



Executive Summary and PPANI Strategic Management Board
Response to
Serious Case Review in respect of
Barry Shay Johnston

At the outset the Strategic Management Board for the public protection arrangements of NI (SMB) acknowledge the hurt and harm inflicted on the victim in this case. The SMB also pays tribute to the victim's bravery in cooperating with the police to ensure Johnston was quickly apprehended and brought before the court.

The Strategic Management Board welcomes the opportunity to publish an Executive Summary of the Serious Case Review in respect of Barry Shay Johnston. This review was undertaken by an independent assessor, Mr David Watkins CB.

In accordance with section 17 of the PPANI Manual of Practice introduced in October 2008, a Serious Case Review is commissioned by the SMB, when an offender who is subject to the arrangements commits or alleges to have committed an offence. The terms of reference for the Serious Case Review was to:

- Establish whether there are lessons to be learnt from this case about the way professionals and agencies work to minimise the risk posed by offenders, and

- Identify clearly what those lessons are, how they should be acted upon and what improvements should flow from them by way of improved inter agency working to safeguard the public and promote public protection.

Background Context

Johnston was convicted on 17th April 2007 for the offences of rape, false imprisonment and theft which occurred on 12th July 2005. He was sentenced on 17th August to 8 years imprisonment, followed by 2 years probation supervision. Prior to these offences he had 23 convictions dating back to July 1999, none of these offences involved sexual offending.

Johnston was released from custody on 19th January 2010 and in accordance with the requirements of his Custody Probation Order he was placed in a hostel approved by the Probation Board. The following day he failed to return to the hostel and an arrest warrant was issued. Following his arrest a court bailed him to reside in the same hostel as before, but on 6th February 2010 he again failed to return, surrendering himself at Ballymena PSNI station 4 days later. His Custody Probation Order was revoked and he was returned to custody on a 12 month sentence.

As per the Manual of Practice a pre-release LAPPP was held and the risk deemed to be posed by Johnston was set at Category 2 which states:

‘Someone whose previous offending and / or current behaviour and / or current circumstances present clear and identifiable evidence that they could cause serious harm through carrying out a contact sexual or violent offence.’

Johnston was subsequently released on 11th August 2010 and made contact with PSNI Ballymena that day. The PSNI undertook a post release interview where he was reminded of the conditions of his Sexual Offences Prevention Order (SOPO). This interview took place with Johnston on 12th August 2011. Johnston was arrested 3 days later and subsequently charged with rape, aggravated burglary, and possession of cannabis and breach of Interim Sexual Offences Prevention Order (SOPO). These offences occurred on 14 August 2010.

Johnston was sentenced for these offences on 6th January 2012 and received a Discretionary Life Sentence with a minimum of 10 years before he can apply to the Parole Commissioners for release.

The Serious Case Review, commissioned by PPANI and undertaken by Mr David Watkins reported on 31 March 2011.

The PPANI SMB was restricted in publishing the Executive Summary of this report until after sentencing, however during the intervening period, the agencies actively addressed the recommendations in the SCR on receipt of the report.

In responding to the recommendations outlined in the report, these have been addressed as follows:

1. Northern Ireland Prison Service

1.1 It was recommended the N.I. Prison Service should review the availability of forensic psychologists for treatment of sex offenders in custody and seek to identify any ways to resolve limitations on this

Action taken on recommendation:

NIPS has documented long term recruitment and retention problems with qualified forensic psychologists. This has impacted on its ability to provide timely treatment to all offenders identified as requiring such interventions although higher risk offenders are given clear priority. However delays in treatment in custody can also be caused by the length of time a prisoner spends on remand and/or the prisoner having insufficient sentence time left to undertake meaningful work once an assessment has been completed.

NIPS is currently endeavouring to resolve its recruitment and retention difficulties and hopes to engage with the Department of Finance and Personnel to explore how salaries might be enhanced in order to make them more competitive with other sectors. NIPS has also recently bought in forensic and clinical psychology services to augment and bolster current in-house provision.

