MULTI AGENCY PUBLIC PROTECTION ARRANGEMENTS (MAPPA) SIGNIFICANT CASE REVIEW

EXECUTIVE SUMMARY

PERSON H
Registered Sex Offender

Independent review by Gail Johnston on behalf of Glasgow Local Authority MAPPA Strategic Oversight Group

6th of April 2023

MAPPA
Glasgow
Multi Agency Public Protection Arrangements

Notes on redaction of this Report

This document contains the conclusions and recommendations of the Significant Case Review (SCR) relating to person H. In the interests of transparency, every effort has been made to disclose as much of the SCR as is lawfully possible. The only editing prior to disclosure is the redaction of personal data, disclosure of which cannot be justified under the UK General Data Protection Regulation (GDPR) and Data Protection Act 2018. Although there has been a criminal trial and extensive media coverage of this case, and a certain amount of both personal data and special category personal data is, as a result of this, publicly available, disclosure of the personal data contained in this report must still comply with data protection law. This means that even though some of the redacted information may already be publicly available, or it may be considered to be in the public interest to disclose, it cannot automatically be disclosed, as data protection law contains certain conditions which must first be met. The process of redacting the SCR has involved careful consideration of:

- The need for transparency and the overall purpose of the SCR in the identification of any lessons learned;
- The public interest in disclosure;
- Considering whether information is "special category" personal data, (for example, because it is information about a person's physical or mental health or condition, his/her sexual life, or the commission or alleged commission of an offence) and whether its inclusion in the SCR complies with data protection legislation; and
- Balancing interests in terms of the right to respect for private and family life in terms of Article 8 of the European Convention on Human Rights, meaning that any information contained in the report relating Person H, Woman A and other people whose history was closely linked to Person H or Woman A can only be released if it is lawful, necessary and proportionate to do so.

The full report of the SCR follows but with certain text (generally containing biographical details) redacted for the reasons set out above. Any redactions are clearly marked with the word "[Redacted]". Some minor grammatical changes have been made (unflagged) to maintain consistency of language following some redactions. Text redacted is considered exempt from a request under section 1 of the Freedom of Information (Scotland) Act 2002 as a result of the exemption contained in section 38(1)(b) of that Act; in other words, disclosure of the information would be in breach of the data protection principles contained in the GDPR.

Re-identification of individuals referred to in the report:

Individuals whose names or biographical information have been redacted have been "de-identified" by the controller (Glasgow City Council) for purposes of section 171 of the Data Protection Act 2018, and attempting to re-identify these individuals is likely to constitute an offence under section 171(1) of that Act. Requests for consent to re-identify should be addressed to Glasgow City Council's data protection officer at dataprotection@glasgow.gov.uk.

Response on behalf of the Glasgow MAPPA Strategic Oversight Group

Glasgow MAPPA Strategic Oversight Group (SOG) commissioned a Significant Case Review (SCR) following Person H being charged with the Murder and Section 1 Sexual Offences (Scotland) Act 2009 (Rape) of Woman A. The offence occurred on the 28th of May 2021. Person H was managed under Multi Agency Public Protection Arrangements (MAPPA) as a Registered Sex Offender when the offence was committed. Following conviction Person H was sentenced to life imprisonment with a minimum of 19 years for the murder and 80 months for the Rape of Woman A.

The aim of the SCR was to identify learning as well as areas of good practice in relation to the management of Person H. To ensure objectivity in the review of the case, the SOG appointed an external reviewer. The SCR has identified 11 recommendations, 14 learning points and 7 areas of good practice which will inform a multi-agency improvement plan.

The SOG expresses their sincere condolences to the family and local community in relation to the death of Woman A. To ensure transparency the SOG decided to publish the SCR in full, with redactions in accordance with the Data Protection Act 2018 and offered to share the findings of the report with identified family members and local community who were close to Woman A in advance of publication.

The SOG supports the findings and recommendations of the SCR, and as a SOG, we are fully committed to learning from the SCR and will actively look at how we can introduce recommendations and learning points to positively support the aims of MAPPA.

Pat Togher, Chair of the Glasgow MAPPA Strategic Oversight Group

1. INTRODUCTION

1.1 On 15 October 2021, Person H was convicted of Murder and Section 1 Sexual Offences (Scotland) Act 2009 (Rape) of Woman A and subsequently sentenced to life imprisonment. At the time of the offence Person H was one of 839 Registered Sex Offenders (RSOs) being managed under Multi Agency Public Protection Arrangements (MAPPA) within Greater Glasgow Local Authority area and one of 5,852 RSOs being managed nationally in Scotland.

1.2 After considering the Initial Notification Report and Initial Case Review, Glasgow Local Authority MAPPA Strategic Oversight Group (SOG) commissioned an Independent Significant Case Review (SCR). The aim of the SCR was to examine the Multi-Agency Public Protection Arrangements in respect of the management of Person H with a focus on the effectiveness of information sharing, risk assessment, and risk management. The time period reviewed was 11 October 2013 to 4 June 2021; the date Person H was convicted of rape and placed on the Sex Offenders Register to the date he was arrested for the murder and rape of Woman A.

1.3 The SCR formally commenced on 7 March 2022 with Gail Johnston appointed as the Lead Independent Reviewer. Mrs Johnston is independent of the agencies being reviewed and has not been involved in any way with the management of the case. Mrs Johnston retired from Police Scotland in 2020 having been the Police Scotland lead for Offender Management and Head of the National Offender Management Unit (now known as the National Sex Offender Policing Unit). She has a wealth of experience, having been involved in the management of RSO's since 2004, holding operational, strategic, policy and training roles.

