MULTI AGENCY PUBLIC PROTECTION ARRANGEMENTS (MAPPA) SIGNIFICANT CASE REVIEW

PERSON H

Registered Sex Offender

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

6th of April 2023

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**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 Requests for consent to re-identify should be addressed to Glasgow City Council’s data protection officer at [dataprotection@glasgow.gov.uk](mailto: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

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# INTRODUCTION

* 1. On 15 October 2021 at Glasgow High Court, Person H pled guilty to and was convicted of Murder and Section 1 Sexual Offences (Scotland) Act 2009 (Rape) of Woman A, which had occurred on 28 May 2021. On 17 November 2021, he was sentenced to life imprisonment with a minimum punishment part of 19 years for Murder and 80 months imprisonment for Rape.
  2. At the time of this offence, Person H was a Registered Sex Offender (RSO) being managed under Multi Agency Public Protection Arrangements (MAPPA) within the Greater Glasgow Local Authority area. Person H was one of 839 RSOs registered within Police Scotland’s Greater Glasgow Division, 616 of which were resident in the community and the remaining 223 in prison. Nationally there were 5,852 RSOs in Scotland, 4,355 resident in the community and 1,497 in prison.
  3. 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).

# TERMS OF REFERENCE AND METHODOLOGY

**2.1 AIM**

The aim of this SCR is 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.

**2.2 ANTICIPATED OUTCOMES**

The anticipated outcomes will include:

* The identification of areas of good practice.
* The identification of areas of practice, management, or policy that can be improved to better protect the public and support the needs of offenders.
* Establishing whether single and multi-agency working could have improved the risk management of Person H in respect of the risk of sexual violence he presented.

**2.3 OBJECTIVES**

To examine how Person H was managed between 11 October 2013 to 4 June 2021; the date convicted of rape and placed on the Sex Offenders Register to the date arrested for the murder and rape of Woman A and:

* Establish a chronology or timeline to include all relevant events/meetings /discussions/contact with the offender and or the victim.
* Establish the circumstances culminating in the serious harm to the victim.
* Examine the role of the responsible authorities, duty to co-operate partners and any other agencies involved in the management of the offender.
* What was the risk formulation for Person H, and the associated limitations of the risk formulation?
* Examine critical decision-making processes relating to offence focused interventions and how this informed care planning and risk assessment relating to the previous index offence.
* Examine the extent of the contact between Person H and Woman A prior to the attack and establish whether there were any opportunities for agencies to have identified this and intervened to protect her.
* Establish what lessons can be learned from the case, and where consideration is being given to making a recommendation of national significance, the independent reviewing officer or Strategic Oversight Group chair must consult in advance with the relevant national body.

**2.4 METHODOLOGY**

The methodology employed to undertake this SCR consisted of the following:

1. **INFORMATION GATHERING & REVIEW**

The involved agencies were asked to provide all paper and electronic documents in respect of their involvement with or management of Person H. Where these documents could not be sent, they were viewed by the Independent Reviewer within hard copy folders or on electronic systems held within agency premises. Information out with the identified timeframe was requested to provide additional background information. All information received was documented, reviewed, analysed, and used to complete a chronology and identify key individuals for further consultation.

1. **CONSULTATION WITH KEY MEMBERS OF STAFF**

Key members of staff identified as having a significant role in the management of Person H or who could assist in identifying learning points/good practice were asked to participate in a meeting with the Independent Reviewer. This allowed them to provide their own accounts and views and clarify or confirm information obtained during the document review. Professionals were also identified to provide expert knowledge and advice in respect of practices, procedures, and policies within their respective agencies.

1. **REPORT FINDINGS**

Provide a formal written report and chronology.

**2.5 LIMITATIONS OF THE METHODOLOGY**

It was a decision of the SOG that Person H would not be offered the opportunity to participate in the SCR process.

All information for this SCR has been obtained from agencies involved with Person H. It should be noted that some of this information was previously provided by Person H and his family, the veracity of which cannot be confirmed.

# INDEPENDENT REVIEWER

* 1. 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.
  2. 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) for the previous 5 years. She has a wealth of experience, having been involved in the management of RSO’s since 2004, holding operational, strategic, policy and training roles. In June 2019, Mrs Johnston was awarded the Queen’s Police Medal in recognition of her work within Sex Offender Management.

* 1. Mrs Johnston would like to thank all members of staff for their participation, support, and assistance in this SCR.

# MURDER AND RAPE OF WOMAN A

**[Redacted – full version of section 4 and replaced with executive summary]**

* 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. 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.

# BACKGROUND AND OFFENDING HISTORY

**[Redacted – full version of section 5 and replaced with executive summary]**

* 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.
  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. 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:
  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.

* 1. **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.

* 1. **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.

* 1. 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.

# MULTI AGENCY PUBLIC PROTECTION ARRANGEMENTS (MAPPA)

* 1. The primary purpose of MAPPA is public protection and managing the risk of serious harm.

* 1. MAPPA is not an agency, department, or statutory body, but a set of statutory arrangements designed to facilitate the effective multi-agency management of the following category of offenders:
* Registered Sex Offenders
* Restricted Patients
* Other Risk of Serious Harm Offenders
  1. MAPPA was introduced to Scotland on 1 April 2007 by virtue of Sections 10 and 11 of the Management of Offenders etc. (Scotland) Act 2005 and places a statutory duty on the Responsible Authorities in a local authority area to jointly establish arrangements for assessing and managing the risk posed by the above categories of offenders.
  2. The Responsible Authorities are:
     + The Chief Constable of the Police Service of Scotland
     + The Local Authority
     + A Health Board or Special Health Board for an area any part of which is comprised within the area of the local authority; and
     + Scottish Prison Service
  3. The Responsible Authorities are supported by Duty to Cooperate (DTC) agencies, and in general includes Health Boards, Social Security Scotland, Registered Social Landlords, Electronic Monitoring Service Providers and Scottish Children’s Reporter Administration.
  4. Health Boards are a Responsible Authority in respect of Restricted Patients but additionally are a DTC agency and have a duty to co-operate with other agencies for all individuals subject to MAPPA.
  5. MAPPA National Guidance provides the framework under which MAPPA operates, identifying the three levels at which risk can be assessed and managed. These risk management levels are:
* Level 1 – Routine Risk Management
* Level 2 – Multi-Agency Risk Management; and
* Level 3 – Multi Agency Public Protection Panels (MAPPP)
  1. The risk management structure is based on the principle that individuals should be managed at the lowest MAPPA level commensurate with delivering a defensible risk management plan designed to address the risk of serious harm posed by them.
  2. Risk of serious harm is defined as: ***‘the likelihood of harmful behaviour of a violent or sexual nature which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, may reasonably be expected to be difficult or impossible’*.**
  3. For MAPPA purposes the imminence and likelihood of risk of serious harm is classified as follows:
* **Very High** – there is an imminent risk of serious harm. The potential event is more likely than not to happen imminently, and the impact would be serious.
* **High** – there are identifiable indicators of risk of serious harm. The potential event

could happen at any time and the impact would be serious.

* **Medium** - there are identifiable indicators of risk of serious harm. The individual has the potential to cause such harm but is unlikely to do so unless there is a change in circumstances, for example failure to take medication, loss of accommodation, relationship breakdown, drug, or alcohol misuse.
* **Low** – current evidence does not indicate likelihood of causing serious harm.

# The Violent and Sex Offender Database (ViSOR)

* + 1. ViSOR is a secure Home Office database used across the UK and Northern Ireland by all police forces, Probation Trusts and HM Prison Service. In Scotland it is used by all MAPPA Responsible Authorities.
    2. ViSOR provides a central repository for up-to-date information about all individuals managed under MAPPA that can be accessed and updated by the Responsible Authorities.
    3. The benefits of using ViSOR are:
* Provision of a secure database enabling the safe retention and prompt sharing of sensitive risk management information on all individuals managed under MAPPA.
* Capacity to share intelligence and facilitate the safe transfer of key information when relevant offenders move between areas.
* It acts as a central store for the minutes of MAPPA meetings.
* Production of consistent management information to support the strategic oversight and management of the MAPPA arrangements in Scotland, informing consideration of effective performance and contributing to improved working practices.
* Provision of information for MAPPA annual reports.
  + 1. All individuals subject to MAPPA should be recorded on ViSOR, including those currently serving custodial sentences. All live ViSOR records should be actively and accurately maintained and updated by the lead agency, record managers and relevant partners.
    2. The 2016 MAPPA National Guidance was revised, and new guidance published on 31 March 2022. In the 2016 guidance, ViSOR was recorded as “***the agreed system used by MAPPA to facilitate the secure exchange and storage of information***”. The new 2022 guidance has changed to, “*ViSOR is one of the systems used by MAPPA to facilitate the secure exchange and storage of information*”.
    3. ViSOR was introduced to Scotland in 2005 for police, 2007 for local authority social work and thereafter for the Scottish Government Restricted Patients Casework Team and SPS. The use of ViSOR in Scotland has proved challenging given the classification of information held on the system and security measures required. Staff must be vetted, and ViSOR terminals are stand-alone systems with specific security measures dictating where they can be located. Vetting requirements, terminal access, double keying, and the fallacy ViSOR is a police system and not a Home Office system to be used by all MAPPA agencies has resulted in limited use of the system by local authority social work. This varies from one local authority to another with some areas using it more than others and others not using it at all. SPS and the Restricted Patients team have small centrally located teams who use ViSOR on behalf of their agencies. Police have the necessary vetting, IT security and infrastructure to allow ViSOR to be on desktops and is used routinely by SOPU staff and other appropriate officers.
    4. These ongoing long-term ViSOR issues were highlighted in the 2017 Joint Thematic Review of MAPPA in Scotland by Her Majesty’s Inspectorate of Constabulary in Scotland (HMICS) 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.
    5. The new 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 MAPPA 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.

# AGENCY INVOLVEMENT & KEY FINDINGS

**8.1 INTRODUCTION**

8.1.1 This section of the report will consider agency involvement and highlight areas of good practice and discuss practice and policy issues, this is for the purpose of improving practice and sharing learning. Notwithstanding, a SCR is one individual case with its own distinctive set of circumstances. As a result, 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 the learning, they do not necessarily require a recommendation. Findings will be categorised as follows:

**Good Practice:** Areas of good practice which should be acknowledged and shared.

**Learning Point**: Findings that do not necessarily require action or review but highlight learning. This would include practice unique to individuals’, appropriate practice/policy exists but has not been fully or correctly interpretated or issues not fully considered.

**Recommendation**: Findings that require action as there is no current practice/policy or there are identified issues with current practice/policy.

8.1.2 During the period of review, Person H was:

* a remand and long-term prisoner with the Scottish Prison Service,
* subject of a non-parole licence supervised by CJSW,
* a RSO managed by police,
* involved with mental health services in prison and in the community, and
* being managed under MAPPA.

8.1.3 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.

8.1.4 The following sections will examine the involvement of each agency, the operation of MAPPA and the assessment of risk of Person H:

**8.2 SCOTTISH PRISON SERVICE (SPS)**

8.2.1 Person H entered HMP Barlinnie on 17/06/2013 and spent almost 6.5 months on remand prior to being sentenced to 7 years & 6 months imprisonment for rape. As a long-term prisoner and RSO, he was transferred to HMP Glenochil on 28/03/2014 and remained there for the duration of his sentence. He had no community access.

8.2.2 On 13/03/2015, a Generic Programme Assessment (GPA) was completed for Person H. This considers what programmes are most appropriate for the prisoner and leads to the development of a programme plan. The GPA is presented to the Programme Case Management Board (PCMB) who decide what programmes are appropriate. Only after this ratification will a prisoner be placed on a programme waiting list. The PCMB met on 21/04/2015 and agreed Person H had two primary needs:

* Substance Related Offending Behaviour Programme (SROBP) - Identified as a primary need to address his substance misuse and related offending behaviour.
* Moving Forward Making Changes (MFMC) Programme - Identified as a primary need to address his sexual offending behaviour.

8.2.3 These programmes are not mandatory and there is no requirement on prisoners to participate. There are no penalties for refusing to participate but failing to engage in offence focussed work could impact on a prisoner’s progression through sentence and consideration of parole. Person H agreed to participate in both programmes.

8.2.4 Person H completed the SROBP, his participation within the group was variable but overall made positive progress. He also completed a SMART recovery course for alcohol and drug use and attended the Sycamore Tree project run by chaplaincy. This is not a formal intervention, purely voluntary and is a restorative justice/victim awareness course.

