.37 ceases, but the S.41 remains and the conditions of the order usually includes

- Requiring the person to live at a particular place
- Requiring the person to keep appointments with their Responsible Clinician and/or Social Supervisor and grant access to them
- Requiring the person to take prescribed medication and/or treatment (subject to their consent)

8.10 Conditionally Discharged patients can be subject to recall to hospital under certain circumstances.

8.11 The Mental Health Casework Section (MHCS) at the Ministry of Justice take decisions on behalf of the Secretary of State in relation to restricted patients and will inform the police force for the area where a restricted patient is detained under the following circumstances

- The patient is sentenced and admitted to hospital
- The patient is exceptionally given a one-off leave from hospital
- The patient's RC is given discretion to grant escorted or unescorted leave
- The patient transfers to a different hospital
- The patient is discharged into the community, by either the Secretary of State or Tribunal
- The patient is recalled to hospital from the community
- The patient receives an absolute discharge and is no longer liable to detention

8.12 Where a patient is transferred to a hospital in a different force area, or is discharged to live in a different force area from the detaining hospital, the MHCS will also inform the police force in the receiving area.

9. TRUST DELIVERY OF MAPPA REQUIREMENT

9.1 In order to comply with MAPPA requirements the following process will be adopted in the Trust

- The Mental Health Act Administrator at the Partnership Trust will identify all Patients who have been sentenced by the Court to a S.37 Hospital Order, or patients who are transferred from outside the County under the same section, S45A (Hospital Direction or S.47 and S.48 (Prison Transfer) and who are admitted to a Mental Health ward in Cumbria.
- Once identified the Partnership Trust's Mental Health Act Administrator will complete MAPPA Form I and submit it to the MAPPA/MARE Single

Point of Contact (SPoC) (The Development Officer for Mentally Disordered Offenders).

- For those patients who are subject to the same legal status (S.37, S.47, S.48 and S.45A) who are returning from an Out of Area NHS or Private Hospital Placement back into the community the MAPPA Form I must be completed and sent to the SPoC by the Partnership Trust's Repatriation Care Manager or NHS Cumbria's Assertive Case Manager.
- MAPPA I Forms need only to be submitted for those patients in 1, 2 and 3 above, if the offence for the detention under the Mental Health Act is also a relevant offence under Schedule 15 of the Criminal Justice Act 2003.
- The SPoC will screen submitted MAPPA I Form's and ensure that data is recorded appropriately within the Trust. The SPoC will submit the MAPPA I Forms to the MAPPA Co-ordinator
- The SPoC will ensure that the Mental Health Act Administration Office Staff, the Repatriation Manager and Assertive Case Manager receive a current list of relevant offences under Schedule 15 of the Criminal Justice Act 2003.
- MAPPA eligible service users/offenders who are subject to S.42 Conditional discharge from a Restriction Order, or, who are in the community subject to a Community Treatment Order (CTO) must also be referred into the MAPPA Co-ordinator (MAPPA form I). The SPoC will be responsible for completing Form I in those cases and submitting the form to the MAPPA Coordinator

9.2. Restricted Patients

- It is the responsibility of the Mental Health Casework Section of the Ministry of Justice to inform relevant Police Forces when Restricted Patients are in, or are coming into their areas.
- Cumbria Constabulary (through their Headquarters Public Protection Unit) will inform the SPoC of all notifications of Restricted Patients coming into Cumbria.
- The SPoC will establish if the patient is known to Cumbria Mental Health Services and ensure that the patient has an allocated RC and care co-ordinator, if they are known.
- If not known to Cumbria Mental Health Services the SPoC will ensure, through Mental Health Team Managers/Team Leaders and the Clinical Director, that an RC and care co-ordinator is allocated.
- The SPoC will also establish whether the patient requires MAPPA/MARE Pathway process and whether there are definitive Crisis/Contingency Plans in place, that includes other agencies (Police, Probation etc) if appropriate.
- The SPoC will ensure training needs for practitioners dealing with conditionally discharged patients in the community, is included on the agenda at the County Criminal Justice & Mental Health Training sub group.

10 PROCESS OF REFERRING A SERVICE USER INTO MAPPA AND THE MARE FRAMEWORK

10.1 Having assessed a service user who is allocated to a team member as meeting the criteria for inclusion in the MAPPA (or MARE) framework, a multi-disciplinary Case Review should take place where the clinical team can discuss the risks and agree upon a management strategy, including the sharing of information. The SPoC can be approached for advice prior to the submission of a formal referral if necessary.

10.2 The Team Manager / Clinical Manager may discuss the case with the SPoC who will liaise as appropriate with Police and Probation. The Care Coordinator has responsibility for ensuring the relevant documentation is completed including the referral for MAPPA/MARE which must be sent to the SPoC **(see Appendix 1).**

10.3 Referral information should be comprehensive and relevant to the risks posed in order that it can be determined whether a criterion for inclusion into the MAPPA/MARE process is appropriate. All sections of the referral form must be completed to minimise any delay in the process.

10.4 The SPoC, in collaboration with the MAPPA Coordinator, will check the service user against their data on convictions which will inform the decision making in relation to the applicability to MAPPA, and the specific level of management.

10.5 Where referral for a MAPPA meeting is made by the Trust, and accepted by the "Responsible Authority" as a MAPPA case, it will be the responsibility of the Clinical Manager / Service Manager to identify representatives to attend the meeting. The time, date, venue and invitations for the meeting will be organised by the MAPPA Admin, PPU at Police Headquarters.

10.6 Once accepted into MAPPA, the case must be processed through the SPoC's office, to ensure the Trust maintains a record of MAPPA cases.

10.7 If there is disagreement within a team concerning referral of a particular service user to MAPPA, a Clinical Manager and the Medical Director will make the ultimate decision in consultation with the SPoC. The discussions and decision should be noted in the patient's clinical records.

11 ROLE OF THE SINGLE POINT OF CONTACT

11.1 The key responsibilities of the Single Point of Contact are to:

- facilitate the coordination of referrals
- liaise with Police, Probation and Prison Services in regard to information required to make an assessment of category and level
- ensure data collection
- act as a consistent source of support for staff and other agencies

- take operational issues as appropriate to the MAPPA Strategy Group and Mental Health & Criminal Justice Steering Group
- develop specialist links
- identify training needs

11.2 All new referrals must be directed through the SPoC. If an urgent case needs to be sent directly to Police and Probation, the referral should be copied to the SPoC. All referrals must also be endorsed by a manager in section 8 of the referral form

11.3 All MAPPA referrals will be assessed by the MAPPA Referral panel, to determine whether the referral is appropriate for the MAPPA process. If MAPPA process is not supported, the MAPPA decision maker will endorse reasons on the referral form and may make suggestions regarding management and will return the form within ten working days.

11.4 Where MAPPA criteria is not met, but the risk of serious harm to another is present, a decision will be made by the SPOC whether or not it is appropriate that a MARE meeting should be convened.

11.5 Any issues or concerns related to the operation of MAPPA should be brought to the attention of the SPoC, who will bring them to the appropriate forum.

11.6 The MARE meetings will be a stand-alone meeting; however, if the risk of serious harm to others escalates, or the service user becomes involved in the Criminal Justice System for an offence that involves risk of serious harm to others, a further MARE meeting can be convened via the usual referral process (see 10.2 & 10.3)

12 LEVELS OF OPERATIONAL MANAGEMENT & MAPPA/MARE MEETINGS

12.1 Clinical Managers and Team Managers should discuss on a case by case basis which of them is best placed to attend MAPPA or chair MARE meetings. Factors influencing this decision are likely to include

- The complexity and seriousness of the case.
- The level of resource approval likely to be required.
- The likelihood of press involvement.
- The effect on the team.

13 RISK MANAGEMENT ACTION PLANS

13.1 One of the functions of the MARE meeting is to determine, through multi-agency information exchange the nature and level of risks that a service user/offender poses. The meeting must also assess whether, or not, the risk has, or is likely to develop into actions or behaviour that will cause a high risk of serious harm to others and to formulate a Risk Management Action Plan (RMAP)

13.2 The RMAP must include actions to monitor and where possible, change the actions/behaviour and attitude of the service user/offender in order to alleviate, minimise, eliminate or manage the risk of serious harm.

13.3 RMAP's must be specific to the service user/offender. All actions must be realistic and achievable and each specific action must be allocated to an individual, who must complete the action within a timeframe agreed at the MARE meeting.

14 CLOSING THE MAPPA/MARE COMPONENT OF A CPA CASE

14.1 MARE qualification ceases if the Service User is discharged from the clinical/care team. When MAPPA/MARE involvement in a case comes to an end, the Team or Service Manager should inform the Single Point of Contact, to enable the database and records to be updated.

15 HUMAN RIGHTS

15.1 Summary

15.2 Human Rights Legislation exists to safeguard our rights in the UK and expand our awareness of the basic values and standards we share. Anyone in the UK for any reason has fundamental rights, which government and public authorities are legally bound to respect.

15.3 The Convention is made up of a series of Articles; each Article is a short statement defining a right or freedom, together with any exceptions. These Rights affect matters of life and death, such as freedom from torture as well as rights which exist in everyday life. The Human Rights Act came into effect in the UK in October 2000. The Act enabled people in the UK to take human rights cases to court in the UK, whereas before they had to be taken to Strasbourg.

15.4 Articles which make up the Human Rights Act:

15.5 There are 16 basic rights in the Human Rights Act, all taken from the European Convention on Human Rights.

- Article 1: This article is introductory and not included in the Human Rights Act
- Article 2: Right to life
- Article 3: Prohibition of torture
- Article 4: Prohibition of slavery and forced labour
- Article 5: Right to liberty and security
- Article 6: Right to a fair trial
- Article 7: No punishment without law
- Article 8: Right to respect for private and family life
- Article 9: Freedom of thought, conscience and religion
- Article 10: Freedom of expression

- Article 11: Freedom of assembly and association
- Article 12: Right to marry
- Article 13: This is not included in the Human Rights Act
- Article 14: Prohibition of discrimination
- Article 1 of protocol 1 (A protocol is a later addition to the Convention): Protection of property
- Article 2 of Protocol 1: Right to education
- Article 3 of Protocol 1: Right to free elections
- Article 1 of Protocol 13: Abolition of the death penalty

15.6 A more detailed explanation of these Rights is available on the website below: http://www.direct.gov.uk/en/Governmentcitizensandrights/Yourrightsandresponsibilities/DG_4002951.

15.7 Public authorities have a duty to treat people in accordance with their Convention (law or standard) Rights and must not breach the Right's unless there is a legitimate reason:

15.8 The basic principle of Human Rights legislation is that those rights are open to all in society. When dealing with service user offenders, who present with a high risk of serious harm to others, it is important that an assessment and balanced view is undertaken to determine the impact of risks, not only to the service user, but also to the victim or potential victim of those risks.

15.9 The following Human Rights Articles will be affected when service users present with a high risk of serious harm to others.

15.10 Article 2: Right to Life
Does the threats/risks posed by the service user's/offender's beliefs, actions, behaviour or thoughts present a high risk of serious harm that may affect another's right to life

15.11 Article 3: Prohibition of torture, inhuman and degrading treatment.
Does the service user's/offender's beliefs, actions, behaviour or thoughts amount to a high risk of serious harm that would interfere with the rights in Article 3 for a victim, or potential victim?