- 1.2 PPANI should remind all involved in handling sex offenders under the Manual of Practice on the need for the highest standards of administration and interagency communication in order to ensure joined up handling.
- 1.3 It should be normal practice for there to be one-to-one discussions between the prisons DRM (Designated Risk Manager) and the official taking over that duty on the prisoner's release. This should be specified in the Manual of Practice. It should be a standing item of business for such handovers that the question of a special LAPPP (Local Area Public Protection Panel) be considered

Action on recommendations:

PPANI agencies accepted these recommendations for enhancing good practice in improving communication between different agencies involved in cases. Within the revised Manual of Practice the importance of formal handover of information relating to a case is recorded and sharing of information between agencies is emphasised to all those working with any offender within the arrangements. The revised Manual of Practice also allows any agency to request a further pre-release LAPPP at any time when they have significant concerns.

2. Northern Health and Social Care Trust

- 2.1 In conjunction with other health and social care trusts and involving PPANI as appropriate, the Northern Trust should ensure that a protocol is in place

which, among other things, both advises representatives on the need to be fully briefed by other Trusts in advance of LAPPP meetings considering cases from their area, and sets out the need to ensure a full flow of information to those Trusts on the course and outcome of the discussion.

Action on recommendation:

Each Health and Social Care Trust has a dedicated Principal Officer with responsibility for PPANI cases within their own Trust. The Principal Officers are in the process of drafting operational guidance outlining their role within PPANI addressing such areas as communication within and between Trusts and links with other PPANI agencies.

3. Police Service of Northern Ireland

The Serious Case Review after reviewing the role of the PSNI within this case did not deem it necessary to make any specific recommendations relating to the PSNI.

4. Probation Service for Northern Ireland

The Serious Case Review after reviewing the role of the PBNI within this case did not deem it necessary to make any specific recommendations relating to the PBNI.

5. Public Protection Arrangements of Northern Ireland

5.1 The Strategic Management Board should put in hand consideration of the term 'compelling evidence' in relation to the threshold for classification to Category 3 Risk of Harm.

Action on recommendation:

This was accepted by SMB and in the revised Manual of Practice further clarity on the term 'compelling evidence' has been inserted.

5.2 PPANI should consider a revision to the Manual at paragraph 6.2.4 or guidance relating to it might facilitate an inter agency meeting in circumstances where difficulties about offender management arise in the immediate run up to release.

Action on recommendation:

This recommendation has been accepted and new guidance for agencies included in the Manual of Practice to allow for review LAPPPs to be held immediately prior to release

5.3 PPANI , in conjunction with NIPS, PBNI and health and social care trusts, should consider whether the requirements contained in the social care sector's guidance ' Co-operating to Safeguard Children' and 'Sharing to Safeguard' should be more explicitly reflected in the Manual.

Action on recommendation:

This recommendation has been accepted and the Manual of Practice now refers to this guidance. The Principal Officers of the Health and Social Care Trusts within the draft of their Operational Guidance highlight their role in ensuring the adherence and cognizance of child and vulnerable adult protection within PPANI and LAPPPs.

5.4 Information from medical staff such as doctors or psychiatrists could have a significant bearing on risk assessment and categorisation and subsequently how those risks are managed in the community. PPANI should consider exploring with prisons, PBNI and Trust personnel whether there is an issue over availability to LAPPP meetings of information based on medical assessments and second how it might be resolved

Action on recommendation:

PPANI Co-ordination Unit in conjunction with Trusts Training Departments and Principal Officers has developed and delivered PPANI awareness training for all Trust staff to ensure they understand PPANI and their role within the arrangements. The sharing of information for risk assessment and risk management is emphasised to all medical personnel and an agreed information sheet on their role in sharing information is being developed.

In summary, the Independent Serious Case Review chaired by Mr Watkins found there was a high probability that, even if the risk posed by Johnston had been assessed as category 3, this would not have prevented the second rape, not least given his highly impulsive behaviour. The Review found nothing to cast doubt on the public protection arrangements and that the agencies had followed all the steps prescribed. Overall the Serious Case Review acknowledged that the Public Protection Arrangements aim to minimise the risk posed but that they cannot eliminate that risk.

The Review identified a number of recommendations for future practice: the Strategic Management Board has accepted, and the agencies are implementing, all the recommendations of the serious case review.

PPANI Strategic Management Board

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