



**MULTI-AGENCY PUBLIC
PROTECTION
ARRANGEMENTS
(MAPPA)
SIGNIFICANT CASE
REVIEW**

Prisoner Z

**Report by Mark Cooper, Independent Reviewer
on behalf of
Tayside MAPPA Strategic Oversight Group**

26 November 2019

Foreword to Significant Case Review (SCR)

This SCR was initiated by the MAPPA Tayside Strategic Oversight Group (SOG) and commissioned by the Angus Chief Officers Group (Angus COG) following a vicious and unprovoked attack on an innocent member of the public. The SCR was commissioned to allow for a thorough, independent review of the events and circumstances that led up to this serious offence. As the Review concludes, this incident was as a consequence of the perpetrator's actions alone and could not have been predicted. Nonetheless, there are a number of findings within the SCR that lead to ten recommendations that I am confident will ensure strengthened policy and practice in public protection.

Uppermost in my thoughts and those of the Tayside SOG throughout this detailed process has been the victim of this appalling crime. They have suffered significant physical and emotional harm and their family, as well as all previous families and individuals, have suffered the impact of this individual's actions. We deeply regret that this incident happened.

I am very appreciative of the role that the victim has played in this SCR and the dignity, drive and determination they have shown in seeking systemic improvement to try to ensure the protection of others. Throughout this process, the team involved in the SCR have tried to ensure that the victim and close family have been as involved as possible in discussions about the Review and have been available to hear and understand their concerns. We hope the publication of this report provides them with the details of the events leading up to the attack and the role of the agencies involved.

It should be noted that, in line with other SCRs, this review was commissioned to recommend actions that will strengthen, change and improve future arrangements and practice. It is not about apportioning blame to individuals. My thanks go to all the staff who have been involved in this review. They have participated openly, fully and with integrity and we recognise they are not immune to the stress and strain such matters can have upon those professionals involved.

The report has been completed by an Independent Reviewer and has proven to be a complex review, involving a range of different agencies and professionals, each with their own area of expertise, their own arrangements and processes. I fully acknowledge that, because of the complexity of the subject, the need to work across agency and geographical boundaries, and adhere to data protection legislation, that it has taken some time to complete and publish this report. It is also unusual in that it involves the Scottish Prison Service (SPS) as the lead agency managing the individual's case at the time of the incident.

The Independent Reviewer who completed the report has worked hard to ensure the facts of the case have been accurately represented and the recommendations have been unanimously agreed by the Tayside SOG. Throughout the process of completing this report, several points relating to factual accuracy and interpretation have been highlighted to the Independent Reviewer. He has sought to address these, but the report remains his own views. The Tayside SOG came to the decision that we would accept the final report to ensure that the integrity of the independent review process was maintained.

It is my belief that all individuals involved in this case did their best to manage this individual and the associated risks. However, as the SCR details, there were opportunities where more effective information sharing between agencies and

clarification of roles and responsibilities might have ensured more thorough decision making and management of risk to the public.

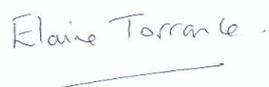
The recommendations from the Review are wide ranging, with some national actions identified, as well as learning for arrangements in Tayside.

The Tayside SOG has produced an action plan to deliver on the recommendations with clear timescales. This will be closely monitored to ensure actions are completed in a timely way and deliver the change required to improve public protection. It is important to note that, throughout what has been a lengthy review process, early learning has been shared and action already taken where applicable to address a number of the improvements identified. These include:

- New risk management progression and release guidance implemented by the SPS.
- Revised community access risk assessment guidance in place.
- Review of Multi-Agency Public Protection Arrangements (MAPPA) minute taking and chair arrangements undertaken.

We have been as transparent as possible in publishing the full review. However, on the basis of legal advice we have had to redact certain personal information, particularly that relating to third parties, their location of residence, the health conditions of victims etc.

The MAPPA in Tayside support a significant number of offenders in the community in an effective way every day, but we recognise that improvement can always be made. I, along with all members of the Tayside SOG, are committed to ensure that the learning from this case is shared and action is taken to meet the recommendations in this review. In doing so, we can continue to assure the ongoing safety of the public.

A handwritten signature in black ink that reads "Elaine Torrance". The signature is written in a cursive style and is underlined with a single horizontal line.

Elaine Torrance

Independent Chair of Tayside MAPPA SOG

CONTENTS	PAGE
1. Introduction	4
2. Terms of Reference for SCR (SIGNIFICANT CASE REVIEW)	5
3. Appointment of Independent Reviewer and Statement of Independence	6
4. Methodology	7
5. Chronology of Key Events	8-12
6. The Nature and the Extent of the Involvement of the Victims and their Families	13-14
7. Background and National Context - An Overview of the 'Prison Journey' for Life Sentence Prisoners	15-18
8. Multi-Agency Public Protection Arrangements (MAPPA)	18-20
9. VISOR (VIOLENT AND SEX OFFENDER REGISTER)	21
10. Key Findings	22-45
11. Local Observations	45-46
12. Areas of Good Practice	46
13. Conclusions	46-49
14. Recommendations	50-51

1 INTRODUCTION

In 2002, Prisoner Z was sentenced to life imprisonment at K High Court for the Murder of Person A. Person A, who had been walking a dog, had been attacked, head butted, repeatedly stabbed with a sharp instrument and stamped upon by Prisoner Z at the murder scene close to where Prisoner Z and Person A both lived. Her body had been dragged into undergrowth and partially hidden.

Prisoner Z was sentenced to life Imprisonment with a minimum punishment part of fifteen years, backdated to 2001.

In 2017, while on Unescorted Home Leave and three days before his second Life Prisoner Parole Tribunal, Prisoner Z attacked Person B with a blunt instrument as she walked her dog close to her home. Person B suffered life changing head injuries including two fractures of the skull and defensive blunt force trauma injuries to one of her hands.

In 2017, Prisoner Z pled guilty to Assault to Severe Injury, Permanent Disfigurement, Permanent Impairment and Danger to Life and Attempted Murder. In 2018, he was sentenced to an Order of Lifelong Restriction with a punishment part of five years.

2 TERMS OF REFERENCE FOR SIGNIFICANT CASE REVIEW (SCR)

This SCR has been commissioned by Angus Council on behalf of the Angus Chief Officers Group (COG) following a recommendation from the Tayside MAPPA Strategic Oversight Group (SOG). Although Prisoner Z was a serving prisoner at the time of the offence, and therefore the responsibility of the SPS, representatives of the Tayside SOG formed the view that the circumstances of Prisoner Z's offence should be considered through a SCR; the circumstances of the offence meet the criteria set out in the MAPPA National Guidance 2016 in so far as a MAPPA referral had been received and there was multi-agency involvement; ***"When an offender managed under MAPPA at any level, is charged with an offence that has resulted in the death or serious harm to another person"***.

Aim

The aim of the SCR was to examine the single agency and multi-agency involvement in the management of Prisoner Z, with particular focus on risk assessment and risk management prior to and during periods of unescorted home leave. To identify where systems worked appropriately and where improvements can be made in systems, processes and practice.

Anticipated Outcomes

To assess whether the attack should have been anticipated and/or prevented and, if so, what are the implications for multi-agency practice?

To identify key professional and organisational learning regarding how single and/or multi-agency working could have improved the management of Prisoner Z prior to and during Home Leave and better protected Person B and any other person who may have been at risk of harm.

Objectives

To examine how Prisoner Z was assessed and managed between the date of his transfer to 'National Top End' (NTE) in HMP Greenock in December 2014 and the attack on Person B in 2017 and determine:

- Areas of good practice and practice/or processes that should be strengthened and replicated in managing prisoners on transition to Home Leave/or release.
- The extent and quality of multi-agency risk assessment and risk management planning for offenders prior to Home Leave/on Home leave/in the community and any opportunities for improvement.
- The extent to which agencies involved worked together, shared relevant information and used information to influence decision making in respect of Prisoner Z.

By considering the above, the Review was asked to determine whether agencies appropriately assessed and managed risk to the public and in doing so, identify learning on a local, regional and national basis to improve public protection.

In line with MAPPA National Guidance (2016) the Tayside SOG assessed that the SCR should be delivered by an external Reviewer as there was an indication that recommendations may have national significance, the case is high profile and there is a high degree of public interest.

3 APPOINTMENT OF INDEPENDENT REVIEWER AND STATEMENT OF INDEPENDENCE

Mark Cooper retired as a Detective Superintendent from Police Scotland in July 2015.

He has been involved in the Management of Sexual Offenders since 2006 at which time he was in the role of Crime Manager (Detective Chief Inspector) within Aberdeen City Division under legacy Grampian Police arrangements.

He continued to be involved in the management of sexual offenders at a strategic level in his next posts as Superintendent (Operations) within Aberdeen Division and as Divisional Commander within Moray. He was a regular MAPPA chair while in these roles.

Mark continued to be involved in this area of policing under Police Scotland arrangements as Superintendent (Operations) in Aberdeenshire and Moray Division and took on the portfolio for Public Protection in his final role in the Police Service in 2014, when he was appointed Detective Superintendent for Local Policing and Public Protection for Aberdeen City, Aberdeenshire and Moray.

Following his retirement in 2015, he spent a year working in the private sector as a Training Manager with a company within the oil and gas sector.

In March 2017, he started his own consultancy when he was appointed to the Independent Review Team examining non-recent sexual abuse in Scottish Football.

Following this piece of work, Mark was approached by the Scottish Government with a view to undertaking SCRs and was invited to apply to undertake the Prisoner Z SCR. Following a competitive tendering process, he was appointed to the role in June 2018.

Mark Cooper has no connection to Prisoner Z, his family nor to Person B and her family. He has no connection with any of the professionals involved in this case with the exception of the officer who was the Detective Superintendent in Tayside at the time of the Person B crime in 2017. They had previously been on call together for Specialist Crime Division in Police Scotland but had never met.

4 METHODOLOGY

The methodology adopted by the Reviewer to undertake this SCR was to:

- Compile and agree a communications strategy to ensure that the boundaries were clear in relation to ongoing contact with Person B and her family and to ensure that senior and operational staff across the MAPPA partnership were aware of the Review and how it was going to be conducted.
- Agree with Senior Managers how approaches and meetings with operational staff would be achieved.
- Meet with and obtain the views of Person B and her husband.
- Meet with the partner of Person A and her family to obtain their views.
- Meet with operational staff to obtain their accounts and views on the management of Prisoner Z.
- Examine documents relating to the internal review conducted by the SPS.
- Meet and consult with representatives of the Scottish Government and other relevant agencies in relation to MAPPA processes.
- Examine the Violent and Sex Offender Register (VISOR) and its use by those involved in the management of Prisoner Z.
- Examine all policies, procedures and practices utilised in the risk assessment and management of Prisoner Z including the SPS Home Leave policy.
- Examine the SPS reports submitted to Scottish Ministers recommending the First and Second Grants of Temporary Release.
- Examine and review all files relative to the risk assessment and management of Prisoner Z for the period outlined in the Terms of Reference.
- Meet with the perpetrator Prisoner Z, in custody, to ascertain his position in relation to his management and the commission of the Attempted Murder on Person B.
- The essence of the Review was based around identifying any single and multi-agency learning and highlighting good practice.
- The Independent Reviewer compiled notes of all meetings to assist with the compilation of this report, its key findings, and recommendations and to ensure that all learning is evidence based.

The Independent Reviewer has further assessed that in order to ensure the task to deliver the whole of the Terms of Reference was discharged, there was a need to work outside those Terms of Reference to take account of and consider matters such as the past behaviours of Prisoner Z and the context of his crimes.

5 CHRONOLOGY OF KEY EVENTS

To assist readers, a chronology of key events relevant to Prisoner Z is provided:

- 1985** Prisoner Z was born. His parents separated when he was an infant and he lived with his mother. His mother was attending university as well as working which meant that some of his care was provided by his grandparents who also lived in the same town. Prisoner Z was regarded as being close to his grandparents.
- 2001** Prisoner Z left school, aged 15. He did not obtain work.
- Person A was found deceased at murder scene. She had suffered multiple stab wounds and a broken nose.
- Prisoner Z was charged and arrested in relation to Murder.
- 2002** Prisoner Z was convicted of Person A's Murder at the High Court in K. During the trial, he incriminated a friend for committing the Murder. After his trial, Prisoner Z appealed his conviction, but this was rejected in 2003.
- 2003** Prisoner Z transferred to HM Young Offenders Institute (YOI) Polmont.
- 2006** Prisoner Z was assigned Low Supervision status at HM YOI Polmont and retained this level up to his time in HMP Castle Huntly in 2017.
- Having attained adult status, Prisoner Z transferred to HMP Shotts where he commenced his induction within the adult prison setting.
- 2007** Prisoner Z completed offending behaviour programmes in relation to Cognitive Skills and Alcohol Awareness and in July 2007, he completed the Anger Management Programme. These were assessed to best suit his needs.
- 2008** Prisoner Z was temporarily transferred to HMP Peterhead where he underwent an assessment to ascertain whether there was a sexual element to his index crime in 2001. The result of this assessment was that it was deemed that there was insufficient evidence to determine that there was a sexual element. However, the author of this assessment suggested that information may come to light in the future which might alter this finding and that professionals should continue to be vigilant in this regard. A Psychological Risk Assessment (PRA) was completed.
- 2010** Prisoner Z transferred to HMP Perth.
- 2012** A further PRA was completed.
- This PRA also recommended that Prisoner Z be considered for the Violence Prevention Programme (VPP).
- Prisoner Z was seen by a Psychiatrist who conducted a routine review and concluded that there was no clear evidence of

psychosis. It was further concluded that Prisoner Z was a difficult man to assess in terms of providing a diagnosis. He was identified as having long standing suspiciousness and feelings that people were making life difficult for him.