15.12 Article 8: The right to respect for private and family life
Will the risks presented by the service user/offender have an impact upon the physical or psychological wellbeing of the victim or potential victim which will impede their right to privacy and a family life?

15.13 Article 14: Prohibition of Discrimination
Does the service user's/offender's discriminating beliefs, actions, behaviours amount to a breach of another's equality and diversity rights?

15.14 A Service User's/Offender's Human Rights in respect of confidentiality and disclosure should never supersede the need to protect individuals from a high risk of serious harm. **(See para 17 Confidentiality and Sharing Information and Appendix 8 for legislation and further information relating to disclosure of information).**

16 CONFIDENTIALITY AND SHARING INFORMATION

16.1 This chapter provides guidance on the sharing of information between agencies under MAPPA and MARE. These agencies are the Responsible Authority, duty-to-co-operate agencies, and other bodies with an interest in the management of these cases.

16.2 Information that is shared under MAPPA and MARE remains the responsibility of the agency that owns it. For example, The Trust own information regarding their care, supervision and treatment of a service user, and the police own information regarding their management of a registered sexual offender. It will be for the relevant agency to deal with Subject Access Requests under the Data Protection Act 1998.

16.3 MAPPA and MARE are not organisations, but a set of arrangements for managing the risks posed by high-risk service users/offenders. It therefore cannot be the owning agency for any information on MAPPA or MARE service users/offenders.

16.4 This guidance should be read alongside the Data Sharing Code of Practice issued by the Information Commissioner in May 2011. It is available from the website of the Information Commissioner's Office ("ICO") which is at http://www.ico.gov.uk. The code of practice deals with a number of important issues such as Data Sharing and the Law; Fairness and Transparency; Security; Governance; and Individuals' Rights. It is a statutory code. Although it is not binding, it can be used in evidence in legal proceedings. .

16.5 Principles of information-sharing

16.6 The purpose of sharing information about individuals ("data subjects") is to enable the relevant agencies to work more effectively together in assessing risks and considering how to manage them. This points towards sharing all the available information that is relevant, so that nothing is overlooked and public protection is not compromised. On the other hand, agencies must respect the rights of data subjects, which will tend to limit what can be shared. In order to strike the right balance, agencies need a clear understanding of the law in this area. The most relevant legislation is the **Data Protection Act 1998 ("DPA 1998")** and the **Human Rights Act 1998 ("HRA 1998").** The principles derived from this legislation may be summarised as follows.

16.7 Information-sharing must be lawful

This means, first, that the sharing of information must be in accordance with the law. As far as the MAPPA agencies are concerned, there should be a statutory basis for sharing information. This exists for the agencies who make up the Responsible Authority or who have a duty to co-operate with it. Section 325(4) of the Criminal Justice Act 2003 ("CJA 2003") expressly permits the sharing of information between these agencies for MAPPA purposes.

16.8 The Responsible Authority and the "Duty to Co-operate" agencies are routinely and regularly involved in the management of MAPPA and MARE

service users/offenders, but, from time to time, other agencies can contribute significantly to the Risk Management Plan. Information-sharing between the MAPPA agencies and these third parties do not benefit from section 325(4) of the CJA 2003. In general, non-statutory bodies are able to share information provided this does not breach the law. They are bound by the common law duty of confidence. The key principle of the duty of confidence is that information provided should not be used or disclosed further in an identifiable form, except as originally understood by the provider, or with his or her subsequent permission. However, case law has established a defence to breach of confidence where an individual breaches the confidence in the public interest. The prevention, detection, investigation and punishment of serious crime and the prevention of abuse or serious harm will usually be sufficiently strong public interests to override the duty.

16.9 Second, the information-sharing must comply with the eight Data Protection Principles set out in the DPA 1998 and reproduced in the ICO Code of Practice. Among other things this means that the information shared must be accurate and up-to-date; it must be stored securely; and it must not be retained any longer than necessary.

16.10 Information-sharing must be necessary

16.11 Article 8 of the European Convention on Human Rights, given domestic effect by the HRA, provides a right to respect for private and family life, home and correspondence. Any interference with this right by a public authority (such as a criminal justice agency) must be

> "necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

16.12 The sharing of information by MAPPA and MARE agencies for MAPPA and MARE purposes satisfies these conditions in that it is clearly aimed at preventing disorder or crime, public safety, or administering justice. Provided the information shared is only used for MAPPA and MARE purposes the necessity test will be met, as information-sharing by way of MAPPA and MARE is not an excessive or unreasonable way of assessing and managing these risks.

16.13 Information-sharing must be proportionate

16.14 In human rights law, the concept of proportionality means doing no more than is necessary to achieve a lawful and reasonable result.

16.15 The third Data Protection Principle provides that personal data must be relevant, and not excessive in relation to the purpose for which it is being shared.

16.16 For MAPPA and MARE agencies, this essentially means ensuring that information about the data subject is relevant to assessing and managing risk and that no more information is shared than is needed to manage that risk. For example, if what are actually needed are the names and addresses of individuals, sharing their race and religion as well would be likely to be disproportionate.

16.17 Standards Regarding Information-Sharing

16.18 Each agency should follow its own data protection policies in sharing information with other agencies under MAPPA and MARE. There may be differences on points of detail. Co-operation between agencies will be easier if there is a shared understanding of each other's policies.

16.19 When requests for information are made by other agencies, staff need to consider policies relating to confidentiality, the Data Protection Act 1998, the Human Rights Act 1998, and their own professional Codes of Conduct. The statutory duty to co-operate for Health and Adult Care Services does not include a statutory duty to disclose.

16.20 In cases where there is a high risk to the public, it will usually be the case that disclosure of information to the MAPPA Responsible Authorities or to the MARE will be appropriate. However, this should only be as much as is necessary for the purposes of risk assessment and risk management. In determining the amount of information to disclose, reference should be made to the guidelines established in W v Egdell and others (1989):

- the risk must real, immediate and serious
- the risk will be reduced by disclosure
- the disclosure is no more than is needed to reduce risk
- damage to the public interest in respect to the breach of confidentiality is outweighed by the public interest of reducing risk

16.21 The nature of any disclosure and the reasons for it should be noted clearly in the service user's files.

16.22 If staffs have concerns about any aspect of confidentiality or disclosure they should contact their Team or Clinical Manager. If there are issues for the Trust Caldicott Guardian, the Guardian should be approached only by Clinical Managers or above.

17 DISCLOSURE AT REFERRAL

17.1 Disclosure at the referral stage should include appropriate information only, sufficient to enable agencies to determine whether it meets the criteria for inclusion into MAPPA/MARE. The Team or Clinical Manager must agree that disclosure of the information is necessary.

17.2 Disclosure in MAPPA and MARE meetings

17.3 Decisions on disclosure should be taken by the Clinical/Care Team and Team Manager in negotiation, if appropriate, with the Clinical Manager. Tribunal reports or discharge summaries should not be routinely reproduced for MAPPA and MARE meetings, and if used should be edited so that only relevant information is shared.

18. REQUEST FOR INFORMATION ABOUT CLOSED CASES

18.1 The Service or Team Manager whose team was involved with the service user will make decisions regarding the appropriateness of disclosure from closed cases, if necessary in liaison with the Clinical Managers.

18.2 The Service or Team Manager will attend any MAPPA meetings being called in relation to closed cases from their service and take responsibility for following through any actions relevant to their service.

19. OTHER ASPECTS OF DISCLOSURE

19.1 There is no general expectation that the Police should be notified routinely about Section 17 leave. However, where the patient is high or potential high risk and subject to MAPPA/MARE process or is likely to be referred to that process, notification of S17 leave to the Police should be implemented. Where it is felt necessary to disclose this information, the reasons for the decisions should be documented.

19.2 Community teams should be provided with information regarding the risk assessment and risk management plans for open MAPPA/MARE cases if there is potential for them to become involved with the patient.

19.3 Disclosing information to individuals or agencies in respect of a specific service user/offender under MAPPA or MARE as part of a Risk Management Action Plan

19.4 For the purposes of the Guidance, ***information-sharing*** is the sharing of Information between all the agencies involved in MAPPA/MARE. ***Disclosure,*** on the other hand, is the sharing of specific information about a MAPPA/MARE service user/offender with a third party (not involved in MAPPA/MARE) for the purpose of protecting the public. The third party could be a member of the public such as a victim, an employer, a person forming a relationship with an offender, or a person acting in a professional capacity but not party to the MAPP arrangements.

19.5 Whether disclosure should be made

19.6 This section summarises the standards applying to the disclosure of information about a MAPPAMARE service user/offender with a third party.

19.7 Standard – Disclosure to a third party must be considered for all MAPPA/MARE service users/offenders at each initial and review meeting.

19.8 The risk assessment of all MAPPA/MARE service users/ offenders must identify those persons who may be at risk of serious harm from the service user/offender. The Risk Management Action Plan must identify how these risks will be managed. As part of this process, the meeting must consider in each case whether disclosure of information about a service user/offender to others should be made to protect victims, potential victims, staff, and other persons in the community. This applies to all categories and levels of MAPPA/MARE cases. The overriding factor is the need to protect the public and safeguard children.

19.9 Some examples of what could be considered are:

- When there is evidence that grooming may be taking place, for example through leisure clubs, churches, employment.
- If there is a condition in a Sexual Offences Prevention Order / licence excluding service users/offenders from a specific location or having contact with named persons.
- Where others may be at risk, for example in supported accommodation. This may include other service users, but usually it will be staff and managers who are told for placement purposes and for greater vigilance to be exercised.
- Where there is a need to protect past or potential victims, in particular where service users/ offenders strike up new relationships with partners who have children or grandchildren. In some cases, this may include friends or neighbours who have children.
- Where the public may be at risk through the service user/offender's employment, training or education.
- In schools and colleges if grooming needs to prevented. In the case of young offenders, limited and controlled disclosure may be made to school or college staff.
- Where a person may be in a position to actively assist in the risk management of an offender by being briefed about risk factors and scenarios.

19.10 Standard **– The disclosure decision must be recorded on the case management system (level 1) or in the MAPPA/MARE meeting minutes**

19.11 Where disclosure is not to take place, the reasons must be fully recorded in the MAPPA/MARE meeting minutes.

19.12 In the event that, after considering the balance of public protection issues and human rights issues, the MAPPA/MARE meeting attendees cannot agree whether to make disclosure, the agency that holds and owns the information will make the decision. This should be in line with its own policies and should take account of the relevant legislation and other issues.

19.13 Any significant concerns should be referred to the Assistant Chief Constable for information as he or she will have to manage any public order consequences resulting from the decision. In other cases, the meeting will agree on disclosure and the relevant agency will carry it out. This must be fully recorded in the MAPPA/MARE meeting minutes.

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19.14 Standard – Disclosure of the details of MAPPA/MARE service users/ offenders to a third party must comply with the law, must be necessary for public protection, and must be proportionate

19.15 There are various areas of law to consider when making a disclosure decision:

- The common law power for the police to share information for policing purposes (for the prevention and detection of crime).
- The Data Protection Act 1998.
- The Human Rights Act 1998.
- The Children Acts 1989 and 2004.
- The Criminal Justice and Immigration Act 2008.

19.16 In relation to the proportionality requirement, the following criteria should be met before disclosing information about a service user/offender to a third party:

- Consideration of the potential risk to the service user/offender, although this should not outweigh real risk to the safety of others were disclosure not to be made.
- Correct identification of the individual(s) to receive disclosure.
- Alternatives to disclosure were considered and reasonably rejected as inappropriate or ineffective in all the circumstances. This must be recorded.

