## Response on behalf of the Tayside MAPPA Strategic Oversight Group

As Chair of the Tayside MAPPA Strategic Oversight Group I acknowledge that any circumstances in which people have died are both tragic and distressing for everyone affected and that we need to learn any lessons arising from these events. This detailed report, completed by an independent reviewer, has looked into the circumstances leading up to these events. All members of the Tayside MAPPA Strategic Oversight Group continue to extend our condolences to the family members and friends of the two people who died, acknowledging the impact that such events have on everyone involved.

We also understand the impact on staff involved and will continue to support the practitioners who were involved in the management of Person X.

I am pleased that the report recognises some of the strengths of local MAPPA arrangements including the co-location of practitioners from NHS Tayside, Criminal Justice Social Work and Police Scotland who support MAPPA processes and the robust initial MAPPA response to individuals who are subject to Sex Offender Notification Requirements.

In common with all Significant Case Reviews, this report identifies a number of recommendations for improvement where all agencies involved in the management of sexual and violent offenders, both within Tayside and beyond, can learn from what has happened. The reviewer in the case has made 14 recommendations, the Responsible Authorities accept all of the recommendations and are already working to address these, with the majority already completed. Some key actions include:

- Refresher training has been provided to MAPPA Chairs. Relevant staff across Police Scotland, local authority Community Justice Services and Neighbourhood Services, and NHS Tayside have participated in a development day focused on the risk formulation process for those people subject to MAPPA 1 management.
- Strengthened arrangements for attendance and information sharing at MAPPA meetings within NHS Tayside, including standardised approaches for collating information from mental health services prior to MAPPA meetings and for sharing information from MAPPA meetings.
- Steps have been completed to ensure that alert systems that inform NHS Tayside staff of individuals who may present a risk to staff or patients are fully up-to-date in relation to all people managed under MAPPA arrangements.
- Police Scotland D Division (Tayside) have provided guidance regarding the management of offenders who are Foreign Nationals to those staff involved in offender management, including instructions regarding the use of translators for all visits to foreign nationals who are not fluent in English.
- A number of steps have also been completed to enhance the involvement of Local Policing functions within MAPPA arrangements including attendance of local officers at MAPPA meetings and implementation of a range of clear communication mechanisms.
- 4 Offender Management Courses were delivered during 2018, which include risk management plan training, meaning that all staff working within the Offender Management Unit have completed training.
- At a national level, Police Scotland issued a revised Offender Management Toolkit in April 2018 which provides clear, concise and accessible role and rank specific guidance for every aspect of Offender Management. In August 2018 an accompanying toolkit for Risk Management Planning was also published, which includes clear guidance in relation to allocation, handover and briefing arrangements for Offender

Management Officers. The national guidance and toolkit has been implemented within D Division (Tayside).

The Tayside MAPPA Strategic Oversight Group will continue to seek assurances from partner agencies regarding the completion of actions agreed in response to the recommendations within the report. The group will also continue work with national partners, including the Scottish Government, to further progress recommendations that are of national interest.

I hope that communities across Tayside are reassured that through the work of the Tayside MAPPA Strategic Oversight Group and other partners that recommendations from this SCR are being progressed. The Strategic Oversight Group is committed to a culture of learning and continuous improvement and to continuing to collaborate with other Public Protection Committees in order to protect children and adults living within Tayside from abuse, neglect and harm.

This report contains the conclusions and recommendations of the Significant Case Review relating to the management under MAPPA arrangements of Person X. In the interests of transparency every effort has been made to disclose as much of the SCR as is lawfully possible. However, all personal information which is disclosed must be shared lawfully and in accordance with the General Data Protection Regulations (GDPR) and the Data Protection Act 2018 (DPA). Although there has been a criminal trial and media coverage of this case, and consequently a certain amount of personal data and special category personal data is publicly available, disclosure of personal data contained in this report must still comply with data protection legislation. For this reason details such as names, dates of birth and other personal identifiers have not been included in this executive summary. In addition other personal information has been redacted as disclosure of this information cannot be justified in law. This means that even though some of the withheld information may already be publicly available, or it may be considered to be in the public interest to disclose, it cannot be disclosed because the relevant conditions under data protection legislation have not been met.