8.2.5 Person H was placed on the MFMC waiting list on 21/04/2015 with programmes only delivered at HMP Glenochil, HMP Barlinnie, HMP Edinburgh and HMP Polmont (youth offenders). A national waiting list was in operation so no matter where a prisoner was located, they were added to the list and on reaching the top attended the prison delivering MFMC. Positions on the list were not static and dictated by critical dates such as Parole Qualifying Date (PQD) or Earliest Date of Liberation (EDL). As a result, a prisoner could be 10th on the list one week and 15th the next depending on the critical dates of others. The requirement to move establishments to participate on a programme is not mandatory and prisoners must consent to any transfer.

8.2.6 Person H confirmed he would engage in MFMC in HMP Glenochil or Barlinnie but not Edinburgh. A Report for Release on Parole Licence by Prison Based Social Work (PBSW) dated 18/11/2016 noted Person H was over 100th on the national MFMC waiting list and would be unlikely to access a programme within the next 12 months or even prior to his EDL. Person H appeared motivated to engage with MFMC but was frustrated he had been unable to access a programme.

8.2.7 Person H being a long-term determinate sentence prisoner was entitled by law to be considered for parole once he had served half of his sentence, known as the PQD. On 17/01/2017, a Parole Board Hearing noted in many respects Person H had been a model prisoner but the one crucial element of work that needed to be undertaken had not been, namely MFMC. Consequently, the key causes of the index offence had not been explored or addressed and the Board unanimously agreed not to recommend parole. Convicted prisoners have the right to treatment if deemed appropriate, rehabilitation and be offered a clear pathway to progression at the earliest opportunity, whether they agree to participate is a personal choice. Person H agreed to participate in MFMC but was not offered a programme prior to his PQD. Participation in MFMC was the only reason parole was not recommended.

8.2.8 Following the Parole Boards decision, Person H was approached on three occasions regarding MFMC selection boards but declined the programmes as he did not want to move to another prison to participate. He did not participate in MFMC prior to being released.

8.2.9 Timescales, waiting lists and programme availability all impacted on MFMC provision. Person H was placed on the MFMC waiting list after a GPA and PCMB meeting, some 13 months after being transferred to HMP Glenochil. SPS intimated this was not unusual due to prisoner numbers and allowing prisoners time to settle into their sentence. While this is acknowledged and may be appropriate for longer term prisoners, a quicker process would have added Person H to the waiting list sooner and may have provided greater opportunity of a programme place prior to his PQD.

8.2.10 A report on 18/11/2016, highlighted Person H was over 100th on the MFMC waiting list, some 19 months after being placed on the list and just 2 months prior to his PQD Parole Board Hearing. While positions on the list are not static and are managed by critical dates, no reason was recorded as to why Person H was not offered a programme prior to his PQD.

8.2.11 The following table 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 |

8.2.12 In 2021, SPS introduced the Self-Change Programme (SCP) to replace MFMC, this is a programme for men convicted of sexual violence and assessed as high risk of causing harm. Additionally, a further programme, MF2C is being jointly developed with community partners for men convicted of sexual violence and assessed as medium risk of causing harm. It is positive that more offender specific and tailored programmes are being introduced.

8.2.13 Pilots of SCP were initiated in late 2021 in HMP Glenochil and HMP Edinburgh and remain ongoing. Each prisoner on the MFMC waiting list will be reviewed and a decision made on the most appropriate programme. These reviews remain ongoing with some limited provision of MFMC until programmes are fully operational.

8.2.14 The delivery of these new programmes and impact on the waiting list is currently unknown. The fact MF2C is only 4-5 months duration should provide a greater throughput of prisoners but will be dependent on staffing and programme delivery.

**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*.***

8.2.15 Enhanced Integrated Case Management (ICM) was implemented for Person H within defined timescales with a total of four Case Conferences held between 08/07/2014 and 15/03/2018. All relevant persons attended including family of Person H. Minutes of these case conferences were shared with CJSW and police.

8.2.16 The ICM Coordinator submitted two MAPPA referrals for Person H, one prior to his PQD Parole Hearing and the other prior to his release, both were well populated. The referral prior to release noted Person H had 11 mandatory drug tests all of which were negative, no further information was recorded in respect of any drug use or concerns and there was no evidence to suggest any sexualised behaviour in custody. Notwithstanding, the Independent Reviewer was provided with an Intelligence Summary Report containing all prison-based intelligence relating to Person H. This included 3 reports of Person H selling his prescribed medication, 2 reports of his involvement in dealing cannabis and a report he was in a sexual relationship with another prisoner. None of this information was included in the MAPPA referrals. It is acknowledged this information is classed as intelligence and cognisance must be taken of source and information/intelligence evaluation. Notwithstanding, it would still have been valuable to those managing Person H in the community and assessing areas of risk.

8.2.17 SPS confirmed the ICM Coordinator was provided with ‘Establishment Prisoner Intelligence Read Only’ access to prison intelligence on 8 August 2017. He therefore did not have access to this information when the first referral was submitted but it was available when the second was submitted and should have been included. This would allow for more informed decision making when considering a prisoners’ assessed areas of risk, plans for reintegration and management within the community and sharing of all relevant information with partners. Police can request intelligence from SPS and share it with MAPPA partners when appropriate to do so but this should not be the routine pathway for accessing or sharing SPS intelligence within the MAPPA arena. It was noted police did obtain intelligence from SPS in respect of Person H, but this was only in respect of his sexual relationship with another prisoner.

**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.**

**8.3 NON-PAROLE LICENCE**

8.3.1 Person H was released from prison on 15/06/2018 on a non-parole licence with expiry on 16/12/2020. Full conditions of the licence are recorded in Appendix B. The purpose of licence conditions is to protect the public, prevent re-offending and help secure successful re-integration back into the community. The conditions are intended to be preventative rather than punitive. Supervision to ensure compliance with licence conditions is the responsibility of CJSW.

8.3.2 At the pre-release MAPPA meeting on 08/05/2018, a curfew was discussed with the panel agreeing it may assist in the risk management of Person H. A request was made to the Parole Board, which was approved, and the following condition included 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’*. Staff were unable to provide why a curfew and not an electronic tag had been requested.

8.3.3 Within MAPPA Level 2 meeting minutes there was limited discussion in respect of the curfew. An update by CJSW on 03/07/2018, provided the curfew was 10pm-7am. The MAPPA meeting on 18/09/2018 agreed the curfew should remain in place and MAPPA meeting on 11/12/2018 reduced it incrementally, initially by one day and if no issues then by a further day. No specifics of the days to be relaxed were recorded with the assumption this would be agreed at an operational level. An update by the Sex Offender Policing Unit (SOPU) officer at this meeting provided the curfew was 11pm-7am with no issues arising. There was no mention of the curfew within the 4 MAPPA Level 1 meeting minutes.

8.3.4 CareFirst is the Glasgow Social Work Services Client Based Recording System. There were four case notes on CareFirst which detailed the curfew, the first on 03/07/2018 and the last on 18/12/2018. The curfew was initially recorded as 10pm-7am and a week later as 11pm-7am, no explanation was provided for the change. The CJSW supervising officer provided the standard curfew time would be 10pm-7am but could not explain why 11pm was recorded. On 18/12/2018 it was noted the curfew would be relaxed for two nights per week and these would be agreed in advance with the supervising officer. Specified days when the curfew would be relaxed over the festive period were recorded but no other days after this. There was no further record of the curfew on CareFirst and no mention of it in licence reviews or social worker supervision meetings.

8.3.5 The ViSOR record for Person H was maintained by police, the only reference to the curfew was the information contained in MAPPA minutes and an Activity Log dated 18/12/2018 containing an email from CJSW detailing the relaxation of the curfew over the festive period. This resulted in the SOPU officer circulating an ebriefing to local policing detailing Person H’s curfew (11pm-7am) and relaxation over the festive period. Details of the curfew were not recorded on the Scottish Intelligence Database which is a system available to all Police Scotland officers.

8.3.6 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 and any subsequent variations could not be established from agency records or meetings with staff.

8.3.7 The CJSW supervising officer provided Person H agreed to and responded well to having a curfew but acknowledged compliance with this was based purely on self-report. There were no plans by the CJSW supervising officer or actions raised at MAPPA to actively supervise the curfew. There was an assumption by CJSW and the MAPPA chair this would be done automatically by police. This in part may have been a result of discussion at the pre-release MAPPA meeting when police stated an early morning/late night curfew from a police perspective would be easier to 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.

8.3.8 As part of Person H’s management as an RSO, the SOPU officer carried out unannounced visits to his home address. This officer was not specifically tasked, but as they worked shifts including a 2pm-12pm shift and were aware of the curfew, the expectation would be for some visits to be completed during curfew hours. No visits were carried out during the curfew period with the latest visit recorded at 9.10pm. There were no actions given to or raised by police to assist CJSW in managing the curfew.

8.3.9 Despite the fact a curfew was deemed necessary to assist in the risk management of Person H, 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 that 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** - **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.**

8.3.10 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 as directed by your supervising officer” and “Undertake testing, random or otherwise, for substances as directed by your supervising officer”.**

8.3.11 Person H had a history of alcohol and drug use which was linked to his criminal offending. On release from prison this did not appear problematic and although referred to Glasgow Council on Alcohol (GCA) was closed off as he was assessed as not having any addiction issues. There was one lapse on 02/08/2018 when he reported being the victim of a robbery and was extremely intoxicated. He thereafter reported drinking in moderation if at all and denied any substance misuse. Both CJSW and police saw no evidence of either excessive alcohol use or use of illegal substances during his period of licence.

8.3.12 From 03/02/2019 to 14/02/2019, CJSW and Police received approximately 6 anonymous calls stating Person H was breaching his licence conditions by drinking excessively and taking illegal drugs. Person H denied these allegations and no drug tests were carried out. On 19/09/2019, CJSW received a further anonymous call stating Person H was abusing drugs and involved in criminality. On 20/09/2019, Person H was subject of a random drugs test which was negative.

8.3.13 CJSW intimated they were unable to undertake either alcohol or substance tests for Person H as he did not fit the criteria for testing and the test that was completed was very much an obligement, not within the approved process and a one off. For testing to be undertaken, the individual must be open to Addiction Services and be prescribed medication such as methadone for substance misuse or specific drugs for alcohol abuse. As the individual is on prescribed medication and health services are managing their treatment they can legitimately test to monitor and manage any suspected alcohol/substance misuse and the impact this may have with prescribed medication and on their health. Out with this Health are unable to test and no other resources are available to CJSW for testing.

8.3.14 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. If testing was made readily available for all, it would assist in identifying substance/alcohol misuse at an early stage, allow for early intervention and possibly prevent it becoming problematic. It would also allow suspicions and allegations to be immediately acted upon, provide quick definitive answers, and reduce the workload for staff trying to establish the facts by other means. This issue is not unique to Glasgow and is replicated across the country.

**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*.***

8.3.14 Following an incident on 02/08/2018 when Person H had been drinking, was extremely intoxicated and reported being the victim of a robbery, he was given a verbal warning by his CJSW supervising officer and signed an alcohol contract. This contract contained an additional condition under licence condition number 3 and stated, ‘*You shall not consume any alcohol without the express written approval of your supervising officer*’.

8.3.15 A CareFirst case note on 07/08/2018 recorded a verbal warning was given but MAPPA meeting minutes for 18/09/2018 and licence review on 19/09/2018 recorded Person H had been given a written warning and signed an alcohol contract. The CJSW supervising officer confirmed it was a verbal warning and signed alcohol contract and could not account for the discrepancies in recording. Case recording issues highlighted in this section will be considered with others in the Local Authority CJSW section of the report.

**8.4 MAPPA**

8.4.1 Person H was a MAPPA offender by virtue of his RSO status. MAPPA referrals were submitted by SPS at appropriate times and Person H was correctly assessed as meeting MAPPA level 2 criteria. A total of eight MAPPA meetings were held, four at MAPPA level 2 and four at MAPPA level 1. All meetings were held within prescribed timescales. A pre-release MAPPA level 2 meeting was held a month prior to Person H’s release from prison. While this is considered routine for MAPPA level 2 and 3 offenders, this is not always the case for those assessed as MAPPA level 1. This allowed necessary plans and actions to be implemented in advance of his release.