19.17 Preparation and discussion with those third parties receiving the information.

19.18 This includes checking what they already know; checking that they understand the confidential and sensitive nature of the information they are receiving; and checking that they know how to make use of the information, what to do in the event of anything occurring which they need to report, and whom to contact; and how to access support if required.

19.19 An informed decision within the MAPPA/MARE meeting about what level of disclosure is required. For example, this might include risk factors but not necessarily an offence history.

19.20 Details of the key triggers for offending behaviour and the requirements for successful risk management, for example, “This is what you need to look out for…” or “if you see X, you need to do Y.”

19.21 Mechanisms and procedures to support both victims and service users/offenders in case there is a breakdown in the process.

19.22 For service users/offenders under 18, their wellbeing and safety must be taken into account. Except for urgent cases, no decision on disclosure should be made unless a senior member of the Youth Offending Service (YOS) and of Children's Services is present.

19.23 Even in emergency situations, the decision to disclose should, wherever possible, be made on a multi-agency basis. Single agency decision-making about the disclosure of information on service users/offenders is strongly discouraged.

19.24 Involvement of the service user/offender

19.25 It is preferable that the service user/offender knows that disclosure is taking place. It may be appropriate that the service user/offender may make the disclosure himself or herself in the presence of the clinical/care team, police or the Offender Manager, or may later confirm or verify the content of the disclosure. However, there will be cases where informing the service user/offender that disclosure is taking place could increase the potential risks to the victim(s) or other individuals. In those cases, informing the service user/offender may not be appropriate. In such circumstances, the person receiving the disclosure should be told that the service user/offender does not know that disclosure has been made.

20 THE CHILD SEX OFFENDER DISCLOSURE SCHEME

20.1 In June 2007 the Government published the Review of the Protection of Children from Sex Offenders. Action 4 of the Review resulted in a process which allows members of the public to register a child protection interest in an identified individual who has access to or a connection with a particular child or children

20.2 If an individual is found to have convictions for sexual offences against children and poses a risk of causing serious harm, there is a presumption that this information will be disclosed to the person who is best placed to protect the child or children, where this is necessary for this purpose.

20.3 This disclosure process (The Child Sex Offender Disclosure Scheme) builds on existing MAPPA procedures and on the provisions of section 327A of the Criminal Justice Act 2003. It provides a clear access route for the public to raise child protection concerns and to be confident that action will follow.

20.4 It is of paramount importance to all involved in delivering this process that children are being protected from harm. By making a request for disclosure, a person will often be registering concerns about possible risks to the safety of a child or children. For that reason, it is essential to this process that police forces, local authority children's social care and Local Safeguarding Children Boards work closely together to ensure that any possible risks of harm to the child or children are fully assessed and managed.

20.5 The Child Sex Offender Disclosure Scheme was rolled out across the country in three stages and was implemented throughout England and Wales in April 2011. The scheme is primarily the responsibility of the police, but they may ask other agencies to provide information on the subject(s) of the external enquiry.

20.6 It is important that the current practice of the disclosure of information about previous convictions for offences which are not child sexual offences continues, where necessary to protect others or prevent crime or both. It is not the intention of the disclosure process to restrict access to information which helps to safeguard children.

21 SERVICE USER AND CARER INVOLVEMENT IN MEETINGS

21.1 In general it is preferable that the service user knows that disclosure and referral into MAPPA/MARE is taking place. However, there will be cases where informing the service user that disclosure and referral is taking place could increase the potential risks to the victim(s) or other individuals, or present a risk of self-harm by the service user. In those cases, informing the service user may not be appropriate.

21.2 The clinical/care team, (which must include the Responsible Clinician and Care Coordinator) must, prior to a disclosure and referral into MAPPA/MARE assess whether they consider informing the service user is appropriate. The clinical/care team must take into account, before making the decision, the service user's diagnosis, current presentation and possible effects that knowledge of disclosure and referral may have upon their own mental health and the safety of others.

21.3 The referral form must include whether, or not the clinical care team recommend that the service user be informed of the disclosure and referral. **The service user must not be informed of the disclosure and referral before it has been discussed within the multiagency forum of MAPPA or MARE**

21.4 The Service User, carer, relative, advocate or legal representative must not be invited to the MAPPA or MARE meeting. The presence of a service user or representative could significantly affect the free flow of information and the core business of sharing and analyzing information objectively and formulating a Risk Management Action Plan.

21.5 The Home Office is reviewing the position regarding service user and carer involvement. The appropriateness and consequences of service user or carer disclosure or involvement should be discussed at the first meeting, following which a decision can be made regarding these issues. The rationale for this decision must be clearly documented. No disclosure to the service user will be made of anything discussed at the MAPPA/MARE meeting unless part of the management action plan and documented within the meeting.

21.6 All applications for MAPPA/MARE minutes must be made to the MAPPA/MARE "Chair" and also copied to the SPoC. This is vitally important as it is part of the SPoC's responsibility to monitor and assist in this process.

22. SAFEGUARDING

22.1 In order that there is a collaborative approach to Safeguarding Procedures, all MARE referrals will be subject to liaison with the Cumbria County Lead for Safeguarding. This will be implemented through the SPoC's office.

22.2 Where a child or young person (under 18) is the service user/offender, or the victim or potential victim of the risks posed, the Child Protection Lead within the Trust will be informed of the referral. This will be implemented through the SPoC's office.

23. PRISON AND OUT OF AREA PLACEMENTS OR SUBJECT'S WHO MOVE OUT OF CUMBRIA

23.1 Please note: If the term of imprisonment is less than 12 months, the local care coordinator retains care coordination responsibility. If the sentence is 12 months or more, care coordination becomes the responsibility of Prison Healthcare.

24 VICTIMS OF MENTALLY DISORDERED OFFENDERS

24.1 The Domestic Violence, Crime and Victims Act (DVCVA) 2004 give the victims of Mentally Disordered Offenders certain rights. This was enhanced by the Mental Health Act 2007 to include victims of unrestricted patients.

24.2 The DVCVA puts the responsibility of informing victims on to the Victim Liaison Officers within Probation Trusts and stipulates the information that can be passed to the victim.

24.3 It only applies to those patients who were sentenced on or after the 1st July 2005. Any victims of restricted patients before that date must contact the Mental Health Case Section (MHCS) of the Ministry of Justice for relevant information.

24.4 In relation to unrestricted detained patients it is the Hospital Managers who have the responsibility for informing the victims of Mentally Disordered Offenders.

24.5 An eligible victim is entitled to the following.

- Whether discharge is being considered either by the Secretary of State or Mental Health Tribunal for restricted patients, or the RC, Hospital Managers or Mental Health Tribunal for unrestricted patients

- They can make representation about any conditions that will be added to a CTO
- To know whether discharge took place and any conditions within a CTO, including any conditions that are in place to protect the victim and victim's family
- To know when those arrangements end, either because of recall to hospital, absolute discharge or the CTO has been terminated

24.6 The victim has no statutory right to know when the patient is being allowed leave, where he is being detained, or where he will live on discharge.

25 INFORMATION STORAGE

25.1 In order to comply with the Data Protection Act 1998 and in recognition of the sensitivity of service user records, MAPPA and MARE information and minutes must only be relayed/sent in line with the Trust's existing policy on patient information. All information should be held securely. The SPoC should keep in a locked cabinet in a locked room all copies of MAPPA/MARE referrals and minutes. Staff should keep MAPPA/MARE minutes and material in the confidential or third party section of the service user's file.

26. DISPUTES

26.1 Where there is a dispute relating to referral into the MAPPA/MARE process between Mental Health Services and the "Responsible Authority", the Service Manager for the relevant area of the Trust will discuss the issues with the SPoC or MAPPA Co-Coordinator responsible for Public Protection. Where matters remain unresolved either party can refer the dispute to the "Chair" of the Strategic Management Board.

27 ACCESS TO LEGAL ADVICE

27.1 Requests for legal advice should be in accordance with the Trust's procedure for Accessing Legal Advice.

28 TRAINING

28.1 This will be determined by the County Mental Health & Criminal Justice Training sub group in collaboration with the County MAPPA SMB and the Mental HealthTrust's Training and Development Section.

29 AUDIT/REVIEW and DATA COLLECTION

29.1 A review of the policy will take place 12 months after the date of the commencement of this reviewed policy

29.2 **Data**

1. Cumbria Partnership Foundation NHS Trust will maintain a Public Protection section within their Integrated Electronic Record (IER) database.
2. The section will contain details of whether a service user is in the MAPPA/MARE process within Cumbria. The section will only include whether the service user is currently subject to MAPPA or MARE (Yes or No) and give the Category and Level of management within MAPPA (1, 2 or 3).
3. No details of MAPPA/MARE Meetings will be included in this section, other than that outlined in 2 above and health practitioners must contact the SPoC's Office if further information is required.
4. This section of the database will be searchable in order to
    - Inform Healthcare Professionals coming into contact with service users that there may be a high risk of serious harm
    - Inform Clinical Governance, Locality Managers and Senior Managers within the Trust of the number of High Risk of Serious Harm cases that are currently being managed
    - Provide Partnership Trust audit figures for the MAPPA Annual Report

29.3 Audit

29.4 A Risk Governance Report will be completed quarterly for the Senior Management Team which will include.

1. The number of cases in the MAPPA and MARE process
2. The number of cancelled meetings
3. The non-attendance of appropriate health professionals at meetings
4. The number of late (or no minutes) from meetings that have taken place.
5. Areas of identified good practice

29.5 Failure to comply with items 2, 3 and 4 in par 30.4 will result in the Locality General Manager being informed, who will then have responsibility to ensure compliance of the process.

Appendix 1 Referral Form

1	**Name:**			**NHS No:**	
				IPM No:	
	Dob:		**Gender:**	**Ethnicity:**	
	Address:			**Current location (e.g. hospital, community)**	

2	**Referrer**	**Contact Details**:	**Date of Referral:**
	Care Coordinator Name:	**Contact Details:**	

3. Assessing Risk

Offence/ Behaviours giving rise for concern

When assessing the risk of harm we are considering

- The behaviour that is of concern
- The likelihood of that behaviour occurring
- The circumstances in which the harmful behaviour might occur
- The degree of harm that might be caused
- Who might be harmed

4. Information required

When completing the form indicate sources of information and their reliability, accuracy and validity.

Completion

Name of the person completing form/assessment

Names of other individuals and agencies involved in the assessment

Has the service user contributed to the assessment and is s/he aware of the contents? **YES/NO**

Does the clinical/care team believe that the service user should be informed of the MAPPA/MARE referral? **YES/NO**

DO NOT INFORM THE SERVICE USER BEFORE THE MAPPA/MARE MEETING

5. Assessing Harm	**Sources of Information (I.e. Files, Police, Probation, etc)**
Full details of the offence/behaviours	
Previous convictions	
Details of previous offences/Risk behaviours	
Other (unconnected) offending behaviour	
Employment, Health, Education	
Social information	

Media/public response	

Initial analysis	**Comment**
Has the person already caused significant harm?	
Is the behaviour/number of offences, the frequency or the harm escalating?	
Does the service user display different types of different risk behaviours/commit different types of offences?	
Is there a risk to children/partners or other vulnerable groups?	
Are there aspects of the person's life that might increase risk e.g. alcohol abuse or mental health problems?	
Does s/he comply with treatment, supervision, care plans and/or court orders?	
Is the service user at risk of being harmed and what impact might this have on his/her behaviour?	
Is the service user motivated to change their behaviour?	