The process of redacting the SCR has involved careful consideration of:

- The need for transparency and the overall purpose of the SCR in identifying learning.
- The provisions of the GDPR and the DPA and the statutory bases for sharing information.
- The public interest in disclosure, and in particular the public interesting in ensuring public protection is not compromised and that the relevant agencies work together effectively in assessing risks and taking action where necessary to manage those risks.
- Whether information is sensitive personal data (for example, because it is information about a person's physical or mental health, their sexual life or alleged commission of offences) and whether inclusion in the SCR complies with data protection legislation.

The executive summary of the SCR follows but with certain text redacted for the reasons set out below and any redactions are clearly marked. Some minor grammatical changes have been made (unflagged) to maintain consistency of language following some redactions.

**Elaine Torrance, Independent Chair, Tayside MAPPA Strategic Oversight Group**


# INDEPENDENT SIGNIFICANT CASE REVIEW RELATIVE TO THE MANAGEMENT OF PERSON X

## EXECUTIVE SUMMARY

PUBLISHED 1ST MAY 2019

INDEPENDENT REVIEWING OFFICER MR ALEXANDER MCLEAN

# 1. INTRODUCTION

**1.1.** During 2016, Person A and Person B were murdered within their home in Dundee.

**1.2.** Later in 2016 Person X**,** a Registered Sex Offender [RSO], was initially identified as a significant witness outside the murder scene, before being detained and thereafter charged with the Murder of both Person A and Person B.

**1.3.** In 2017 Person X was found guilty by unanimous verdicts of the murders and sentenced to life with a punishment part of 26 years.

**1.4.** Person X had been managed under the Multi Agency Public Protection Arrangements [MAPPA] since becoming the subject of Sex Offender Notification Requirements [SONR] as a result of an Interim Notification Order being granted in early 2014 with a full order granted three months later. Person X was never at any point subject to any statutory supervision by Community Justice Social Work.

**1.5.** Following the submission of a Significant Case Review [SCR] Initial Notification Report [INR] by Police Scotland, the Tayside Strategic Oversight Group [SOG] Chair made the decision to progress the incident to a full, independent SCR.

**1.6.** On the 9th May 2018 Mr Alexander McLean was appointed as the SCR reviewing officer. Together with assistance from other suitably qualified and experienced professionals he began examining the circumstances in the respect of the management of Person X whilst subject of Sex Offender Notification Requirements. Mr McLean is independent of the organisations being reviewed and a retired Detective Chief Inspector of Police. Mr McLean retired in February 2016 as the then Deputy Head of the Police National Offender Management Unit. He had nearly 30 years' experience within Police Scotland, working up through the ranks to operate at a senior operational and strategic management level within both the Criminal Investigation Department and Offender Management Unit, driving major crime investigations, crime prevention strategies and latterly, being responsible for the national standardisation of Offender Management procedures across Scotland.

**1.7.** The SCR focused on:

- Whether the deaths of Person A and Person B could have been anticipated and / or prevented – if so, what are the implications for the professional multi-agency practice?

- To identify key professional and organisational learning regarding how single and / or multi-agency working could have improved the management of Person X within the community and better protected Person A and Person B and any other person who may have been at risk of harm.

**1.8.** The overall Objectives were identified as the following:

- To identify the extent and the quality of agency engagement and intervention.

- To identify whether the assessed level of risk was appropriate.

- To identify whether the response to any changes in circumstances were proportionate and timely.

- To identify whether key information was appropriately shared across all relevant agencies.

- To identify whether there are any specific, local learning points arising from the fact that Person X was not a UK national.

**1.9.** During the SCR process there were 3 main issues identified which are discussed fully in the body of the report, to summarise they are:

- A general lack of communication between the NHS medical professionals treating Person X and MAPPA and vice versa. This included pertinent information regarding Person X's mental health which was apparently never shared with the MAPPA partners. As a result there was limited analysis and understanding of Person X's mental health issues and how the events in their life were impacting on Person X's wellbeing and risk.

- The police reaction to the life events impacting on Person X, the effectiveness of the police contact to gather information and the comprehensiveness and accuracy in relation to the risk assessments conducted.

- The lack of a cohesive co-ordinated approach in relation to the deportation process and intermittent communication flow between MAPPA partners and Home Office Immigration Enforcement (HOIE) and vice versa.