2013 Prisoner Z completed the Methadone Reduction Programme. (The Review was unable to determine when he commenced this programme due to patient confidentiality).

Prisoner Z transferred to HMP Shotts where he commenced the VPP completing same in 2014. Following this, it was deemed by the Programme Case Management Board that Prisoner Z had no outstanding behavioural needs.

2014 Prisoner Z transferred to NTE within HMP Greenock.

2015 Prisoner Z was referred to the Mental Health team following a request by him to be downgraded and returned to closed conditions.

Prisoner Z's First Grant of Temporary Release was authorised and signed by Scottish Ministers following the submission of a report by the SPS.

2016 Prisoner Z commenced a community-based work placement which he attended 4 days per week.

Legislation now came into force in respect of MAPPA Category 3 Offenders (Other Risk of Serious Harm Offenders).

Prisoner Z commenced his first period of Unescorted Leave to his home leave address. This date coincides with an Integrated Case Management (ICM) meeting at HMP Greenock.

Level of Service/Case Management Inventory (LS/CMI) was completed by a Prison Based Social Worker at HMP Greenock and this resulted in his Risk and Needs Level being assessed as 'Medium' in relation to causing harm, meriting a fuller assessment. A Risk of Serious Harm (RoSH) assessment was not fully completed. At this stage, this precluded Prisoner Z from automatically presenting as a person who may qualify as a MAPPA Category 3 Offender.

The punishment part of Prisoner Z's sentence was reached. The following day, he was represented at a Parole Life Prisoner Tribunal and it found '*that it was not satisfied that it was no longer necessary for him to be imprisoned for public protection*'. A review period of 12 months was set, and it was recommended that Prisoner Z be transferred to the Open Estate (OE) where he could be further supported and tested.

Prisoner Z transferred to HMP OE known as HMP Castle Huntly following his second Grant of Temporary Release being signed off by Scottish Ministers. This led to an informal discussion between Prison staff and the local Tayside MAPPA Coordinator where it was suggested that a multi-agency group meeting should be

held to discuss the likely expected media attention around Prisoner Z.

A Risk Management Team (RMT) meeting was held at HMP Castle Huntly. At this meeting, it was agreed to convene a multi-agency meeting to discuss the potential for media intrusion and interest in Prisoner Z and how this may be mitigated. It was also decided to commence phased community access prior to this multi-agency meeting taking place.

Prisoner Z commenced a period of Home Leave over two days which included one overnight stay at his home leave address.

A multi-agency meeting chaired by the Tayside MAPPAs Coordinator was held at HMP Castle Huntly, attended by Police Scotland Offender Management Unit, a MAPPAs officer, Community Based Social Work for Angus and Dundee City, Prison Based Social Work and the SPS.

A RMT meeting was held at HMP Castle Huntly. Additional licence conditions were agreed.

Prisoner Z commenced a three day Home Leave period which included two overnights at his home leave address.

An adverse occurrence was noted when Prisoner Z was found in his cell at HMP Castle Huntly under the influence of an unknown substance assessed to be New Psychoactive Substance (NPS). The following day, a RMT meeting was convened to consider this incident which found him guilty and his community access was suspended for a period of one month. It was decided not to return him to closed prison conditions.

A RMT meeting was held at HMP Castle Huntly and decisions around his community access were deferred pending the outcome of an impending multi-agency meeting which was to be held in 2017.

A further LS/CMI was completed by a Prisoner Based Social Worker at HMP Castle Huntly and on the basis of that assessment, a RoSH was also completed. The LS/CMI indicated Prisoner Z's risk and needs as 'medium'. The RoSH part indicated there was a High Risk of Serious Harm posed by Prisoner Z.

2017

On the basis of the RoSH, a MAPPAs Category 3 referral was submitted to the Tayside MAPPAs Coordinator by the SPS.

A further multi-agency meeting was held at HMP Castle Huntly chaired by the MAPPAs Coordinator for Tayside. At this meeting, it was acknowledged and recorded that Prisoner Z would be a Category 3 MAPPAs subject on his release on Life Licence. Areas of concern were raised at this meeting by a Police Scotland Offender Management Unit supervisor in relation to further risks being identified by partners in relation to Prisoner Z.

A RMT meeting was held at HMP Castle Huntly. It referenced the fact that Prisoner Z would be managed at MAPPAs Level 2.

Prisoner Z's Home Leave was reinstated by the SPS without the knowledge of his Community Based Social Worker or Police Scotland and he spent two overnights at his home leave address.

Prisoner Z was on Home Leave at his home leave address.

Although discussion between Dundee City Council and Angus Council about the need to transfer responsibility for Prisoner Z's community management had started in 2014, the final process of handover began at this time (March 2017).

A RMT meeting was held at HMP Castle Huntly where it was agreed to commence Prisoner Z on full community access.

Prisoner Z was on Home Leave at his home leave address.

A further Multi-Agency meeting was held at HMP Castle Huntly chaired by the MAPPAs Coordinator. Angus Council was not represented due to the Social Worker being on annual leave; Dundee City Council were in attendance as the supervising local authority. The meeting minute noted that Prisoner Z would be managed at MAPPAs Level 3 at the point of his expected release on Life Licence due to the expected media interest and that the Local Area Commander would be invited to the next meeting of the group.

A RMT meeting was held at HMP Castle Huntly where it was noted that his responsible Community Based Social Work Department had transferred to Angus Council.

Prisoner Z was on Home Leave at his home leave address.

A RMT meeting was held at HMP Castle Huntly.

An ICM meeting was held at HMP Castle Huntly. This was in anticipation of a potential Parole Tribunal on 10 August 2017.

A multi-agency meeting took place at HMP Castle Huntly chaired by the Tayside MAPPAs Coordinator. There were no Police in attendance as none had been invited. At this meeting, it was recorded that Prisoner Z would be managed at MAPPAs Level 3 when/if he was released and that a MAPPAs Level 3 meeting would be arranged for late July 2017.

Prisoner Z's parole dossier notes that Prisoner Z would be a MAPPAs Category 3 offender and that he would be managed at MAPPAs Level 3 on his anticipated release date.

A RMT meeting was held at HMP Castle Huntly where it considered and agreed a request by Prisoner Z to pursue an application to attend a course at Perth College.

Prisoner Z was on Home Leave.

Prisoner Z was on Home Leave.

A RMT meeting was held at HMP Castle Huntly.

Prisoner Z was released on Home Leave from HMP Castle Huntly for seven nights at his home leave address.

Prisoner Z attacked Person B close to her home and attempted to murder her. Prisoner Z was detained at his home leave address shortly after the attack. Person B suffered life threatening and life changing injuries. Prisoner Z was arrested and returned to closed prison conditions after his appearance in court.

Prisoner Z pled guilty to Assault to Severe Injury, Permanent Disfigurement, Permanent Impairment and Danger to Life and Attempted Murder. Sentence was deferred for Reports. This included a PRA.

2018

Prisoner Z was sentenced an Order of Lifelong Restriction with a five year punishment part.

6 THE NATURE AND THE EXTENT OF THE INVOLVEMENT OF THE VICTIMS AND THEIR FAMILIES

Person B

Person B and her immediate family helped shape the Terms of Reference for this SCR.

The Reviewer has met Person B and her husband on four separate occasions during the Review. These meetings were designed to get their perspective as victims of Prisoner Z.

It should never be underestimated the catastrophic impact this incident has had on Person B, her husband and their wider family. As Person B continues to seek a full recovery, she doubts this will ever be achieved. [REDACTED]

Person B feels that [REDACTED]

She has been robbed of her daily routine of [REDACTED]

Person B has been keen to provide her perceptions and experiences in a very balanced and measured way with the sole purpose of helping to prevent others from falling victim to convicted prisoners who may be released on Home Leave from prison in the future.

Person A

The Reviewer met with Person A's partner and her sister during the Review because it was important to understand their feelings as the family of Prisoner Z's first victim.

It remains the case that Person A's family have had to endure the last 18 years without her being in their lives and have been robbed of whatever the future may have held for them to share with her.

Both are members of the Victim Notification Scheme (VNS) so both had been contacted in the lead up to the parole tribunal for Prisoner Z in 2016 and for the proposed tribunal in 2017. They had intimated their anger and disappointment should Prisoner Z have been released during the lead up to both processes.

Notwithstanding the legislative restrictions, both her partner and her sister remain frustrated, as victims, in relation to the very sparse information which has been shared with them since Prisoner Z's conviction in 2002.

Both were very angry that, whilst they had been notified that Prisoner Z was to receive Home Leave, they were oblivious to the fact that Prisoner Z had been receiving unescorted periods of Home Leave [REDACTED]

Although Prisoner Z had licence conditions preventing him from accessing the murder scene and from entering the streets close to Person A's address [REDACTED]

[REDACTED].
They question whether Person A's home address and its close proximity to Prisoner Z's home leave address was ever considered when it was decided to allow Prisoner Z Home Leave.

7 BACKGROUND AND NATIONAL CONTEXT - AN OVERVIEW OF THE PRISON JOURNEY FOR LIFE SENTENCE PRISONERS

This section has been prepared to assist in the understanding of the systems and processes that are in place to manage a life prisoner through their sentence. Whilst many of the systems and processes apply to long term prisoners (those sentenced to four years or more) because Prisoner Z is a life sentenced prisoner, this section concentrates solely on the management of life sentenced prisoners.

When a life sentenced prisoner goes into custody, that individual will have a number of risks and needs which require to be assessed and addressed in order to reduce the risk of re-offending. For life sentenced prisoners, it is important that a period of induction into prison life takes place. In many cases, adult male prisoners serving a life sentence will spend time in the National Induction Centre (NIC) at HMP Shotts. The average length of stay there would be around 18 months. The time that someone spends in the NIC is not limited or specified upon arrival but depends upon their response to custody and their readiness to transfer to a mainstream prison. This allows them to have the time and space to reflect and come to terms with their sentence and supports them towards the transition to a mainstream prison where they will spend the majority of their sentence.

During their time in a mainstream prison, prisoners' offending behaviour needs are identified through a Generic Programmes Assessment which considers what programmes are most appropriate for the individual and this leads to the development of a sequenced programme plan. This is then considered by the SPS Programme Case Management Board (PCMB). These interventions can target offending behaviours as well as health and addiction issues. In the SPS, the risks and needs of an individual are managed through an ICM approach.

Integrated Case Management

ICM is a multi-agency approach to the management of an individual's progression through custody which is focussed on reducing re-offending. This is achieved through ensuring that risks are identified and a plan is in place for each prisoner to reduce those risks in a sequenced and coordinated manner.

The ICM is also aimed at establishing an effective system which facilitates closer cooperation and joint working practices between partner agencies, usually Criminal Justice Social Work but also the Police.

The ICM process should, where applicable, fit directly with the MAPPAs to ensure the transition of high-risk individuals into the community is consistently managed.

Risk Management

The RMT, chaired by a senior member of SPS staff, has multi-disciplinary representation from a range of agencies involved in the management of prisoners. The group may include, prison management, social work, psychology, and health including mental health and addiction services. Its primary purpose is to consider the assessment, intervention and management needs of those prisoners referred via the ICM process; or where local management have a particular concern in relation to a prisoner's behaviour or on-going management which requires immediate intervention. It is also the decision-making body that considers prisoners for progression to less secure conditions and/or community access. In considering whether it is appropriate to

grant temporary release to an eligible prisoner, the RMT must assess the risk that the prisoner may abscond, pose a danger or cause harm to the public.

When a prisoner is approved for progression to less secure conditions, the receiving establishment NTE or OE will review the proposed management plan prior to granting community access.

LS/CMI is the key risk management tool used in the assessment and management of life sentence prisoners.

Level of Service/Case Management Inventory (LS/CMI)

LS/CMI is an offending risk and needs assessment and case management tool designed to share and record information in a standardised format which will be consistent across all of Scotland. It is the tool utilised by Criminal Justice Social Workers to assess and determine the risks and needs of the individual's offending; wider risks and needs that impact on the offender's likelihood to respond, as well as any strengths that the individual may have. This is the information that forms the basis of case management planning.

If a RoSH is identified, then a more involved assessment RoSH is triggered. Parts of the tool enable the assessor to consider what case management planning is required to help the individual address their needs whilst also enabling the assessor to consider the range of actions required to case manage any anticipated RoSH. All risk assessments using LS/CMI will be conducted by Social Work staff, but they will obtain all available information from other agencies including those in the community. Relevant SPS staff have access to LS/CMI information, although they cannot amend the data in any way.

When a prisoner is near to their parole qualifying dates and/or progression is being considered which means the prisoner may have access to the community, the LS/CMI will be completed in full by Prison Based Social Work staff including progress reporting. A LS/CMI is applied to all prisoners who are subject to post-release supervision.