Assessment Process

- Describe and detail current behaviours/offence(s) and characteristics. Where there has been a previous serious behaviour/offence, particularly of a different nature this should also be described.
- What actually occurred immediately before, during and after the event?
- Where and when?
- Who was present and involved?
- Any weapons, poisons or chemicals used?
- Any unusual or bizarre aspects?
- Was it planned or impulsive, details of planning?
- What triggered the behaviour/offence and what were the reasons the service user gave at the time?
- The service user's thoughts and feelings before, during and after the event
- The service user's attitude to the behaviour/offence(s) and victim(s) at time of the behaviour/offence

Analyse current and previous behaviours/offences

- Sadistic or explosive rage
- Victim(s) random or targeted
- Victims(s) groomed/stalked
- Degree of planning and preparation
- Unnecessary violence/aggravating features
- Power and control factors e.g. the desire to have their own way
- Victim characteristics e.g. gender, race, age or occupation
- Triggers/reasons

Analyse behaviour/offending patterns

- Similar to previous behaviours/offences in terms of type of behaviour/offence, victim and circumstances?
- Other non-violent behaviour/offences and any patterns and connections
- Serial or single offender
- Particular triggers or reasons?
- Escalation of offending/seriousness?

Assess service user's attitude to behaviours/offending (now) and attitude to others

- Denial, blaming, indifferent, justified
- Service user indicates that repetition is likely
- Service user's understanding of seriousness of their behaviour and why it is

Assess attitude to others

- Degree of empathy
- Hatred of other groups e.g. ethnic minorities
- Need for control and domination
- Family relationships
- Isolation
- Jealousy or unrealistic attachments

Consider mental health issues. Indicate if the service user has been diagnosed as having a specific mental health problem or whether you suspect that s/he might have one.

- Specified mental illness
- History of psychiatric intervention
- Response to medication/treatment
- Low intelligence or low emotional intelligence
- Stress
- Delusions or fantasies
- Paranoia
- Depression
- Obsession – weapons, pornographic sexual/violent material
- Insight
- Capacity and responsibility for actions

Consider substance misuse

- Presence or absence of excess alcohol or abuse of other substances
- Significance in terms of behaviour/offence (under the influence, behaviour/offence committed to purchase)
- Previous response to treatment

6.	**Current Risk Status:** (delete as appropriate)	**LOW** **MEDIUM** **HIGH** **VERY HIGH**	**Risk Defined by:** (delete as appropriate)	**HCR 20** **OASys** **Thornton** **Other Mental Health** (please specify)

7. Contact details for other agencies/professionals involved:				
Name:	**Designation:**	**Address**	**Telephone no:**	**E-mail address:**

8.	**Decision of Consultation:**	**Remain MAPPA Level 1 –Single Agency management** **Refer to MAPPA (Level 2/3)?** **Refer to MARE?** (delete as appropriate)		
	If referred to MAPPA/MARE, identify envisaged outcomes of meeting:			
	Plan completed by: (Line Manager)		**Date :**	
	Location:		**Telephone no:**	

9.	**Confirmation by MAPPA/MARE SPOC:**	**Remain MAPPA Level 1 –Single Agency management** **Refer to MAPPA/MARE (Level 2/3)?** **Refer to MARE? (delete as appropriate)**		
	Any further action to be taken/ comments:			
	Completed by: SPOC		**Date:**	
	Telephone no:		**Email address**	

All Referrals

1. **Sections 1- 7 to be completed by the referrer in collaboration with clinical/care team.**

2. **The details in Section 5 relating to Criminal Justice information and sentencing should be completed by liaising with one of the following**
   - **The patients/clients Probation Officer**
   - **Public Protection Officer (Police)**
   - **The Development Officer for Mentally Disordered Offenders (SPoC)**

3. **Section 8 to be completed by the referrer's line manager.**

4. **Section 9 will be completed by the SPoC/MAPPA Co-ordinator and returned to the referrer with recommendations whether or not MAPPA/MARE process is supported.**

5. **If MAPPA process is not supported, the SPoC/MAPPA Co-ordinator will endorse reasons on Section 9 and may make suggestions regarding management.**

Contact

Phil Lea
Development Officer for Mentally Disordered Offenders (Cumbria)
Tel. 01228 608321 (Office)
Tel. 07825114308 (Blackberry
Secure E-mail Address: cpt.mdo@nhs.net

Or

Esther Elliott
Management Secretary to Development Officer for Mentally Disordered Offenders
Cumbria Partnership NHS Foundation Trust
A9 Medical Corridor
Carleton Clinic
Cumwhinton Drive
Carlisle
Cumbria
CA1 3SX
Tel. 01228 608343 (Office)
Secure E-mail Address: cpt.mdo@nhs.net

APPENDIX 2

CHAIR'S GUIDE - MARE MEETINGS

Preparation

- Ensure all attendees are aware of the process and function of the MARE
- Circulate relevant reports
- Hand out any previous minutes
- Identify minute taker

Introductions

- Identify attendees and their link with subject
- Confidentiality and diversity declaration

Purpose of Meeting

- To determine the risks posed by sharing information which is seen to be reasonable and proportionate to this risk assessment and management meeting
- Assess the level of risk - Identify historical risk factors, potential victims and the implications of current risk factors, including gravity and immediacy of risk
- Decide upon appropriate actions through a risk management plan to eliminate or minimise risks
- Including any possible intervention using Mental Health legislation, clinical/care pathway, Criminal Justice process or combination
- Consider the impact on the subject, or any other if appropriate action is not taken to manage the risks

Legal Status – Medical and Criminal Justice

- Medical – MHA83 (amended 2007) detained subject to S.117 aftercare? On CTO?
- Criminal Justice – On licence with Probation - any Sex Offender Registration requirement or orders - any Community Orders, ASBO etc.?
- Any cases pending – bail conditions?

Disclosure

Will revolve around each individuals own circumstances and the meeting will take into account

- the effective management of the individual within Mental Health Services including the individual's engagement with services and compliance with treatment/rehab programmes
- the nature and pattern of previous offending
- compliance with previous sentences or Court Orders

- the probability that a further offence will be committed and the harm such behaviour would cause
- any predatory behaviour which may indicate a likelihood that s/he will re-offend
- the potential objects of the harm (and whether they are children or other individuals who are especially vulnerable)
- the potential consequences of disclosure to the offender and their family.
- the potential consequences of disclosure in the wider context of Law and Order.

Information Exchange/Risk Factors

- Including current offences and previous history.
- Any Police Intelligence and cases not proceeded with?
- Include any known risk assessments by any agency
- Who is at risk? General Public? Females? Children? Staff?
- From what? Violence? Sexual Offending? Arson? Other?
- Are victims/potential victims known or is offending indiscriminate?
- Is there an impulsive element to offending?
- Engagement with services?
- Compliant with medication/treatment?
- Can the risk be managed in the Community?
- Is there a current Management Plan, Crisis Plan and Contingency Plan?
- Is there any family influence and control?
- Attitude to offending?
- Capacity and responsibility for offending behaviour?
- Is there any victim empathy or awareness of offending behaviour?
- What will deter or motivate to stop offending?
- Is the subject vulnerable to vigilante action?

Risk Profile

- Agree a level of risk
- Identify risk groups/individuals
- Summarise previous interventions or attempts at intervention
- Summarise possible or future interventions and support
- Identify deficits that could assist management

Risk Management Strategy

There is no set formula and each case must revolve around an individual's own circumstances

- Include decision whether to refer to MAPPA
- Include whether disclosure to a third party will take place
- Include whether the service user/offender will be informed that they are in the MARE process
- Whether Forensic referral necessary
- A comprehensive action plan to eliminate or minimise risks actively involving any agency that can assist in the process
- Consider whether or not use of clinical legal process and legislation appropriate
- Consider whether or not Criminal Justice process appropriate
- The importance of the ongoing sharing of information to aid management

APPENDIX 3

CHAIR'S GUIDE - RISK ASSESSMENT MATRIX

1. Plans

1.1 An assessment of the risks a service user/offender poses to another must revolve around the particular circumstances of the service user/offender who is subject of the MARE. It must include static factors (what we do know about the service user/offender, how they have acted or behaved in the past etc) and dynamic factors (what is their current situation in relation to relationships, health, employment, associates, substance/alcohol intake, engagement with various services etc, etc)

1.2 A combination of static and dynamic factors will, in the vast majority of cases, enable a risk profile to be formulated at the MARE meeting.

1.3 The degree of dangerousness as to whether or not, a service user/offender represents a high risk of serious harm to another, is usually determined by a combination of the behaviour/actions occurring and the severity of those behaviours/actions.

1.4 The following tables will generally assist in determining whether, or not, the service user/offender is a high risk of serious harm to others. The tables must never be used solely to determine this and must be used as a guide for discussion on the real risks a service user/offender poses to another.

SEVERITY OF HARM

	1	2	3
	MINOR	MODERATE	MAJOR
Impact on the safety of others physically and psychologically from identified risks	Minor harm. Requiring no or minimal medical/clinical intervention	Physical injury that requires medical attention Psychological trauma that impinges on the persons quality of life and sense of well being	Major harm leading to death or permanent injury Requiring long term Secondary or Tertiary medical/clinical intervention

LIKELIHOOD OF EVENT OCCURRING

	1	2	3
	UNLIKELY	POSSIBLE	LIKELY
Is there a likelihood that the event will occur from the identified risks? Only consider the likelihood of it occurring in the next 6 months	It will most probably never happen or do not expect it to happen or recur	Might happen or recur, or event occurs occasionally	Will probably happen or recur

1.5 The following Risk matrix will assist in determining whether or not, the service user/offender remains in the more formal High Risk MARE process or the risks are managed solely within CPA.

1.6 The risk matrix must be used objectively and MUST NOT be used alone to determine whether or not the service user/offender remains within the MARE process. At either end of the scoring spectrum it will be quite obvious that the service user/offender should remain in or be taken out of the process. Where the scoring is not so clear, a flexibility of approach is needed and factors that would increase the risk taken into account before deciding upon status within the MARE process (e.g. non-compliance with medication, missed appointments, homelessness etc, etc).