**1.10.** It is not possible to infer that a more comprehensive intervention strategy or assistance in the form of support would have broken the chain of events leading up to the murders and prevented them taking place. Person X actively concealed their relationship and contact with Person A and Person B as a result of Person A allegedly supplying Person X with illicit substances. Even if their relationship had been known to the police and MAPPA partners, any identified risk of Person X causing them significant harm would have been considered remote and I believe could not have been predicted.

## 2. BACKGROUND AND KEY EVENTS

**2.1.** Person X is not a UK national.

**2.2.** On 4th December 2002 Person X was convicted at a Court outside of the UK of: Robbery; Obstructing or Perverting the course of Justice (using violence or an unlawful threat in order to influence the actions of a witness, expert, translator or prosecutor); and, Rape. These offences were committed between 27th August 2001 and 19th September 2001. Person X was sentenced to a total of 8 years imprisonment.

**2.3.** Person X stated that they moved from their country of origin to the United Kingdom in 2009 *"to avoid persecution"* due to their conviction, initially living in England. After a short period of time Person X moved to Scotland and it is known that Person X had resided in the Fraserburgh and St Andrews areas before settling in Tayside.

**2.4.** Person X has a history of mental illness and was known to psychiatric services in Tayside since April 2013, when Person X was initially treated for depression.

**2.5.** On 17th November 2013 Person X came to the attention of the Police and, as a result, a request to the authorities in Person X's country of origin was submitted to confirm if there were any previous European convictions.

**2.6.** On 2nd January 2014 the results of these checks were received which confirmed Person X's previous conviction for Rape. On receipt of this information, Police Scotland instigated legal proceedings, pursuing a Notification Order in terms of the Sexual Offences Act, 2003 which would make Person X subject to Sex Offender Notification Requirements [SONR].

**2.7.** In early 2014 an interim notification order under Section 100 (3) of the Sexual Offences Act 2003 was granted at Dundee Sheriff Court. Person X initially notified 10 days later and the Police Offender Management Unit [OMU] based in Dundee had responsibility for monitoring Person X in the community.

**2.8.** Approximately 3 months later a full order under Section 100 (3) of the Sexual Offences Act 2003 was granted at Dundee Sheriff Court making Person X subject SONR for an indefinite period, with a review date of in 2029.

**2.9.** From Person X's arrival in the UK in 2009 and prior to being made subject to SONR, Person X had only come to the attention of the police for an attempted suicide [drugs overdose] [redacted].

**2.10.** During the course of Person X's MAPPA management Person X was the subject of one initial MAPPA meeting, which followed the framework and participation levels of a MAPPA 2 meeting, and subsequently of five MAPPA 1 meetings.

**2.11.** At the "initial" MAPPA meeting on 23rd April 2014 Person X was initially assessed as 'MEDIUM RISK' and referred for MAPPA 1 management.

**2.12.** Whilst in the community, Person X's mental health fluctuated and there were a number of significant life events which impacted on Person X's mental health and at times manifested as serious self-harm incidents.

**2.13.** On 14th May 2014 Person X was admitted to hospital with a serious self-inflicted stab wound to the neck which punctured Person X's internal jugular vein.

**2.14.** From the first police visit to Person X it was evident that Person X's family were a significant social support for Person X. At this time Person X was receiving benefits and living alone, however it was not unusual for family members to stay with Person X when they were concerned about Person X's illicit drug use or mental health issues. Person X's substance use was self-disclosed during the first police OMU visits, however it is thought that Person X minimised, or failed to comprehensively disclose their substance use.

**2.15.** In September 2014, Person X formed a relationship with a person and this appeared to have a stabilising effect on Person X.

**2.16.** In August 2015, Person X's mental health appeared to dip and Person X appeared to be ruminating over their RSO status and management by the police. This coincided with a report from Person X's housing officer in October 2015 that Person X had admitted to not taking their prescribed medicine for a 2 month period.

**2.17.** In November 2015, Person X received intimation by letter that the Home Office were considering deportation proceedings against Person X and this appeared to have an impact on Person X's mental health. Person X was assisted by their housing officer to obtain legal representation in relation to the deportation procedure

**2.18.** In February 2016 the housing support for Person X was terminated as Person X appeared relatively stable.

**2.19.** On 9th June 2016 Person X experienced another significant self-harm incident when Person X took an overdose of prescription medicine, together with alcohol and then cut their wrists. [redacted]. The episode was possibly triggered by the death of Person X's closest brother who had been suffering from terminal cancer and who had returned home from Scotland to their country of origin in the weeks preceding his death. The impact of this was compounded for Person X as their mother returned to their country of origin and there was erosion of Person X's close family support. Further to this Person X's benefits stopped as a result of their partner obtaining full-time employment and the partner becoming Person X's only means of financial and social support.