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

8.4.2 CJSW were the lead agency in respect of Person H as he was subject of statutory supervision. Within Glasgow, MAPPA meetings are chaired by representatives from the lead agency. MAPPA level 2 meetings are chaired by either a social work Service Manager or Detective Inspector and MAPPA level 1 meetings by a social work Team Leader or Detective Sergeant.

8.4.3 During Person H’s period of licence, all MAPPA level 2 meetings were consistently chaired by the same Service Manager and MAPPA level 1 meetings by the same Team Leader apart from one. When the licence expired on 16/12/2020, police became the lead agency, the first police led MAPPA level 1 meeting was scheduled for June 2021 but did not take place due to Person H’s arrest for murder. Having a consistent Chair ensured continuity and a good understanding of the case.

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

8.4.4 Attendance and agency representation at MAPPA level 2 meetings was good, but issues were noted with prison-based staff. CJSW and police attended all meetings with representation from both frontline staff (CJSW supervising officer and SOPU officer) and their respective supervisors (Team Leader and Detective Inspector). Health was represented by the MAPPA Health Manager who attended all meetings. The MAPPA Health Manager 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. Attendance by Third Sector organisations such as Turning Point Scotland, Marie Trust etc was also considered good.

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

8.4.5 Staff at HMP Glenochil including the ICM Coordinator, PBSW and Mental Health Nurse were invited to Person H’s pre-release MAPPA meeting. All tendered apologies resulting in no prison-based representation at the meeting, and in addition, no further update was provided. Person H had been the responsibility of SPS, PBSW and prison-based NHS for a 5-year period, therefore their attendance would have provided invaluable information to inform risk formulation and risk management.

8.4.6 Attendance of prison-based staff at MAPPA meetings was described as an ongoing issue, with limited attendance. Attendance by staff at HMP Glenochil was considered particularly problematic. The majority of RSOs are held at HMP Glenochil, therefore there is an increased 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:** **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.**

8.4.7 Part of the MAPPA process is pre-MAPPA meeting information sharing, this is facilitated by the MAPPA Coordinator who requests a written update from each agency. This information is used to populate a pre-read document which is shared with all attendees prior to the meeting. This reduces the time spent exchanging information, allows the focus to be on current issues and areas of risk and greatly assists MAPPA Chairs. The pre-read written submissions for Person H’s MAPPA meetings from all agencies 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 the Glasgow MAPPA SOG. They initiated a review in late 2018, resulting in improved practice and a vastly improved written pre-read document. Despite this, the MAPPA Health Manager continued not to submit any written updates for meetings attended.

8.4.8 It was noted there was insufficient information recorded in MAPPA minutes for Person H either in pre-read written submissions, verbal updates at meetings or updates on the Action Log to detail 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 lack of information as an issue and since early 2019 documents must now include a full update detailing how allocated actions have been addressed or discharged.

**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.**

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

8.4.9 The MAPPA Level 2 meeting on 11/12/2018 agreed Person H should be reduced to MAPPA level 1, medium risk. The justification for reducing risk was his level of engagement with a variety of agencies and willingness to comply with them and licence conditions. There was discussion on whether to reduce to MAPPA level 1 or remain at MAPPA level 2 until there was clarity around Person H’s PTSD diagnosis, his involvement with mental health services and investigations by SPS and police had concluded into letters received by social work. It was suspected these letters were from a prisoner in HMP Glenochil or his mother who at times also purported to be a female friend of Person H. The purpose of these letters was to establish contact with Person H. He was reduced to MAPPA level 1 with the proviso the outstanding issues would continue to be investigated for defensibility purposes and respective actions raised.

8.4.10 The next meeting was a MAPPA level 1 meeting on 29/05/2019. The outstanding issues and actions from the previous MAPPA level 2 meeting were not carried forward nor were they discussed or included in the minute or subsequent meeting minutes. Additionally, there was little, or no information recorded on either CareFirst or ViSOR to confirm what enquiries had been undertaken and whether actions had been completed. Similarly, there were no updates for the outstanding actions allocated to the MAPPA Health Manager who due to volume and capacity does not routinely attend MAPPA level 1 meetings.

8.4.11 Given the circumstances the reduction in risk was considered justified. While there was discussion and agreement to reduce the MAPPA level and actions raised to address the outstanding issues, the better option may have been to retain Person H at MAPPA Level 2 until these had been clarified and thereafter reduce the MAPPA level if appropriate.

**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.**

8.4.12 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. For example, from 11/12/2018 to 29/05/2019 the following was noted in respect of Person H:

* He was a victim in respect of Section 38, Criminal Justice & Licensing (S) Act 2010 (BOP) whereby his uncle shouted, swore at him, and threatened him.
* He stated his home was impacting on his mental health and was offered but declined temporary accommodation.
* Anonymous calls received by police and CJSW stating Person H was breaching his licence conditions by drinking, taking illegal drugs and was in a sexual relationship with Woman D. Woman D was known to agencies, she was Person H’s cousin, and they spent a lot of time together.
* Person H and his family were receiving anonymous calls.
* Enquiries undertaken by CJSW, police and PBSW regarding the anonymous calls.
* SOPU staff met with Woman D alone, she denied being in a sexual relationship with Person H.

8.4.13 None of this information was presented at the MAPPA Level 1 meeting on 29/05/2019. This may have been down to familiarity between staff and the Chair and the assumption this information had previously been discussed in other forums. Irrespective, this information should have been shared and recorded to inform the need for further action and allow for a more defensible risk management plan. Similarly, there was no auditable trail to detail how and if actions had been 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.**

8.4.14 One of the roles of the MAPPA Health Manager is the creation and management of MAPPA health alerts. This is simply a notification process whereby an alert is placed on an individual’s health record and when accessed by a member of staff they are immediately advised of the alert. The purpose of the alert is to highlight an individual’s specific areas of risk within health settings, for example, must only been seen by a male member of staff or no contact with children in the health setting. These alerts are considered on a case-by-case basis and must be justified and proportionate. In 2014, a formal process for MAPPA health alerts was introduced between NHS Greater Glasgow & Clyde and Glasgow MAPPA. This requires the lead agency (either CJSW or Police) to complete a MAPPA Health Alert form and submit it to the MAPPA Health Manager. If deemed appropriate the MAPPA Health Manager will thereafter arrange for the alert to be added.

8.4.15 At Person H’s pre-release MAPPA meeting on 08/05/2018, it was agreed a health alert was deemed necessary and would advise health staff that Person H was ‘*not to be seen alone by Female staff visiting his home*’. The following action was allocated to the MAPPA Health Manager – ‘*Health Alert to be put in place so no female has to see Person H alone*’. At the MAPPA meeting on 03/07/2018, this action was marked as ‘*complete’* and within the Disclosure and Public Protection Decisions section of the minute under Health Alert the following was recorded – ‘*In place – not to be seen by lone female Health staff visiting his home*’. As the MAPPA Health Manager was at the meeting and the action allocated to them, it is assumed this update was provided by them. No pre-read written update was submitted by the MAPPA Health Manager and there was no reference to this action in their verbal update. As highlighted previously there was no auditable trail detailing how and when the action had been discharged.

8.4.16 During the review, it was discovered the action to add a MAPPA health alert to Person H’s health record had not been completed and no alert was added. Enquiries to establish the reason for this identified a breakdown in understanding, delivery, and communication around the MAPPA health alert process. The MAPPA Health Manager was allocated the action to add a MAPPA Health alert to Person H’s health record, but CJSW as the lead agency did not complete and submit the MAPPA health alert form. As a result, no alert was added by the MAPPA Health Manager. No explanation could be provided as to why this action was recorded as being complete on MAPPA minutes. Staff interviewed from both CJSW and police intimated they were unaware of the health alert form and the requirement to submit it to the MAPPA Health Manager. They believed when the MAPPA Health Manager was directly tasked at MAPPA meetings to add a health alert this was solely his responsibility to complete. Likewise, they believed requests for health alerts sent directly by email to the MAPPA Health Manager were similarly dealt with and a completed form had never been asked for. The MAPPA coordinator provided that at this time a MAPPA health alert form was in use by all agencies. It could not be established when or how this breakdown in understanding occurred and whether other MAPPA health alerts were similarly affected. As a result, the Independent Reviewer notified the Responsible Authorities who took immediate action. The formal process introduced in 2014 has now been fully re-established and a review of health alerts completed.

8.4.17 CJSW and police have limited knowledge of health systems and MAPPA health alerts and would benefit from a reference document to provide a general overview and understanding. In respect of health alerts, it would be of benefit to staff and especially MAPPA chairs to know that one alert does not cover all health systems. An alert can be added if an individual’s name, date of birth and Community Health Index (CHI) number is known and covers most general health settings but does not cover GP’s. An individual’s GP needs to be established and thereafter they are notified of the MAPPA health alert directly by the MAPPA Health Manager. Therefore, there may be delays completing an action to add a MAPPA health alert if there are difficulties establishing the individual’s GP. If an individual does not have a GP this does not preclude a general MAPPA health alert being raised.

8.4.18 It was noted Person H’s GP record did contain an alert which advised ‘*To be seen by a male Doctor only’*. This was raised internally by one of the GP’s and not as a result of a MAPPA health alert.

**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.**

8.4.19 Person H was diagnosed with PTSD in 2011/2012 by a Consultant Psychiatrist and this diagnosis was reaffirmed during his period of imprisonment. On 15/03/2018, Person H’s Mental Health Nurse stated at the pre-release ICM case conference that Person H was at the point where he had a firm diagnosis of PTSD. Social work, SPS, NHS and prison-based NHS records all contained entries or reference to Person H’s PTSD diagnosis.

8.4.20 At the pre-release MAPPA meeting on 08/05/2018, attendees were aware of Person H’s PTSD diagnosis. As there was no prison-based representation at the meeting, the MAPPA Health Manager was tasked with contacting prison-based health colleagues for an update on Person H’s health needs prior to release. On 17/05/2018, the MAPPA Health Manager spoke with Person H’s Mental Health Nurse and thereafter updated the MAPPA meeting on 03/07/2017 that Person H did not have a diagnosis of PTSD but one of chronic anxiety and sleep problems. It is unknown how or why this information differed from what was previously known or provided.

8.4.21 At subsequent MAPPA level 2 meetings, there was a significant amount of discussion on whether Person H had PTSD given the conflicting information known. The MAPPA Health Manager was actioned at the MAPPA meeting on 18/09/2018 to clarify Person H’s PTSD diagnosis. This action was never completed and the confusion around Person H’s PTSD diagnosis was never clarified during the 6-month period he was managed at MAPPA level 2 nor was it carried over, discussed, or clarified at subsequent MAPPA level 1 meetings.

8.4.22 Similar confusion was noted in respect of mental health referrals for Person H. Person H’s Mental Health Nurse intimated at the pre-release ICM case conference on 15/03/2018 that a mental health referral would be made to the community prior to release. On 29/03/2018, the same nurse provided in a Healthcare Report for the Parole Board that there were no plans to refer to the Community Mental Health Team (CMHT) and Person H was to register and gain ongoing support from his GP. A PBSW report of the same date for the Parole Board noted Person H’s Mental Health Nurse would liaise with community-based colleagues to try and ensure he received the support required once released. No referral was ever made by Person H’s Mental Health Nurse and no contact made with community-based services.

8.4.23 On 25/06/2018, the CJSW supervising officer submitted a written referral to the Douglas Inch Centre requesting an assessment of Person H for possible Personality Disorder or traits of such. There was no response to this referral, and it was never followed up by the CJSW supervising officer. Enquiries during the review identified the referral had been sent to the wrong address and never received by the Douglas Inch Centre. The Douglas Inch Centre moved premises in 2017 with social work notified of this change. This issue was highlighted to social work by the Independent Reviewer.

8.4.24 Confusion and lack of information in respect of referrals resulted in actions being raised at the MAPPA meeting on 03/07/2018 for the MAPPA Health Manager to contact Person H’s GP to confirm if a referral had been made to the CMHT and for the CJSW supervising officer and MAPPA Health Manager to follow up referrals made to the CMHT and Douglas Inch Centre. These actions were not completed for the MAPPA meeting on 18/09/2018 and carried over. The MAPPA Health Manager contacted Person H’s GP practice on 20/09/2018 who confirmed he was open to the CMHT and being seen by a Consultant Psychiatrist.

8.4.25 Person H attended and registered with a new GP on his day of release from prison on 15/06/2018. He had appointment on 19/06/2018, the result of which the GP made a referral to the CMHT on 26/06/2018. Person H had appointments with the Consultant Psychiatrist, CMHT on 24/07/2018 and 12/09/2018. This information was recorded on Person H’s EMIS health record and was available to the MAPPA Health Manager but was not provided in updates at MAPPA meetings.