2. MURDER & RAPE OF WOMAN A

2.1 Woman A was 67 years of age and resided alone. On the evening of Friday 28 May 2021, she was at home on her own. Person H spent that afternoon at a public house drinking alcohol, smoking cannabis and was ejected shortly after 6pm after becoming aggressive towards other patrons. On parting company with family members he was heard to say, "I know when I am not wanted". About an hour later, CCTV captured Person H alone entering the rear lane servicing the street where Woman A lived. Sometime between 6:57pm and 9:15pm Person H forced his way into Woman A's home and subjected her to a prolonged violent attack, whereby he raped and murdered her. On 1 June 2021, Woman A was found and a murder investigation initiated.

2.2 All enquiries failed to establish any known connections between Person H and Woman A or any previous contacts, they were both unknown to each other. The crime perpetrated by Person H was a completely opportunistic and impulsive attack carried out against a stranger.

3. BACKGROUND & OFFENDING HISTORY

3.1 Person H had a turbulent childhood. His mother had a history of schizophrenia and his father had little or no involvement in his life. When 5 years old, Person H witnessed his mother fall to her death from their fifth-floor home. It is unknown if

her death was accidental or suicide, but Person H considered it most likely to be suicide. Person H's maternal grandparents were awarded Guardianship of Person H.

3.2 From 10 years old Person H was regularly using cannabis and alcohol and was engaged in criminality and antisocial behaviour. He used a wide variety of drugs with alcohol becoming problematic from the age of 14 years. He was homeless from 2009 until 2013, during this period his alcohol and drug use increased and were a significant factor in his criminal offending behaviour. He was also assessed by a Consultant Psychiatrist and diagnosed with Post Traumatic Stress Disorder (PTSD). The symptoms were of considerable severity and significance coinciding with flashbacks of witnessing his mother's death. He was prescribed medication and attended therapy sessions with a Clinical Psychologist. Person H made three separate attempts to take his own life during 2012/2013.

3.3 Person H had 6 recorded offences as a juvenile and 12 previous convictions as an adult. These were for public order, dishonesty, domestic, sexual, and violent offences. The following convictions were viewed as significant when considering the nature and pattern of Person H's violent and sexual offending behaviour:

3.4 **Section 27(1)(a) Criminal Procedure (S) Act 1995 (Fail to Appear at Court) - 2010**
Person H had been in a short relationship with a 17-year-old woman. He had been drinking, pinned her to a bed, strangled her and punched her. He failed to appear at court for this and was arrested. He pled guilty to Failing to Appear at Court and not guilty to Domestic Assault to Injury. The case continued and called at court several times before being marked as 'not called'. There was no conviction for or further record of the Domestic Assault to Injury charge.

3.5 **Section 38(1) Criminal Justice & Licensing (S) Act 2010 (Aggravation - Domestic) - 2012**
Person H had been in a very short relationship with an 18-year-old woman. He had been drinking and became aggressive. She tried to leave several times, but he stopped her, pulled her back, and kissed her. On the final attempt to leave he grabbed her, pulled her back, tried to kiss her, sat on her, and strangled her.

3.6 **Section 1 Sexual Offences (S) Act 2009 (Rape) - 2013**
Person H had been drinking, taking illicit drugs and was extremely intoxicated. He stated he was chased by a rival gang and attended his uncle's home which was nearby. He gained entry to the common close but attended at a 50-year-old female neighbour's home. She had recently suffered a fall resulting in a broken collar bone and had her arm in a sling. He forced his way in and subjected her to a sustained sexual and violent attack whereby he raped her, attempted to strangle her, bit her, and repeatedly punched and kicked her. Person H stated the woman was known to him as she was a neighbour of his uncle and had socialised with her at her home on two occasions.

3.7 Person H was convicted and sentenced to 7 years and 6 months imprisonment for Rape. This was his only custodial sentence. He was also made subject of the

Notification Requirements of Part 2 of the Sexual Offences Act 2003 and placed on the Sex Offenders Register. Person H complied with all his Sex Offender Notification Requirements.

4. The Violent and Sex Offender Database (ViSOR)

4.1 ViSOR is a secure Home Office database used across the UK and in Scotland used by all MAPPA Responsible Authorities. All individuals subject to MAPPA should be recorded on ViSOR and the record actively maintained by the lead agency and relevant partners.

4.2 The use of ViSOR in Scotland has proved challenging with a number of issues impacting on local authority social works use of the system. These long-term issues were highlighted in the 2017 Joint Thematic Review of MAPPA in Scotland by Her Majesty's Inspectorate of Constabulary in Scotland and The Care Inspectorate. Scottish Government and the Responsible Authorities are fully aware of the issues, work has been done, is ongoing, however 5 years post the Joint Thematic Review the issues continue and remain unresolved. The new 2022 MAPPA guidance may now have ViSOR as '*one of the systems used by MAPPA to facilitate the secure exchange and storage of information*' but it remains the only system currently available which can be used by all Responsible Authorities to share information. There needs to be national discussion on the benefits of a single repository for multi-agency information sharing and positive action to progress the use of ViSOR by all local authority social work.

5. KEY FINDINGS

5.1 A SCR is one individual case with its own distinctive set of circumstances, some findings may be unique to the case or specific members of staff and may not be a wider issue for agencies. While there is benefit from highlighting these findings and sharing learning, they do not necessarily require a recommendation. Therefore, findings have been categorised as **Good Practice**, **Learning Points** or **Recommendations**.

5.1.1 It is the opinion of the Independent Reviewer that the following findings had no influence or bearing on the circumstances surrounding Woman A's death. The rape and murder of Woman A was a spontaneous and impulsive act which could not have been predicted or prevented. The following details the involvement of each agency and key findings:

5.2 SCOTTISH PRISON SERVICE (SPS)

5.2.1 Person H was remanded to HMP Barlinnie on 17/06/2013 for rape and transferred to HMP Glenochil on 28/03/2014, where he remained for the duration of his sentence.