**2.20.** In September 2016 the fifth [final] MAPPA meeting was held and after a comprehensive NHS update detailing that the deportation process may have a significant impact on Person X's mental health, together with the information regarding a self-harm incident in June 2016 Person X's risk was raised to HIGH.

**2.21.** In late November 2016 Person X's relationship with their long term partner ended and they left Person X and moved out of their apartment. This was significant as the partner was Person X's last social and financial support. At this time Person X also self-reported to the Police Offender Management Officer (OMO) their drug use escalating from smoking heroin to intravenous heroin use.

**2.22.** In 2016 outside the murder scene Person X was initially identified as a significant witness and taken for interview before being detained and thereafter charged with the Murder of both Person A and Person B.

**2.23.** In 2017 Person X was found guilty by unanimous verdicts of the murders and sentenced to life imprisonment with a punishment part of 26 years.

**2.24.** From November 2015 deportation proceedings had continued throughout the period of Person X's MAPPA management. It is beyond the scope of this SCR to comment on the practices of a non-MAPPA agency. Deportation decisions are exclusively a matter for Home Office Immigration Enforcement (HOIE). However this SCR did conclude that mutual expectations of information sharing between HOIE and MAPPA agencies could be improved through the establishment of a protocol.

# 3. Key Findings

**3.1.** Within the Tayside area, all individuals who become subject of SONR are discussed at an 'Initial' MAPPA meeting, which is normally held within 1 month of notification. This follows the framework and participation level of a MAPPA 2 meeting and is a robust process where all partners are fully sighted on all individuals subject of SONR within their area of responsibility. I regard this as **GOOD PRACTICE**.

**3.2.** The subsequent MAPPA 1 meetings were robust in respect of timings, general structure and the minuting arrangements. Again, I hold them as an example of **GOOD PRACTICE.**

**3.3.** However, I believe the effectiveness of the MAPPA 1 meetings may have been improved in relation to: the Chairs of the meetings (who were from Police and Social Work, and on one occasion the MAPPA Co-ordinator) being more specific and directing actions for other MAPPA Partners; and, also more actual practitioner level participation / input in order to enhance communication links and dynamic information flow. This may not have necessitated the NHS and Housing representatives attending or giving written updates at all MAPPA 1 meetings; it would have been more beneficial if those attending the meetings were the practitioners from Health and Housing who were actually having interaction with Person X and thereafter in regular contact with the police OMO and vice versa. (*Recommendation 1*)

**3.4.** MAPPA guidance is generally silent in relation to the MAPPA 1 process and left to the discretion of the individual Responsible Authorities. In line with the MAPPA guidance at that time all the MAPPA meetings followed the correct structure, however during the management of Person X there appeared to be limited objective analysis of risk formulation including: linking likelihood, types of offences Person X might commit, circumstances under which Person X might commit offences, who might be at risk, the potential seriousness and how the linked actions would manage and mitigate the risks identified. (*Recommendation 2*)

**3.5.** In relation to Criminal Justice Social Work participation they were well represented at all the MAPPA meetings in their capacity as one of the MAPPA Responsible Authorities however, Person X had never been open to criminal justice social work service having never been subject to a UK court order.

**3.6.** In relation to the NHS involvement in the MAPPA process, in 2009, NHS Tayside took an extremely pro-active approach and appointed a full-time MAPPA representative. This officer is based in the same co-located office as the MAPPA co-ordinator, a Criminal Justice Social work representative and the Police OMU. This was an innovative step. I regard both the co-location of multi-agency partners and the role of the NHS representative as **GOOD PRACTICE**.

**3.7.** NHS Tayside was represented at all the MAPPA meetings in person or via a written update. The 'Initial' MAPPA meeting was pivotal in setting the tone for future meetings and there appears to have been an important initial diagnosis that was known to the NHS representative however was not shared with partners at this or subsequent MAPPA meetings. The diagnosis was a significant piece of information which would have assisted in informing a more accurate risk assessment.