8.4.26 The CJSW supervising officer intimated calls were made to the Consultant Psychiatrist, CMHT but were unsuccessful, calls were not returned and no follow up was made. There was no request for the MAPPA Health Manager to assist with contact nor did the MAPPA Health Manager consider contacting the Consultant Psychiatrist to assist in clarifying the PTSD diagnosis or confirming current treatment and plans. There was no consideration of inviting the Consultant Psychiatrist to MAPPA meetings.

8.4.27 There was a lack of communication both within prison and in the community regarding the submission and progress of health referrals for Person H. The role of the MAPPA Health Manager is to assist with information sharing between MAPPA and Health, in respect of Person H, this should have been better. Information was available at an early stage which was not shared, and direct contact was not made with health professionals involved in Person H’s care. There was an element of the MAPPA Health Manager providing his own professional opinion and clinical experience when providing updates for Person H as opposed to seeking this information directly from health colleagues involved.

8.4.28 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 – 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.**

**8.5 National Health Service (NHS)**

8.5.1 Person H had a history of involvement with mental health services as detailed in the Background and Offending History section.

8.5.2 During Person H’s period of imprisonment, he was actively involved with prison-based mental health services including a Consultant Psychiatrist, Mental Health Nurse and Addiction Counsellor. The Addiction Counsellor carried out Cognitive Behavioural Therapy (CBT) for substance misuse and trauma work. Person H’s medication for his PTSD was reviewed while in prison and Trazodone replaced with Prazosin & Amitriptyline.

8.5.3 Following Person H’s release, a Discharge Summary Report was prepared by prison-based NHS staff and sent to Person H’s GP on 21/08/2018. This report detailed all health involvement with Person H during his period of imprisonment. The reason for this report is prison-based NHS use a standalone database for prisoners’ health records which is not accessible by community-based NHS services. It was noted the provision of this report to GP’s was variable and was not always provided.

8.5.4 Person H registered with a new GP on 15/06/2018, had appointment on 19/06/2018, following which the GP made a referral to the CMHT on 26/06/2018. The reason for the referral was Person H’s PTSD, previous involvement with psychiatry and GP not being familiar with the use of Prazosin to treat PTSD.

8.5.5 On 24/07/2018, Person H had his first appointment with the Consultant Psychiatrist, CMHT. The contents of the referral were discussed and identified incorrect information had been recorded by the GP in respect of his sexual offending. It advised he had recently been released from prison for the sexual assault of a minor when under the influence of alcohol and drugs and did not know her age. Person H provided the correct information regarding his offence. The Consultant Psychiatrist contacted the GP, but it was unknown how or why inaccurate information had been provided. Had the Consultant Psychiatrist been correctly informed of Person H’s offence, or the MAPPA health alert had been in place as requested, she would not have seen him on her own for the initial appointment. The GP shared the HMP Glenochil Discharge Summary Report with the CMHT, who added it to Person H’s EMIS health file. This was considered unusual, not routine and was the result of the previous misinformation provided.

8.5.6 Person H was open to the CHMT until his arrest on 04/06/2021 and had nine face to face appointments with the Consultant Psychiatrist and three cancelled appointments. The role of the Consultant Psychiatrist was to assess Person H for any mental disorders, review medication, assess risk of self-harm/suicide and any violent risk posed by him to staff and others and consider appropriate services and psychological interventions. Person H was being treated for PTSD. Following the third appointment on 31/10/2018, the Consultant Psychiatrist decided Person H should be considered for trauma work, but clarification was required as to who would provide this.

8.5.7 Person H was discussed at a multidisciplinary team (MDT) meeting at CMHT premises on 07/11/2018 where it was agreed there was no clear role for psychiatry, he would be reviewed once more by the Consultant Psychiatrist and would be referred to Trauma Services. It was also noted he had moved out with the CMHT area. He was seen again by the Consultant Psychiatrist on 13/03/2019 and a referral submitted to the Psychological Trauma Service on 06/06/2019. It was unclear if submission of the referral was to be completed following the MDT meeting or after the further appointment with the Consultant Psychiatrist.

8.5.8 Following referral to the Trauma Service, Person H remained open to the CMHT and continued to be seen by the Consultant Psychiatrist. This was in part due to sharing care while undergoing psychological intervention and due to Person H’s housing situation. He provided he was in temporary housing and waiting on permanent accommodation, he therefore could not be transferred to a new CMHT until a new address was confirmed. The transfer was further delayed by COVID and did not take place prior to his arrest.

8.5.9 On 06/11/2019, Person H’s GP highlighted an issue with the long-term supply of Prazosin. The Consultant Psychiatrist requested the GP run a short course of Diazepam until their next appointment on 22/11/2019. At this appointment the Consultant Psychiatrist introduced Olanzapine as a replacement for Prazosin and continued with the Diazepam. Health professionals were unaware of Person H’s previous abuse of Diazepam and similarly CJSW and Police were unaware Diazepam had been prescribed.

8.5.10 Throughout the time the Consultant Psychiatrist was involved with Person H they found him to be mentally well, well maintained, never under the influence, polite, jovial, and never angry, hostile, or aggressive. Person H never presented as someone that was acutely mentally unwell. Person H complained of PTSD symptoms which occurred at night including nightmares and bedwetting and was treated for this with medication and onward referral to Trauma Services.

8.5.11 Person H was placed on the waiting list for the Psychological Trauma Service on 10/06/2019 and provided with an appointment for assessment on 11/10/2019. Having failed to attend the appointment and respond to a follow up letter, it was wrongly assumed he was not ready to engage and was discharged from their care. Both Person H and the Consultant Psychiatrist contacted the Psychological Trauma Service explaining he was still keen to engage, and his non-attendance was due to being on holiday and letters had been sent to his grandfather’s address in error.

8.5.12 Person H was provided with a further appointment on 12/12/2019 and was assessed by Clinical Psychologist – Doctor E at the Psychological Trauma Service as meeting the diagnostic criteria for complex PTSD and as being suitable for psychological therapy. Doctor E contacted Person H’s CJSW supervising officer to confirm the exact nature of his sexual offending due to differing information within referrals on his EMIS health record. Doctor E thereafter updated Person H’s record with the confirmed offence details.

8.5.13 Following assessment, Person H was placed on a waiting list to start psychological therapy. On 20/03/2020, a letter was sent explaining COVID would have a knock-on effect for waiting times. On the 11/06/2020, Person H was called by the Psychological Trauma Service and provided with details on how to access digital psycho-educational sessions online. He later provided he had watched the videos which he found helpful.

8.5.14 Person H’s CJSW supervising officer contacted the Psychological Trauma Service on 27/07/2020 for an update on waiting times for therapy and for advice in respect of managing Person H’s presentation and behaviour. She intimated Person H was making vexatious complaints about his accommodation, police had reported ‘*bizarre behaviour’* when visiting and she was concerned about his weight and possible issues around his sexual identity. There were no immediate concerns, the worry being the future impact these may have on Person H maintaining his tenancy and ability to engage with treatment. Neither agency records nor interviews with staff could confirm what the ‘*bizarre behaviour’* was. Doctor E intimated Person H was developmentally immature, living alone during lockdown and was possibly using this behaviour as a tool to initiate contact with others. Doctor E provided a referral to the CMHT should be submitted if Person H’s mental health deteriorated and consideration of a referral to the Sandyford Clinic to address any recurrent eating disorder and issues with his sexual identity. Neither were aware that in March 2020 Person H had been referred by his GP to a Community Dietetic Service due his low weight. He had been seen by the service who advised he was an erratic eater and not much of a cook. His weight was within normal range and diet advice was provided. No further referrals were submitted in respect of Person H.

8.5.15 Person H’s psychological therapy started on 16/12/2020 with the first appointment with Clinical Psychologist – Doctor F being an Attend Anywhere (AA) online treatment appointment. There were four further online appointments up to 10/03/2021. Person H then cancelled appointments on 08/04/2021 and 26/04/2021 stating he found being online strange and requested a face-to-face appointment. Person H had his first face-to-face appointment with Doctor F on 20/05/2021. Doctor F called Person H on 26/05/2021 as it was the anniversary of his mother’s death and he had previously intimated he would appreciate contact on that day. He provided he was spending time with his family and no concerns were raised. Doctor F’s last appointment with Person H was on 03/06/2021, 4 days after the murder.

8.5.16 Doctor F provided Person H’s presentation was entirely consistent across all appointments and interactions. He engaged well with everything, was polite, respectful, stated he was taking his prescribed medication and did not appear under the influence at any time. The last appointment involved Person H completing a timeline of his life. The idea being to anchor memories in contextual positions and initially gather brief information with the aim of examining these in more detail as sessions progressed. Person H’s presentation remained unchanged from previous interactions, and he even discussed plans for the future.

8.5.17 NHS Greater Glasgow & Clyde Mental Health Service has a Clinical Risk Screening and Management policy for staff which was introduced in September 2014 and revised in October 2019. Its purpose is to establish a framework and standards for the assessment and management of clinical risk within the overall context of the provision of high-quality clinical care. It supports professional judgement and a multi-professional approach to the assessment and management of risk through standardised practice and procedures and use of structured documentation and tools. In 2019, the Clinical Risk Screening & Management Tool (CRSMT) was replaced with Clinical Risk Assessment Framework in Teams (CRAFT). 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 EMIS health file of compliance with this policy and completion of either the CRMST or CRAFT formal assessments and processes.

8.5.18 Person H routinely requested letters from health professionals in support of benefit applications and requests to housing providers to offer more appropriate accommodation as he stated his accommodation was impacting on his mental health. This was based on Person H having witnessed his mother fall to her death from their home in a high rise flat and as a result he stated he could not be housed in a high-rise building. Person H was never happy with housing, continually complained and had unrealistic expectations regarding location and type of housing he should be offered. Person H made approximately eleven separate approaches to his GP, CMHT and Psychological Trauma Service for letters, these were provided on nearly all occasions. Doctor E was the only health professional to contact CJSW to discuss a letter request for new housing, following which, the request was declined. Person H thereafter contacted his GP and CMHT and was provided with supporting letters from both. These requests also included approaches by Person H to the CMHT and Doctor E for a letter to CJSW intimating his participation on the MFMC group was impacting his mental health and his involvement should be suspended. The matter was not progressed by the CMHT and Doctor E tried to contact CJSW without success. MFMC was suspended shortly thereafter due to COVID. No letters were ever provided and CJSW were never made aware of the approaches and issues raised by Person H.

8.5.19 The CMHT and Psychological Trauma Service use the EMIS patient record database and recorded all contact with Person H including requests for letters and whether these had been issued. There did not appear to be any research of previous entries prior to issuing letters. GP’s do not have access to EMIS and have a standalone patient record system.

8.5.20 Apart from Doctor E, there was no consideration by other health professionals of contacting either CJSW or police prior to these letters being issued or the resultant impact these letters 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.

8.5.21 Doctor E was the only health professional invited to a MAPPA meeting. He was invited to the MAPPA meeting on 14/12/2020 and provided a written update. Despite being involved with Person H since his release from prison there was no consideration of inviting the Consultant Psychiatrist or GP. Had they been invited, or direct contact made with them or by them this would have opened lines of communication, established points of contact, and allowed for better information sharing, similar to that highlighted with Doctor E.

8.5.22 Learnpro is an online training database accessible by all Health employees. A MAPPA e-learning module was created several years ago, this training is not mandatory and has not been regularly promoted since its inception. Additionally, the MAPPA Health Manager provides face to face or online training to health staff when requested and also to social work and police. All health professionals had limited knowledge of MAPPA, advised they had not completed the training and were unaware of the MAPPA Health Manager and their role. The health service is a vast organisation with the large majority of staff having no involvement with MAPPA. Training and raising awareness of MAPPA needs to be targeted to those most likely to be involved. Review of health involvement with current and previous MAPPA cases may provide a starting point to identify areas of health and specific health professionals to be targeted.

8.5.23 Overall communication between Health and MAPPA partners could have been better. The role of the MAPPA Health Manager was created to improve and make communication easier. From a Health perspective staff were unaware of this role, from a MAPPA perspective there could have been more specific tasking and better utilisation of the role and from a MAPPA Health Manager perspective they could have been more proactive and better informed. 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*** – ***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.***

**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***

**8.6 LOCAL AUTHORITY CRIMINAL JUSTICE SOCIAL WORK (CJSW)**

8.6.1 Person H was subject to statutory supervision and managed by CJSW for the duration of his non-parole licence. He had only one appointed CJSW supervising officer during his period of imprisonment and supervision on licence. This provided consistency and allowed a good relationship to be established.