5.2.2 A Generic Programme Assessment (GPA) was completed for Person H on 13/03/2015 and presented at the Programme Case Management Board (PCMB) on 21/04/2015. The PCMB agreed Person H had two primary needs which would be addressed by a Substance Related Offending Behaviour Programme (SROBP) and Moving Forward Making Changes (MFMC) Programme. A prisoner will only be placed on programme

waiting lists after ratification at the PCMB. Programmes are not mandatory and there is no requirement on prisoners to participate. Person H completed the SROBP and agreed to participate in MFMC in HMP Glenochil or HMP Barlinnie but was not offered a programme prior to his Parole Qualifying Date (PQD).

5.2.3 The Parole Board did not recommend parole for Person H as the one crucial element of work that needed to be undertaken had not been, namely MFMC. This was the only reason parole was not recommended. Following this decision, Person H was subsequently offered three opportunities to participate in MFMC but declined all.

5.2.4 Timescales, waiting lists and programme availability all impacted on MFMC provision. Person H was placed on the MFMC waiting list some 13 months after being transferred to HMP Glenochil. A quicker process would have added him to the waiting list sooner and may have provided greater opportunity of a programme prior to his PQD. Person H was over 100th on the MFMC waiting list, 19 months after being placed on the list and just 2 months prior to his Parole Hearing. While positions on the list are not static and managed by critical dates, no reason was recorded as to why Person H was not offered a programme prior to his PQD. The following details the number of prisoners who participated on MFMC during the relevant period of Person H's incarceration and highlights the limited availability of MFMC places:

	Barlinnie	Edinburgh	Glenochil	Polmont	Total
2015/2016	10	20	30	6	66
2016/2017	8	17	31	20	66
2017/2018	11	16	20	8	55

5.2.5 In 2021, SPS introduced the Self-Change Programme (SCP) to replace MFMC and a further programme, MF2C is being developed. The delivery of these new programmes and impact on the waiting list is currently unknown but as MF2C is shorter in duration it should provide a greater throughput of prisoners but will be dependent on staffing and programme delivery. **RECOMMENDATION 1** and **RECOMMENDATION 2**

5.2.6 Enhanced Integrated Case Management (ICM) was implemented for Person H within defined timescales and minutes of case conferences shared with Criminal Justice Social Work (CJSW) and police. MAPPA referrals were submitted by the ICM Coordinator prior to Person H's PQD Parole Hearing and release. These were well populated but did not include information from prison intelligence of Person H's involvement in dealing cannabis, selling his prescribed medication, and of being in a sexual relationship with another prisoner. The ICM Coordinator was provided with access to prison intelligence on 8 August 2017 and therefore this information was not available when completing the first referral but was available for the second and should have been included. **LEARNING POINT 1: SPS**

5.3 NON-PAROLE LICENCE

5.3.1 Person H was released from prison on 15/06/2018 on a non-parole licence with expiry on 16/12/2020. Supervision to ensure compliance with licence conditions is the responsibility of CJSW.

5.3.2 At a pre-release MAPPA meeting, it was agreed a curfew may assist in the risk management of Person H and a request made and approved by the Parole Board, to include the following in the licence, **'You shall remain within the confines of your approved address between hours as directed by your supervising officer, subject to a maximum of 12 hours per day'**. The curfew was in place for the duration of the licence with no requests to the Parole Board to have the condition removed. The exact curfew restrictions imposed, and any subsequent variations could not be established from agency records, MAPPA meeting minutes or meetings with staff.

5.3.3 There were no plans by the CJSW supervising officer or actions raised at MAPPA to actively supervise the curfew. There was an assumption this would be done automatically by police. While police may assist when requested to do so, and do so regularly, the responsibility ultimately sits with CJSW. CJSW should have the necessary resources to supervise licences and specific conditions without relying on the assistance of partner agencies.

5.3.4 As part of Person H's management as an RSO, the SOPU officer carried out unannounced home visits. No visits were completed during the curfew period and no actions were given to or raised by police to assist CJSW in managing the curfew.

5.3.5 Despite the fact a curfew was deemed necessary, there was no supervision of this condition apart from Person H's self-reporting. Poor recording of curfew restrictions and the fact it was last discussed or recorded in December 2018 evidenced it was not actively managed for the duration of the licence. An electronic tag would have been a significantly better option and would have eliminated several of the issues highlighted. **LEARNING POINT 2: CJSW** and **LEARNING POINT 3: CJSW**

5.3.6 A condition of Person H's licence related to the assessment, counselling and testing for alcohol and substance misuse. In respect of testing, it specified "**Undertake testing, random or otherwise, for alcohol/substances as directed by your supervising officer"**.

5.3.7 In February 2019, CJSW and Police received anonymous calls stating Person H was drinking and taking illegal drugs. Following a further similar call in September 2019 a random drugs test was completed which was negative. This test was very much an obligement and not within approved processes as Person H did not meet the testing criteria. Only individuals open to Addiction Services and on medication for their addictions can be tested. Out with this Health are unable to test and no other resources are available to CJSW for testing. This licence condition is an extremely useful tool for supervision and protecting the public but is not being utilised fully given the limited numbers meeting the testing criteria. This issue is not unique to Glasgow and is replicated across the country. **RECOMMENDATION 3**

5.4 MAPPA

5.4.1 All MAPPA meetings were held within prescribed timescales with a MAPPA level 2 meeting held prior to Person H's release from prison. This allowed plans and actions to be implemented in advance of his release. **GOOD PRACTICE 1: MAPPA**

5.4.2 CJSW were the lead agency while Person H was subject to statutory supervision. All MAPPA level 2 meetings were chaired by the same Service Manager and MAPPA level 1 meetings by the same Team Leader apart from one. Police became the lead agency on expiry of the non-parole licence but did not chair a MAPPA meeting as Person H was arrested prior to the meeting date. Having a consistent Chair ensured continuity and a good understanding of the case. **GOOD PRACTICE 2: *MAPPA***