RISK MATRIX

SEVERITY	LIKELIHOOD		
	1 UNLIKELY	2 POSSIBLE	3 LIKELY
1. MINOR	1	2	3
2. MODERATE	2	4	6
3 MAJOR	3	6	9

KEY	Low Risk	Moderate Risk	High Risk
	1 - 2	3 - 4	6- 9

APPENDIX 4

CHAIR'S GUIDE - FREQUENTLY USED MANAGEMENT ACTIONS

Each subject of a MARE must have, (in order to eliminate or minimise the risk posed) a Risk Management Action Plan. The plan must be specific, appropriate and relevant to each individual who is subject to the MARE process. The following are actions that may be appropriate in relevant and specific circumstances after analysis of all the information exchanged within the MARE

1. The Police will ensure that subject is entered on their system as requiring assessment under the Cumbria Mentally Disordered Offenders County Protocol if arrested for any offence. Action – Police
2. The Police will ensure that the Neighbourhood Policing and Response Teams (covering the home address of the subject, victim, others) are made aware of the subject's risk profile. Action – Police
3. The Police will consider whether or not it is appropriate to put a STORM alert on the subject's (subject's victim, other) home address. Action – Police
4. If the subject has capacity and is responsible for his/her actions they must go through the Criminal Justice System if criminal offences are committed with the safeguard of an MDO Assessment. Action – All
5. The subject's care plan must include if he/she has been assessed as having capacity at the specific time of an offence and is responsible for their actions they must take the consequences of any criminal offending. Action - Care Coordinator/Ward Staff/ALIS Team
6. The Police/Probation will be informed of any relapse indicators or triggers that become apparent when the individual's mental health begins to deteriorate (but only if they are readily identifiable by lay observers). Action - Care Coordinator/RC/ ALIS Team
7. The Clinical Care Team must assess the current placement to determine whether or not it is appropriate for the subject's needs, the risks he/she poses to others, including staff and other residents. Action - Care Coordinator/RC/ ALIS Team
8. Where the MARE meeting or Clinical Care Team determines that the current placement is not appropriate and an alternative placement is required, immediate contact must be made with the relevant Commissioner if funding is required. Action - RC/Care Coordinator (possibly Chair) / ALIS Team
9. All section 17 leave must be reported to the Police Public Protection Unit (if appropriate) and/or Police Problem Solvers. Action - Ward Manager/Care Coordinator/ ALIS Team
10. Discharge date into the community with discharge address to be notified to the Police Public Protection Unit and/or Police Problem Solvers. Action - Ward Manager/Care Coordinator/ ALIS Team
11. An urgent forensic opinion should be sought to assess the risks posed by the subject. The request to forensic services must include
    A. Does the subject require in-patient forensic placement for assessment/treatment IF NOT
    B. Does the subject require in-patient placement in specialist placement for assessment/treatment IF NOT

C. Can you recommend a community management plan. Action - RC/Care Coordinator/Ward Manager

12. Where non urgent forensic opinion is sought this can be requested via the Forensic Consultation Clinics (the questions at 11 A, B and C must still be asked. Action - RC/Care Coordinator
13. Where the subject of the MARE is currently in the Criminal Justice System with cases pending, the RC must complete a form DP (3a) and submit it to the Criminal Justice Unit of the Police via the office of the Mentally Disordered Offenders Development Officer. Action – RC/Care Coordinator/ ALIS Team
14. All agencies must implement their respective Health and Safety procedures when dealing with the subject particularly (lone working, female working etc, etc). Action – All
15. Where there is a risk to a child from the risks posed by the subject a referral must be made to Children's Services. Action - Police/Probation/Care Coordinator/Ward Manager/ ALIS Team
16. Where the risks revolve around domestic violence the Police must consider referring the victim to the MARAC process. Action – Police/Care Coordinator/ Ward Manager/ALIS Team
17. Where there is a risk to Acute Trust community staff/Accident and Emergency Departments or Ward staff in their locality or across other areas, they must be made aware of the subject's risk profile. Action – Ward staff/Care Coordinator/ ALIS Team.
18. The Integrated Electronic Record (IER) system must be updated with the subjects risk profile and management action plan in order that any MH team coming in to contact with the subject will be informed of the risks. Action - Care Coordinator/ ALIS Team
19. The GP will be given a copy of the MARE minutes in order that any GP that comes into contact with the subject will be aware of the risks posed. Action - Care Coordinator / ALIS Team / Ward staff / Admin
20. The MARE Proforma (Appendix 14) will be emailed to Cumbria Health on Call (CHoC) in order that any GP that comes into contact with the subject will be aware of the risks posed. Action - Care Coordinator / ALIS Team / Ward staff / Admin
21. All parties at the MARE must be reminded of the confidentiality of the meeting and the safeguarding of the minutes in the confidential section of the individual/organisations files. Action – Chair
22. The minutes of the MARE can be sent to non-attendees of the meeting provided the security provisions in 19 above are met and the meeting agrees. Action - Meeting attendees
23. Outside and after the MARE meeting the minutes will not be distributed to third parties without consultation and agreement of the Chair of the MARE. Action – All
24. Where the subject of a MARE is sentenced to a term of imprisonment, the Care Coordinator will contact the Prison Healthcare of the receiving prison and inform them of the subject's care plan, prescribed medication and full risk profile. Action - Care Coordinator/ ALIS Team
25. If a subject of a MARE is sentenced to a term of imprisonment of less than 12 months the local Care Coordinator must retain care coordination duties and keep in regular contact with Prison Healthcare. Action - Care Coordinator

26. If a subject of a MARE is sentenced to a term of imprisonment of 12 months or more, care coordination passes to the Healthcare Department within the prison. Action Care Coordinator
27. Where the meeting agrees, or outside the meeting the Chair agrees, the MARE meeting minutes can be provided to a Pre-Sentence Report Writer employed by the Probation Services in order to inform the Pre-Sentence Report for the Court. The MARE minutes must only be used for information purposes and not presented as a document to the court. Action - Chair/Meeting
28. The service user/ offender will/will not be informed that they are in the MARE process.
29. When the subject of the MARE moves from the Cumbria area to live outside of the County the Local Police and Mental Health Services must inform their respective counterparts in the new area of the subjects risk profile. Action - Police/Care Coordinator/ ALIS Team

APPENDIX 5

CUMBRIA AREA
Multi-Agency Risk Evaluation Meeting (MARE)
ATTENDANCE SHEET
CONFIDENTIALITY and DIVERSITY PROTOCOL

Confidentiality

In working with offenders, victims and other members of the public, all agencies have agreed boundaries of confidentiality. This panel respects those boundaries and holds the meeting under a shared understanding that:

- It is called in circumstances where it is felt the risk presented by the subject of the meeting is so great that issues of public or individual safety outweigh those of confidentiality.
- The disclosure of information outside this meeting, beyond that agreed at the meeting will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.
- If the consent to disclose is felt to be essential, permission should be sought from the Chair of the Panel, and a decision will be made on the principle of a public safety 'need to know'.

Diversity

Multi-Agency Risk Evaluation Meetings in Cumbria are committed to conducting all of its activities with regard for each person's unique value and potential. Members of the panel are required at this meeting to:

- Treat all colleagues and members of the public with care, compassion, respect and dignity, according to their individual needs and concerns.
- Avoid the use of discriminatory words or behaviour.
- Strive to understand better the issues and viewpoints in relation to discrimination whilst actively identifying and rejecting practices, policies and procedures which are discriminatory.

Subject: **DOB:** **Date of Meeting:**

Attendee Name	Signature	Agency	Contact Details Address/telephone/e-mail

APPENDIX 6

RESTRICTED

Multi-Agency Risk Evaluation Meeting (MARE) Front Sheet

MARE Meeting Chair:
Subject:
Date/ Venue of Meeting:

A MARE is not a clinical meeting, but a risk evaluation meeting

It is vital that all information and intelligence regarding a person should be shared when a person is considered to be dangerous. Harm is defined as 'A risk that is life threatening and/or so traumatic that recovery, physical or psychological, is expected to be difficult or impossible to achieve' (Criminal Justice Act 2003 – Schedule 15).

All agencies and disciplines invited have the following primary considerations:

- To determine the risks posed by sharing information which is seen to be reasonable and proportionate to this risk assessment and management meeting
- Assess the level of risk - Identify historical risk factors, potential victims and the implications of current risk factors, including gravity and immediacy of risk
- Decide upon appropriate actions through a risk management plan to eliminate or minimise risks
- Including any possible intervention using Mental Health legislation, clinical/care pathway or Criminal Justice process
- Consider the impact on the subject, or any other if appropriate action is not taken to manage the risks

Confidentiality Statement

It is expected that information disclosed at this meeting will remain confidential within the agencies and information will only be disclosed pertaining to the imminent risk to others. Minutes of the meeting will be taken and all attending parties will receive a copy of the minutes.

Confidentiality - Case Law – D v Edgell and others (1999)

- **The risk must be real, immediate and serious**
- **The risk will be reduced by disclosure**
- **The disclosure is no more than is needed to reduce risk**
- **Damage to the public interest in respect to the breach of confidentiality is outweighed by the public interest of reducing risk**

1) These minutes are closed under the Freedom of Information Act 2000 under one or more of the following reasons:
   a) Investigations and proceedings by Public Authorities (S.30 (1) (B))
   b) Health and safety (S.38)
   c) Personal information (S.40)
   d) Information provided in confidence (S.41)

2) The discussions and decisions of the meeting take account of Article 8.2 European Court of Human Rights, with particular reference to:
   a) Public safety
   b) The prevention of crime and disorder
   c) The protection of health and morals
   d) The protection of the rights and freedom of others

All documentation will be marked RESTRICTED.

These minutes should not be photocopied or the contents shared outside of the meeting without the agreement of the Chair. Minutes should be kept in the RESTRICTED or CONFIDENTIAL section of agency files. If further disclosure outside your agency is felt essential, permission should be sought from the Chair of this MARE meeting and a decision will be made (share on a need-to-know basis, share information which is proportionate and necessary) as to what information can be shared.

APPENDIX 7

MARE MINUTE TEMPLATE

MULTI AGENCY RISK EVALUATION MEETING on (date******)**

@ (venue********)**

Re – (Name of Service User********), Date of Birth ********

1. In Attendance:

2. Apologies:

3. Introductions:

4. Purpose of meeting:

- Determine/review the risks posed by (Name of Service User **)
- Identify victims and potential victims
- Decide on appropriate actions to eliminate, minimise and manage risks
- Including any possible intervention using Mental Health legislation, Criminal Justice process, other clinical/care pathway or combination
- Consider impact on (Name of Service User **) and others if appropriate action not taken.

5. Legal Status – Medical and Criminal Justice:

Medical

-

Criminal Justice

-

6. Actions from previous meeting (dated) (if applicable):

-

7. Information Exchange/ Risk Factors (include any formal risk assessments):

-

8. Risks:

Risk of repeat behaviour/risk of re-offending (consider previous offending)

What is the nature of the risk? (What behaviour is of concern- be specific)

Who is at risk? (Specified or unspecified individual groups)

What are the consequences? (The likely degree of harm/who would be affected)

What is the immediacy of the risks (What are the likely timescales of risks/behaviour happening)

What factors could increase the risk? (Personal and environmental)

What factors could decrease the risk? (Personal and environmental)

Change of their environment (Housing, move to a different area, custody, hospital?)

9. Level of Risk:

CURRENT ASSESSMENT OF RISK						DATE OF RISK ASSESSMENT:					
	Children		Public		Known Adult		Staff		Patients	Self	
	Risk in Community	Risk in Hosp/custody	Risk in Community	Risk in Hosp/custody	Risk in Community	Risk in Hosp/custody	Risk in Community	Risk in Hosp/custody	Risk in Hosp/custody	Risk in Community	Risk in Hosp/custody
Very High	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Med	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Low	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Comments:										

10. Risk Matrix

SEVERITY	**LIKELIHOOD**		
	1. UNLIKELY	2. POSSIBLE	3.LIKELY
1. MINOR	1	2	3
2. MODERATE	2	4	6
3. MAJOR	3	6	9

KEY	Low Risk	Moderate Risk	High Risk
	1 - 2	3 - 4	6 - 9

11. Disclosure:

Was disclosure considered?
Will disclosure occur – give details?

12. Is it appropriate to refer to MAPPA Panel (Level 2/3): YES/NO?

Will the Service User be informed they are subject to MARE: YES/NO?