8.6.2 On release from prison, the level of contact with Person H was initially set at weekly and on 03/12/2018 was reduced to fortnightly. Fortnightly contact was in place until 11/12/2019 when it was reduced to monthly and remained at monthly until expiry of the licence on 16/12/2020. It is good practice to have enhanced contact levels taking into consideration the offender and their current circumstances. 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, home visits and reviews. Although Licence Reviews and actions from MAPPA meetings detailed contact levels of ‘*weekly contact*’ etc, there was never specific mention of home visits. The minimum standard for home visits is ‘*monthly during the first quarter and then quarterly’*.

8.6.3 Although contact levels were set above the minimum standards these enhanced levels were not always complied with and maintained. There was only one month out of six where weekly contact levels were maintained, four months out of twelve where fortnightly contact was maintained and eleven months out of twelve where monthly contact was maintained. In respect of home visits, there were three home visits in 2018, one home visit in 2019 and one home visit and two visits outside Person H’s home (COVID restrictions) in 2020. The CJSW supervising officer provided contact levels were better maintained but the recording of these on CareFirst was not as it should have been. This was highlighted in a supervisory session dated 10/06/2019, which noted case recordings had slipped but Person H was in MFMC group every week and had been seen fortnightly. Weekly attendance at MFMC was not considered as part of the contact regime.

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

**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.**

8.6.4 Glasgow Social Work Services use CareFirst and EDRMS to record information on clients. CareFirst should be used to record all information in respect of that client including supervision contacts, home visits, meetings, incidents of note, contact with other professionals etc. EDRMS is used to record documents, reports, letters, risk assessments, MFMC session notes etc. 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.

8.6.5 The CareFirst record for Person H was not of the standard expected, the following were some of the issues identified:

* Not every contact with Person H was recorded.
* Discrepancies in information recorded, i.e. written or verbal warning given regarding incident on 02/08/2018, difference in curfew times and lack of information on curfew.
* No entries recorded between 21/09/2019 – 07/11/2019.
* Information and issues highlighted during supervisory sessions were not recorded on CareFirst.
* Entry dates for information not reflective of the date of the event/information but the date the entry was added.
* Engagement with other agencies not recorded.
* Referral to Children & Families regarding Person H’s contact with a family member’s children not recorded (only mention of this was in the MAPPA minute of 03/07/2018).
* No continuity of information recorded. Actions or questions raised but nothing further recorded to confirm if these had been addressed, i.e. no follow up with CMHT or referral to Douglas Inch, no update or outcome to the letters received by social work suspected to be from a prisoner in HMP Glenochil or his mother.

8.6.6 The CJSW supervising officer provided personal emails detailing contact and work with other agencies including prison-based NHS, MAPPA Health Manager, SACRO, GCA and Children & Families. None of this information was recorded on CareFirst or EDRMS. For a full and accurate picture of an individual to be established, all information needs to be recorded in a single repository. While the demands of the job, other pressures, and reduced staffing can all be acknowledged this should never be allowed to impact on case recording. Succinct, brief updates would have been preferable to none and would have confirmed contact levels had been maintained and emails could have been copied and added to CareFirst. Records need to be accurate and up to date to allow supervisors to make informed decisions, allow colleagues to react appropriately when required and ensure information is not lost. There was only one entry on CareFirst dated 11/05/2020 raised by a supervisor which noted “*Case recording read & countersigned*”. This was a check of the case recording and is normally done at every licence review.

**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.**

8.6.7 ViSOR was the agreed system used by MAPPA to facilitate the secure exchange and storage of information. As the lead agency, CJSW were responsible for the maintenance and update of Person H’s ViSOR record. The ViSOR access and usage issues identified in the 2017 Joint Thematic Review of MAPPA and detailed in the ViSOR section of this report were evident in Person H’s ViSOR record despite there being significant discussion at both national and local level at this time.

8.6.8 Person H’s ViSOR record was populated with information from SPS including ICM case conference minutes and the MAPPA Coordinator added MAPPA minutes and associated information. CJSW were the lead agency for 2.5 years but had no footprint on Person H’s ViSOR record. The ViSOR 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. When information is not centrally recorded or accessed there is a reliance on individuals to share what information they deem necessary and relevant. Had all information been recorded on ViSOR it would have better informed both the individual and multi-agency risk management of Person H by CJSW and Police.

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

8.6.9 Person H participated in MFMC on a weekly basis from 23/08/2018 until it was suspended due to COVID on 12/03/2020. There were 76 sessions, Person H completed 55, did not attend 9 and 12 sessions were cancelled. Person H’s participation and feedback were mixed with some sessions being good and others he was distracted and disinterested. He found it difficult to separate out the issues relating to the trauma of his mother’s death and dealing with his offence. Overall, he completed all required modules and assignments.

8.6.10 All MFMC session notes were recorded on EDRMS with a brief entry on CareFirst to indicate if Person H had attended. While all session notes were recorded there were a significant number of occasions where the session and Person H’s attendance were not recorded on CareFirst. There were also a couple of issues raised in session notes which were to be discussed with the CJSW supervising officer but no record of this or action taken was noted on CareFirst.

8.6.11 Person H presented as polite, respectful, attended all appointments, answered all questions, and would freely hand over his phone for examination. He came across as genuinely remorseful, ashamed, and guilty about his offence. He would continually discuss his mother’s death and his trauma work and used this as a deflective tactic at times. It was known he could be manipulative with agencies especially in relation to demands for housing. He actively engaged with all agencies and was thankful for the support which he stated was helping him. Apart from the verbal warning, there were no other issues, no concerns in respect of further drinking and never any indication he was abusing substances. It was identified he was gambling online and on 19/03/2020, he was asked to reduce his gambling from daily to weekends, reducing it from £300 to £150. It was felt he was not being entirely truthful on the amount he was spending. Person H’s benefits appeared to provide him with sufficient money to finance his gambling. There was sporadic and limited information recorded in respect of his gambling.

8.6.12 During his period on licence, Person H was supported by GCA in respect of running his tenancy and any addiction issues of which there were none, SACRO in respect of PIP and grant applications, Elevate regarding job applications and the Marie Trust in respect of building relationships with peers through mindful walking groups. He was encouraged to attend the gym which he did occasionally and was referred to Street Soccer but did not attend. He also attended Men Matter which provided activities to support positive mental health.

8.6.13 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 the 2.5-year period he was on licence.

8.6.14 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, her mother being the cousin of Person H’s mother. Woman D first came to the notice of agencies when she was present at Person H’s home during a SOPU visit on 05/09/2018. She was present at further visits and he intimated he was spending a lot of time with her. He stated they were just friends and denied they were in a sexual relationship. Following anonymous calls to police and social work that Person H was abusing drugs and in a sexual relationship with Woman D, SOPU staff attended her home address on 26/02/2019 and spoke with her alone. She denied being in a sexual relationship with Person H and confirmed they were just friends. Person H and Woman D went away for weekends, went on 2 holidays abroad and spent considerable time in each other’s company. Following the rape and murder of Woman A, Woman D and Person H continued to deny they were in a relationship despite statements from Person H’s family providing they had been in a relationship for over 18 months. Woman D’s family denied any knowledge of her having a relationship with Person H.

8.6.15 During Person H’s period of imprisonment, he was visited by another female cousin and following his release socialised and spent time with her. Agencies did not meet her and again their relationship was never formally established. Contact stopped in late August 2018 and she was not mentioned again by Person H. Agencies were unaware this cousin and Woman D **[Redacted]**. Statements provided by family members following the murder provided Person H had been friendly with this cousin, but there was a fall out and contact stopped. The reason for this was unknown and shortly thereafter Person H began spending time with Woman D.

8.6.16 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 – Staff should not solely rely on self-reported information and where possible all opportunities should be taken to test and corroborate information provided.**

**8.7 POLICE SCOTLAND**

8.7.1 Following conviction for Section 1 of the Sexual Offences (S) Act 2009 (Rape) on 11 October 2013, Person H was made subject of the Notification Requirements of Part 2 of the Sexual Offences Act 2003 and placed on the Sex Offenders Register for an indefinite period. Person H complied with all his SONR. Apart from the incident on 02/08/2018, when Person H was extremely intoxicated and reported being the victim of a robbery, he did not come to the adverse attention of police.

8.7.2 Police Scotland has dedicated units to manage RSOs, these are known as Sex Offender Policing Units (SOPU). Person H was managed by Greater Glasgow, ‘G’ Division SOPU and by the same SOPU officer following his release from prison. As with CJSW, this provided consistency and allowed a good relationship to be established with Person H and his CJSW supervising officer.

8.7.3 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 – It is considered good practice to implement enhanced visit regimes.**

8.7.4 Following release from prison, Person H was subject of unannounced weekly home visits until 18/09/2018, and then fortnightly visits until the end of December 2018. This was complied with apart from 2 missed visits. A monthly visit regime was initiated at the start of January 2019, reduced to every 2 months in May 2019 and then every 3 months from December 2019 onwards. Visit regimes were complied with apart from 2 visits which were office visits. In total there were 38 visits completed of which 35 were successful and three unsuccessful. From December 2018 to April 2019 there were five successful visits with Person H at his grandfather’s address with no unsuccessful visits at his own home recorded. This was highlighted by supervisors who instructed visits to be carried out at his home address. These were thereafter successfully completed. It was considered unusual that successful visits were completed at Person H’s grandfathers address without any unsuccessful visits having been completed first at his home address. This would tend to suggest that either visits were not unannounced or unsuccessful visits were not always being recorded.

8.7.5 Visits were carried out at various times of the day and various days of the week. Five visits were evening visits after 7pm, the latest being 9:10pm and there were six visits on a Saturday and Sunday. As previously discussed, as Person H was subject of a curfew from 11pm-7am, visits should have been completed during these times. Two home visits and one office visit were carried out jointly by the SOPU officer and CJSW supervising officer. This is considered good practice but would have benefitted from occurring more often.

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

8.7.6 All home visits apart from four were added to ViSOR within the prescribed 3-day timescale. All visits were approved by a supervisor with seven visits approved out with the prescribed 5-day timescale. All visits except for two had a corresponding Acute assessment. Supervisors should read and approve visit reports in tandem with the corresponding Acute assessment to be fully appraised and to ensure Acute assessments are appropriately scored and representative of the visit. In 14 out of 35 successful visits this was not done with assessments on occasions being approved anything from a month up to 5 months after the visit was approved. These issues were predominately noted during 2018 and 2019 with no recurrence of the issue in 2020 and 2021.

8.7.7 The force home visit template was used for all visits bar one. The standard of visit updates was variable with the following issues noted:

* Evidence of cutting and pasting information from one visit to another.
* Limited probing of and information gathered from Person H.
* Information was at times very general with little specific information noted. For example, ‘**property searched, and phone examined with no issues identified’** but no specific details recorded to highlight what was searched and found and whether there were any changes.

8.7.8 Following a visit on 02/07/2019, a supervisor noted - *‘***some sections would benefit from more detail being documented- if comments could be expanded to ensure lifestyle is thoroughly explored and to include demeanour/presentation allows for a more informed risk assessment’***.* Subsequent visit updates improved with more relevant and detailed information being recorded but there was still room for improvement.

8.7.9 On 16/12/2020, Person H’s licence expired, and social work involvement stopped. There were no concerns or known issues at this time but given the removal of licence conditions 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. Person H’s first scheduled visit after this was 04/02/2021 during which he acted completely out of character, was obstructive, agitated, slightly aggressive and it was felt he may have taken illegal substances. A check of his flat found Woman D hiding behind the bedroom door. Person H was under the impression both social work and police involvement had stopped and did not expect police visits to continue.

8.7.10 As a result, an additional visit was completed on 15/02/2021 with Person H apologising for his previous behaviour. He appeared to be back to his normal self, engaged fully with officers and there were no concerns regarding drug use. He intimated he had been concerned about breaching COVID rules and that is why Woman D hid in the bedroom. No further additional visits were completed, and visits returned to a minimum of one every 3 months.