5.4.3 Attendance and agency representation at MAPPA level 2 meetings was good from CJSW, police, Health and Third Sector organisations but issues were noted with prison-based staff. Health was represented by the MAPPA Health Manager, this is a dedicated post created for the purpose of attending MAPPA meetings, managing health alerts, and acting as the conduit for information sharing between MAPPA and the various facets of the NHS.
GOOD PRACTICE 3: MAPPA

5.4.4 Staff at HMP Glenochil including the ICM Coordinator, Prison Based Social Worker (PBSW) and Mental Health Nurse were invited to Person H's pre-release MAPPA meeting. All tendered apologies and provided no further update. Attendance of prison-based staff in general was described as an ongoing issue, with attendance of HMP Glenochil staff considered particularly problematic. The majority of RSOs are held at HMP Glenochil, therefore increasing the demand for attendance from all MAPPA areas. During COVID, Microsoft Teams was introduced to facilitate meetings. This is now considered part of routine business, is more time efficient and should assist and improve attendance. **RECOMMENDATION 4**

5.4.5 Part of the MAPPA process is pre-MAPPA meeting information sharing and submission of a written update from each agency. The pre-read submissions for Person H's MAPPA meetings were of a variable standard, with some not being completed at all. This was not unique to Person H and recognised as an issue by Glasgow MAPPA SOG. A review was initiated in late 2018, resulting in improved pre-read documentation and practice. Despite this, the MAPPA Health Manager continued not to submit any written updates for meetings attended.
RECOMMENDATION 5

5.4.6 There was insufficient information recorded in MAPPA minutes detailing how allocated actions had been specifically discharged. Some actions were simply updated as '**complete**', with no record to indicate how this had been done and no auditable trail. The aforementioned 2018 review also identified this as an issue and since early 2019 pre-read documents must now include a full update detailing how allocated actions have been addressed or discharged. **LEARNING POINT 4: MAPPA**

5.4.7 The MAPPA Level 2 meeting on 11/12/2018 reduced Person H to MAPPA level 1, medium risk. Given the circumstances the reduction in risk was considered justified. There was discussion on whether to reduce the MAPPA level as clarity was still required around a number of issues. MAPPA level 1 was agreed on the proviso these outstanding issues would continue to be investigated and respective actions raised. The subsequent MAPPA Level 1 meeting on 29/05/2019 did not carry forward these outstanding issues and actions nor were they discussed or included in the minute or subsequent meeting minutes. Retaining Person H at MAPPA Level 2 until matters had been clarified and then reducing the MAPPA level if appropriate may have been the better option. **RECOMMENDATION 6**

5.4.8 The updates provided by CJSW and police at MAPPA Level 1 meetings were not always representative of the issues ongoing for Person H at that time with key events, incidents and pertinent information not always shared. This may have been down to familiarity between staff and the MAPPA Chair, and the assumption information had previously been discussed in other forums. Irrespective, this information should have been shared and recorded to allow for a more defensible risk management plan. **LEARNING POINT 5: CJSW & Police**

5.4.9 MAPPA health alerts are used to advise health staff of any risks presented by MAPPA offenders. A formal MAPPA health alert process has been in place between NHS Greater Glasgow & Clyde and Glasgow MAPPA since 2014. The MAPPA Health Manager is responsible for the management of this process.

5.4.10 At Person H's pre-release MAPPA meeting, an action was raised to add a MAPPA health alert and was shown as complete at the next meeting. During the course of the SCR, it was discovered a health alert had never been added to Person H's health record. Enquiries identified a breakdown in communication, understanding and compliance with the MAPPA health alert process by staff involved. **RECOMMENDATION 7**

5.4.11 Person H was diagnosed with PTSD in 2011 and diagnosis reaffirmed during his period of imprisonment. Social work, SPS, NHS and prison-based NHS records all referenced this diagnosis. Staff were aware of the diagnosis but there was confusion when subsequent information from prison health staff stated he did not have PTSD but chronic anxiety and sleep problems contradicting previously provided information. An action was raised at MAPPA meetings to clarify Person H's PTSD diagnosis but was never completed and the confusion around Person H's PTSD diagnosis was never clarified.

5.4.12 Similar confusion was evident in respect of mental health referrals for Person H. There was inconsistent and contradictory information recorded by prison-based health and social work staff that a mental health referral would be made to the community prior to release, no referral was ever made. CJSW submitted a referral to the Douglas Inch Centre, but it was never received as it was sent to the wrong address and was not followed up. Following release Person H was referred to the Community Mental Health Team (CMHT) by his GP and was being seen by a

Consultant Psychiatrist. MAPPA were unaware of this until several months later despite actions being raised to clarify the situation and the information being available to the MAPPA Health Manager on Person H's health record. CJSW attempted contact with the Consultant Psychiatrist but were unsuccessful and no follow up was made. There was no request for or consideration by the MAPPA Health Manager to contact the Consultant Psychiatrist or for them to be invited to MAPPA meetings. Neither CJSW or police were aware how Person H's PTSD affected him, why he was involved with a Consultant Psychiatrist, what treatment he was receiving and any possible effects from his medication or failure to take his medication. **LEARNING POINT 6: All agencies**

5.5 National Health Service (NHS)

5.5.1 Person H had a history of involvement with mental health services prior to and during his period of imprisonment. On release Person H registered with a new GP who made a referral to the CMHT which contained incorrect information in respect of Person H's sexual conviction. At their first appointment the Consultant Psychiatrist saw Person H on her own. This would not have occurred had the MAPPA health alert been in place or correct conviction information been provided.

5.5.2 Person H was open to the CHMT until his arrest for murder and had nine face to face appointments. He was being treated for PTSD and was referred by the Consultant Psychiatrist to the Psychological Trauma Service and placed on their waiting list on 06/06/2019. The Consultant Psychiatrist found Person H to be mentally well, never under the influence and never angry, hostile, or aggressive.