The LS/CMI method allows for the reassessment of prisoners where necessary. It is envisaged that reassessments within the custodial setting will predominantly be performed at transition points only, i.e. transfer from closed conditions to NTE or OE. The option to reassess can be considered where a significant event occurs. A significant event is defined as an occurrence that could alter the management pathway of a prisoner, this might be, for example, a relapse into substance misuse. If a significant event is presented at the ICM which would impact on the risk assessment, Prison Based Social Work will update the LS/CMI case management plan.

Progression

Following an initial period of induction, a life sentenced prisoner will be allocated to an appropriate long-term prison and will be held there in secure and closed conditions for a significant period of time. Closed conditions mean that an individual will not have unescorted access to the community. It is important that the SPS prepare prisoners for release therefore once a prisoner has addressed their risks and needs and it is assessed by the RMT that they can progress to less secure conditions, a life sentence prisoner would transfer to a NTE. In most cases, a prisoner is unlikely to spend more than two years in the NTE before progressing to open conditions. The actual time required for an individual to spend in the NTE will be determined by the RMT, based on the specific risks presented by the individual. At the NTE, a prisoner will be

given the first controlled access to the community by means of Special Escorted Leave, where they are accompanied by staff for short periods of time on community visits to shops or family visits.

First Grant of Temporary Release

For a life sentence prisoner, First Grant of Temporary Release is required to be approved by Scottish Ministers before any unescorted access to the community can take place. These decisions are based upon recommendations made by the RMT who have access to all reports in relation to the prisoner, including PRAs. The RMT is involved at all stages of a life sentence prisoner's progression. It is important to note that progression is not linear and is dependent upon positive progress being made. The RMT may decide not to progress an individual and can recommend that someone is returned to closed conditions. If progress is satisfactory at the NTE, the next step would be progression to the OE. Open conditions allow more access to the community in preparation for the individual's eventual release.

Temporary Release-License Conditions

When a prisoner has unescorted access to the community, such access is regulated by applying licence conditions. The purpose of these conditions is to ensure that community access is done in a controlled and managed way. For example, conditions can include regular contact with community based Social Work; exclusion from licensed premises; exclusion from particular areas for the protection of victims etc. In addition to these licence conditions, there may be certain instructions provided to the individual relating to their specific circumstances.

Life Sentence Prisoner Journey

When a prisoner receives a life sentence, the judge will determine the punishment part of the sentence. The SPS seeks to provide life prisoners with reasonable opportunities, by the time of the punishment part expiry date, to determine that they are suitable for release by the Parole Board for Scotland.

In most cases, this is unlikely to require more than two years in the NTE and two years in OE. The actual time required for a prisoner to spend in both settings will be determined by the RMT, based on the specific risks presented by the individual. While there is a general expectation that life sentenced prisoners will be given opportunities to prove themselves through community access prior to release, the Parole Board for Scotland can direct release from closed conditions.

The timing of a transfer of a prisoner to less secure conditions depends on a number of factors including; the extent to which a prisoner has positively engaged with the prison regime, a prisoner's supervision level, conduct in custody, addiction problems and steps taken by the prisoner to address his or her offending behaviour. Where it is assessed as necessary to evidence reduction of risk, life sentenced prisoners will require to be given access to the community in order to demonstrate that a prisoner can reintegrate into the community safely. Community access is managed in a number of ways depending on the circumstances and the assessed risks of the individual prisoner. This can be achieved through access to Special Escorted Leave, temporary release for various purposes including work placements and Home Leave. The kind of opportunities required to demonstrate a reduction of risk are considered and determined by the RMT.

Temporary Release (Home Leave)

Temporary Release is the generic name for any period of unescorted release from prison during a prisoner's sentence. Unescorted leave means that the prisoner travels independently to and from the leave address or approved place within the specified time detailed on the temporary release licence.

Part 15 of the Prisons and Young Offenders Institutions (Scotland) Rules 2011 sets out the criteria and conditions for temporary release for all prisoners. An eligible prisoner is a prisoner who has been assigned a low supervision status and is not disqualified from obtaining temporary release for any reason. A prisoner is disqualified from obtaining temporary release if, for the time being, the prisoner is subject to proceedings under the Extradition Act 2003 or in the written opinion of a healthcare professional, is not fit enough to be granted temporary release.

A life prisoner is disqualified from obtaining temporary release unless the Governor has obtained the prior consent of the Scottish Ministers. Any consent granted by the Scottish Ministers will apply to the first grant of temporary release and any further grants of temporary release but will cease to have effect if the prisoner is subsequently assigned a supervision level other than low supervision level.

In considering whether it is appropriate to grant temporary release to an eligible prisoner, the Governor must assess the risk that the prisoner may abscond or pose a danger, or cause harm, to the public.

Home leave is unescorted temporary release from prison of an eligible prisoner for the purpose of enabling the prisoner to visit his or her home or other approved place for a period not exceeding seven nights excluding travelling time.

The principle purposes of temporary leave are to assist in the prisoner's preparation for release, to maintain contact with family members and to assess the prisoner's ability to cope outside the prison environment.

8 MAPPA

MAPPA is a framework in which responsible authorities have a statutory duty to cooperate in the management of offenders who present a RoSH to the public.

The responsible authorities for the area of a local authority are:

- The Chief Constable of Police Scotland.
- The local authority. The responsibility for the joint arrangements primarily lies with the Chief Social Work Officer, however, other local authority services such as Education and Housing, also have key responsibilities in relation to this function.
- A Health Board or Special Health Board for an area any part of which is comprised within the area of a local authority.
- SPS (acting on behalf of Scottish Ministers).

People, who fall under MAPPA fall into three categories.

Category 1 – offenders subject to the Sex Offender Notification Requirements (SONR).

Category 2 – mentally disordered restricted patients.

Category 3 – those offenders who, by reason of their conviction, are assessed as posing a RoSH to the public. These include:

- Offenders who are not required to comply with the SONR or are not defined as 'Restricted Patients'.
- Offenders who have been convicted of an offence and by reason of that conviction, are required to be subject to supervision in the community by any enactment, order or licence.
- Are assessed by the Responsible Authorities as posing a high or very high RoSH to the public at large.
- Require active multi-agency management at MAPPA Level 2 or 3.

To be included in the Category 3 MAPPA, offenders must meet all four criteria above.

Legislation commencing MAPPA for offenders in Category 1 was enacted in 2007 and legislation for Category 2 was enacted in 2008. However, plans to enact Category 3 were delayed. Following consultation with agencies and organisations across the Criminal Justice System, Scottish Ministers reviewed the planned implementation of MAPPA for Category 3 and concluded that a tightly focussed approach was required to target resources at managing those offenders who pose the highest risk. Consequently, legislation to commence MAPPA Category 3 was enacted and commenced on 31 March 2016.

As well as the three categories, there are three risk management levels which allows for a consistent approach to MAPPA throughout the country. However, each area has discretion so thresholds for the three levels may differ slightly across the country, but each local authority area must establish arrangements based on the three levels.

The three management levels are:

Level 1 – Routine Risk Management.

Level 2 – Multi-Agency Risk Management.

Level 3 – Multi-Agency Public Protection Panels (MAPPP).

The risk management structure is based on the principle that cases should be managed at the lowest MAPPA level commensurate with delivering a defensible Risk Management Plan (RMP) designed to address the RoSH posed by the offender.

On 31 March 2016, referral to MAPPA for Category 3 offenders was applied retrospectively to offenders serving existing sentences.

Meetings and Structure

The decision to refer to the MAPPA process at Level 2 or Level 3 should be discussed and considered at a pre-progression and/or pre-release ICM case conference as part of the risk assessment and risk management process. When an offender is considered to meet the criteria for inclusion as an 'other RoSH' offender, SPS must send the MAPPA Coordinator a referral as soon as possible.

Where offenders are considered for progression to the OE with potential access to the community, a MAPPA referral should be made to the MAPPA Coordinators of the home local authority and the local coordinator for the OE (Tayside) as soon as possible in the planning process.

SPS must send the MAPPA Coordinator a referral as soon as possible and not less than ten weeks prior to release following the pre-release ICM case conference unless there are extenuating circumstances along with supporting evidence. The MAPPA Coordinator will consider the referral and either accept it or decline it on the basis that it does not meet the threshold. It would be normal for the MAPPA Coordinator to consult with Senior Community Based Social Workers and, in such cases, a rationale will be provided, documented and retained locally.

Where the MAPPA Coordinators identify that a MAPPA Level 2 or Level 3 referral has been accepted, a meeting will be convened. Prior to Level 2 or Level 3 meetings, agencies will share information held about the offender and complete the relevant risk assessment and risk management planning templates. The information sharing process is managed by the MAPPA Coordinators.

For Level 2 or 3 meetings, representatives must have the necessary level of seniority and possess the authority to make decisions which commits their agency's involvement and resources. The representatives require the relevant knowledge and experience in risk needs, assessments and management, as well as in partnership working.

An initial Level 2 or 3 MAPPA meeting will be held in accordance with the MAPPA Guidance timescales. The MAPPA Coordinators will identify and organise appropriate attendance at Level 2 or 3 meetings.

Level 2 Multi-Agency Risk Management Meetings should be used where the active involvement of multiple agencies is required to manage and actively reduce the RoSH posed. The responsible authorities, through the MAPPA Coordinator, are responsible for convening and supporting the Level 2 arrangements, depending upon the needs of the case.

It is important that the Level 2 meetings are chaired by a suitable representative of either the Police, the local authority, SPS or Health.

The Multi-Agency Public Protection Panel (MAPPP) is responsible for the management of offenders at Level 3. The criteria for referring a case for the MAPPP are where the offender is assessed as presenting a high or very high RoSH and presents risks that can only be managed by a plan which requires close cooperation at a senior level or although not assessed as presenting a high or very high RoSH, the case is exceptional because the likelihood of media scrutiny and/or public interest in the management of the case is very high and there is a need to ensure that public confidence in the criminal justice system is sustained.

Following initial meetings, review meetings should be scheduled to assess progress against the RMT for Level 2 or 3 cases.

9 ViSOR (THE VIOLENT AND SEX OFFENDER REGISTER)

ViSOR is the agreed system used by MAPPA to facilitate the secure exchange and storage of information in accordance with the MAPPA guidance document.

It provides a central store for up-to-date information about offenders that can be accessed and updated by the Responsible Authorities.

ViSOR is a Home Office system that operates in other UK jurisdictions and is potentially a vital component for any cross-border transfer discussions.

The benefits of using ViSOR are:

- Provides a secure database enabling the safe retention and prompt sharing of sensitive risk management information on individual offenders who are deemed to pose a RoSH to the public.
- Provides the 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.
- It can produce consistent management information to support the strategic oversight of MAPPA in Scotland which influences improvements in process.
- Provides the information for MAPPA annual reports.

There are agreed National Standards to be adopted by all responsible authorities. All MAPPA offenders should be entered on ViSOR, including those offenders 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.

10 KEY FINDINGS

In this section of the report, the Independent Reviewer will outline the key findings of the SCR and recommendations will be drawn out to provide context and offer opportunities for learning and improvement.

It will also offer areas of identified good practice.

To provide some structure to this part of the report, it will be presented in chronological order and chaptered into the following headings:

1. Offender Behaviour Programmes.
2. Psychological Risk Assessment – 2012.
3. Prisoner Z in 'NTE', HMP Greenock.
4. Prisoner Z in HMP OE (HMP Castle Huntly) and Multi-Agency Involvement including Risk Assessment and Management.
5. Interface between RMT (SPS) and the Multi-Agency Meetings.
6. Risk Management Planning.
7. Transfer between Local Authorities.
8. Multi-agency communication.
9. MAPPA National Guidance.
10. Intelligence Flow.

1 Offender Behaviour Programmes

Prisoner Z was assigned Low Supervision status at HM YOI Polmont and retained this level up to his time in HMP Castle Huntly in 2017.

Prisoner Z completed three separate offending behaviour programmes in 2007. These were the Cognitive Skills Programme, Alcohol Awareness and Anger Management Programmes.

The report from his time on the Cognitive Skills Programme notes that Prisoner Z's level of participation was "quite limited" and that "he was never disruptive but questioned the content of the programme". The author noted that overall Prisoner Z "demonstrated a satisfactory understanding of the sessions delivered in the programme".

The Anger Management Post-Programme report indicates that Prisoner Z did not initially believe that he should have been on the programme at that stage in his sentence. His work was of an "average standard" and that there was limited evidence of his progress with regard to understanding the material presented to him, but the authors commented that there was some evidence of his ability to manage himself in anger provoking situations. Testimony from a number of professionals spoken to during the Review suggest that these are not unusual comments provided regarding prisoners attending such programmes.

During an interview with a Psychologist who was tasked with preparing a Psychological Risk Assessment (PRA) in 2012, Prisoner Z was very clear that he did not believe interventions to address offending behaviour were effective and that at some point in the future "people will wake up and realise they wasted money on these things". He stated that everything within these programmes is "common sense" and that he did not believe he had benefitted in any way from work done previously.

However, he stated that he would continue to participate in any work identified for him "but only to assist his chances of progression through the prison system".