**3.8.** On analysing the NHS updates recorded in the minutes of all the MAPPA meetings, they tended to be of a general nature regarding both medical and psychological issues,

together with listing medication. There was no specific detail or discussion noted with regard to risk formulation or how the life issues impacting on Person X and the fluctuation in Person X's mental health might affect their risk. No actions were ever raised for the NHS representative at any of MAPPA meetings and it appears to have been accepted that the role of the officer was to supply all relevant information without being specifically actioned. (*Recommendation 3*)

**3.9.** The information flow between the NHS representative and the NHS colleagues treating Person X within psychiatric services appeared minimal and some appeared to be unsighted in relation to: Person X's RSO status; MAPPA involvement; the threat of deportation and the risk Person X may have posed to them. I would have anticipated that the significant issues being reported by the police would have been communicated directly to those health professionals treating Person X and vice versa. The effectiveness of the dissemination of collated, general, non-specific and somewhat historic information from a third party at 6 monthly MAPPA meetings is questionable. (*Recommendations 4 and 5*)

**3.10.** It is my observation that from the initial MAPPA meeting held on 23rd April 2014 until the last meeting on 23rd September 2016 the MAPPA group never fully comprehended or understood how Person X's mental health impacted on their risk in the community. However, it is not possible to infer that a more comprehensive approach to information sharing in this case would have broken the chain of events leading up to the murders and prevented them taking place.

**3.11.** In relation to Housing input at MAPPA meetings the Housing representative attended the majority of the MAPPA meetings or supplied written updates which were fairly comprehensive in relation to mostly housing and tenancy information. Again information flow may have been enhanced in relation to lifestyle information and mental health observations if the actual practitioner who was seeing Person X on a mostly weekly basis was in regular contact with the police OMO and vice versa.

**3.12.** Regarding Police visits it must be emphasised that the vast majority of individuals subject of SONR, and in this case Person X, are not legally compelled to give information or co-operate with regular police visits or risk assessments being carried out etc. The monitoring and management process conducted by the police on those subject of SONR requires enhanced rapport building and excellent communication skills to be able to obtain as much information as possible from sometimes evasive and devious individuals.

**3.13.** Person X was evasive and supplied limited lifestyle information regarding employment, associates and general movements. Person X appeared to use their lack of English as a barrier at times and to deflect questions asked by the OMO. On one occasion an officer speaking the same language as Person X assisted with the visit and the level of information was noticeably more comprehensive. There were no further visits using officers or interpreters speaking the same language as Person X and it is unclear whether this was ever considered. It should be noted that other organisations who had contact with Person X noted issues regarding lack of English language skills and employed the services of an interpreter. In relation to further police involvement, other than placing Person X's details on the Local Policing briefing site, there was little Local Policing interaction, involvement or tasking recorded. This may have assisted in obtaining information regarding movements and associates as Person X was non-disclosing and evasive towards the OMO's. (*Recommendations 6 and 7*)

**3.14.** In general terms the visits to Person X could have been more intrusive in relation to: more detailed questioning with a view to obtaining more information regarding movements and lifestyle, mobile phone checks and periodically requesting Person X give permission for a cursory search of their apartment. It is noted however that Person X was generally vague and only supplied information that Person X wanted too; this included concealing the relationship with Person A due to its criminal nature. Person X already felt the OMU management was overly intrusive and unjust and therefore was very selective with any information disclosed to the police

**3.15.** In relation to information self-disclosed by Person X, there appears to have been limited cross checking and confirmation, including suspected employment and attending addiction services. On numerous visits Person X admitted to illicit drug abuse but would intimate it had been in the recent past, then at the next visit would admit to taking illicit substances. This appeared to have been a pattern of misleading, minimising behaviour and to an extent appeared to be accepted at face value at each contact without fully considering Person X's evasive nature.

**3.16.** On analysing the SA07 Stable assessments carried out on Person X they appeared to be rather ad hoc in nature and it is my observation that the quality of these assessments could have been improved. In relation to the Stable assessment it is recognised good practice in relation to jointly managed RSO's that two practitioners [one from the Police and one from another partner agency such as Criminal Justice Social Work] carry out this assessment in the form of a structured interview in a formal setting. Consideration should be given as to whether it may be possible to have a joint initial Stable assessment in Police only cases. Consent would be required from the RSO as Criminal Justice Social Work have no legal locus to intervene however, with consent it would provide the platform to provide a wider perspective on initial factors and a more comprehensive assessment. If the RSO refuses to participate with the Stable assessment in any form then the 'fall-back' position would be obtaining the required information by 'stealth' i.e. information gleaned from a number of visits, together with analysis of the historical file and any collateral information known.