5.5.3 Following a missed appointment Person H was assessed on 12/12/2019 by Clinical Psychologist – Doctor E as meeting the diagnostic criteria for complex PTSD and as being suitable for psychological therapy. Due to differing information within referrals, Doctor E contacted CJSW to confirm the nature of Person H's sexual conviction and updated his health record. Person H was placed on a waiting list for psychological therapy, but this was impacted by COVID. He was provided with digital psycho-educational sessions online prior to his first psychological therapy appointment with Clinical Psychologist – Doctor F on 16/12/2020. Initial and subsequent appointments were online with the first face-to-face appointment on 20/05/2021. The last appointment was on 03/06/2021, 4 days after the murder. Person H's presentation was entirely consistent across all appointments and interactions.

5.5.4 NHS Greater Glasgow & Clyde Mental Health Service has a Clinical Risk Screening and Management policy for staff. While there was evidence of risk assessment and the risks to and posed by Person H being considered there was no recorded evidence on Person H's health file of compliance with this policy and completion of the formal assessments and processes.

5.5.5 Person H routinely requested and was provided with letters from health professionals in support of benefit applications and requests to housing providers to offer more appropriate accommodation. Apart from Doctor E, there was no

consideration by other health professionals of contacting either CJSW or police prior to letters being issued or the resultant impact these may have. While some health professionals were aware of CJSW and police involvement, none were fully aware of their role and implications of managing an individual under statutory supervision, RSO notification and MAPPA. Doctor E was the only health professional invited to a MAPPA meeting.

5.5.6 All health professionals had limited knowledge of MAPPA, had not completed the MAPPA e-learning module, although not mandatory and were unaware of the MAPPA Health Manager and their role. Overall communication between Health and MAPPA partners could have been better. There were various opportunities for lines of communication to be established with and without the assistance of the MAPPA Health Manager, all agencies had opportunities which were either not taken or taken but not followed up to conclusion.
LEARNING POINT 7: All Agencies and **RECOMMENDATION 8**

5.6 LOCAL AUTHORITY CRIMINAL JUSTICE SOCIAL WORK (CJSW)

5.6.1 Person H was managed by the same CJSW supervising officer for the duration of his licence which provided consistency and allowed a good relationship to be established. Contact levels were set above minimum standards which is good practice but these enhanced levels were not always complied with. The Glasgow City Council Throughcare Guidance and the National Objectives and Standards (NOS) for Social Work in the Criminal Justice System provides minimum standards for contact levels, home visits and reviews. Although Licence Reviews and actions from MAPPA meetings detailed contact levels for supervision appointments there was never specific mention of home visits. **GOOD PRACTICE 4: CJSW** and **LEARNING POINT 8: CJSW & MAPPA**

5.6.2 CareFirst is the client-based recording system used by Glasgow Social Work Services. The CareFirst narrative should contain sufficient information to provide someone with no knowledge of the case with an understanding of that individual, their issues, risks, current management and involved agencies and personnel. This was not the case for Person H, his CareFirst record was not of the standard expected. Issues included, not all contact being recorded, no entries for a 6-week period, discrepancies in recorded information, engagement with other agencies not recorded, no continuity or follow up to information noted and entry dates for information not being reflective of the date of the event/information. The CJSW supervising officer provided personal emails detailing contact and work with other agencies but none of this was recorded. There was only one recorded check of case recording by a supervisor, this is normally done at every licence review. **LEARNING POINT 9: CJSW**

5.6.3 The ViSOR issues identified in the 2017 Joint Thematic Review of MAPPA were evident in Person H's ViSOR record despite there being significant discussion at both national and local level at this time. Person H's ViSOR record was populated with information from SPS and the MAPPA Coordinator but CJSW who were the lead agency for 2.5 years had no footprint on Person H's ViSOR record. The record was

maintained and managed solely by police. Information was shared at MAPPA meetings, licence reviews and direct communication between staff but there was a significant amount of information recorded on social work files and on ViSOR which was never shared. **RECOMMENDATION 9**

5.6.4 Person H engaged fully with CJSW and the other involved agencies including Glasgow Council on Alcohol, SACRO, Elevate and Marie Trust. Apart from one verbal warning for drinking excessively, there were no other issues, no concerns in respect of further drinking and never any indication of substance misuse. Person H participated in MFMC and completed all required modules and assignments.

5.6.5 CJSW involvement with Person H's family was mainly prior to his release from prison with limited involvement following release. While it was acknowledged his family could be difficult and challenging, attempts to engage with them may have assisted in corroborating Person H's lifestyle, movements and may have provided clarity regarding his relationship with Woman D. Person H denied having any form of sexual contact with anyone during his period on licence.

5.6.6 Woman D was 24 years old, both she and Person H intimated they were cousins, the exact family relationship was never confirmed. The Independent Reviewer established Woman D was his second cousin. They spent a considerable amount of time together and went away for weekends and holidays abroad. They stated they were just friends and denied being in a sexual relationship. Following the murder of Woman A, they continued to deny they were in a relationship despite Person H's family providing they had been in a relationship for over 18 months. During Person H's period of imprisonment, he was visited by another female cousin and following his release socialised and spent time with her. Contact stopped just before he started spending time with Woman D. Agencies did not meet her and again their relationship was never formally established. Agencies were unaware this cousin and Woman D **[Redacted]**.

5.6.7 The majority if not all information in respect of Person H was self-reported. While there are limitations to what can be tested and corroborated, if there are opportunities for this they should be taken. The curfew should have been tested and checked, contact should have been attempted with family members and especially females he was spending time with, and dialogue with health professionals would have shown whether he was providing consistent information to all agencies. **LEARNING POINT 10: CJSW & Police**

5.7 POLICE SCOTLAND

5.7.1 Police Scotland has dedicated units to manage RSOs, these are known as Sex Offender Policing Units (SOPU). Person H was managed by the same SOPU officer following his release from prison. This provided consistency and allowed a good relationship to be established with Person H and his CJSW supervising officer. Person H did not come to the adverse attention of police.