The Independent Reviewer found evidence that although Prisoner Z was offered a place on the VPP at HMP Shotts in 2013, he declined this offer at that time. He did however agree to attend this programme later in December 2013, so he effectively delayed his own progress through the prison system by around nine months and the reason for this is unclear. Prisoner Z has given no insight into his decision to delay earlier involvement in the programme. Prison staff suggest that some prisoners decline such offers as they can be settled in their own respective prison environments and find the move to HMP Shotts disruptive, while others are wary of exposing themselves to potential bullying in a different prison setting. It should also be noted that the move to HMP Shotts from HMP Perth would have made visits by his family and friends, who all live in the Dundee area, more geographically challenging. However, his placement on the programme at HMP Shotts was supported by his family.

In June 2014, Prisoner Z completed the VPP. It is noted in his Post Programme Report that he was initially very reserved whilst on the programme and the facilitators had to manipulate his seating position within the group which resulted in him becoming more engaged during discussions. The report is mainly positive about his participation.

When he met the Independent Reviewer in September 2018, Prisoner Z maintained his 2012 view that he did not find his offending behaviour interventions, including the VPP, beneficial and that he merely participated on these as a means to progress towards release. He stated that he would never 'bare his soul' around his own offending during group sessions like the VPP.

The SPS holds data on the success of Offender Behaviour Programmes. As with all interventions, the purpose is focussed towards changing attitudes and behaviours of offenders while offering them coping methods and management strategies to assist them from a return to offending. The data held demonstrates that such interventions are often successful and this is based on outcomes as opposed to attendance only.

While reviewing the meeting notes of the ICM and RMT minutes, Prisoner Z's attendance and limited participation on the earlier programmes do not appear to have been considered or there is nothing recorded in his notes to demonstrate such consideration.

All notes refer only to him having completed these programmes and the Independent Reviewer feels that it would have been beneficial for the full outcomes and feedback of such interventions to have been considered and referred to at Risk Management Meetings. The benefit of this would have allowed the RMT to question and document whether these programmes and interventions had made any positive impact on Prisoner Z or reduced his risk of re-offending.

The Independent Reviewer considered making a recommendation in relation to the SPS reviewing how it measures the success or otherwise of its suite of offender behaviour programmes. However, on the basis of a written submission received from the SPS, the Independent Reviewer is satisfied that such a process or processes have been developed and are utilised in this regard.

The Independent Reviewer also considered making a recommendation regarding how the RMT consider attendance and completion of intervention programmes against positive engagement and participation. However, given that the earlier

programmes were in 2007 and his 2014 intervention programme feedback was generally positive, no such recommendation is being made.

2 Psychological Risk Assessment – 2012

In March 2012, Prisoner Z undertook a PRA while he was at HMP Perth. The purpose of this assessment was to provide a psychological contribution to the management of Prisoner Z's risk of re-offending.

The tools utilised for the assessment were the Historical Clinical Risk – 20 (HCR-20) which is a tool used to assess the risk of future violence and The Psychopathy Checklist – Revised (PCL-R) which is a rating scale for the assessment of psychopathy. It assesses behaviour and personality traits widely understood to relate to a clinical concept of psychopathy.

The report refers to there being numerous occasions during interviews between the Psychologist in Training and Prisoner Z during the assessment process where he provided information which was inconsistent with evidence contained in collateral sources. This raised the possibility that Prisoner Z was attempting to present himself in a manner that he believed would be viewed more favourably and that would lessen perceptions of his future risk. However, this also made analysis of his case challenging due to difficulties in establishing fact from fiction.

It was noted that Prisoner Z “had a number of factors present and partially present relating to violent re-offending indicating a high risk or re-offending if he were at liberty.”

It further commented that “Prisoner Z's personality traits including features of paranoia, narcissism, callousness, shallow affect, and a lack of empathy and remorse serves to increase the likelihood of future violent offending. This includes persecution beliefs and beliefs about the world being a dangerous place”.

It continued that Prisoner Z provided information which suggested that “he has a tendency to disassociate within situations that would provoke a negative reaction”.

“Prisoner Z was keen to highlight that his attitude towards offending had improved since incarceration.....however, due to concerns about him engaging in impression management it was difficult to gauge the genuineness of these comments”.

The PRA also noted, “During the course of assessment, Prisoner Z's behaviour raised questions regarding whether or not he suffers from paranoid delusions. He makes comments which could indicate the presence of auditory hallucinations, delusions of reference and delusions of persecution. These delusions may relate to his personality characteristics or could indicate the presence of a more serious mental health problem. It would therefore be beneficial to have Prisoner Z assessed by a Psychiatrist to either verify or discount the latter”.

This PRA recommended that Prisoner Z be considered for the VPP.

The PRA was conducted by a Forensic Psychologist in Training who was under the supervision of a Chartered Forensic Psychologist.

As a result of this PRA, Prisoner Z was seen by a Psychiatrist who conducted a routine review of him in 2012 and concluded that there was no clear evidence of psychosis. It was further concluded that Prisoner Z was a difficult man to assess and diagnose. Prisoner Z was identified as having long standing suspiciousness and feelings that people were making life difficult for him.

3 Prisoner Z in 'National Top End', HMP Greenock

Prisoner Z was transferred to 'NTE', HMP Greenock in December 2014.

By this time, he had been in custody for over 13 years and 4 months which includes the time spent on remand prior to his conviction in 2002.

The Independent Reviewer was advised that, in September 2015, Prisoner Z requested that he be downgraded from the NTE and returned to closed conditions. It is unknown why he made this request, but this was the first of several comments contained within his file that suggests he was anxious as a result of his continuing progression through the prison system. Professionals involved in his care alluded to the point that prisoners who arrive in NTE can feel anxious about their own progression especially if they have served significant prison terms up to that point. Some prisoners struggle to come to terms with the trust and responsibility placed on them within a more relaxed prison environment in NTE although most feel better after discussions with staff and further mentoring.

In any case, Prisoner Z was referred to Mental Health professionals within the Prison and they had further discussions with him which appeared, to Prison staff, to have a positive effect on him and he remained within NTE. It should be noted that prior to the prisoner's request to return to closed conditions and throughout his time in HMP Greenock thereafter his mental health was discussed and reviewed at a multi-agency forum (Multi-Disciplinary Mental Health Team Meeting), which Prison Based Social Workers at HMP Greenock were part of. This resulted in on-going support from a mental health nurse and changes to his prescribed medication. At the point of his subsequent transfer to HMP OE, his mental health was viewed as stable and moreover he had been able to evidence periods of community access without letting his anxiety take control.

The Independent Reviewer found considerable evidence that Prisoner Z was aware of how he could progress through the system. Time and again, and in retrospect, contributors involved in his management questioned whether Prisoner Z had been merely 'box ticking' or 'playing the system' to allow him to progress to the point where he was considered for community access and release on Life Licence. Indeed, Prisoner Z himself had previously told a professional involved in his management that 'he would only do just enough to ensure his progression continued' and this suggests a form of manipulation of the system on his part.

The SPS can provide many examples where RMTs have returned prisoners from the NTE and the OE to closed conditions when new risks in relation to prisoners are identified.

Although the ICM and RMT processes within the SPS is considered to be a good framework to manage the progression of prisoners to the point of release, there is evidence to suggest that neither process was particularly effective in the management of Prisoner Z. Despite having an awareness of the identified risks that were relevant to Prisoner Z, the RMT appear to have concentrated on his journey towards community access as opposed to dealing with and mitigating and managing the identified risks.

The Independent Reviewer is of the view that key information considered appropriate to be shared at the RMT meetings were not considered and this includes some parts of the LS/CMI and the latest 2012 PRA. Indeed, the Independent Reviewer is of the view that it may have been appropriate to consider conducting another PRA in 2015 prior to his first grant of temporary release being recommended and signed by Scottish Ministers to ascertain any changes in Prisoner Z's behaviour especially as it was recorded in the 2012 PRA that Prisoner Z was assessed as 'having a number of risk factors present relating to violent re-offending indicating a high risk of re-offending if he were at liberty.'

On 15 October 2015, the SPS submitted a report to Scottish Ministers making a recommendation that Prisoner Z's First Grant of Temporary Release be agreed and signed.

In reviewing this report, the Independent Reviewer believes that there is a lack of balance contained within the evidence provided to Scottish Ministers. The comments are all very positive and there is no conflicting evidence contained within the report. For example, there are no comments relating to any breaches of prison rules by Prisoner Z and no reference to a number of issues highlighted in his PRA of 2012 which speaks about heroin addiction within the prison setting. More critically, there was no reference to the issues raised and risks identified in the 2012 PRA which concluded that Prisoner Z had a number of risk factors present and partially present relating to violent re-offending indicating a high risk of re-offending if he was at liberty. The fact that one month prior to the submission of the report, Prisoner Z had requested a return to closed prison conditions because of his anxiety was also omitted and therefore it must be concluded that Scottish Ministers signed his First Grant of Temporary Release based on only some of the information which was available and which existed at that time.

Recommendation 1

The Scottish Prison Service should review the information provided to Scottish Ministers when submitting reports that recommend First Grants of Temporary Release to ensure that the report gives a balanced reflection of a prisoner's period of imprisonment and the assessed risk.

On 23 October 2015, the First Grant of Temporary Release in respect of Prisoner Z was signed off by Scottish Ministers following the recommendation by Senior SPS officials. He had attended all Offender Behaviour Programmes considered relevant for him, and although his positive participation in the 2007 programmes is questionable, he displayed no obvious violent tendencies, he had provided 36 negative Mandatory

Drug Test samples and he had successfully completed ten Special Escorted Leaves (SEL's) and four Unescorted Leaves – all without incident. The minutes at the RMT recorded that Prisoner Z had matured and that he was on a positive trajectory.

However, the Independent Reviewer has a concern that the recommendation to sign off his First Grant of Temporary Release was provided only one month after Prisoner Z had requested to be returned to closed conditions. It may have been appropriate to monitor him and further assess him for a longer period of time after his request to return to a closed prison. There is no evidence that this event was specifically considered by the RMT at that point.

A work placement was obtained for Prisoner Z and he commenced this in 2016 (ten weeks after the First Grant of Temporary Release was signed) working four days per week. The feedback from the placement was always positive and he was regarded as reliable and hard working.

On 9 August 2016, the date that the punishment part of his sentence expired, Prisoner Z video linked into his Tribunal Hearing with the Parole Board for Scotland.

The RMT at HMP Greenock had recommended that Prisoner Z should receive further opportunities to demonstrate his ability to reintegrate in society within the Open Estate and the Parole Board for Scotland agreed with this. He was advised that the Parole Board 'was not satisfied that it is no longer necessary for the protection of the public to keep him confined' and it recommended that a decision to release him from custody would be reassessed in 12 months.

It was argued by Prisoner Z, or on his behalf, that his case should be reviewed after 9 months but this was rejected by the Parole Board for Scotland.

The RMT at HMP Greenock then sought to transfer Prisoner Z to the HMP OE (HMP Castle Huntly) and this was approved on 13 September 2016.

4 Prisoner Z in HMP Open Estate (HMP Castle Huntly) and Multi-Agency Involvement including Risk Assessment and Management

Risk Assessments

In March 2016, the Risk Management Authority commenced a programme of three day Risk Practice Training and these inputs focussed on the application of RoSH assessments. Initially, places on these courses were quite limited and it has taken several years to implement nationally but this has been a key driver in improving the quality of practice in this area.

On 20 September 2016, Prisoner Z transferred to HMP Castle Huntly.

At the time of his transfer to the OE, Prison Based Social Workers at HMP Greenock had completed the LS/CMI for Prisoner Z but his RoSH assessment was incomplete. His risk needs assessment was 'Medium'. It should be noted that there was an opportunity to override the medium risk needs assessment (as would eventually be done by a Senior Social Worker at HMP Castle Huntly). The effect of this was that at the point of his transfer to HMP Castle Huntly, Prisoner Z did not automatically meet the criteria or threshold to make him a potential MAPPA Category 3 subject. The question of whether a MAPPA Category 3 referral was required at that time was discussed at a Risk Management Team Meeting at HMP Greenock in June 2016. It was agreed by

those professionals present that this was not required at that time as it was felt that there were no grounds to substantiate this. This decision made collectively by the professionals at the meeting and was based on their collective professional judgement.

The evidence gathered during this Review shows that only parts of the LS/CMI were considered at the RMT meetings. This appears to be a common practice at RMT meetings as opposed to a deliberate attempt to withhold information. Previous risks to the public as highlighted in his 2012 PRA had not been resolved and it is therefore the case that key decisions made in relation to the progression of Prisoner Z were not based on all the information that was available at that time.

Recommendation 2

The Scottish Prison Service should review what information is available and considered during the Risk Management Team meetings when considering a prisoner's progression. The full Level of Service/Case Management Inventory risk assessment, together with any other risk assessments carried out, should be considered in full.

In late September or early October 2016, a conversation took place between Prison staff at the OE and the Local Tayside MAPPAs Coordinator in relation to Prisoner Z's arrival at the OE. It was suggested and agreed to hold a 'Risk Management Case Conference' to discuss the high media interest around Prisoner Z.

On 4 October 2016, the MAPPAs Coordinator sent an email to a Police Scotland Offender Management Unit supervisor asking for guidance as to who from Police Scotland should be invited to the meeting to discuss Prisoner Z. The supervisor replied indicating that they would attend the meeting and take away any actions allocated to the Police.

Following his transfer to the OE, a RMT meeting chaired by the Deputy Governor and attended by other Prison staff and a Prison Based Social Worker was convened on 6 October 2016. In considering his index offence, it was agreed that there was the potential for media interest and intrusion during any period of Home Leave and it was suggested that it would be appropriate to meet with external partners to help mitigate this.