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

8.7.11 Two unsuccessful home visits were completed on 08/05/2021 and 09/05/2021 and it was suspected Person H may be residing elsewhere. Enquiries with family members established he was not spending as much time with them as suggested and he had resumed contact with an uncle whom he had previously had a turbulent relationship. On 13/05/2021, Person H called his SOPU officer and came across as slightly hostile. Details of this call and enquiries with family were not recorded. On 14/05/2021, Person H presented himself at Govan police station and an office visit was completed by his SOPU officer. Person H confirmed he was spending more time with his uncle but denied living elsewhere. He intimated he was drinking slightly more than he had previously and due to his demeanour the SOPU officer suspected he may have taken illegal drugs. The update for this visit and Acute assessment were not added to ViSOR until 20/05/2021 with ‘*Review of visits to be carried out’* recorded at the end of the update. Both were approved by a supervisor on 21/05/2021 and an action raised to monitor Person H’s drug use, but nothing further recorded or actioned in respect of reviewing visits.

8.7.12 Following expiry of Person H’s licence there were some changes noted in his behaviour and demeanour. 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 quite rightly a review of visits was deemed necessary but was not actioned prior to the murder. Increased visits may have provided a better understanding of Person H’s lifestyle and whether the identified areas of risk were becoming problematic.

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

8.7.14 Similarly, completion of the various Risk Management Planning documents was poor and not of the standard expected. The following details each of the documents and highlights the issues identified:

Action & Update Documents (A&U):

* None of the documents were fully populated or completed.
* Most actions were only updated as ‘*completed’* and with a date, the date on most occasions being the date the document was closed. Nothing recorded in either A&U documents, Activity Logs, visit updates or other ViSOR attachments to record how and when allocated actions had been discharged. It was apparent some were showing as complete when they had not been.
* Insufficient information recorded which would provide supervisors with an overview of Person H’s current circumstances and issues. For example, one A&U document had nothing recorded apart from ‘*completed’* foraction updates. During this period, Person H moved house twice, SA07 Stable assessment was completed, he had started gambling, he called police twice due to disturbances in his common close and he attended social work supervision with a black eye. None of this was recorded.
* One A&U document recorded all police system checks as ‘*no new entries’*. During this period Person H reported his uncle for threatening him and committing a breach of the peace and two anonymous calls were received by police stating Person H was breaching his licence conditions by drinking and taking drugs.
* A&U documents were approved by supervisors despite not being fully populated or completed.

8.7.15 An A&U document is a single repository to record all allocated actions and current issues or concerns about an individual. It is a dynamic document which should be continually updated with pertinent information and key issues in respect of an individual’s management over the period of review. It provides supervisors and colleagues with a summary of the current issues and risks and action being taken to address and manage those risks. The A&U documents created in respect of Person H were not utilised or populated in the manner they should have been. When correctly populated, the A&U document can be used as the basis for any pre-read updates for MAPPA.

8.7.16 Police Risk Management Plan (RMP):

* Inaccurately populated, two RMPs had the MAPPA Level recorded as High and not Level 1 or 2, and five had the wrong risk level recorded at the beginning of the document.
* Not always fully completed, one did not have a description of risk & risk factors and two did not contain details of the date compiled and by whom and no mention of a contingency plan.
* Comments added by Detective Sergeants were more bespoke and relevant compared to the generic comments noted on the A&U documents.
* Supervisory acknowledgement of RMPs was not always adhered to. Two MAPPA Level 2 RMPs had Superintendent & Chief Inspector ratification but no SOPU Detective Inspector comment. Of the five MAPPA Level 1 RMPs, four were ratified by a Chief Inspector and only two had a SOPU Detective Inspector comment.

8.7.18 The Offender Profile contained very little information and was poorly populated. There appeared to be very little research carried out in respect of Person H.

8.7.19 The SOPU officer had issues in respect of their written work which was evident in the standard of work submitted. This was acknowledged by supervisors 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 – Supervisors should continually challenge and address the standard of information gathered and recorded and reinforce practice and process standards.**

8.7.20 The SOPU officer and the 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. The SOPU officer made no attempts to engage with health professionals involved in Person H’s care.

**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.**

8.7.21 As with CJSW, the majority if not all the 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. There were opportunities to test the curfew and make more frequent use of family members to confirm information where possible.

8.7.22 During enquiries into the murder of Woman A, it was identified Person H had been in contact with a 33-year-old woman. She had been residing in a woman’s hostel near to Person H’s home, they met in the street and entered into a sexual relationship. It started the end of April 2021 and ended on [**redacted** – date was some weeks later], when the woman moved out of the hostel. The woman reported no issues or complaints in respect of Person H. The change in Person H’s behaviour and the difficulties experienced by police visiting him may have been as a result of him concealing this relationship. The woman had a history of alcohol and drug use.

8.7.23 An Environmental Risk Assessment (ERA) was completed and approved in respect of Person H’s home address. The women’s 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 at the opposite end and separated by a main road. The hostel did not fall within the 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.

**8.8 ASSESSMENT OF RISK**

8.8.1 Risk assessment should follow a structured four-step process to identify, analyse, evaluate, and communicate relevant information. It is essential all necessary background and current information about an individual is obtained and the relevant information identified. 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.

8.8.2 Not all relevant background and current information was obtained or known in respect of Person H’s offending history, health, sexuality, and family circumstances. These will be considered in more detail:

8.8.3 **Offending History**

All Criminal Justice Social Work Reports including the most recent for murder and ICM Case Conference minutes noted Person H had been convicted of 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 information appeared to be accepted and reused without further checking. Similarly, no further enquiry was made by Person H’s CJSW supervising officer or SOPU officer. This offence was clearly marked as a domestic 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 contained within the Modus Operandi (MO) chapter of Person H’s CHS record. The following was the MO information recorded in respect of the Fail to Appear conviction:

Crime Type Violent, Assault, Domestic

Crime Type Disorder, Breach of Peace; Domestic

Time Night

Day Weekend, Saturday

Locus Residential, House/Flat

Victim Injuries to/contact with neck, throat

Victim Action with, pinion; violence, grab

Victim Description, female/adult; age,21-40

8.8.4 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.

8.8.5 These domestic incidents (fully detailed in the Background and Offending History section) were not known and not considered in the risk assessment of Person H. Person H’s 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 to these crimes.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:** **Local Authority Social Work in consultation with Police Scotland and Scottish Courts and Tribunal Service review the information provided by a CHS court print*.***

8.8.6 **Health**

Person H made 3 suicide attempts in 2012 and 2013. This information was contained in health records and within his CareFirst record but was never raised at MAPPA meetings and was not considered in Person H’s wider risk assessment.

8.8.7 There were 2 incidents when Person H intimated, he was having suicidal thoughts. The first was on admission to hospital following being the victim of a robbery on 02/08/2018. He was noted to have suicidal ideation and given a liaison psychiatric appointment but discharged himself prior to the appointment. He was deemed safe to be discharged as the suicidal ideation was not active. The second occasion was on 17/02/2020 when he called the CMHT and reported an increase in suicidal thoughts and of taking an overdose but denied any current plan to commit suicide. This information was not shared with or known to CJSW or police.

8.8.8 Person H had PTSD and a history of involvement with mental health professionals. This history 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 which would have confirmed the diagnosis made in 2011/2012. Similarly, there was no consideration by Clinical Psychologists to obtain hard copy notes which would have highlighted Person H’s previous trauma therapy undertaken by a member of staff they were currently working with.

8.8.9 CJSW and Police were aware of Person H’s PTSD but in name only and had no knowledge of how it manifested, if it impacted on his risk and what the possible effects were of not taking or taking too much medication. This was never explored with Health professionals.

8.8.10 **Sexuality**

Prison intelligence provided Person H had a sexual relationship with another prisoner, but this was not included in MAPPA referrals, and neither was information within his prison-based health records which supported this intelligence. A ViSOR Activity Log dated 16/01/2018, contained intelligence from 09/02/2015 intimating Person H was in a sexual relationship with another prisoner. This Activity log had been added by police, but the contents had obviously been obtained from SPS. This intelligence 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.

8.8.11 **Family Circumstances**

In general terms, the main adverse childhood experiences affecting Person H were known despite various versions of events being provided and difficulties confirming exact details. There was confusion regarding the family dynamics which in part was due to the Person H referring to his grandfather as father and his uncles as brothers. There was no consideration of a family tree which may have clarified matters.

8.8.12 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. Better communication would have improved the information available to CJSW and police.

8.8.13 Despite the foregoing, 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 – An accurate risk assessment is based on thorough research and sharing of relevant information.**

8.8.14 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.

8.8.15 ViSOR has a specific attachment to record risk assessments and was used by police to record RM2000 and SA07 assessments. RM2000 assessments were completed annually for Person H with three being recorded. These were completed by the same SOPU officer and were correctly scored apart from the last assessment on 14/12/2020. The sexual aspect of this assessment was not scored in relation to criminal appearances and the violent aspect was not scored in relation to violent appearances or House Breaking (Burglaries). The overall sexual risk remained at medium although the scoring had changed, and the violent risk dropped to medium when previously assessed as very high. These issues were not identified by the supervisor who approved the risk assessment.

8.8.16 CJSW did not use ViSOR and the only reference to a RM2000 assessment was within licence reviews which noted an overall risk of high completed on 19/09/2018.

8.8.17 SA07 Stable assessments were undertaken jointly by the CJSW supervising officer and SOPU officer with the written assessment completed by the CJSW supervising officer. Two assessments were completed on 25/07/2018 and 10/01/2020, both assessed Person H’s risk as moderate with the first having a score of six and the second a score of four. Overall, these assessments were considered accurate and correctly scored. It is the practice and policy of both police and CJSW to complete a Stable assessment within 3 months of an individual being released from prison and thereafter annually or when there are any significant changes to an individual’s circumstances. Stable assessments were not completed annually for Person H and only the Stable assessment completed on 10/01/2020 was recorded on ViSOR.

8.8.18 SA07 Acute assessments were completed independently by police and CJSW. Police Acute assessments are completed for every contact with an individual unless an assessment has already been completed within the preceding 7 days. Acute assessments were completed for every police visit with Person H apart from two. The quality of evidence recorded within all assessments was poor with no more than a single sentence used to justify the score in each area assessed. The use of cut and paste was prevalent throughout, and the information recorded called into question the SOPU officers understanding of the risk assessment tool and overall understanding of risk. For example, when considering ‘Victim Access’, the assessor should evaluate the extent to which the offender is placing themselves at risk by increasing their contact with or access to potential victims, whether that be via chance/contact/grooming/interaction with persons who fall within the known victim demographic. On every occasion the SOPU officer recorded a score of ‘0’, which would suggest the offender had little or no opportunity to meet and/or interact with potential victims*.* However, the SOPU officer’s rationale for recording this score on every assessment was *“The nominal's victim died a number of years ago”.* Similar issues were noted in other areas of the assessment. The content of these assessments was never questioned and approved by several different supervisors. Again, capacity, volume of work and increased demands when colleagues are absent may account for assessments being approved somewhat robotically without any real consideration of the 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.

8.8.19 In February 2021, Police Scotland introduced a mandatory eLearning annual assessment for SA07/RM2000 to continually reinforce and test understanding of these assessments. Person H’s SOPU officer did not complete this training.

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

8.8.20 CJSW should complete 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 formally scored when there is a change. There is no defined policy for the completion and recording of these assessments. CJSW had contact with Person H on 45 occasions with 11 acute assessments formally recorded. Only the overall risk level was recorded, i.e. Low/Low with no scoring or formal rationale for scoring noted. The first recorded Acute assessment was 12/11/2018, some 6 months after Person H’s release from prison. 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. More formal recording of the assessment would allow them to be considered as a whole and not just as individual assessments. Taking an average across a number of assessments provides a higher predictive accuracy.

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

# CONCLUSION

9.1 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.

9.2 MAPPA and the management of RSOs is a challenging and demanding working environment due to the number and nature of offenders being managed. The professionalism and dedication of staff is 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.

9.3 The focus of a SCR is on one individual case with its own distinctive set of circumstances. As a result, 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 the learning, they do not necessarily require a recommendation and action. Therefore, findings have been considered and categorised as either good practice, learning points or recommendations.

9.4 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.

9.5 Person H had a complex and challenging childhood with a number of adverse events which affected him into adulthood. He had a history of criminal and antisocial behaviour linked to alcohol and substance misuse. He was diagnosed with PTSD, was on medication, and was actively involved with psychiatric and psychological services over a 10-year period. There were two incidents of domestic violence prior to the rape of a 50-year-old woman. This was his only known sexual crime and was a significant escalation from his previous offending when considering the level of violence and nature of the crime. Similarly, following his release from prison he had a sustained period of compliance with no indication of and no further offending reported 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.