(Document reasons in Information Exchange and include in actions)

13. Risk Management Action Plan:

	Action	By Whom/When
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
25.		

NB – it is of paramount importance that all agencies continue to exchange information and report any further incidents or escalation of risks to the Police Public Protection Officer for the area.

Please return a copy of the completed meeting minutes to the SPoC within 5 working days of the date of the meeting to:

Esther Elliott
Management Secretary to Development Officer for Mentally Disordered Offenders
Cumbria Partnership NHS Foundation Trust
A9 Medical Corridor
Carleton Clinic
Cumwhinton Drive
Carlisle
Cumbria
CA1 3SX
Tel. 01228 608343 (Office)
Secure E-mail Address: cpt.mdo@nhs.net

APPENDIX 8

Information Sharing - The legal grounds for sharing information

This information can be used as a guide to thinking about situations where it may be necessary or desirable to share information with other agencies.

1. **Safety.**
   Consider risk factors – how great is the risk?
   Children – careful consideration should be given to disclosure even about low risks to children
   For an adult, a relatively high risk is necessary before considering over-riding the duty of confidentiality

2. **Consent.**
   With consent, can disclose.
   Without consent, must make a professional judgement balancing the following considerations:

3. **Balancing consideration**
   Do you have the legal authority to disclose?
   Balancing against
   - Duty of confidentiality
   - Respective risks to those affected
   - Pressing need
   - Need of other agencies to know
   - Proportionate response

4. **Make decision**
   If decide not to disclose:
   - Record decision, going through checklist
   - Consider ways to reduce risk to an adult and/or any children
   - Consider ways to help client access help from other agencies herself

   If decide to disclose:
   - Record decision, going through checklist
   - Make decisions/enquiries about the amount of information to disclose, how and to whom
   - Discuss with potential victim, if appropriate
   - Note when/whether the potential victim was informed and reasons why if not informed (for example, that it would increase risk)
   - Disclose

5. **Finally**
   - Review the professional's safety and the repercussions for their/your organisation.

Legal grounds when considering sharing information without consent
Protection against disclosure

Legal Issues	Source
Protection of personal data	Data Protection Act 1998
Duty of confidentiality	Common Law
Right to private and family life	Human Rights Act, Article 8

Main lawful grounds for sharing without consent

Purpose	Legal authority
Prevention and detection of crime	Crime and Disorder Act 1998
Prevention and detection of crime and/or the apprehension or prosecution of offenders	Section 29, Data Protection Act (DPA)
To protect vital interest of the data subject; serious harm or matter of life or death	Schedule 2 & 3, DPA
For the administration of justice (usually bring perpetrators to justice)	Schedule 2 & 3, DPA
For the exercise of functions conferred on any person by or under any enactment (police/social services)	Schedule 2 & 3, DPA
In accordance with a court order	
Overriding public interest	Common law
Child Protection – disclosure to CYPS or the police for the exercise of functions under the Children Act, where the public interest in safeguarding the child's welfare overrides the need to keep the information confidential	Schedule 2 & 3, DPA
Right to life Right to be free from torture or inhuman or degrading treatment	Human Rights Act, Articles 2 & 3

Balancing Principles

Proportionate response ❑ Respective risks to those affected ❑ Pressing need ❑ Need to know of other agencies	
Public interest in disclosure	

Checklist for use when sharing information without consent

If you are in a situation where you feel that you have to disclose information without the consent of the service user, you must record your decision and the reasons for making it. These are always very difficult decisions and ones where you may be concerned about the impact that they will have on the trust that a service user has placed in you. Remember, you need to take defensible not defensive decisions, but neither must you put yourself in a situation where you are effectively joining with the service user to prevent critical information being disclosed.

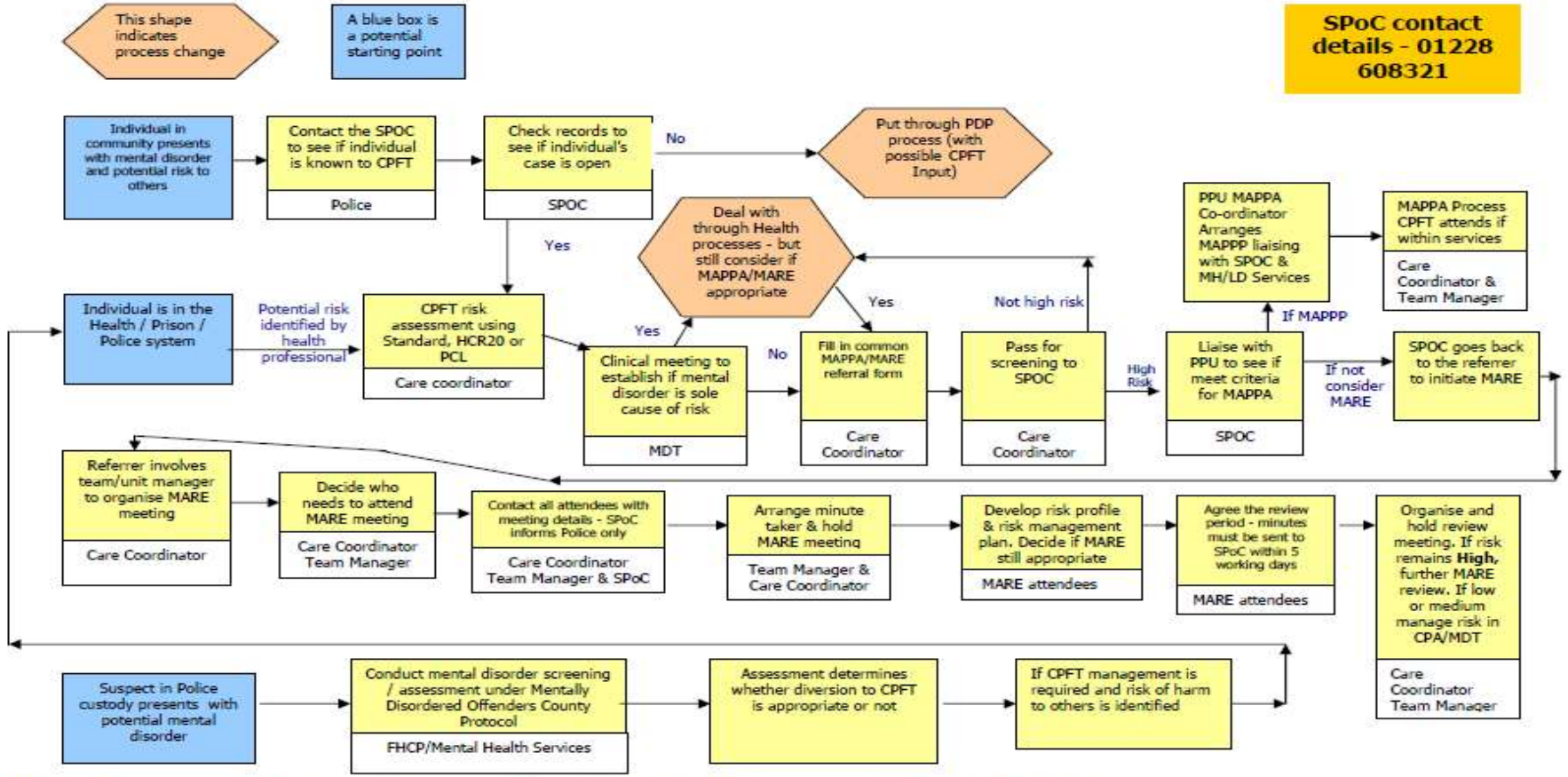
1. **You must record that a decision has been made to share/disclose information without consent.**
2. What are the protocols/guidance that you referred to and which agencies or colleagues have been consulted about this decision? Set these out clearly in your records (e.g. Home Office guidance, own protocols).
3. What is the legal basis for sharing without consent in this case? Record it clearly. It will usually be for the Crime and Disorder Act (prevention or detection of crime) or under the DPA or the Children Act.
4. Are you clear exactly what details of the information is to be shared and with whom? Set this out in your records.
5. Think through the balancing exercise that you have undertaken; that you have considered the interest of the other agency/person in receiving the information and the degree of risk posed to any person by disclosure/nondisclosure; that you have considered the duty of confidentiality, human rights and the public interest. Record this. Record whether the sharing is proportionate and there is a pressing need and summarise why in one or two sentences.
6. What is the amount of information to be disclosed and the number of people/agencies disclosed to? Is this no more than strictly necessary to meet the need for disclosure? Record why this is the case.
7. Set out whether and when the service user affected has been informed that the information will be disclosed and to whom, whether reasons have been given and whether details of next steps explained. Has this been done in advance of the information being disclosed? If the service user affected has not been informed set out reasons why.

If in doubt, **ALWAYS** seek specialist advice and **ALWAYS** consult with your Supervisor