**3.17.** I found that the STABLE 2007 acute assessments carried out on Person X could have been more comprehensive and towards the end of the monitoring period there were a number of significant events that were not fully understood, accurately assessed with regard to the acute scoring guide or reacted to in a particularly effective manner. These events were mainly in relation to: Person X's mental health; the value of, then erosion of social supports [including the loss of family, then partner support]; the impact of deportation; significant self-harm episodes; the loss of benefits; and, escalating illicit substance misuse. (*Recommendations 8, 9 and 10*)

**3.18.** Whilst it is my opinion that risk assessment practice in this specific case could have been more comprehensive and dynamic It is not possible to infer that a more comprehensive approach would have broken the chain of events leading up to the murders and prevented them taking place. Person X actively concealed his relationship and contact with Person A and Person B as a result of Person A allegedly supplying Person X with illicit substances. Even if their relationship had been known to the police and MAPPA partners, any identified risk of Person X causing them significant harm would have been considered remote and I believe could not have been predicted.

**3.19.** During the latter stages of Person X's management the Police OMO changed from an experienced officer to one newly appointed. I believe the number of RSO's allocated to this officer was disproportionate to their experience and the handover and mentoring process requires to be reviewed and guidance issued. (*Recommendations 11 and 12*)

**3.20.** Whilst conducting the SCR I found the use of a chronology crucial in understanding Person X and those issues which were impacting on them, together with identifying the erosion of certain aspects of the support network surrounding them. The police OMOs did not have any form of chronology available to them at the time of managing Person X. The use of a chronology may have assisted the police OMO in identifying the erosion of the stable factors, including family, financial and organisational support and prompted the OMO to seek additional support for Person X. A chronology can be used as a quick reference and briefing tool, to identify significant events/issues which have historically impacted on the RSO, however their use may also be relevant to understanding future risk. This would also ensure that all MAPPA practitioners have adequately researched each of the RSO's they are managing in the community and assist with the risk formulation process. (*Recommendation 13*)

**3.21.** It is beyond the remit of this SCR, where the primary focus is concerned with local MAPPA processes, to make a definitive statement regarding the deportation process. The specific decisions regarding the detention and deportation of individuals rests solely with the Home Office Immigration Enforcement (HOIE). The SCR did identify certain areas in which communication between MAPPA partners and HOIE could have been improved. One of the recommendations for action focusses on the creation of an information sharing protocol between MAPPA partners and HOIE in relation to those foreign nationals subject to SONR who meet the criteria for deportation. This protocol should include consideration as to how the MAPPA meeting process might facilitate discussion as required concerning the potential early detention of foreign nationals subject to SONR, who meet the criteria for deportation. (*Recommendation 14*)

# 4. Conclusion

**4.1.** The management and monitoring of those individuals subject of SONR is an extremely dynamic and complex area of business and it should be noted that in several respects the SCR document is somewhat historic in perspective as the management period of Person X began in 2014 and concluded in 2016

**4.2.** It should also be recognised that the SCR reviews one specific case and the majority of the recommendations are in relation to the isolated analysis of the management of Person X.

**4.3.** Person X was atypical of the majority of RSO's who are managed by MAPPA in the community. Person X was at times a paranoid, evasive and devious individual who used lack of English language skills as an obstacle when they wanted to deflect questions and, at times, refused to fully co-operate with the police officers who were trying to manage Person X in the community. In tandem with fluctuating mental health issues Person X was a complex individual to manage and I believe this complexity was not fully apparent, recognised or understood whilst being managed under MAPPA.

**4.4.** During the period of time Person X was in the community Person X was predominately monitored by one Responsible Authority, Police Scotland. The Police Offender Management Unit with the responsibility for monitoring Person X was sufficiently resourced in respects of both personnel and physical resources and adequately supported by Senior Police Management within Tayside Division. However, I believe more interaction and support in relation to the OMU could have been provided from a Local Policing perspective.