After the transfer to HMP Castle Huntly, a Prison Based Social Worker there reviewed Prisoner Z's file and identified a need to review the LS/CMI. They had concerns around the risk needs assessment, which they felt could be further enhanced, and they noted that a RoSH assessment had not been fully completed at HMP Greenock. The Social Worker advised the RMT that they would review the LS/CMI.

It should also be noted that the eventual LS/CMI and RoSH also took into account the circumstances that led to the submission of a Critical Incident Report in November 2016.

The Independent Reviewer is of the view that some aspects of the LS/CMI completed at HMP Greenock could have been enhanced and that there was no evidence of

the documents having been checked and endorsed by a more Senior Social Worker or Manager. However, it is accepted that the LS/CMI is an electronically generated document and that information is automatically populated from the LS/CMI into the RoSH. Recent developments of this system have included a section for Line Managers endorsement which supports a system of quality assurance and endorsement, and this is seen as positive. The importance of quality and consistency is paramount together with a process that ensures that all documents are prepared and sent to OE at the time of the proposed transfer.

Recommendation 3

At the point where a prisoner is considered for progression to the Open Estate, the chair of the Risk Management Team within the Scottish Prison Service must ensure that the Level of Service/Case Management Inventory and any Risk of Serious Harm assessment have been fully completed, endorsed by a Senior Prison Based Social Worker and that all documentation is forwarded to the Open Estate for their consideration within seven days before the date of the proposed transfer.

Currently the process of transferring prisoner files can take several weeks, and this is an area that should be improved in order that the professionals who were immediately responsible for managing Prisoner Z were aware of and had access to all the information relating to him.

It is of significance that despite knowing that a further Risk Assessment was in the process of being conducted, the RMT at HMP Castle Huntly continued Prisoner Z on a phased community access plan in October 2016. It is not known why this was decided or agreed given that the result of that assessment was not known. The rationale relating to this decision has not been recorded. The Independent Reviewer considers that the more defensible decision at that stage would have been to defer community access until the result of the Risk Assessment had been clarified and considered.

Therefore, key decisions made by the RMT in respect of Prisoner Z's Home Leave in 2016 were not based on or being informed by the most current information and risk assessment.

An incident also occurred on 27 November 2016, where Prisoner Z was found under the influence of an unknown substance, assessed to be New Psychoactive Substance (NPS) in his cell which would lead to his community access being suspended.

The LS/CMI and RoSH were completed on 22 December 2016 and this showed that Prisoner Z's risk and needs assessment was categorised as 'medium' and that he posed a High RoSH to the public.

The effect of this meant that on 22 December 2016, Prisoner Z met the criteria for the SPS to make a referral to the MAPPA Coordinator to suggest that he may be considered a Category 3 MAPPA offender at the point of any future release.

When his RoSH was completed and shared, not only would it have been appropriate for the SPS to consider, review and continue with the suspension of Prisoner Z's

community access but it would also have been appropriate to question whether it remained appropriate for Prisoner Z to continue to be held in the OE.

The Independent Reviewer could find no evidence that such decisions had been considered by the RMT nor is it evident what difference, if any, the increased Risk Assessment and the comments contained within the RoSH made in terms of any Risk Management Plan (RMP). This leads the Independent Reviewer to question whether Prisoner Z had been set on an irreversible and inevitable pathway towards release. There is evidence in this Review to suggest that opportunities were missed by the SPS to assess and take appropriate action in respect of Prisoner Z in order to protect the public.

5 Interface between Risk Management Team (SPS) and the Multi-Agency Meetings

Discussions between Prison staff at HMP Castle Huntly and the local MAPPA Coordinator in Tayside took place in relation to Prisoner Z and it was agreed to hold a multi-agency meeting to share all relevant information. It does not appear that consideration was given to invite community partners from MAPPA to future RMT meetings. This could have reduced the subsequent confusion that holding separate meetings to discuss the risk posed by Prisoner Z would cause.

This multi-agency meeting was held at HMP Castle Huntly on 31 October 2016 and was chaired by the local MAPPA Coordinator.

An Offender Management Unit supervisor, a Prison Based Criminal Justice Social Worker, and Senior Community Based Criminal Justice Social Workers from Angus Council and Dundee City Council and the relevant Prison staff were also at this meeting. It was considered relevant to have both Dundee City and Angus Council present as his supervising local authority for the entirety of his prison sentence had been Dundee City Council. However, it was expected that he would transfer to Angus Council for supervision in the future as that was his home leave address. Prisoner Z had intimated he would live with his home leave host when on Home Leave and at the point of his eventual release.

The Independent Reviewer believes that, while it was good practice to hold a multi-agency meeting, it actually created a confusion amongst attending agencies as to its purpose and fit with the Prison RMT meetings that continued to be held. This appears to be due to the fact that the multi-agency meeting strayed into areas of Risk Management as opposed to dealing with the need to discuss a strategy to manage the likelihood of media intrusion. Some attendees believed they were MAPPA meetings due to them being arranged and chaired by the MAPPA Coordinator and the meeting minutes were provided on MAPPA headed notepaper. Some other attendees believed that they were not MAPPA meetings but were multi-agency meetings put in place to support the RMT in its considerations and management of Prisoner Z specifically around his notoriety and the potential for media intrusion and interest.

The remit and purpose of these multi-agency meetings should have been clearly articulated at the outset and detailed in all minutes so that all professionals were clear on these points.

The Independent Reviewer believes that the confusion caused by the multi-agency meetings could have been eradicated had the RMT from the SPS chosen to invite external agencies to their meetings.

Recommendation 4

The Scottish Government should work with partners to undertake a review of National MAPPA guidance and improve consistency of application across the country. Guidance should specifically lay out how the Home Leave and release decision making processes; Scottish Prison Service Risk Management Team meetings; community based multi-agency meetings; and MAPPA arrangements interfaces with MAPPA risk management arrangements in practice.

This review of guidance should leave no room for doubt about when MAPPA meetings should commence for relevant offenders in prison and the Review should make absolutely clear the relative roles of RMT and MAPPA meetings. Ultimately the Review should ensure that all relevant prisoners are managed under a single unequivocal process, with a single agreed multi-agency RMT.

For the avoidance of doubt, the RMT meeting within the SPS remained the decision-making body in relation to Prisoner Z although this became blurred as both groups continued to meet independently. It is acknowledged that Prison staff and, on occasions, senior Prison staff attended the multi-agency meetings in relation to Prisoner Z.

The Independent Reviewer is of the view that the local MAPPA Coordinator was not the most appropriate person to chair the multi-agency meetings at HMP Castle Huntly. Indeed, the role of meeting chair does not feature in the role description of the MAPPA Coordinator. It is believed that in conducting the role of chair at these meetings, this detracted from the Coordinator's actual role in this critical process.

The Independent Reviewer would have included a recommendation in this report suggesting that Tayside SOG should review and consider the appropriate post holders and skills set to perform the role of chair in MAPPA and other partnership meetings to ensure appropriate seniority and defensibility. However, this issue had already been identified internally and the appropriate guidance has been provided to all staff prior to the commencement of this review.

It is accepted that there may be occasions when an identified chair for a MAPPA meeting will become unavailable but there are other professionals within the MAPPA partnership who are better placed to fulfil the role of chair which would allow the MAPPA Coordinators to fully discharge their core duties at meetings.

The Review found evidence of a lack of a robustness around how the multi-agency meetings were arranged, including meeting invitations and what information should be shared in advance. It also concluded that the administration and management of meeting minutes could be improved.

A number of key documents examined during the course of the Review contained information around key decisions in relation to risk management but were found not

to contain a sufficiency of rationale or a record of the discussion which led to the decision or key action. This is relevant to the SPS, who have already acknowledged this, and also the multi-agency meeting notes, where, despite areas of risk being raised, there was no rationale provided that made it clear what action, if any, was being taken. It is also good practice to accurately record decisions that lead to no action being taken.

Recommendation 5

The Tayside MAPPA Strategic Oversight Group should ensure that concise and accurate pre read material for MAPPA and multi-agency meetings is sent to attendees in advance of all meetings. This should include formal meeting invitations for all attendees. Meeting minutes should be concise, accurate, ensure tasks are detailed and clear in terms of ownership with updates and outcomes captured. Minutes should clearly reflect the rationale for decision making.

6. Risk Management Planning

Prior to the multi-agency meeting held on 31 October 2016, no information was shared with partners other than the fact that the subject of the meeting was Prisoner Z. From the minute of the meeting, it seems the key decisions arising from it were an acknowledgement that Prisoner Z did not, at that time, fall into the MAPPA remit, that his LS/CMI risk need was 'medium' and that his RoSH assessment was being progressed.

The meeting also made suggestions around Licence Conditions for the RMT to approve. These were:

- A map to be provided to Prisoner Z marked with areas where he was restricted from attending near the locus of his first crime.
- Monitor any new or existing associates.
- To drug test him on his return to the OE.
- SPS to provide a mobile phone and Criminal Justice Social Worker to request a licence condition to examine this phone.
- Prisoner Z would be asked to keep a diary relating to his time spent on Home Leave.

It is recorded that these suggested licence conditions were passed to the RMT held on 3 November 2016 and the following additional licence conditions were consequently approved:

- The prisoner must not visit specified addresses – not to enter areas identified unless approved by your supervising officer. This included the area of the murder scene and the streets in close proximity to the home address of Person A.
- To disclose any emerging or platonic relationships to your supervising officer.
- To be supplied with an SPS phone and have it switched on at all times whilst on Home Leave.

It is the conclusion of the Independent Reviewer that the multi-agency meeting had strayed into areas of Risk Management instead of discussing issues relating to any media attention.

It is also his view that a robust RMP and tiered approach to manage the identified risks in relation to Prisoner Z was missing from the RMT Meeting at HMP Castle Huntly. Consequently, there was no request or offer to provide any form of proactive activity to monitor Prisoner Z by any of the partner agencies other than a requirement that Prisoner Z would contact his Community Based Social Worker during his periods of Home Leave.

Indeed, the SPS states that it relies on reporting from community partners as a means of monitoring periods of Home Leave as well as self-reporting from the prisoners themselves.

While it is accepted that Prisoner Z was not considered a High Risk of Causing Serious Harm at that time (October 2016) his updated Risk Assessment was in the process of being carried out and, as previously stated, it may have been appropriate to defer community access at that time and until the new risk assessment was complete and considered. Therefore, it is the conclusion of the Independent Reviewer that the decision to release Prisoner Z at that time was flawed.

In addition, the Independent Reviewer considers the lack of a robust RMP around Prisoner Z's community access, including his Home Leave to be a significant opportunity missed to ascertain if Prisoner Z was adhering to his licence conditions and to identify any new or emerging risks.

Prisoner Z would appear to have been put on a methadone programme while he was in custody at HMP Perth. The exact circumstances around the commencement of this treatment are unknown but it is recorded that he completed the programme in August 2013. It is of note that since this time, Prisoner Z has provided 36 negative Mandatory Drug Tests.

On 27 November 2016, Prisoner Z was found within his cell at HMP Castle Huntly to be under the influence of an unknown substance, assessed by Prison staff as being a form of NPS (New Psychoactive Substance). It is of note that use of NPS will not be identified through the Mandatory Drug Testing process.

The following day, this incident was discussed at an internal RMT meeting, where he was found guilty of breaching Prison Rules. It was Prisoner Z's position that he had run out of the anti-psychotic drugs he had been prescribed for anxiety and he did not know how to order more. He claimed this had a destabilising effect on his mental wellbeing which, in turn, led to him taking NPS. However medical staff were of the view that the dosage of the anti-psychotic drugs was so low, it was highly unlikely to have had such an effect on him.

It was decided at the RMT meeting that Prisoner Z would remain at the OE and have his community access suspended for a period of one month. The rationale for these decisions were not recorded.

It could have been deemed appropriate for Prisoner Z to be returned to closed prison conditions at that time given that substance misuse was known to be likely trigger for him to reoffend. It might also have been relevant to pull together a Multi-Agency meeting or to invite external partners to a RMT meeting to discuss the NPS incident and the overall risk posed by Prisoner Z, but this was not done.

This adverse incident also appeared, to prison and Social Work staff, to have caused a significant rift between Prisoner Z and [REDACTED]. It is not known what caused this to happen, but it was later documented in the minutes of the multi-agency meeting held at HMP Castle Huntly in January 2017 that the relationship between Prisoner Z and [REDACTED], was not as strong and supportive as it had previously been reported.

On 19 December 2016, there was a further RMT meeting held at HMP Castle Huntly chaired by the Deputy Governor and attended by other Senior Prison Managers, a Prison Based Social Worker and medical professionals including members of the NHS Mental Health and Substance Use Teams. The minute of this meeting states that a decision around Prisoner Z's future progression would be made once the minute of the multi-agency core group was available in early January 2017. This is suggesting that the RMT were looking for some direction from the multi-agency group regarding future community access for Prisoner Z.

On 22 December 2016, the Prison Based Senior Social Worker completed the LS/CMI and RoSH and assessed Prisoner Z as posing a high RoSH and this confirmed that Prisoner Z was now meeting the threshold to be considered for management as a Category 3 offender under MAPPA.