5.7.2 As part of the management and monitoring of RSOs, police undertake unannounced visits to their home address. There is no legal requirement on RSOs to comply with these visits. In respect of Person H, an enhanced visit regime was implemented following his release which was incrementally reduced over a period of time and in line with his behaviour and risk. This is considered good practice. **GOOD PRACTICE 5: *Police***

5.7.3 In the main visit regimes were complied with and visits carried out at various times of the day and various days of the week. As previously discussed, visits should have been completed during the curfew period. Home visits were carried out jointly by the SOPU officer and CJSW supervising officer but would have benefitted from occurring more often. **GOOD PRACTICE 6: *Police & CJSW***

5.7.4 The standard of visit updates was variable with evidence of cutting and pasting information from one visit to another, limited probing and very general and limited information recorded. These issues were highlighted by a supervisor and subsequent visit updates improved but there was still room for improvement. On 16/12/2020, Person H's licence expired, and social work involvement stopped. There were no concerns at this time but consideration should have been given to increasing home visits for a short time to ensure Person H's lifestyle remained stable during this period of transition. **LEARNING POINT 11: *Police***

5.7.5 Following expiry of Person H's licence there were some changes noted in his behaviour and demeanour and difficulty experienced getting him at home for a visit. He admitted drinking more than he had previously, but it was not considered problematic, and it was suspected he may have been taking illegal drugs. These were known areas of risk and rightly a review of visits was deemed necessary but was not actioned prior to the murder occurring. Increased visits may have provided a better understanding of Person H's lifestyle and whether the identified areas of risk were becoming problematic.

5.7.6 ViSOR is the main database used by police to record information on RSOs. Person H's ViSOR record contained visit updates and risk assessments but in the main was poorly populated with most attachments containing limited or no information.

5.7.7 Similarly, completion of all police Risk Management Planning documents was poor and not of the standard expected. In respect of Action & Update Documents none were fully populated, allocated actions were only updated as '*completed*', insufficient information was recorded which would provide supervisors with an overview of Person H's current circumstances and all documents were approved by supervisors despite not being fully completed. Likewise, Police Risk Management Plans were not always fully populated and supervisory acknowledgement not always adhered to. The Offender Profile was poorly populated with little research being carried out. The SOPU officer had known issues with their written work and assistance was being provided. Notwithstanding, overall defined practices and processes were not fully complied with and not challenged or addressed by supervisors. **LEARNING POINT 12: *Police***

5.7.8 The SOPU officer and CJSW supervisory officer had a good working relationship with visits and risk assessments being completed jointly. In addition, the SOPU officer attended licence reviews which is considered good practice. **GOOD PRACTICE 7: *Police & CJSW***

5.7.9 The majority if not all information gathered by police in respect of Person H was self-reported. Given Persons H's compliance and lack of intelligence or criminal behaviour there was no opportunity to consider more intrusive policing techniques, but a greater degree of professional curiosity would have been expected from officers.

5.7.10 Enquiries into the murder of Woman A identified Person H had been in a sexual relationship with a 33-year-old woman for a 4-week period. The woman had a history of alcohol and drug use and they met as she was residing in a hostel near to his home. The woman raised no complaints in respect of Person H. The change in Person H's behaviour and difficulties experienced visiting him may have been as a result of him concealing this relationship.

5.7.11 An Environmental Risk Assessment (ERA) was completed in respect of Person H's home address. The hostel was a Glasgow City Council Social Work Services Homelessness Emergency/Assessment Centre and was on the same street as Person H's home but did not fall within ERA parameters and was not mentioned by any of the agencies. Given the nature of the hostel and vulnerabilities of its residents, the expectation would have been for agencies to have local knowledge and considered it in the overall ERA.

5.8 ASSESSMENT OF RISK

5.8.1 The assessment of risk and the risk management plan it is intended to inform are only as effective as the information on which they are based. Risk assessment is not a precise science and relies on comprehensive information research, use of accredited risk assessment tools and ongoing information gathering. In respect of Person H, not all information was obtained or known in respect of the following:

5.8.2 **Offending History**

CJSW Reports and ICM Case Conference minutes noted Person H had a conviction for Section 38(1) Criminal Justice & Licensing (S) Act 2010 with a Domestic aggravator but there was no further research to confirm the exact nature of this offence. This was clearly marked as a domestic offence but there was a further domestic incident resulting in a conviction for Section 27(1)(a) Criminal Procedure (S) Act 1995 (Fail to Appear at Court) which was more difficult to identify. It was identified from information within the Modus Operandi (MO) chapter of Person H's Criminal History System (CHS) record. When completing court reports CJSW are provided with a CHS court print containing only previous convictions and not a full CHS print which would include the MO chapter.

5.8.3 These domestic incidents as detailed in paragraphs 3.4 and 3.5 were not known or considered in the risk assessment of Person H. The conviction for Rape was

considered an isolated incident with no precursor when in fact there had been two previous incidents of violence towards women although no apparent sexual element. If known, not only would it have indicated a pattern of domestic violence but would have shown a pattern of violent behaviour towards women with the use of strangulation evident in all three crimes. This information was available to police and with better research would have been identified. CJSW should have made further enquiry to establish the nature of the crime with the Domestic aggravator but would not have identified the second domestic incident. Providing CJSW with access to MO information for each conviction would benefit not only RSO risk assessments but the preparation of Criminal Justice Social Work Reports as a whole. **RECOMMENDATION 10**

5.8.4 **Health**

Person H had in the past attempted suicide the details of which were contained in his health and CareFirst records. This was not considered in his wider risk assessment. Following release from prison, Person H intimated to health professionals on two occasions that he had suicidal thoughts. This information was not shared with or known to CJSW or police.

5.8.5 Person H's involvement with mental health professionals was fully documented within his electronic and hard copy health notes and to a lesser extent within his CareFirst record. No research of these records was undertaken when there was confusion around his PTSD diagnosis. Similarly, Clinical Psychologists did not obtain hard copy notes which would have highlighted his previous trauma therapy undertaken by a member of staff they were currently working with. CJSW and police were aware of Person H's PTSD in name only and never explored this with Health professionals. They had no knowledge of how it manifested and if it impacted on his risk.