CUMBRIA MAPPA/MARE PATHWAY DOCUMENT

APPENDIX 9

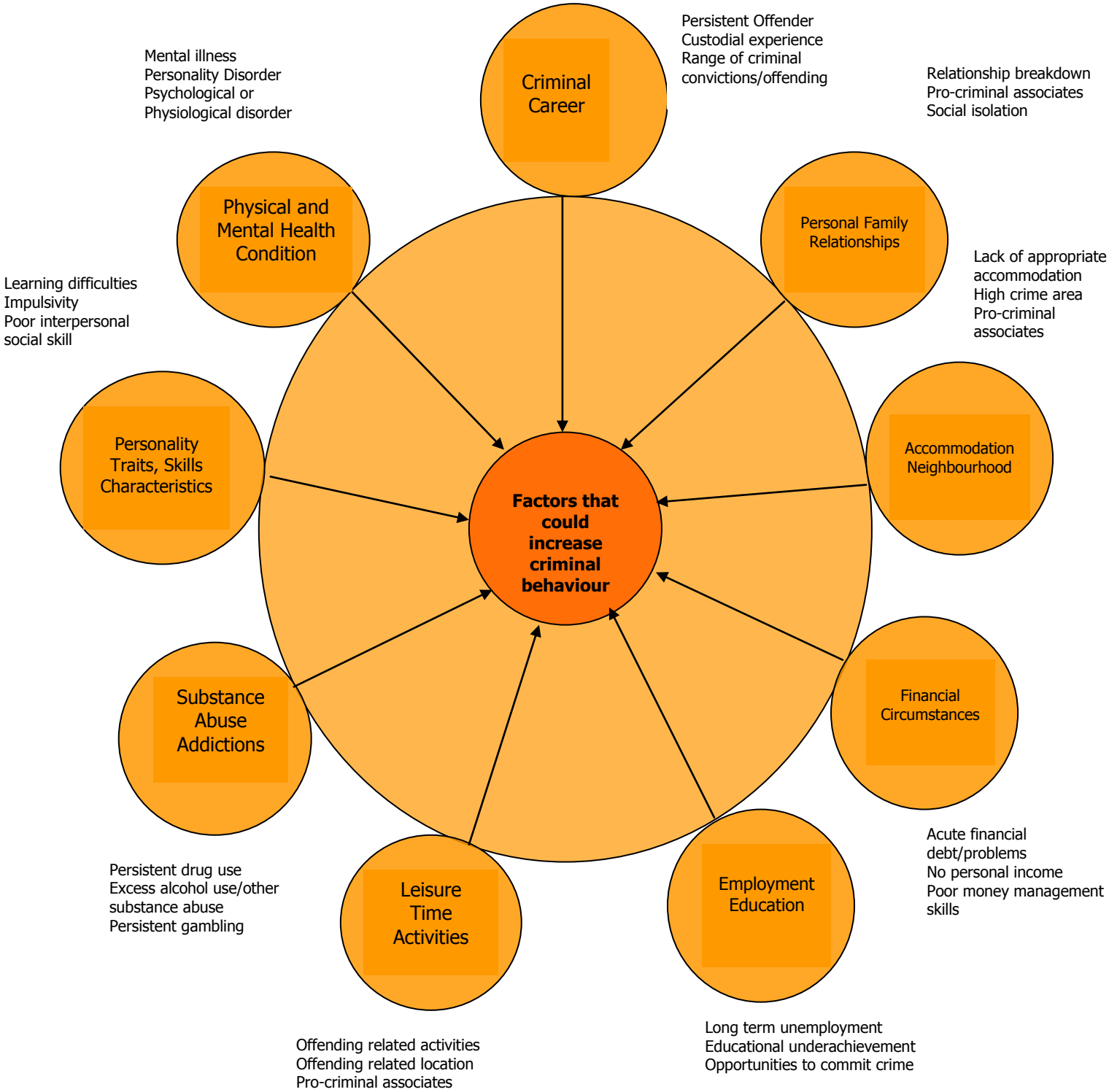
CUMBRIA MENTALLY DISORDERED OFFENDERS MAPPA/MARE FLOWCHART



MAPPA - Multi Agency Public Protection Arrangements
MARE - Multi Agency Risk Evaluation
FHCP - Forensic Health Care Professional
PPU - Public Protection Unit
PDP - Potentially Dangerous Person
SPoC - Single Point of Contact
MDT - Multi Disciplinary Team
CPA - Care Programme Approach
CPFT – Cumbria Partnership Foundation Trust

APPENDIX 10

Factors that Increase Risk of Criminal Behaviour/Offending



Appendix 11

INITIAL NOTIFICATION OF MAPPA-ELIGIBLE PATIENT (MENTAL HEALTH) **MAPPA I**

→ Responsible clinician:
If you are planning discharge for this patient as part of his long-term rehabilitation into the community, please complete sections 1 to 6 of this form and send it to your local MAPPA Co-ordinator.

→ MAPPA Co-ordinator:
If you have any relevant information about this patient, please complete section 7 of this form and send it to the referring agency.

1. CATEGORY OF OFFENDER	
The patient must fall into one of the MAPPA Categories summarised below. Please tick one box below.	
1. Registered sexual offender	
2. Violent or other sexual offender who has been sentenced to 12 months or more custody for a Schedule 15 offence under the Criminal Justice Act 2003 and is transferred to hospital under s.47/49 MHA 1983, or is detained in hospital under s.37 with or without a restriction order under s.41	

2. OFFENDER INFORMATION	
Last name:	
First name:	
Date of birth:	
Aliases:	
Last known address before hospitalisation:	
Gender:	
Ethnicity:	

3. DETAINED IN HOSPITAL	
Name of responsible clinician:	
Hospital:	
Please indicate the relevant section of Mental Health Act	

Part 2 Notification of Discharge Planning **to be completed at stage at which the patient is assessed as ready to take unescorted leave.**

4. Details of	
Details of community leave arrangements (include dates and addresses)	

Details of permanent release / discharge if known (include dates and addresses)	
Date of next CPA if applicable:	
Date of next tribunal if applicable:	
5. CONVICTION / CAUTION INFORMATION	
Index offence:	
Date of conviction / caution:	
Sentence:	
6. VICTIM CONCERNS	
Has the victim asked to be kept informed of relevant dates and decisions by the Hospital Managers?	YES / NO
If YES:	
Please state what information has been provided	
7. CONTACT DETAILS OF LEAD CLINICIAN	

Appendix 12

GLOSSARY AND DEFINITION OF TERMS

Age – There is no age restriction for this policy

ALIS – Assessment Liaison Integrated Service

Care Coordinator – A professional who oversees and implements the key elements of the Care Programme Approach

CPA – Care Programme Approach – A care programme that encompasses an individual's needs and risks

CHOC – Cumbria Health on Call (Out of hours Doctor Service)

CMHART – Community Mental Health Assessment and Recovery Team

HCR 20 – Forensic Risk Assessment Tool incorporating 10 historic, 5 clinical and 5 risk domains that assesses the risks an individual poses

L&D – Liaison and Diversion Service

Likelihood of Event Occurring (Frequency) – How often might the behaviour/actions occur (For more details see Appendix 4)

MAPPA – Multi Agency Public Protection Arrangements

MARAC – Multi Agency Risk Assessment Conference (Domestic Violence)

MARE – Multi Agency Riske Evaluation

MDO – Mentally Disordered Offender

MHAAM – Mental Health Act Administration Manager

NPT – Neighbourhood Policing Team

PPU – Public Protection Unit (Police)

PSR – Pre Sentence Report (for Court)

Relevant Offences – Qualifying Offences for referral to MAPPA/MARE

Responsible Authority – Police, Probation and Prison are the three agencies responsible for MAPPA

RC – Responsible Clinician (Usually Consultant Psychiatrist, but can be other Health Professional)

Risk Profile – A summary of a person's characteristics of perception, attitude, decision-making and behaviour relating to risk to others

Section 17 Leave – Section 17 Mental Health Act 1983 (amended 2007) that allows clinical/care staff to grant leave for detained patients

Serious Harm – "A risk that is life threatening and/or so traumatic that recovery, physical or psychological is expected to be difficult or impossible to achieve"

Severity of Harm – The impact on the safety of others physically and/or psychologically from identified risks

SPoC – Single Point of Contact

Storm Alert – An immediate response alert used by the Police containing an action plan on a specific address (For more details see Appendix 4)

Strategic Management Board – Multi Agency Public Protection Group

YOS – Youth Offending Service

APPENDIX 13 (SPoC use only)

REFERRAL TO MAPPA LEVEL 2/3

MAPPA A

Fields marked with * are mandatory

Name of MAPPA area:		
Referral to which level?	2	3

1. CATEGORY OF OFFENDER	*** All agencies**
The offender can fall into only one of the MAPPA Categories summarised below. Please place an X against only one of the following three Categories.	
1. Registered Sexual Offender	
2. Violent or other sexual offender: Who has been sentenced to 12 months or more custody for an offence under Sch.15 of the Criminal Justice Act 2003; or Who has been sentenced to 12 months or more custody and is transferred to hospital under s.47/49 of the Mental Health Act 1983; or Who has been detained in hospital under s.37 of the Mental Health Act 1983 with or without a restriction order under s.41.	
3. Other dangerous offender – has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm **AND** which requires multi-agency management. This might not be for an offence under Sch.15 of the Criminal Justice Act 2003.	

2. OFFENDER INFORMATION		
Last name:		*** All agencies**
First name:		*** All agencies**
Date of birth:		*** All agencies**
Aliases (including nicknames):		**All agencies**
Prison:		**All agencies**
Prison number:		**All agencies**

Last known address before sentence:		**All agencies**
Proposed release address:		*** All agencies**
Current address if in community:		*** All agencies**
Gender:		*** All agencies**
Ethnicity:		*** All agencies**
PNC ID:		**Police / Probation**
ViSOR Reference (must be completed for all Registered Sexual Offenders):		**Police / Probation**
Agency unique identifier:		**All agencies**
3. CONVICTION / CAUTION INFORMATION		
Index offence / Relevant caution:		*** All agencies**
Date of conviction / caution:		*** All agencies**
Sentence:		**All agencies**
Brief offence(s) details:		*** All agencies**
Relevant previous convictions and pattern of offending:		**All agencies**
Other relevant information:		**All agencies**
Relevant dates		
Automatic Conditional Release Date:		**YOT / Probation**
Parole Eligibility Date:		**YOT / Probation**
Non-Parole Date:		**YOT / Probation**
Licence Expiry Date:		**YOT / Probation**
Sentence Expiry Date:		**YOT / Probation**
Home Detention Curfew:		**YOT / Probation**
Community Order end date:		**YOT / Probation**

Disqualification Order:	YES / NO	*** Police**
Imprisonment for Public Protection:	YES / NO	*** Probation**
Extended Sentence for Public Protection:	YES / NO	*** Probation**
Lifer:	YES / NO	*** YOT / Probation**
Mental Health review date(s):		**Mental Health**
Sexual Offences Prevention Order:	YES / NO	*** Police / Probation**
Registered Sex Offender Notification end date:		**Police / Probation**
Violent Offender Order:	YES / NO	*** Police**
4. DETAINED IN HOSPITAL		**Mental Health**
Name of responsible clinician:		
Hospital:		
Earliest possible discharge date:		
Proposed release address:		
Name / contact details of Forensic Social Worker:		
Date of next tribunal:		
Please indicate the basis for detention from the options below		
Guardianship order – s.7/s.37 MHA 1983	YES / NO	
Hospital order – s.37 MHA 1983	YES / NO	
Restriction order – s.41 MHA 1983	YES / NO	
Transfer from prison – s.47 MHA 1983	YES / NO	

5. RISK ASSESSMENT					
RM 2000 Risk of Reconviction [complete for all sexual offenders]					**Police / Probation**
	Level			**Date of assessment**	
RM 2000 Sexual:					
RM 2000 Violent:					
RM 2000 Combined:					
OASys Risk of Reconviction					**Prison / Probation**
	1 year %	**2 year %**	**Band**		**Date completed**
OGP:					
OVP:					
OGRS3:					
OASys Risk of Serious Harm – (1) Risk in the Community					**Prison / Probation**
	V High	**High**	**Medium**	**Low**	**Date completed**
Children:					
Public:					
Known adult:					
Staff:					
Prisoners:					
OASys Risk of Serious Harm – (2) Risk in Custody					**Prison / Probation**
	V High	**High**	**Medium**	**Low**	**Date completed**
Children:					
Public:					
Known adult:					
Staff:					
Prisoners:					
SARA Assessment [complete for all domestic abuse offenders]					**Probation**
	High	**Medium**	**Low**		**Date completed**

Risk to partner:				
Risk to others:				

ASSET Risk of Serious Harm [complete for all offenders under 18]					**YOT**
	V High	**High**	**Medium**	**Low**	**Date completed**
Risk of serious harm:					
ASSET risk of reconviction					**Date completed**

Mental Health / Psychological Risk Tool	**Mental Health**
	Date completed

Lead Agency Risk Assessment Summary **(Take this information from the Lead Agency Risk Management Tool)**	*** All agencies**
Who is at risk?	
What is the nature of the risk?	
When is the risk likely to be greatest?	
What circumstances are likely to increase risk?	
What factors are likely to reduce the risk?	