It should be noted that there is no automatic management of Category 3 cases via MAPPA – only those where it is assessed and agreed that the case “assessed by the responsible authorities was posing a high or very high RoSH to the public, which requires active multi-agency management at MAPPA level 2 or 3.”

On 9 January 2017, on receipt of the RoSH, Prison staff at HMP Castle Huntly submitted a MAPPA Category 3 referral to the Tayside MAPPA Coordinator by email. The Review has been unable to secure a clear understanding on what happened to this referral. There is no evidence that the referral was shared or discussed with Dundee City Council Criminal Justice Social Work at that time which would have been normal practice and there is no reference to the Category 3 referral within their file notes.

It is apparent that due process was not followed after the submission of the MAPPA Category 3 referral. The referral from the SPS should have been immediately acknowledged by the MAPPA Coordinator and the referral returned to them with the rationale for either agreeing with the referral or not accepting the referral. Contact with a senior Community Based Criminal Justice Social Worker should have been made in relation to the referral and arrangements made to formally hold a MAPPA Level 2 meeting.

The MAPPA referral was not recorded on ViSOR until 15 June 2017 – over five months after its submission. This does not adhere to current ViSOR Standards.

On 26 January 2017, another multi agency meeting was held at HMP Castle Huntly which was again chaired by the MAPPA Coordinator. The minute for this meeting clearly indicates that Prisoner Z was regarded as a Category 3 MAPPA subject but the Category 3 referral and RoSH and do not appear to have been discussed in depth, despite the author of the RoSH being present at the meeting.

A Local Policing Officer from Dundee was at this meeting as it was one of his roles to manage MAPPA Category 3 offenders within Dundee for Police Scotland. It appears that he had been invited due to [REDACTED] and it was initially

believed that Prisoner Z may spend much of his time whilst on Home Leave within Dundee city. However, it was learned at this meeting that Prisoner Z had a peer group associate (Person K) living in Angus, it was agreed that the relevant Local Area Commander from Police Scotland would be invited to the next meeting of the group.

NB. The lead agency and responsible authority for managing prisoners who are on Home Leave is the SPS. The Lead Agency and responsible authority for dealing with MAPPAs Category 3 subjects who have been released from prison into the community rests with Community Based Criminal Justice Social Work. Police Scotland stipulate that Category 3 MAPPAs subjects will be managed through Local Policing structures and not through Offender Management Units. A memorandum from a senior Executive Officer within Police Scotland dated March 2016 clearly stipulate that the Local Area Commanders will have this responsibility for managing such offenders in the community on behalf of the Police.

Concerns were raised at the multi-agency meeting on 26 January 2017 by the Police Scotland Offender Management Unit supervisor regarding Prisoner Z's petulance, substance abuse, him being in a relationship, [REDACTED], that he had been dishonest about the reasons for taking NPS and it is noted that of these factors 'provides a whole gambit of risk around community access which is problematic'.

Whilst it is accepted that at this point in time, Prisoner Z's community access remained suspended and therefore there was no imminent risk to the public, it is clear from what is recorded at this meeting that it was likely that Prisoner Z would have his community access reinstated quite soon thereafter. The meeting does not deal with the concerns raised by the Police Scotland Offender Management Unit supervisor and there are no details contained within the minute that reflects that these concerns were being managed or mitigated. The minute does state that the concerns would be raised at the next RMT meeting, however there is nothing in the RMT minute of 2 February 2017, chaired by the Deputy Governor, which suggests that these concerns were raised and discussed. One senior Manager and another Prison Officer from the Prison Service were present at both meetings.

It was however noted that Prisoner Z would be managed as a MAPPAs Category 3 at Level 2, which he was required to agree to contact being made with Person K and additional licence conditions were agreed.

The Independent Reviewer considers that it would have been appropriate that these identified risks, together with the risks identified in the RoSH would have formed the basis for a structured RMP but there remained none at that time. The responsibility for doing this remains with the RMT at the OE.

The Review has concluded that there are significant issues in the system and processes surrounding the Risk Management Meetings at HMP Castle Huntly that require to be resolved through clear and consistent guidance including external agency attendance and having access to the most up to date assessments to ensure that it manages and mitigates risk.

Recommendation 6

The Scottish Prison Service should develop how risk is assessed and mitigated within RMT meetings. Risk requires to be the main consideration and decisions made should serve to mitigate and manage risk rather, than trigger progression.

The Independent Reviewer is aware that the SPS have reviewed and strengthened this process in relation to convening what would currently be regarded as 'non MAPPA' multi-agency meetings at HMP Castle Huntly. All such meetings are now structured and are conducted under the umbrella of MAPPA.

Although the Independent Reviewer has no concerns about attendees and structures around routine MAPPA meetings, the multi-agency meeting lacked an agreed purpose and because its MAPPA status was, at best, blurred, there was a lack of consistency in terms of its flow and attendance.

There is also no evidence that the Police Scotland Offender Management Unit supervisor elevated their concerns to Senior Management within Police Scotland or that they provided a structured briefing to the relevant Local Area Commander in relation to Prisoner Z. Whilst there is nothing to suggest any other partner elevated any concerns to their respective agency managers, the Offender Management Unit supervisor demonstrated leadership to articulate their concerns around the additional risks at the January multi-agency meeting but the next logical step could have been to escalate these concerns within their own agency especially as it was agreed that they would not be in attendance at future meetings to discuss Prisoner Z.

A task was raised at the multi-agency meeting in January to have Community Based Social Work 'screen' Person K. It is recorded that community access would only be re-instigated once this task had been completed.

However, in February 2017, prior to the Social Worker and a Police Scotland Offender Management Unit supervisor meeting with Person K, Prisoner Z called his Community Based Social Worker and left a message on her answering service advising that he was out on Home Leave. She was unaware of this Home Leave at that time. She later contacted Prison staff who confirmed that he was on a period of two nights Home Leave and it was suggested that the lack of notification to the Community Based Social Worker was due to an oversight or breakdown in communication.

The meeting between Person K, the Community Based Social Worker and the Police did eventually take place and it is of note that Person K was of the view that Prisoner Z was innocent of his index offence. This tends to indicate that Prisoner Z had not been honest with Person K and it was concluded that this potentially increased Person K's risk at the hands of Prisoner Z. This was fed back to the multi-agency meeting in April 2017 but there is no evidence that this risk was discussed in terms of how to manage or mitigate the risk to Person K nor is there any evidence that it was discussed at any subsequent Risk Management meetings held by the SPS.

This period of Home Leave was not recorded on ViSOR by Prison staff which falls short of the National Standards.

Prisoner Z remained on Home Leave at his home leave address for a further two days and this passed without incident.

As previously stated, the Independent Reviewer concludes that the presence of a high RoSH made no difference to the Risk Management Planning for Prisoner Z when it should have. Any identified increase in risk should have been met with a set of actions that are allocated to individuals in order to manage or mitigate that risk.

The Independent Reviewer is aware that Prisoner Z was subject to both standard and additional licence conditions during his periods of Home Leave but there is no evidence that the full list of licence conditions for Prisoner Z were consistently and formally communicated to his Community Based Social Workers and other community partners prior to ongoing periods of Home Leave. This practice presents additional risks and should be addressed.

7. Transfer between Local Authorities

Prisoner Z was on Home Leave in March 2017 and this passed without incident.

This period of Home Leave was not recorded on ViSOR which falls short of the ViSOR Standards.

During March 2017, the process of transferring Community Based Social Work ownership of Prisoner Z to Angus Council commenced following conversations between both local authorities. This involved a joint meeting being held in Dundee on 16 March 2017 between Prisoner Z, his home leave host, his Dundee City Council Community Based Social Worker and the nominated Social Worker from Angus Council.

Dundee City Council submitted a formal 'transfer in' request on 22 April 2017 and this was accepted by Angus Council on 26 April 2017 and the allocated Social Worker is noted on this form. Although it appears that the transfer was well structured and there was a full handover between practitioners, there is an area of ambiguity around when, or indeed, if this process had been completed and formally written off.

There was no document contained within his Angus Council Social Work file that this process had been fully completed but there was reference to Angus Council Community Based Social Workers meeting with Prisoner Z on numerous occasions from 28 March 2017 and July 2017 while his Dundee City Council Community Based Social Worker was not present.

However, this ambiguity is further evidenced as it was noted at his Integrated Case Conference held at HMP Castle Huntly on 16 May 2017, at which both his Dundee and Angus Council Community Based Social Workers were present, that Prisoner Z was the responsibility of Dundee City Council Criminal Justice Social Work. It is stated in the minute of this meeting that as his home leave and release address was in Angus, that Angus Council had agreed to formally accept his transfer. The Angus Council Social Worker is recorded as stating that she would be Prisoner Z's supervising officer on his eventual release.

Whilst in practice it appears that the process of his transfer had been undertaken in March and April 2017, it is not clear at what point the actual transfer was accepted and when Angus Council's responsibility formally commenced.

However, on examining the files held by Dundee City Council, they have recorded that the transfer was complete prior to 18 May 2017 and their file was closed.

The Reviewer concludes that while a strong handover was carried out at practitioner level, systems and processes for transferring prisoners between local authority areas were not clear and it appears that there was some confusion in this regard. Whilst the Reviewer notes that there are areas of good practice in transferring Prisoner Z's case between authorities, there remains a lack of robustness in terms of being able to audit the document trail for this.

It is also noted that the completion of the transfer between local authority areas was not recorded on ViSOR. This does not meet the National ViSOR Standard.

Prisoner Z was released on Home Leave in April 2017 and there appears to have been no issues.

However, no ViSOR entry was recorded in relation to this period of Home Leave and this falls short of ViSOR Standards.

8. Multi-agency Communication

On 20 April 2017, a further multi-agency meeting was held at HMP Castle Huntly chaired by the MAPPAs Coordinator. In the minute for this meeting, it was articulated that Prisoner Z would be managed at MAPPAs Level 3 at the point when he was to be released on Life Licence. This has been a source of confusion for the Independent Reviewer given that these meetings were deemed NOT to be MAPPAs meetings so therefore it is highly questionable whether it was appropriate for such a decision to be made at this meeting. Even if it was appropriate for a such a decision to be made, no rationale or details of any of the discussion around Level of Risk is provided other than owing to the likely media interest.

A task was raised for the MAPPAs Coordinator to have the relevant Local Area Commander for Police Scotland invited to the next multi-agency group meeting and the Offender Management Unit supervisor, who had attended previous meetings, was no longer required to attend.

Prisoner Z was released on Home Leave in May 2017 and this passed without incident but again details of this period of Home Leave were not recorded on ViSOR.

The Case Conference ICM was held at HMP Castle Huntly on 16 May 2017 and attended by the Community Based Social Workers from both Angus and Dundee City Council as well as the Prison Based Social Worker from HMP Castle Huntly who completed the LS/CMI and RoSH in December 2016.

At the Case Conference ICM, the RoSH was noted as having been completed but there was no reference to it and the identified risks contained within it having been discussed at the meeting; the plan arising from the ICM did not reflect the risks to be managed and focused on what Prisoner Z was responsible for rather than active multi-agency management of the risk. There was no reference within the minute of this meeting that the 2012 PRA had been discussed nor was there any discussion about any possible psychopathic traits in relation to Prisoner Z.

The next multi-agency meeting chaired by the Tayside MAPPAs Coordinator was held on 18 May 2017 but through an oversight on the part of the person tasked with

organising the meeting, the Local Area Commander was not invited nor was that Police Officer aware of the meeting. Consequently, there was no Police representative in attendance at this meeting.

The person ultimately responsible for ensuring that the relevant professionals are invited to these meetings rests with the MAPPA Coordinator. The MAPPA Coordinator did try to contact another supervisor in Angus via email on the morning of the meeting, but that officer was not on duty. Whilst recognising this was an oversight, arranging invites to an important meeting at such late notice is far from ideal.

The action to invite the relevant Local Area Commander was not discharged and even in the minute of the May multi-agency meeting, the result of the action is marked 'Local Police will be made aware of the situation' which infers that at the time of completing the minute, there was an acknowledgement that the original task had not been discharged.

It is also of note that no apologies are recorded in the minute which is out of sync with the previous minutes produced.

The flaw already highlighted in the dual meeting structure is illustrated within the minute of this meeting when it is noted that an ICM took place two days before and the Senior Prison Based Social Worker states "an ICM was held and a RMP put together looking at substance misuse, mental health, relationships, violence conflict, lack of constructive time and media and how this will be monitored and supervised". Once again, a structured RMP flowing from full discussion of both positive observations and underlying risk assessment does not take place at either meeting as the ICM RMP is quite light. In fairness to staff, they were responding to 16 years of general good behaviour and more and more evidence of successful Home Leaves but in neither the ICM meeting nor the multi-agency meeting is the 2016 RoSH/2012 PRA (possibility of psychopathic traits) mentioned as something to be wary of or plan for.

It was agreed at the meeting that Prisoner Z was 'a manageable risk and SPS, Community Based Social Work and Prison Based Social Work were recommending his release' at his tribunal on 10 August 2017. It should be noted that those present at this meeting were practitioners within their respective agencies and that there were no Senior Managers there with the exception of the Acting Deputy Governor from HMP Castle Huntly. Given the Level of Risk and the fact that is recorded that Prisoner Z would be managed at MAPPA Level 3, it would have been appropriate for partner agencies to be represented by Senior Managers at the meeting.