**4.5.** The Police were assisted throughout the MAPPA management of Person X by Criminal Justice Social Work, Housing and NHS Tayside. NHS Tayside whilst regarded as a Responsible Authority in relation to the assessment and management of mentally disordered offenders and restricted patients were in the case of Person X a Duty to Co-operate agency.

**4.6.** During the SCR process there were 3 main issues identified which are discussed fully in the body of the report, to summarise they are:

- A general lack of communication between the NHS medical professionals treating Person X and MAPPA and vice versa. This included pertinent information regarding Person X's mental health which was apparently never shared with the MAPPA partners. As a result there was limited analysis and understanding of Person X's mental health issues and how the events in Person X's life were impacting on his wellbeing and risk.

- The police reaction to the life events impacting on Person X, the effectiveness of the police contact to gather information and the comprehensiveness and accuracy in relation to the risk assessments conducted.

- The lack of a cohesive co-ordinated approach in relation to communication flow between MAPPA partners and Home Office Immigration Enforcement and vice versa.

**4.7.** There were a number of life events which were impacting on Person X and contributed to their mental health fluctuating in the lead up to the murders of Person A and Person

B. These included: the ongoing deportation process; the death of Person X's closest brother; thereafter an erosion of Person X's family supports, lack of benefits and any assistance to claim for them; Person X's relationship with their partner ending and the resultant loss of financial as well as social support; and the escalation of Person X's illicit drug abuse.

**4.8.** It is not possible to infer that a more comprehensive intervention strategy or assistance in the form of support would have broken the chain of events leading up to the murders and prevented them taking place. Person X actively concealed their relationship and contact with Person A and Person B as a result of Person A allegedly supplying him with illicit substances. Even if their relationship had been known to the police and MAPPA partners, any identified risk of Person X causing them significant harm would have been considered remote and I believe could not have been predicted.

**4.9.** The motive for the Murders of Person A and Person B was never fully identified and the trial Judge commented that he considered the motive unclear; whether it was to steal drugs or having committed the murders Person X then took the opportunity to steal from the apartment.

**4.10.** Having analysed all the information available it is my opinion that the version of events given by Person X whilst presenting evidence in court could be viewed as plausible and the murders were an impulsive act.

**4.11.** There were a number of occasions when Person X's risk escalated whilst being managed under MAPPA, however they had been in the community in the UK since 2009 and had not shown significant violence towards any other individual other than Person X. Person X did have a close affinity to their brother and the loss of their brother's jacket and the subsequent reaction by Person A may have been an emotional trigger which initiated the spontaneous fight and resulted in the murders. It is clear however that Person X stole money, drugs and personal items from the scene of the crime and that Person X or some other person returned there on a number of occasions before the two victims were discovered by the police.

**4.12.** It is absolutely apparent that if Person X had been detained pending deportation Person X would not have been in the community or had the opportunity to commit the murders. It is beyond the remit of the SCR to comment on whether Person X could have been deported or detained pending deportation. The decisions regarding deportation are exclusively at the discretion of Home Office Immigration Enforcement (HOIE) and outwith the scope of the SCR. I have recommended that a Protocol between MAPPA partners and HOIE, setting out agreed steps to respond to foreign nationals subject to SONR, should be considered. This Protocol should set out how HOIE attendance at MAPPA meetings might enhance the process.

**4.13.** However, at the time of the murders Person X had not been detained and after carefully considering all the circumstances at that time and Person X being present in the community, it is my opinion that the murders of Person A and Person B were the result of a spontaneous and impulsive act which could not have been predicted or prevented.

**4.14.** All practitioners who enter the specialism of MAPPA management quickly appreciate both the responsibility placed on them and the magnitude of the task in relation to applying preventative strategies on those individuals subject of SONR in the community. In relation to the Police the role carries a level of responsibility that few other police constables will ever experience. Those practitioners who work within the MAPPA environment are devoted individuals who at times are attempting to prevent

some of the most callous, devious and evasive individuals living in our communities from inflicting harm and their dedication and commitment to this complex role should be recognised.

**4.15.** If implemented the recommendations articulated within this SCR document will enhance the management of those SONR and be another step closer to protecting the public from harm.

# 5. Areas of Good Practice

**5.1** Within the Tayside area, all individuals who become subject of SONR are discussed at an 'Initial' MAPPA meeting which is normally held within 1 month of notification and follows the framework and participation level of a MAPPA 2 meeting. This is a robust process where all partners are fully sighted on all individuals subject of SONR within their area of responsibility.