Lead Agency Risk Management Plan	*** All agencies**
Restrictive factors / interventions	
Rehabilitative factors / interventions	

Protective factors / interventions	
6. RELEVANT INFORMATION	*** All agencies**
Reason for referral	
What inter-agency work has been undertaken so far?	
How will active multi-agency management add value to the management of the risk(s) of serious harm?	
Diversity considerations linked to risk of serious harm	
Add any other relevant information (e.g. media handling, disclosure, medical issues etc)	
7. VICTIM CONCERNS	**All agencies**

Outline any concerns about the victim of the index offence or potential victims:		
Has the victim taken up the Victim Liaison Service?	YES / NO / NOT APPLICABLE / NOT KNOWN	*
If YES, give contact details of VLO		
Are there any domestic abuse concerns? If YES, answer **a** to **e** below	YES / NO / NOT APPLICABLE / NOT KNOWN	*
a. What are they?		
b. Has the victim been referred to MARAC?	YES / NO / NOT APPLICABLE / NOT KNOWN	*
c. Has a meeting been held / Is a meeting due to be held?	YES / NO / NOT APPLICABLE / NOT KNOWN	*

d. Date of meeting (if known)	
e. Actions from MARAC	

8. SAFEGUARDING	**All agencies**
Child Protection Concerns (continue on additional sheet if required)	
Are there any child protection concerns? If YES, answer **a** to **c** below	YES / NO / NOT APPLICABLE / NOT KNOWN *
a. What are they?	
b. Is there an allocated social worker? If so, please give details	
c. Is the child or children currently subject to a Child Protection Plan?	YES / NO / NOT APPLICABLE / NOT KNOWN *
Child 1	
Last name:	
First name:	
Date of birth:	
Gender:	
Relationship to offender:	

Child 2		
Last name:		
First name:		
Date of birth:		
Gender:		
Relationship to offender:		
Child 3		
Last name:		
First name:		
Date of birth:		
Gender:		
Relationship to offender:		
Vulnerable Adult Concerns (continue on additional sheet if required)		
Name:		
Date of birth:		
Gender:		
Does this person live with the offender?	YES / NO	
Relationship to offender:		
Name of social worker (if relevant):		
9. REFERRING AGENCY INFORMATION		
Referring agency:	*	
Name:	*	
Grade:	*	
Office:	*	
Telephone number(s)	* (w)	(m)

Email address:	*	
Date sent to line manager:		
Endorsement by line manager (where required by your area)		
Name:		
Grade:		
Office:		
Telephone number(s):	(w)	(m)
Email address:		
Date endorsed by line manager:		
10. ADDITIONAL MAPPA INVITEES		**All agencies**
Invitee 1		
Name:		
Agency:		
Address:		
Email address:		
Telephone number(s)	(w)	(m)
Invitee 2		
Name:		
Agency:		
Address:		
Email address:		
Telephone number(s)	(w)	(m)

Invitee 3		
Name:		
Agency:		
Address:		
Email address:		
Telephone number(s)	(w)	(m)
Invitee 4		
Name:		
Agency:		
Address:		
Email address:		
Telephone number(s)	(w)	(m)
Invitee 5		
Name:		
Agency:		
Address:		
Email address:		
Telephone number(s)	(w)	(m)
Invitee 6		
Name:		
Agency:		
Address:		
Email address:		

Telephone number(s)	(w)	(m)
Once completed, please send this form to the SPoC at philip.lea@cumbria.nhs.uk		
Date sent:		
11. MAPPA CO-ORDINATION UNIT DECISION (for official use only)		
Screened by:		
Name:		
Title:		
Area:		
Date referral received:		
MAPPA qualifying offender?	YES / NO	
If NO, return form to referring agency line manager		
Comments:		
Does referral meet threshold for Level 2/3? If YES, which level?		
If NO, return form to referring agency line manager		
Comments:		
Date referral accepted / rejected:		
Date referring agency notified:		
Meeting to which referral is to be taken:		

	Notes for completion	**MAPPA A**

- The MAPPA Area should be identified at the top of the form
- The referrer should identify the Level being referred to (2 or 3)
- The agency that should complete the sections is identified on the right hand side of the field

1. CATEGORY OF OFFENDER

This section identifies which category brings the offender into MAPPA, and therefore avoids wrong identification from the outset. The offender can only fall into **one** category.

2. OFFENDER INFORMATION

- Nicknames have been included as this is relevant for a number of reasons including gang membership
- Where the offender was NFA prior to imprisonment that should be stated, and then the area to which the offender has closest links identified
- The proposed release address should be that which has been approved
- State the actual ethnicity, not the code.
- ViSOR reference should be included when a ViSOR record has been created e.g. sexual offenders
- Agency unique identifier should be included (e.g. PNC ID, CRAMS/Delius reference number)

3. CONVICTION / CAUTION INFORMATION

- The index offences or caution [for category 3] is the offence/s or caution which has brought the offender into MAPPA
- Sentence - outcome of Court proceedings
- **Brief** details of offence. Information must not be cut and pasted from the Pre-Sentence Report or any other document. Use bullet points
- There may or may not be additional information the referring agency wishes to add
- Relevant dates are those which relate to the current sentence or mental health review dates (input dates where known)
- Previous related offences should be included.

4. DETAINED IN HOSPITAL

This section should be completed by Mental Health and provides relevant information regarding the patient.

5. RISK ASSESSMENT

- The agency required to complete the fields for the assessment tools in this section are identified the on the right hand side of the field. The information in the header line indicates the type of offender the tool should be completed for. It is important to include the date the tool was completed.
- Lead Agency Risk Assessment Summary - For Probation referrals, this information can be copied and pasted directly from the answers to these questions in OASys. For other agencies, these fields must be completed
- Lead Agency Risk Management Plan - these fields must be completed

Restrictive Interventions

These are strategies aimed at controlling and reducing opportunities for harmful behaviour, for example, by restricting access to particular venues like schools, leisure facilities or access to previous victims.

Examples of Restrictive Interventions

- Restrictions on residence, for example, residing at Approved Premises
- The use of restrictive licence conditions
- Use of Restrictive Orders – see below for details
- Home visits (by police and the Probation Service staff) and other regular visits to the offender's premises
- Restrictions on associations, activities and movements
- Interventions which include police surveillance and electronic monitoring
- Enforcement of non-compliance on reporting instructions
- Disclosure of information to third parties
- Contingency plans in case of risk management failure and rapid response arrangements to changing situations or deterioration in the circumstances/behaviours

Restrictive orders

Where offenders pose a continuing risk of serious harm, the police will consider whether the risks posed by such an offender are sufficiently high to justify applying for one of the following orders introduced in the Sexual Offences Act (2003):

- Notification Order (sections 97 – 101)
- Risk of Sexual Harm Order (sections 123 – 129)
- Sexual Offences Prevention Order (sections 104, 106, 107, 108, 110 and 113) and
- Foreign Travel order (sections 114 – 122)

(ii) 226 Criminal Justice Act (2003) (regardless of tariff)

- Violent Offender Orders

Rehabilitative interventions

These are strategies that focus more on developing the offenders own ability to avoid and manage risk situations and will include accredited programmes.

Examples of Rehabilitative Interventions

- Attendance at cognitive-behavioural programmes, which address the causes of offending behaviour
- Interventions that emphasise self-risk management and which promote the use of internal controls over the longer term
- Office based supervision
- Provision of suitable diversion activities, for example, employment

- Interventions which combine intensive supervision with the appropriate use of sanctions and enforcement of non-compliance
- Supportive and integrative approaches where risk assessments indicate their usefulness, for example, “Circles of Support and Accountability”

Protective interventions
These are strategies with a strength based approach; supported by the assumption that offenders want better lives, not simply the promise of less harmful ones. Self-risk management is promoted through programmes of intervention that seek to address the offenders’ readiness to change and to help them develop skills and strategies.

Examples of Protective Interventions

- Avoidance of activities or environments which could precipitate offending
- Active commitment to change and is engaged in change related work
- Pro- social network which provides practical and emotional support and disapproves of criminal activity
- Stable and intimate relationships with adults that provide emotional support
- Involvement in other activities to ‘divert’ away from offending such as employment or voluntary work
- Understanding consequences of behaviour, identifying reasons not to offend or cause serious harm

6. RELEVANT INFORMATION

Reason for referral
The reasons why the referral has been made may include concerns about:

- Behaviour and attitudes
- Previous offences and patterns of offending
- Information gathered from other agencies
- The offenders pattern of cooperation
- Gang involvement
- TACT involvement
- Relevant psychiatric history
- Diagnosed personality disorder
- What the risk of reconviction tool used indicates

What interagency work has been undertaken so far?
Should include the outcomes of:

- Care Plan Approach Meetings
- Child Protection Conferences
- Professionals Meetings
- Which agencies have been contacted and what they have contributed to the risk Management plan?
- MARAC

How will active Level 2 or 3 management add value to the case over and above what is already being achieved? Key words are **active** and **add value.**

Describe what additional resources etc the agencies involved in MAPPA can add to the how the risk of the serious harm the offender poses can be managed more effectively.

Diversity considerations linked to risk of serious harm – only comment on diversity issues that could impact upon risk management, e.g. is the offender a vulnerable adult, does he/she have

learning disabilities, etc.

7. VICTIM CONCERNS

This section should outline any known or suspected concerns regarding the victim of the index offence/s, previous offences or potential victims e.g. children, partners, vulnerable adults etc, and why the referring agency thinks those identified are at risk of serious harm.

8. SAFEGUARDING

- Children's services keep records according to the child. To assist this agency the information should be fully provided as well as to enable the coordination unit to invite the correct person to the meeting.
- Where the concerns relate to children in general, these should be specified
- Vulnerable Adult concerns should be noted. If in doubt, contact the local Safeguarding Adults Unit

9. REFERRING AGENCY INFORMATION

- Must be fully completed
- The line manager must endorse the referral (this ensures that the line manager is fully aware of the case and the reason for the referral to MAPPA). If the referral is being completed by a Line Manager, the referral does not require endorsement if agreed by local agency protocol.

10. ADDITIONAL MAPPA INVITEES

- Invite 1 must be completed by the referring agency identifying themselves.
- Complete for invitations to be sent for the meeting when the case is to be discussed
- If there are more than six, complete this on a separate sheet and attach to the referral

11. MAPPA CO-ORDINATION UNIT DECISION

This section should be complete by whoever has this responsibility in the MAPPA area.

Appendix 14
CHoC Proforma
Notification of Multi Agency Risk Evaluation (MARE) client

NHS No – DoB –

Address

Meeting date -

The above client is currently subject to management within the MARE process. Please find below risk profile, risk levels and risk management action plan.

8. Risks:

Risk of repeat behaviour/risk of re-offending (consider previous offending)

What is the nature of the risk? (What behaviour is of concern- be specific)

Who is at risk? (Specified or unspecified individual groups)

What are the consequences? (The likely degree of harm/who would be affected)

What is the immediacy of the risks (What are the likely timescales of risks/behaviour happening)

What factors could increase the risk? (Personal and environmental)

What factors could decrease the risk? (Personal and environmental)

Change of their environment (Housing, move to a different area, custody, hospital?)

9. Level of Risk:

CURRENT ASSESSMENT OF RISK					DATE OF RISK ASSESSMENT:						
	Children		Public		Known Adult		Staff		Patients	Self	
	Risk in Community	Risk in Hosp/custody	Risk in Community	Risk in Hosp/custody	Risk in Community	Risk in Hosp/custody	Risk in Community	Risk in Hosp/custody	Risk in Hosp/custody	Risk in Community	Risk in Hosp/custody
Very High	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Med	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Low	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Comments:										

10. Risk Matrix

SEVERITY	**LIKELIHOOD**		
	1. UNLIKELY	2. POSSIBLE	3.LIKELY
1. MINOR	1	2	3
2. MODERATE	2	4	6
3. MAJOR	3	6	9

KEY	Low Risk	Moderate Risk	High Risk
	1 - 2	3 - 4	6 - 9

14. Risk Management Action Plan:

	Action	**By Whom/When**
1.		
2.		
3.		