There remained no RMP commensurate with the risks that were set out in the RoSH and there was no evidence that the RoSH was referred to at the meeting.

It was noted in the minute that the next stage prior to the Parole Tribunal was to hold a MAPPP Level 3 meeting at the end of July 2017 in preparation for Prisoner Z's likely release.

The Independent Reviewer has concerns that the Senior Officials from across the partnership, who would have been the likely attendees at such a meeting, were not made aware of Prisoner Z's anticipated Level 3 status and the proposed meeting at the end of July was not arranged and did not take place. The MAPPA guidance document sets out strict timescales for escalating to a MAPPP but these were not adhered to in this case and the reason for this is not known. The responsibility for arranging a MAPPP rests with the MAPPA Coordinator.

There is no rationale for this meeting not taking place and as a result there was no effective RMP with oversight from senior professionals from across the partnership to mitigate the risks posed by Prisoner Z as set out in the RoSH.

Prisoner Z had two further periods of Home Leave in June 2017 with standard and additional license conditions in place and these passed without incident. Although, Angus Council had effectively accepted the transfer of Prisoner Z from Dundee City Council, at no time were they furnished with a full list of the licence conditions that were in place for Prisoner Z during his periods of Home Leave. Conversely, at no time did they request a copy of these from Prison staff or from his Dundee based Criminal Justice Social Worker.

Neither of these periods of Home Leave are recorded on ViSOR which falls short of the National Standard.

There was a requirement for the SPS to update Prisoner Z's record on ViSOR. His ViSOR record has been examined. It shows that there are significant delays in applying important risk assessments including the LS/CMI and RoSH completed in December 2016. These were not entered on his ViSOR record until June 2017. No minutes of the RMT or of the multi-agency meetings held in January, April and May 2017 are recorded on his record. Only one of the seven periods of Home Leave are recorded on his ViSOR record and even this entry was put on the system after his release on Home Leave.

These are all significant shortcomings in relation to the National ViSOR Standard.

The ViSOR Standards document is currently being updated.

Recommendation 7

The National MAPPA Strategic Oversight Group should ensure that ViSOR standard documents are adhered to by all partner agencies.

The only form of management and monitoring for Prisoner Z during his periods of Home Leave continued to be that on each occasion when he was released, Prisoner Z was required to contact his Community Based Social Worker who would then arrange to meet with him in Dundee or at his home leave address or he would report any issues to his Community Based Social Worker or with Prison staff on his return there.

Some professionals who attended the multi-agency meetings at HMP Castle Huntly felt, in retrospect, there were missed opportunities to be more proactive and intrusive around the management of Prisoner Z while he was on Home Leave from the OE despite a recognition that the SPS remained the responsible authority. There are also concerns that some of the attendees at the multi-agency meetings were practitioners and not managers and they did not feel empowered to challenge decisions or the process.

Consequently, the Independent Reviewer has serious concerns that there was no regime of additional management or monitoring in place for the periods when Prisoner Z was on Home Leave as a means of ensuring that he was adhering to the

terms of his licence conditions or so that other emerging risks could potentially be identified. Such measures could have included announced and unannounced visits by Social Workers, uniformed and plain clothes Police Officers, increased patrols in the area of his home leave address and the address of Person K. This would have allowed the Police and other agencies to engage with Prisoner Z, to help build a positive relationship with him and to increase their knowledge regarding his movements and other relationships he was forming while he was on Home Leave.

It is also of note that both Prisoner Z's home leave host and Person K were in employment. It is therefore of further concern that for large parts of his periods of Home Leave, Prisoner Z was left to his own devices and that the professionals charged with assessing and managing his risk, had no real sense of what he was doing or how he was structuring his time.

The SPS Intelligence Unit have a process where they would routinely update Police Scotland's National Intelligence Bureau (NIB) with details of all prisoners who are absent from prison on periods of Home Leave. This is then disseminated by the NIB to the relevant Local Intelligence Offices within Police Scotland.

However, the main driver to provide intelligence to frontline Police Officers in such high-profile cases should come via the multi-agency process and from those attending the multi-agency meetings. Indeed, in February 2017, a Special Intelligence bulletin was compiled in relation to Prisoner Z receiving Home Leave and this was done at the behest of the Offender Management Unit supervisor. This bulletin was available to be read and considered by every officer in Tayside Division from Constable to Chief Superintendent.

It is a matter of concern that the Local Policing Team in Angus were largely unsighted on the specific dates when Prisoner Z was on Home Leave. For example, the Daily Briefing Pages or the intelligence output documents for Dundee and Angus which are used to brief staff regarding matters relevant to their duties, contained no reference to Prisoner Z being on Home Leave in August 2017 or the imminence of a Release Tribunal on 10 August 2017 which would have considered his potential release on Life Long Licence.

Local Policing representatives should have been in attendance at the multi-agency meetings at HMP Castle Huntly. Had this been the case, they would have been fully aware and could have potentially influenced a more proactive response to Prisoner Z being in the community and his presence could have been properly cascaded to all relevant frontline officers. This may also have presented opportunities for the police to influence a more commensurate and structured RMP. However, Police Scotland were represented at all but one of the multi-agency meetings and the officer(s) in attendance appear not to have fully briefed the Local Area Commander in relation to them.

It is the MAPPA Coordinator's position that she spoke personally with the Police Scotland Local Area Commander regarding Prisoner Z but the officer concerned refutes that such a conversation took place.

The Independent Reviewer is concerned that there was no Local Policing input from Angus at the multi-agency meetings held at HMP Castle Huntly on 26 January, 20 April or indeed 18 May 2017 although it is fully accepted that there was Police attendance in the form of the Offender Management Unit supervisor at these meetings with the exception of the one held in May.

The Local Area Commander has intimated concern that no opportunity to attend the meetings was offered and therefore no opportunity was provided to the Local Area Commander to identify the needs and risks in managing Prisoner Z in the community while he was on Home Leave.

Although aware that Prisoner Z was receiving periods of Home Leave, the Local Area Commander was not aware that he was subject of a MAPPA Category 3 referral on 9 January 2017 and that he would have been a Category 3 offender at the point of his eventual and potentially impending release and therefore the responsibility of the Local Area Commander for Police Scotland at that point (August 2017).

The Local Area Commander stated that had there been such knowledge, all meetings relative to Prisoner Z would have had Local Policing representation and that a regime of control measures to manage and mitigate all risks in the community would have been put in place. Based on the management of high-risk offenders in Angus in the past, this may have included announced and unannounced visits, patrols in the area, checks of the mobile phone and other devices used by Prisoner Z and an increased ability to monitor for signs of alcohol consumption, substance misuse and any newly formed or problematic relationships.

The Reviewer therefore concludes that there was a breakdown in communication between the MAPPA Coordinator and Local Policing as well as a lack of structured and documented handover between the Police Scotland Offender Management supervisor and the relevant Local Area Commander.

Recommendation 8

Police Scotland should review and improve lines of communication between Offender Management Units and Local Policing in cases involving MAPPA, particularly in cases where there are crossovers of ownership and accountability.

The way that MAPPA Category 3 subjects are policed is varied across the country. Police Scotland recognise that Criminal Justice Social Work Departments are the lead agency in such cases and that MAPPA Category 3 offenders will not be managed in the same manner as Registered Sex Offenders. In a memorandum issued to all Divisional Commanders, it is stated that all MAPPA Category 3 offenders will be policed by Local Policing Teams who will also support local MAPPA arrangements in such cases with Local Area Commanders having overall responsibility.

In Angus, this responsibility has been devolved to a single nominated officer while in some policing areas, the responsibility is managed by a team e.g. the Divisional Alcohol and Violence Reduction Units. There are obvious strengths with the latter approach and there are flaws with the former approach, particularly if a single nominated officer is on leave or is unavailable. In addition, the Angus Officer conducting this role is unlikely to have the seniority to pledge additional resources, if required.

Strategic leads within Police Scotland and the local authority have confirmed that they were not made aware of the proposal to manage Prisoner Z at MAPPA Level 3

on his expected release from custody on 10 August 2017. Although it could be argued that this was a failing on the part of the MAPPA processes, not all of the practitioners attending the multi-agency meetings at HMP Castle Huntly appear to have made senior managers within their own respective organisations aware of the updates in respect of Prisoner Z and the risk he presented.

Processes in Tayside would have dictated that a MAPPA Level 2 meeting would have been required to consider the risk posed by Prisoner Z and to consider a RMP for him. The Level 2 meeting could have then deferred Prisoner Z to a Level 3 MAPPP should that have been considered the most appropriate course of action to manage and mitigate the risk posed by him being in the community.

These multi-agency meetings were further hampered by an apparent lack of regular attendees from across the wider partnership. This presents challenges in terms of continuity, ownership and accountability in such a critical area of public protection. Attendees require to be aware of all the circumstances, substitutes at meetings need to be fully briefed and also have the necessary seniority to make decisions and be confident to challenge partners when necessary.

9. MAPPA National Guidance

It was evident during this Review that the MAPPA process operates in different ways across Scotland. Some areas will get involved in partnership discussions at different stages during the process of prisoners, who are subject to MAPPA, being released into the community. Some MAPPA Coordinators will decline to get involved in such discussions until they are obliged to do so as per MAPPA guidance.

The Scottish Government Multi-Agency Public Protection Arrangements 2016 National Guidance document has been examined during this review with the conclusion that the relationship between the RMT meeting and the Multi-Agency Risk Assessment Case Conferences (these have different titles in different areas) needs to be more prescriptive in order to effectively deal with those prisoners who will eventually be managed through MAPPA who may be considered for community access including Home Leave.

One of the many challenges facing senior management within the SPS, but particularly at HMP Castle Huntly, is the different processes that are adopted around the country. HMP Castle Huntly disperses prisoners on community access and on release to all eight MAPPA Coordination areas. This creates confusion for Prison staff when dealing with inconsistent processes around the country.

Therefore, the Review finds that such differences in process makes the management of MAPPA subjects who are in the process of being released from prison challenging for the SPS. The Reviewer therefore concludes that these different processes could increase the risk within our communities.

The Review concludes that there is a gap present in the current suite of technological tactical options that are available to effectively manage high risk offenders who are being considered for Home Leave and that discussions currently ongoing to discuss this option should be expedited.

In the case of Prisoner Z, a GPS tag may have identified areas he was frequenting which would have helped build on what was known around how he was spending his time and structuring his days.

Recommendation 9

The Scottish Government and Scottish Prison Service should consider what technological options are available to assist with the management and monitoring of high risk prisoners who are being granted Home Leave - specifically evaluating the viability of GPS tagging solutions.

GPS tagging is currently a tactical option that is not available to monitor prisoners who have community access including Home Leave in Scotland.

The Reviewer is aware that this issue is currently being scoped in England and Wales. It is not being suggested that this should be a suitable or necessary intervention for every prisoner subject to community access and Home Leave but it could be utilised for the 'critical few' who pose a High RoSH to the public or where their risk is unknown and therefore is worth further exploration in the Scottish context.

Alcohol consumption, substance misuse, boredom and rumination were all known triggers that increased the risk of Prisoner Z re-offending.

During the SCR, it was recorded in a myriad of risk assessment documents within the prison setting that Prisoner Z had provided a high number of negative Mandatory Drug Tests during his time in prison. It now appears that the drug of choice within prison settings is NPS. These are commonly referred to as 'legal-highs'. Current Mandatory Drug Testing does not have the capability to detect if a person has consumed NPS. The Independent Reviewer questions if too much emphasis was placed on the negative Mandatory Drug Tests provided by Prisoner Z when considering his risk.

The SPS should also place a higher significance on the issue of boredom and a lack of structure faced by prisoners when they are being considered for periods of Home Leave.

This was extremely relevant for Prisoner Z where boredom was highlighted as an issue in his VPP feedback report. In Prisoner Z's case, his home leave host was in employment and he was left to his own devices much of the time. Ruminating was a key issue identified in his Risk Assessment and while it is documented that he would be required to keep a diary for review with Social Work and Prison staff, it appears that this was never followed through upon and the Independent Reviewer has been unable to locate any diary completed by Prisoner Z.

10. Intelligence Flow

The Independent Reviewer is concerned that although the information regarding his community access was despatched from the SPS, it is not clear when this took place and how much notice was provided. From documents available, it appears that a

spreadsheet is maintained by local Divisional Intelligence Offices that details all prisoner periods of Home Leave.

Notification to Community Based Criminal Justice Social Work is provided locally by the SPS either directly or via the MAPPA Coordinator.

It is therefore possible that the fact that Prisoner Z, a serving prisoner who, from early 2017 was considered to meet the MAPPA Category 3 criteria at the point of his release and the risk he posed to the public was considered to be High, this was either not highlighted or it was missed.

A local Special Intelligence Bulletin was prepared by the Tayside Division Local Intelligence Office in February 2017 but this contained general information in relation to the fact that Prisoner Z was receiving Home Leave at his home leave address without specifically highlighting the dates when he was in the community as these would not have been known at that time.

Although the dates of his periods of Home Leave are recorded on the Scottish Intelligence Database (SID), there was no specific briefing to frontline officers identifying the particular periods when Prisoner Z was on Home Leave. Officers would have been required to specifically interrogate SID to find this information and they would have had no real reason to do so. The dates of his Home Leave should have been highlighted and presented on Daily Briefing documents and they were not.