**5.2** On examining the MAPPA 1 process for Person X I found it extremely robust with comprehensive representation and attendance levels, strict diarised timings and minuting arrangements.

**5.3** The co-location of multi-agency partners and the role of the NHS Liaison Officer.

**5.4** The initial visit regime [frequency of visits] set by the OMU supervisor was set in excess of the minimum standard in order to build rapport and obtain as much relevant information as possible for the purposes of the initial MAPPA meeting.

# 6. Recommendations for Action

**Recommendation 1**

The Tayside MAPPA Strategic Oversight Group review MAPPA 1 chair training and introduce ongoing refresher training where required.

**Recommendation 2**

The Tayside MAPPA Strategic Oversight Group reviews the use of the risk formulation process for those subject of MAPPA 1 management and produces a standardised MAPPA 1 minute template incorporating this practice.

**Recommendation 3**

NHS Tayside should ensure all relevant information is made available to partners in order that a comprehensive and robust risk assessment can be completed taking into consideration all mental health information.

**Recommendation 4**

NHS Tayside reviews the alert system that informs staff of those individuals who may present a risk to staff or patients.

**Recommendation 5**

NHS Tayside reviews the communication and information sharing strategy between MAPPA and local Health Services.

**Recommendation 6**

Tayside Police 'D' Division reviews the use of interpreters [Including utilising Police officers] and issues relevant guidance in relation to the management of Foreign Nationals who are SONR.

**Recommendation 7**

Tayside Police 'D' Division reviews the involvement of Local Policing in relation to those managed under MAPPA.

**Recommendation 8**

The Tayside MAPPA Strategic Oversight Group raise at a national level that consideration be given to whether joint partner participation is possible when completing SA07 Stable assessments for RSO's managed by Police only.

**Recommendation 9**

Tayside Police 'D' Division ensures that that all officers and supervisors within the Offender Management Units have undertaken comprehensive police Risk Management Plan training.

**Recommendation 10**

Police Scotland ensures that all officers and supervisors within the Offender Management Units attend the National Offender Management Unit course as soon as reasonably practicable on being appointed.

**Recommendation 11**

Police Scotland reviews and issues guidance in relation to the allocation of RSO's to newly appointed Offender Management Officers.

**Recommendation 12**

Police Scotland reviews and issues guidance regarding the mentoring of newly appointed Offender Management Officers.

**Recommendation 13**

The Tayside MAPPA Strategic Oversight Group raise at a national level that consideration be given to evaluating the benefit and effectiveness of completing a chronology for all individuals who are subject of SONR.

**Recommendation 14**

The Tayside MAPPA Strategic Oversight Group raise at a national level the issue of an information sharing protocol between MAPPA partners and HOIE in relation to those foreign nationals subject of SONR who meet the criteria for deportation. There should be consideration of a national process whereby, prior to that individual receiving official notification, a MAPPA meeting attended by MAPPA partners and HOIE is held at the earliest opportunity.

# 7. Glossary of Terms

**HOIE:** Home Office Immigration Enforcement

**INR:** Initial Notification Report.

**MAPPA:** Multi-Agency Public Protection Arrangements.

**NO:** Notification Order. Require sexual offenders who have been convicted overseas to register with police, in order to protect the public in the UK from the risks that they pose.

**OMO:** Offender Management Officer

**OMU:** Offender Management Unit

**Police Service of Scotland:** Also known as Police Scotland the service was formally established on 1 April 2013 and is responsible for policing in Scotland.

**Responsible Authorities:** The responsible authorities are the police, local authorities, health boards or Special Health Boards and the Scottish Prison Service (SPS) (acting on behalf of Scottish Ministers).

**RSO:** Registered Sex Offender. This is an offender convicted of an offence specified in the Sexual Offences Act 2003 and therefore subject to the notification requirements of this Act.

**SCR:** Significant Case Review

**SOG:** Strategic Oversight Group

**SONR:** Sex Offender Notification Requirements

**STABLE 2007:** A risk assessment tool that measures sex offender risk factors that can change over time and which informs case management plans and treatment needs.

**Statutory Supervision:** Includes Life Licence, Parole Licence, Non-Parole Licence, Extended Sentence Order, Order for Lifelong Restriction, Short-Term Sex Offender Licence, Probation Order, Community Service Order. All of which are defined.