5.8.6 **Sexuality**

Prison intelligence provided Person H had a sexual relationship with another prisoner, but this was not shared with MAPPA and neither was information within his prison-based health records which supported this intelligence. ViSOR contained this same information but was not included in Person H's Offender Profile and did not appear to have been shared with MAPPA partners. Person H's sexuality was never considered in his overall assessment of risk.

5.8.7 **Family Circumstances**

There was confusion regarding Person H's family dynamics which in part was due to him referring to his grandfather as father and his uncles as brothers. There was no consideration of a family tree which may have clarified matters.

5.8.8 The pressures and demands made of staff are acknowledged and creating time for detailed research can be difficult but it is essential for accurate risk assessment. Information was recorded which with better research would have provided a fuller picture and greater understanding of Person H. Despite this, the Risk Assessment which formed part of the MAPPA Level 2 & 3 document set was well populated

based on the information known. Person H's assessed risk level of high was considered appropriate and would not have changed even if the information highlighted had been known. This information would have better informed the Risk Management Plan, areas of risk and subsequent actions required. **LEARNING POINT 13: All Agencies**

5.8.9 Risk Matrix 2000 (RM2000), Stable and Acute 2007 (SA07) and LS/CMI risk assessment tools were completed in respect of Person H. LS/CMI was completed but considered of limited value when used with sex offenders. RM2000 assessments were completed annually by police. These were correctly scored apart from the last assessment which was approved by a supervisor and scoring issues not identified. The only reference to a RM2000 assessment by CJSW was within licence reviews which was completed on 19/09/2018.

5.8.10 Two SA07 Stable assessments were undertaken jointly by CJSW and police. Both assessed Person H's risk as moderate and were correctly scored. Stable assessments were not completed annually for Person H and only one assessment was recorded on ViSOR.

5.8.11 Police SA07 Acute assessments were completed for every contact with Person H apart from two. The quality of evidence recorded to justify scoring was poor and called into question the SOPU officers understanding of the risk assessment tool and overall understanding of risk. Assessments were approved by several different supervisors and the content never questioned. Capacity, volume of work and increased demands when colleagues are absent may account for assessments being approved somewhat robotically without any real consideration of content and standards, but the issues were obvious and easily identifiable. As highlighted in Learning Point 12, supervisors must challenge and address issues and reinforce practice and process standards. In February 2021, Police Scotland introduced a mandatory eLearning annual assessment for SA07/RM2000 to reinforce and test practice. Person H's SOPU officer did not complete this training. **LEARNING POINT 14: Police**

5.8.12 CJSW should complete SA07 Acute assessments for every contact with an individual but the practice has been for supervision appointments to be framed around obtaining the required information for assessment without it being formally scored and only scored when there is a change. There is no defined policy for the completion and recording of these assessments. 11 assessments were formally recorded out of 45 contacts with Person H, the first being 6 months after Person H's release from prison. Only the overall risk level was recorded with no scoring or formal rationale for scoring noted. There was no formally recorded baseline assessment against which subsequent assessments could be compared and not all the desired elements of the assessment were recorded at every contact. **RECOMMENDATION 11**

6. CONCLUSION

6.1 The primary aim of MAPPA is to protect the public and manage the risk of serious harm posed by offenders. This risk can be managed but never eliminated, and unfortunately offenders will continue to offend despite the best efforts of agencies to prevent this.

6.2 MAPPA and the management of RSOs is a challenging and demanding working environment with the professionalism and dedication of staff rarely acknowledged or praised. MAPPA annual reports provide the vast majority of RSOs are effectively managed and only a very small minority seriously reoffend. When this occurs, it is right this is subject of scrutiny, but only for the purpose of reviewing practice and policy and to identify and share learning.

6.3 The murder and rape of Woman A was a brutal and horrific act which has had a devasting effect on her family, friends, and local community. Person H, and Person H alone was solely responsible for this crime. There were no known connections between Person H and Woman A, the crime was a spontaneous and opportunistic attack carried out against a stranger. His level of intoxication, apparent anger and rejection resulting from the earlier altercation and parting company with family may have been the catalyst to the events which lead to the death of Woman A. It is the opinion of the Independent Reviewer this crime could not have been predicted or prevented.

6.4 Person H had a complex and challenging childhood with a number of adverse events which affected him into adulthood. He was involved in two reported incidents of domestic violence prior to the rape of a 50-year-old woman which was his only known sexual crime. This was a significant escalation from his previous offending when considering the level of violence and nature of the crime. Similarly, following release from prison he had a sustained period of compliance with no further offending until the murder and rape of Woman A. The circumstances of this were similar to the rape in 2013 and Woman A fell within Person H's victim profile.

6.5 Person H was actively supervised and managed by CJSW and police and involved with mental health professionals and a variety of other agencies. He was well supported in the key areas of his life. Multi agency information sharing was evident through MAPPA meetings, Licence Reviews, and direct communication between staff but was not always effective. The quality of information presented at MAPPA meetings was variable, required staff not always in attendance, pertinent information not always shared and there was no auditable trail detailing how actions had been discharged. There was active risk management but a reliance on self-reported information. Opportunities to test and verify information were not exploited and a greater degree of professional curiosity would have been expected from staff.

6.6 The benefits of having a MAPPA Health Manager were not fully realised with available health information not shared and no direct communication established

between CJSW, police and the main Health professionals involved with Person H. Health professionals had limited knowledge of MAPPA.

6.7 Better background research by all agencies and direct communication with health professionals would have enhanced Person H's overall risk assessment, identified new areas of risk, and would have led to a more informed and focused Risk Management Plan but would not have changed his overall MAPPA risk level which was deemed appropriate.