The Independent Reviewer recognises that this may be a failure and breakdown in communication by those who were involved in the multi-agency meetings and feels that this failure represents a missed opportunity to specifically brief and task Police Officers and other community partners to become actively involved in the management of Prisoner Z while he was on Home Leave.

Had the flow of intelligence been seamless, it is possible that officers and other community partners tasked with building on the intelligence profile of Prisoner Z while he was in the community, could have picked up on issues that suggested that Prisoner Z may have been breaching his licence conditions had these been occurring.

Recommendation 10

Scottish Prison Service should review the start to end process of how information regarding individual prisoners' unsupervised community access is consistently reported to and received by Police Scotland and Criminal Justice Social Work in a way that facilitates the identification and management of individuals who may pose a risk in the community.

11 LOCAL OBSERVATIONS

Local residents at his home leave address raised concerns regarding Prisoner Z's presence in the community with a Local Angus Councillor during the periods of his Home Leave prior to August 2017. It was reported to the Local Councillor that Prisoner Z had been seen sitting in the rear garden at his home leave address at odd times during the night and this had an unsettling effect with some neighbours. The

Councillor contacted a senior member of Social Work staff in Angus Council to seek advice on how she should respond to her constituent. She did not specifically detail what the local concerns were, but she received a full response indicating who the responsible authority was at that particular time and how individuals are managed in the community should they be released from prison in such circumstances. The Councillor was also provided with advice to provide to local residents should they continue to have concerns.

Following the attack on Person B in August 2017, the SPS carried out a full internal review of the circumstances of Prisoner Z being given Home Leave. This review acknowledged that there were shortcomings in relation to how the RMTs recorded the rationale for key decisions made in relation to Prisoner Z.

12 AREAS OF GOOD PRACTICE

The ICM approach including the RMT meetings is seen as a strong framework to manage risk and determine whether a prisoner is progressed towards community access and release. Although these systems and processes were deemed not to be particularly effective in this case, the Independent Reviewer believes that such a framework has the basis and structure to allow RMTs to function moving forward.

The ability for the wider partnership to recognise the need to meet to discuss the potential media issues surrounding Prisoner Z's community access and release is seen as reasonable practice.

Although there were some flaws in the process, at practitioner level, the handover of responsibility between Dundee City Council and Angus Council was effective and the professionals did as much as could be expected to ensure that the handover was as strong as it could have been.

The involvement of Prisoner Z's Community Based Criminal Justice Social Work in attending ICM meetings is seen as good practice. It was also good practice that both Social Workers from Dundee City and Angus Council met with Prisoner Z during every period of Home Leave.

The performance of the Offender Management Unit supervisor at the January 2017 multi-agency meeting to appropriately challenge their community partners at the meeting showed good awareness and leadership. Organising the compilation of the Special Intelligence Bulletin in February 2017 is also seen as good practice.

13 CONCLUSION

The Independent Review concludes that Prisoner Z alone was responsible for the attack on Person B in 2017.

This SCR has highlighted that the dual process of RMT meetings and separate multi-agency meetings created a context in which neither meeting compiled a RMP that addressed the most up to date risk assessments. It is the most important recommendation of the SCR that a single multi-agency assessment of risk and resultant RMP must be in place for all MAPPA clients accessing the community on Home Leave.

The Reviewer is of the opinion, based on his own professional experience, that there are four factors that set Prisoner Z aside from the majority of life sentence prisoners, most of whom are convicted Murders.

1. Prisoner Z committed a Murder at the age of 15 years. This was his first real involvement with the Police. He had never had any involvement with the Children's Reporter – so Murder was his first offence and this is very unusual.
2. The disproportionate level of violence used to intentionally kill and murder Person A. Evidence suggests that he may have punched her, head butted her, stamped on her and stabbed her multiple times including stabs to the area of her neck and upper body.
3. For him to have been able to carry on with his life and not feel compelled to 'tell someone' about his crime shows a lack of empathy and remorse. In addition, he was able to dispose of the murder weapon which has never been recovered as well as washing the clothing worn by him at the time of the crime.
4. Finally, the fact he spent the last three years of his adolescence and his entire adult life in custody also sets him out with the norm and makes it highly likely that he will have been, to an extent, institutionalised.

That said, it is also highly unusual for a prisoner to pass so many years with so few adverse reports and to progress and complete so many hours in the community on either work placement or Home Leave without incident.

There is evidence that Prisoner Z did only what he needed to do in order to progress through the prison system to the point where it might be considered that he manipulated the system through a 'grudging compliance'.

The period between Prisoner Z requesting to be returned to closed conditions from NTE and having his first grant of temporary release recommended and signed off by Scottish Ministers seems to be very short. The Independent Reviewer is of the view that this process should have been delayed and Prisoner Z further monitored for a period.

The report submitted by the SPS to Scottish Ministers was found to lack a balance of evidence. It is reasonable to believe that all such reports should contain as much information as is reasonably practicable and the fact that there was a lack of balance in this report shows that this process was flawed.

His community access through his work placements whilst at NTE in HMP Greenock was reported as positive and he progressed to the OE without any concerns being noted.

Prisoner Z had extended periods of community access, progressing from escorted leave, to work placement to unescorted overnight Home Leave. Through all this progression, there was no evidence of any wrongdoing by Prisoner Z or any breaches of Licence conditions. Although the Independent Reviewer accepts this evidence, the Independent Reviewer believes this evidence must be considered incomplete as Prisoner Z was on his own for increasing periods as his Home Leave increased.

His last PRA in 2012 stated that it was considered that Prisoner Z had a number of factors present or partially present that indicated that he was a high risk of violent re-offending if he were at liberty.

However, prior to his transfer to OE, his LS/CMI risk needs were assessed as being Medium and a RoSH was not fully completed in respect of him.

The Independent Reviewer believes that the SPS could have justified seeking an updated PRA in respect of Prisoner Z in 2016.

His LS/CMI was reviewed in OE and while this was being done, Prisoner Z continued with a phased community access plan. Even when his LS/CMI risk need was reviewed and a RoSH indicated that he was a high risk of causing serious harm, this increase in risk did not alter his path towards Home Leave when it can be reasonably argued that it should have.

Neither the RMT nor the multi-agency group had a RMP in place to manage and mitigate the risks as outlined in his RoSH and this is unacceptable.

There is a sense, that Prisoner Z's progress was being driven by process rather than by recognition of the risks that had been identified by the professionals involved in his case.

In any case, there was no information to indicate any adverse situations while he was on Home Leave.

[REDACTED]

Prisoner Z did not display any violent behaviours or attitudes that would have suggested that he harboured murderous intentions and that an attack was imminent.

Following the attack on Person B and during the subsequent criminal investigation, his cell at HMP Castle Huntly was searched. During this search three library books were found. [REDACTED]

[REDACTED]. They contained chapters in relation to his index offence and this may suggest some sort of egotistical notoriety by Prisoner Z. The third was a fictional book about a lone male who attacked females in wooded areas. This poses the question as to whether Prisoner Z held some sort of fantasy about attacking lone females in wooded areas but the books presence in his cell at HMP Castle Huntly only became known after the attack on Person B. Prisoners access reading material from a number of sources including the Prison Library.

Prisoner Z's position that he was 'out of his face' on alcohol and drugs when he attacked Person B is not thought to be credible for a number of reasons.

There is CCTV footage of him leaving his home leave address prior to the attack and returning there following the attack. On both occasions, he appeared to be lucid and coordinated. On his return, he did not appear to be in any way agitated.

His actions following the attack were coordinated. He texted Person K to advise that he had run out of cigarettes and stated that he was feeling rough. Four minutes after returning home, he had removed almost all his clothing and placed them within the washing machine which was switched on. He had cleaned the dumb bell used in the attack and had broken his mobile phone presumably to destroy evidence that it contained and had secreted it down the U bend of the toilet.

These are all very deliberate and coordinated actions.

It is considered likely that Prisoner Z would have been released by the Parole Board for Scotland on 10 August 2017, based on the meeting notes from his 2016 tribunal and

on the recommendations of the SPS, and his Community and Prison Based Social Workers.

It is unlikely that he deliberately sabotaged his own chances of release as this could have been achieved by far easier and less destructive means.

The lack of balance in presenting evidence that has been highlighted throughout this report, led to a dominant narrative that emphasized the many years of positive behaviour by Prisoner Z in custody and on leave, without giving equal weight to the assessments (2012 PRA and 2016 RoSH) that highlighted underlying concerns that may have required more in depth monitoring. The flaws in the dual meeting process also meant that workers were supporting increased community access without a robust RMP.

Although Prisoner Z was subject to a number of standard and additional Licence conditions, the level of monitoring and checking for adherence of these conditions was less than what might be considered reasonable.

A lack of structure, clarity of purpose and appropriate representation/involvement in the RMT and multi-agency meetings is considered to have contributed to this position. There appears to have been minimal structured support/input to Prisoner Z's time spent in the community to enhance his integration and the protection of the public.

It is Prisoner Z's position that he was regularly consuming alcohol and NPS during his periods of Home Leave and if this is true, then opportunities to prove the non-adherence of his licence conditions were missed.

The attack on Person B could not have been predicted. Prisoner Z had no established pattern of behaviour until his second offence. The evidence of his positive behaviour in prison and on community leave did constitute relevant evidence that supported the decisions to increase his community access. However, it is the finding of this Independent Review that there were flaws within the balance of information that was shared to assess risk, particularly from the SPS to Scottish Ministers when applying for approval for Home Leave. There were subsequent flaws in the meeting structure that divided tasks between RMT and MAPPA and resulted in a single or multi-agency forum not being enabled to take full responsibility to compile a structured and fully defensible RMP, on the basis of all available information and the respective views of all partners.

It must be emphasised that the lack of balance in assessing Prisoner Z's readiness to access the community started as early as the partial information supplied by the SPS to Scottish Ministers prior to his First Grant of temporary release. Perhaps similar decisions would have been made but they would have been made on the basis of fuller information. If there had been a more balanced consideration of risk and a single fully agreed multi-agency RMP there may have been more opportunities to observe whether Prisoner Z was breaching his Licence conditions. He may not have been breaching his Licence conditions and an even more robust regime of monitoring may not have uncovered any wrongdoing but the flaws in the risk assessment and the flaws in the RMP meant that the optimal conditions to prevent an offence like that which occurred in August 2017 were not in place.

14 RECOMMENDATIONS

Recommendation 1

The Scottish Prison Service should review the information provided to Scottish Ministers when submitting reports that recommend First Grants of Temporary Release to ensure that the report gives a balanced reflection of a prisoner's period of imprisonment and the assessed risk.

Recommendation 2

The Scottish Prison Service should review what information is available and considered during the Risk Management Team meetings when considering a prisoner's progression. The full Level of Service/Case Management Inventory risk assessment, together with any other risk assessments carried out, should be considered in full.

Recommendation 3

At the point where a prisoner is considered for progression to the Open Estate, the chair of the Risk Management Team within the Scottish Prison Service must ensure that the Level of Service/Case Management Inventory and any Risk of Serious Harm assessment have been fully completed, endorsed by a Senior Prison Based Social Worker and that all documentation is forwarded to the Open Estate for their consideration within seven days before the date of the proposed transfer.

Recommendation 4

The Scottish Government should work with partners to undertake a review of National MAPPAs guidance and improve consistency of application across the country. Guidance should specifically lay out how the Home Leave and release decision making processes; Scottish Prison Service Risk Management Team meetings; community based multi-agency meetings; and MAPPAs arrangements interfaces with MAPPAs risk management arrangements in practice.

Recommendation 5

The Tayside MAPPAs Strategic Oversight Group should ensure that concise and accurate pre read material for MAPPAs and multi-agency meetings is sent to attendees in advance of all meetings. This should include formal meeting invitations for all attendees. Meeting minutes should be concise, accurate, ensure tasks are detailed and clear in terms of ownership with updates and outcomes captured. Minutes should clearly reflect the rationale for decision making.

Recommendation 6

The Scottish Prison Service should develop how risk is assessed and mitigated within Risk Management Team meetings. Risk requires to be the main consideration and decisions made should serve to mitigate and manage risk rather than trigger progression.

Recommendation 7

The National MAPPAs Strategic Oversight Group should ensure that ViSOR Standard documents are adhered to by all partner agencies.

Recommendation 8

Police Scotland should review and improve lines of communication between Offender Management Units and Local Policing in cases involving MAPPA, particularly in cases where there are crossovers of ownership and accountability.

Recommendation 9

The Scottish Government and Scottish Prison Service should consider what technological options are available to assist with the management and monitoring of high risk prisoners who are being granted Home Leave - specifically evaluating the viability of GPS tagging solutions.

Recommendation 10

Scottish Prison Service should review the start to end process of how information regarding individual prisoners' unsupervised community access is consistently reported to and received by Police Scotland and Criminal Justice Social Work in a way that facilitates the identification and management of individuals who may pose a risk in the community.

Independent Significant Case Review (SCR)
Report by Mark Cooper
on behalf of Tayside Multi-Agency Protection Arrangements (MAPPA)
Commissioned by Angus Council

For further information/enquiries contact:

MAPPA Co-ordinator

Friarfield House

Barrack Street

Dundee

DD1 1PQ

Tel: 01382 435518

mappa@dundeecity.gov.uk