9.6 Person H was actively supervised and managed by CJSW and police and was involved with mental health professionals and a variety of other agencies. He was well supported in the key areas of his life. He sought and welcomed this support and intimated he was benefitting from it. All agencies and staff found Person H to be respectful, fully engaged, compliant but could be manipulative, not always truthful, and regularly used agencies to get what he wanted. He continually discussed his mother’s death and trauma work and used this as a deflective tactic with agencies. There was active risk management through regular home visits, supervision contacts, participation on MFMC and engagement with GCA, SACRO and Marie Trust but there was 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.

9.7 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.

9.8 It was considered good practice to have a MAPPA Health Manager, but the benefits of this were not fully realised and available health information was not shared. There were no lines of communication established between CJSW, police and the main Health professionals involved with Person H. Health professionals had limited knowledge of MAPPA and were unaware there was a MAPPA Health Manager.

9.9 ViSOR, the agreed system used by MAPPA to facilitate the secure exchange and storage of information was not used by CJSW.

9.10 Person H’s MAPPA risk assessment was well populated based on the information known. Better background research by all agencies and direct communication with health professionals would have enhanced the overall risk assessment, identified new areas of risk, and would have led to a more informed and focused Risk Management Plan. The overall MAPPA risk level was deemed appropriate and would not have changed had this information been known.

* 1. Case recording and record keeping by CJSW and Police were not of the standard expected. Records must be accurate and up to date to allow supervisors to make informed decisions on risk management, enable colleagues to react appropriately when required and ensure information is not lost. 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. Standards need to be challenged, and continually reinforced.
  2. A number of recommendations and learning points have been identified as a result of this review. 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.
  3. If implemented the recommendations, learning points and areas of good practice highlighted by this SCR will improve and enhance MAPPA and the management of RSOs and will assist in better protecting the public from harm.

# FINDINGS

**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.**

**APPENDIX A - CHRONOLOGY OF KEY EVENTS**

The following provides a chronology of key events and agency contact with Person H:

**2013**

17/06/2013 Remanded to HMP Barlinnie in respect of Section 1 Sexual Offences (S) Act 2009 (Rape).

11/10/2103 Convicted of Section 1 Sexual Offences (S) Act 2009) and placed on the Sex Offenders Register.

26/11/2013 **[Redacted]**

**2014**

06/01/2014 Sentenced to 7 years & 6 months imprisonment for Section 1 Sexual Offences (S) Act 2009.

28/03/2014 Transferred from HMP Barlinnie to HMP Glenochil.

15/04/2014 Seen by Consultant Psychiatrist, medication for PTSD reviewed, and Trazadone replaced with Prazosin & Amitriptyline.

08/07/2014 First Integrated Case Management (ICM) Case Conference.

**2015**

13/03/2015 Generic Programme Assessment completed.

21/04/2015 Placed on waiting list for Moving Forward Making Changes (MFMC) and Substance Related Offending Behaviour Programme (SROBP).

07/07/2015 Annual ICM Case Conference.

14/08/2015 SMART Recovery course completed.

19/08/2015 Started SROBP.

**2016**

18/01/2016 SROBP completed.

14/12/2016 Pre-Parole Qualifying Date ICM Case Conference.

19/12/2016 MAPPA Level 2 referral submitted.

**2017**

17/01/2017 Parole Board Hearing – Parole declined.

17/03/2017 Parole Qualifying Date

06/07/2017 Agreed to be considered for MFMC at HMP Barlinnie but subsequently withdrew.

01/09/2017 Agreed to be considered for MFMC selection board but subsequently withdrew.

**2018**

04/01/2018 Approached regarding MFMC selection board, declined to be considered.

15/03/2018 Pre-release ICM Case Conference.

19/03/2018 MAPPA Level 2 referral submitted.

08/05/2018 MAPPA Meeting – MAPPA Level 2, High risk agreed.

22/05/2018 Parole Board Review – Licence conditions set. (Please see Appendix B for full list of conditions).

**JUNE**

**15/06/2018 Earliest Date of Liberation – Released on licence from HMP Glenochil.**

Meeting with CJSW supervising officer, Sex Offender Policing Unit (SOPU) officer and Housing SOLO.

SONR - Completed Initial RSO notification.

Provided with temporary accommodation within a hostel.

18/06/2018 Unannounced home visit by SOPU officers.

25/06/2018 Letters received by Social Work from mother of prisoner in HMP Glenochil and from a female claiming to be a friend both wishing contact with Person H.

Joint home visit by CJSW supervising officer and SOPU officer.

Referral by CJSW to Douglas Inch Centre for assessment of possible Personality Disorder.

26/06/2018 Referral by GP Practice to Community Mental Health Team.

**JULY**

03/07/2018 MAPPA Meeting – MAPPA Level 2, High risk agreed.

CJSW supervision appointment.

05/07/2018 Unannounced home visit by SOPU officers.

09/07/2018 Unannounced home visit by SOPU officers. Person H handed over a letter received from the female claiming to be a friend.

11/07/2018 CJSW supervision appointment.

16/07/2018 Unannounced home visit by SOPU officers.

24/07/2018 Appointment with Consultant Psychiatrist, CMHT.

25/07/2018 CJSW supervision appointment.

Stable Assessment completed - Moderate risk.

Moved into new temporary furnished flat.

26/07/2018 SONR – Notified new home address.

27/07/2018 Unannounced home visit by SOPU officers.

**AUG**

02/08/2018 Person H extremely intoxicated and reported being the victim of a robbery, admitted to hospital for observations due to a head injury and told staff he was suicidal.

03/08/2018 Person H discharged himself from hospital prior to liaison psychiatric appointment.

Home visit by CJSW, directive given not to consume alcohol.

05/08/2018 Unannounced home visit by SOPU officers.

07/08/2018 CJSW supervision appointment. Verbal warning given and additional licence condition imposed in respect of consuming alcohol.

15/08/2018 Home visit by CJSW supervising officer.

16/08/2018 Unannounced home visit by SOPU officers.

21/08/2018 HMP Glenochil Discharge Summary Report provided to GP.

22/08/2018 Unannounced home visit by SOPU officers.

CJSW supervision appointment.

23/08/2018 First MFMC session.

27/08/2018 CJSW supervision appointment.

30/08/2018 MFMC session

**SEPT**

05/09/2018 Unannounced home visit by SOPU officers – Woman D present, Person H intimated she was his cousin.

SONR - Notified grandfather’s address as an additional qualifying address.

06/09/2018 MFMC session.

12/09/2018 Appointment with Consultant Psychiatrist, CMHT.

13/09/2018 MFMC session.

16/09/2018 Mother of prisoner in HMP Glenochil contacted police expressing concern for Person H. It was confirmed he was safe and well and did not wish contact with her.

18/09/2018 MAPPA Meeting – MAPPA Level 2, High risk agreed.

19/09/2018 3-month Scottish Criminal Justice Review.

20/09/2018 MFMC session.

26/09/2018 Unannounced home visit by SOPU officers, Woman D present.

27/09/2018 CJSW supervision appointment.

MFMC session.

**OCT**

04/10/2018 MFMC session.

11/10/2018 MFMC session.

12/10/2018 SONR - Notification of new passport.

19/10/2018 Joint home visit by CJSW supervising officer and SOPU officer.

29/10/2018 Police received letter from mother of prisoner in HMP Glenochil wishing contact with Person H.

31/10/2018 Appointment with Consultant Psychiatrist, CMHT.

**NOV**

01/11/2018 MFMC session.

07/11/2018 Unannounced home visit by SOPU officers.

SONR – Notified new bank details.

Multidisciplinary Team Meeting held by CMHT to discuss Person H.

08/11/2018 MFMC session.

12/11/2018 CJSW supervision appointment.

15/11/2018 MFMC session.

19/11/2018 Unannounced home visit by SOPU officers.

29/11/2018 CJSW supervision appointment.

Attended MFMC session.

Appointment with GP who provided letter of support for new housing.

30/11/2018 Unannounced home visit by SOPU officers.

**DEC**

01/12/2018 Overnight stay in Oban with Woman D.

03/12/2018 6-month Scottish Criminal Justice Review.

06/12/2018 MFMC session.

11/12/2018 MAPPA meeting – MAPPA Level 1, medium risk agreed.

13/12/2018 MFMC session.

18/12/2018 CJSW supervision appointment.

19/12/2018 CJSW received a letter from a female claiming to be a friend of Person H looking to establish contact with him.

20/12/2018 Unannounced home visit by SOPU officers.

MFMC session.

25/12/2018 Person H called police to report his uncle being abusive and threatening towards him.

26/12/2018 Person H called SOPU office to inform them of incident with uncle.

29/12/2018 Unannounced home visit by SOPU officers at grandfather’s address.

**2019**

**JAN**

10/01/2019 MFMC session.

Unannounced home visit by SOPU officers at grandfather’s address.

14/01/2019 CJSW supervision appointment. Offered emergency accommodation as he stated his mental health was being affected staying in current flat, he declined the offer.

17/01/2019 MFMC session.

24/01/2019 MFMC session.

**FEB**

03/02/2019 Anonymous call to police stating Person H was breaching licence conditions by consuming alcohol and cannabis and was in a sexual relationship with Woman D.

05/02/2019 Unannounced home visit by SOPU officers at grandfather’s address.

07/02/2019 CJSW supervision appointment.

MFMC session.

13/02/2019 Anonymous call to social work stating Person H was breaching licence conditions.

14/02/2019 MFMC session.

Anonymous call to police stating Person H was breaching licence conditions.

21/02/2019 MFMC session.

26/02/2019 Woman D visited by SOPU officers, she confirmed she was not in a sexual relationship with Person H.

**MAR**

07/03/2019 MFMC session.

12/03/2019 Unannounced home visit by SOPU officers at grandfather’s address.

13/03/2019 Appointment with Consultant Psychiatrist, CMHT.

14/03/2019 MFMC session.

20/03/2019 Home visit by CJSW Supervising Officer.

21/03/2019 CJSW supervision appointment.

MFMC session.

28/03/2019 MFMC session.

**APR**

02/04/2019 Unannounced home visit by SOPU officers at grandfather’s address.

04/04/2019 MFMC session.

05/04/2019 CJSW supervision appointment.

18/04/2019 MFMC session.

19/04/2019 SONR – Notified new bank details and foreign travel.

25/04/2019 MFMC session.

**MAY**

02/05/2019 MFMC session.

06/05/2019 Unannounced home visit by SOPU officers.

16/05/2019 MFMC session.

22/05/2019 Meeting with Housing SOLO.

27/05/2019 SONR - Notified new bank details.

29/05/2019 MAPPA Meeting – MAPPA Level 1, medium risk agreed.

30/05/2019 MFMC session.

GP provided letter of support for new housing.

**JUNE**

01/06/2019 **[Redacted]**

06/06/2019 Referral submitted by Consultant Psychiatrist, CMHT to Psychological Trauma Service.

11/06/2019 CJSW supervision appointment.

13/06/2019 Attended MFMC session.

24/06/2019 Attended hospital with a laceration to chin, stated he fell running for bus.

**JULY**

02/07/2019 Unannounced home visit by SOPU officers.

04/07/2019 MFMC session.

10/07/2019 Appointment with Consultant Psychiatrist, CMHT.

12-month Scottish Criminal Justice Review.

11/07/2019 MFMC session.

**AUG**

01/08/2019 MFMC session.

02/08/2019 CJSW supervision appointment.

08/08/2019 MFMC session.

15/08/2019 MFMC session.

16/08/2019 CJSW supervision appointment.

22/08/2019 MFMC session.

28/08/2019 CJSW supervision appointment.

**SEPT**

12/09/2019 MFMC session. Challenged as he was smelling of alcohol.

17/09/2019 Unannounced home visit by SOPU officers.

19/09/2019 Anonymous call to CJSW stating Person H was abusing drugs and involved in criminality.

MFMC session.

20/09/2019 Person H subject of random drugs test which was negative.

26/09/2019 MFMC session.

29/09/2019 Unannounced home visit by SOPU officers.

**OCT**

01/10/2019 **[Redacted]**

11/10/2019 Person H did not attend assessment appointment with Consultant Clinical Psychologist, Trauma Service.

17/10/2019 MFMC session.

24/10/2019 MFMC session.

28/10/2019 Discharge from Care letter sent by Trauma Service.