6.8 Case recording and record keeping by CJSW and Police were not of the standard expected. Similarly, policy and practice standards in a number of areas were not complied with and not challenged by supervisors. This had an impact on the quality of risk assessments and effectiveness of risk management plans. ViSOR, the agreed system used by MAPPA to facilitate the secure exchange and storage of information was not used by CJSW.

6.9 A number of recommendations and learning points have been identified. It is the opinion of the Independent Reviewer these would have enhanced and improved the risk assessment and risk management of Person H but would not have influenced or had a bearing on the circumstances leading to the murder and rape of Woman A. If implemented these will improve and enhance MAPPA and the management of RSOs and will assist in better protecting the public from harm.

RECOMMENDATIONS

RECOMMENDATION 1: The Scottish Prison Service review the timescales for completing Generic Programme Assessments and presentation at the Programme Case Management Board.

RECOMMENDATION 2: The Scottish Prison Service review the management of programme waiting lists and ensure adequate provision of SCPs and MF2C programmes taking cognisance of demand, location, and prisoner progression.

RECOMMENDATION 3: The Scottish Government in consultation with the Responsible Authorities considers the provision of alcohol and substance testing for all individuals with an appropriate licence condition.

RECOMMENDATION 4: The Scottish Government in conjunction with the Scottish Prison Service, Local Authority PBSW and prison-based NHS review practice and policy to provide consistent attendance and appropriate representation at required MAPPA meetings.

RECOMMENDATION 5: The NHS review the MAPPA Health Managers role requirement and include provision to produce and submit written MAPPA pre-read documentation.

RECOMMENDATION 6: Glasgow MAPPA Strategic Oversight Group considers a governance process to manage and monitor outstanding actions when individuals are reduced from MAPPA level 2 to MAPPA level 1.

RECOMMENDATION 7: The NHS produces a reference/guidance document for MAPPA partners outlining NHS systems, health alerts and procedures for requesting and implementing MAPPA health alerts.

RECOMMENDATION 8: The NHS raise awareness of the MAPPA Health Manager and their role with staff, consider a review of MAPPA eLearning to include the operational responsibilities of MAPPA partners and how this may link with Health, consider a MAPPA information leaflet for staff, and introduce a programme to maintain awareness of MAPPA with health professionals.

RECOMMENDATION 9: The Glasgow MAPPA Strategic Oversight Group take positive action to progress the use of ViSOR by local authority CJSW.

RECOMMENDATION 10: Local Authority Social Work in consultation with Police Scotland and Scottish Courts and Tribunal Service review the information provided by a CHS court print.

RECOMMENDATION 11: Glasgow Local Authority Social Work review the practice for recording SA07 Acute Assessments and consider introducing formal policy.

LEARNING POINTS

LEARNING POINT 1: SPS – ICM Coordinators should ensure prison intelligence systems are researched and where appropriate include any relevant intelligence in MAPPA referrals and share with MAPPA partners.

LEARNING POINT 2: CJSW - When requesting specific licence conditions these should be fully considered taking into account the options available, resourcing requirements, and planned supervision. If a condition is no longer deemed necessary, this should be documented, and a request made to the Parole Board to have it removed.

LEARNING POINT 3: CJSW – Licence conditions should be listed and included in Licence Reviews as a reminder to the individual, CJSW supervising officer and supervisor.

LEARNING POINT 4: MAPPA – The MAPPA Coordinator and MAPPA Chairs should ensure MAPPA pre-read information is submitted, is of an acceptable standard and MAPPA minutes contain sufficient information to detail how actions have been addressed or discharged.

LEARNING POINT 5: CJSW & Police – Staff should ensure updates provided for all MAPPA meetings are representative of the circumstances and issues for the individual at that time.

LEARNING POINT 6: All agencies – While it is good practice to have a MAPPA Health Manager, there should always be consideration of inviting health professionals to MAPPA meetings and having ongoing direct contact with them.

LEARNING POINT 7: All Agencies – Where it is known or suspected other agencies are involved with an individual, staff should take responsibility to identify those involved, make initial contact, establish lines of communication, and share and request information when appropriate.

LEARNING POINT 8: CJSW & MAPPA – During Licence Reviews or at MAPPA meetings when considering social work contact with an offender any resultant actions should specify contact levels for both supervision appointments and home visits.

LEARNING POINT 9: CJSW – Case recording standards should be continually reinforced and discussed at supervisory sessions with staff and regularly checked on CareFirst and EDRMS.

LEARNING POINT 10: CJSW & Police – Staff should not solely rely on self-reported information and where possible all opportunities should be taken to test and corroborate information provided.

LEARNING POINT 11: Police – Consideration should be given to increasing visit regimes following expiry of a licence or withdrawal of agency involvement.

LEARNING POINT 12: Police – Supervisors should continually challenge and address the standard of information gathered and recorded and reinforce practice and process standards.

LEARNING POINT 13: All Agencies – An accurate risk assessment is based on thorough research and sharing of relevant information.

LEARNING POINT 14: Police – Risk assessment trained SOPU officers must complete an annual eLearning assessment for RM2000/SA07.

AREAS OF GOOD PRACTICE

GOOD PRACTICE 1: MAPPA – It is considered good practice to have a MAPPA meeting/s in advance of an individual's release from prison.

GOOD PRACTICE 2: MAPPA – It is considered good practice to have a consistent MAPPA chair to provide continuity and understanding of each case.

GOOD PRACTICE 3: MAPPA – It is considered good practice to have a MAPPA Health Manager.

GOOD PRACTICE 4: CJSW – It is considered good practice to implement enhanced contact levels but to be effective these must be achieved and maintained.

GOOD PRACTICE 5: Police – It is considered good practice to implement enhanced visit regimes.

GOOD PRACTICE 6: Police & CJSW – It is considered good practice for police and social work to undertake joint home visits.

GOOD PRACTICE 7: Police & CJSW – It is considered good practice for police to attend and participate in licence reviews and for risk assessments to be completed jointly.