31/10/2019 MFMC session.

**NOV**

04/11/2019 Unannounced home visit by SOPU officers.

06/11/2019 Supply issues with Prazosin medication. Consultant Psychiatrist, CMHT advised GP to prescribe short course of Diazepam.

07/11/2019 CJSW supervision appointment.

MFMC session.

14/11/2019 MFMC session.

15/11/2019 Attended meeting with social work to discuss housing options.

22/11/2019 Appointment with Consultant Psychiatrist, CMHT. Olanzapine medication started and letter of support for new housing provided.

**DEC**

11/12/2019 MAPPA Meeting – MAPPA Level 1, medium risk agreed.

Annual Scottish Criminal Justice Review.

12/12/2019 Assessment appointment with Clinical Psychologist – Doctor E, Trauma Service.

MFMC session.

13/12/2019 Moved to new temporary furnished flat.

14/12/2019 SONR – Notified new address.

19/12/2019 MFMC session.

23/12/2019 Unannounced home visit by SOPU officers.

**2020**

**JAN**

06/01/2020 Unannounced home visit by SOPU officers.

10/01/2020 SA07 stable assessment completed. Moderate risk.

16/01/2020 MFMC session.

21/01/2020 Doctor E, Trauma Service provided a letter to support Person H’s benefit application.

23/01/2020 Registered with new GP Practice.

MFMC session.

27/01/2020 Home visit by CJSW supervising officer.

29/01/2020 MFMC session.

31/01/2020 Appointment with Consultant Psychiatrist, CMHT.

**FEB**

06/02/2020 Attended MFMC session.

15/02/2020 Person H called police to report someone shouting and banging on his door.

17/02/2020 Person H called the CMHT stating he had increased suicidal thoughts. He requested his Consultant Psychiatrist provide a letter for CJSW suggesting he did not attend MFMC sessions as it was impacting his mental health.

19/02/2020 CJSW supervision appointment. Person H had a black eye, stated injury was self-inflicted with a brush.

20/02/2020 MFMC session.

25/02/2020 Person H called Clinical Psychologist – Doctor E, Trauma Service and asked him to provide a letter for CJSW suggesting he did not attend MFMC sessions.

27/02/2020 MFMC session.

**MAR**

01/03/2020 Person H called police reporting a drunk female in the common close.

05/03/2020 MFMC session.

06/03/2020 Joint office visit with CJSW supervising officer and SOPU officer.

11/03/2020 Referral by GP to Dietetic Service due Person H’s low weight.

12/03/2020 MFMC session.

**MFMC suspended until further notice due to COVID.**

14/03/2020 SONR – Notification of new address.

15/03/2020 Moved into new permanent accommodation.

19/03/2020 CJSW supervision appointment.

20/03/2020 Psychological Trauma Service advised appointment waiting times affected by COVID.

**23/03/2020 National COVID lockdown.**

**APR**

14/04/2020 CJSW supervision appointment by phone.

**MAY**

08/05/2020 Unannounced home visit by SOPU officers.

21/05/2020 CJSW supervision appointment outside Person H’s home address.

**JUNE**

11/06/2020 CJSW supervision appointment.

12/06/2020 MAPPA Meeting – MAPPA Level 1, medium risk agreed.

17/06/2020 Scottish Criminal Justice Review.

22/06/2020 Psychological Trauma Service called Person H to discuss options for viewing psycho-educational videos.

30/06/2020 CJSW supervision appointment outside Person H’s home address.

**JULY**

17/07/2020 CJSW supervision appointment by phone.

18/07/2020 Unannounced home visit by SOPU officers.

**AUG**

07/08/2020 Contact by Psychological Trauma Service, Person H found the videos helpful. Discharged from psycho-educational list.

10/08/2020 Person H called police to report group of youths in street, intoxicated and possibly armed with a knife.

21/08/2020 CJSW supervision appointment. Approval given for holiday to Lanzarote with Woman D in November 2020.

**SEPT**

01/09/2020 Person H called Housing SOLO to discuss ongoing anti-social behaviour by neighbour.

Person H called Clinical Psychologist – Doctor E, Trauma Service and requested a letter of support for new housing. Doctor E discussed this request with the CJSW supervising officer and agreed letter would not be provided.

14/09/2020 CJSW supervision appointment.

30/09/2020 Approval given to apply for a Kitchen Porters job.

**OCT**

08/10/2020 GP provided letter of support for new housing.

15/10/2020 CJSW supervision appointment by phone.

**NOV**

06/11/2020 Appointment with Consultant Psychiatrist, CMHT. Provided letter of support for new housing.

**DEC**

04/12/2020 CJSW supervision appointment.

11/12/2020 Appointment with Consultant Psychiatrist, CMHT.

14/12/2020 MAPPA Meeting – MAPPA Level 1, medium risk agreed.

Final Scottish Criminal Justice Review.

16/12/2020 Sentence Expiry Date. Non-Parole Licence expiry and end of CJSW involvement.

16/12/2020 Attend Anywhere (AA) online treatment appointment with Clinical Psychologist – Doctor F, Trauma Service.

22/12/2020 Unannounced home visit by SOPU officers.

**2021**

**FEB**

04/02/2021 Unannounced home visit by SOPU officers. Person H acting out of character, suspected he may have taken illegal drugs and Woman D found hiding in bedroom.

11/02/2021 Online treatment appointment with Clinical Psychologist – Doctor F, Trauma Service.

15/02/2021 Unannounced home visit by SOPU officers. Presentation and engagement back to normal.

Appointment with Consultant Psychiatrist, CMHT.

19/02/2021 Online treatment appointment with Clinical Psychologist – Doctor F, Trauma Service.

**MARCH**

03/03/2021 SONR – Annual notification.

04/03/2021 Online treatment appointment with Clinical Psychologist – Doctor F, Trauma Service.

10/03/2021 Online treatment appointment with Clinical Psychologist – Doctor F, Trauma Service.

**APR**

08/04/2021 Person H cancelled online treatment appointment with Clinical Psychologist – Doctor F, Trauma Service.

26/04/2021 Person H cancelled online treatment appointment with Clinical Psychologist – Doctor F, Trauma Service and asked for face-to-face appointment

End of Apr Person H started a sexual relationship with a 33-year-old woman.

**MAY**

[**redacted**] Relationship with 33-year-old woman ended.

08/05/2021 Unsuccessful home visit by SOPU officers.

09/05/2021 Unsuccessful home visit by SOPU officers.

13/05/2021 Person H called by SOPU officer, noted as being hostile on phone.

14/05/2021 Person H attended Govan Police Station; office visit completed by SOPU officer. Person H appeared under the influence of drugs.

18/05/2021 Person H rescheduled appointment with Consultant Psychiatrist, CMHT.

20/05/2021 Face-to-face treatment appointment with Clinical Psychologist – Doctor F, Trauma Service.

26/05/2021 Clinical Psychologist – Doctor F, Trauma Service called Person H as it was the anniversary of his mother’s death.

28/05/2021 Woman A murdered and raped.

**JUNE**

01/06/2021 Woman A found dead in her home.

03/06/2021 Face-to-face treatment appointment with Clinical Psychologist – Doctor F, Trauma Service.

04/06/2021 Arrested for the murder and rape of Woman A.

**APPENDIX B – NON-PAROLE LICENCE**

You are required to comply with the following conditions (which may be added to, varied, or cancelled at any time before the expiry of the licence):-

1. You shall report on the day of release to the officer in charge of the office at the address notified to you at the time of release;
2. You shall be under the supervision of an officer to be nominated for this purpose from time to time by the Head of Service with responsibility for Criminal Justice Social Work in Glasgow City Council;
3. You shall comply with any requirements that officer specifies for the purposes of risk management supervision;
4. You shall inform your supervising officer immediately if you are detained or arrested by the police or are questioned by the police;
5. You shall keep in touch with your supervising officer as instructed by that officer;
6. You shall inform your supervising officer if change your place of residence or gain employment or change or lose your job;
7. You shall of good behaviour and shall keep the peace;
8. You shall not travel outside the United Kingdom without prior permission of your supervising officer and subject to any restrictions that your supervising officer may impose;
9. You shall reside only in suitable accommodation, supported or otherwise, as approved by your supervising officer and subject to any restrictions that your supervising officer many impose;
10. You shall cooperate with an organisation experienced in job search and advice for offenders as directed by your supervising officer;
11. You shall undertake offence focused work in particular work relating to sexual offending, lack of insight, problem solving, consequential thinking and victim empathy as directed by your supervising officer;
12. You shall undertake an assessment by Community Mental Health Services and co-operate with services after this, all as directed by your supervising officer;
13. You shall not approach or communicate in any way, or attempt to approach or communicate in any way, either directly or indirectly, with **[Redacted]** without the prior approval of your supervising officer and subject to any restrictions that your supervising officer may impose, and you shall immediately report any unavoidable or inadvertent approach or communication in any way to your supervising officer;
14. You shall:
    1. Undertake an assessment for alcohol misuse counselling and:

Undertake any such counselling, as directed by your supervising officer;

Undertake testing, random or otherwise, for alcohol as directed by your supervising officer;

Not approach or communicate in any way, or attempt to approach or communicate in any way, either directly or indirectly, with persons whom you know to be, or should have reason to believe may be, persons who misuse alcohol and subject to any restrictions that your supervising officer may impose, and you shall immediately report any unavoidable or inadvertent approach or communication in any way to your supervising officer;

* 1. Undertake an assessment for substance misuse counselling and:

Undertake any such counselling, as directed by your supervising officer;

Undertake testing, random or otherwise, for substances as directed by your supervising officer;

Not approach or communicate in any way, or attempt to approach or communicate in any way, either directly or indirectly, with persons whom you know to be, or should have reason to believe may be, persons who misuse substances or are unlawfully supplying or concerned in the unlawful supplying of substances without prior approval of your supervising officer and subject to any restrictions that your supervising officer may impose, and you shall immediately report any unavoidable or inadvertent approach or communication in any way to your supervising officer;

1. You shall not undertake paid, unpaid, or voluntary work without prior approval of your supervising officer and subject to any restrictions that your supervising officer may impose;
2. You shall not approach or communicate in any way, or attempt to approach or communicate in any way, either directly or indirectly, with persons whom you know to be, or should have reason to believe may be, sex offenders without prior approval of your supervising officer and subject to any restrictions that your supervising officer may impose, and you shall immediately report any unavoidable or inadvertent approach or communication in any way to your supervising officer;
3. You shall:
4. Immediately inform your supervising officer of any friendships, associations or intimate or domestic relationships you enter into with anyone;
5. Provide your supervising officer with the identities, and all contact information which you have in relation to them, of persons, as he or she may require, who you have spoken to or communicated with, either directly or indirectly, during any period/s that your supervising officer may require;
6. 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.

Failure to comply with these conditions may result in the revocation of your licence and your recall to custody.

This licence expires on 16/12/2020 unless previously revoked.

**APPENDIX C – GLOSSARY OF TERMS**

AA Attend Anywhere Online Treatment Appointment

CareFirst Glasgow Social Work Services Client Based Recording System

CBT Cognitive Behaviour Therapy

CHI Number Community Health Index Number

CHS Criminal History System

CJSW Criminal Justice Social Work

CMHT Community Mental Health Team

EDL Earliest Date of Liberation

EDRMS Glasgow Local Authority Electronic Document and Records Management System

EMIS NHS Patient Health Records Database

ERA Environmental Risk Assessment

GP General Practitioner

GPA Generic Programme Assessment

Housing SOLO Housing Sex Offender Liaison Officer

ICM Integrated Case Management

MAPPA Multi Agency Public Protection Arrangements

MDT Multidisciplinary Team

MFMC Moving Forward Making Changes treatment programme for sex offenders

NOMU National Offender Management Unit

PBSW Prison Based Social Work

PCMB Programme Case Management Board

PQD Parole Qualifying Date

PTSD Post-Traumatic Stress Disorder

RSO Registered Sex Offender

RM2000 Risk Matrix 2000 Risk Assessment

SA07 Stable and Acute 2007 Risk Assessment

SCP Self-Change Programme

SCR Significant Case Review

SED Sentence Expiry Date

SOG Strategic Oversight Group

SOPU Sex Offender Policing Unit

SOR Sex Offenders Register

SONR Sex Offender Notification Requirements

SPS Scottish Prison Service

SROBP Substance Related Offending Behaviour Programme

TFF Temporary Furnished Flat

ViSOR Violent and Sex Offenders Database