

Review of the
Management Arrangements of Colyn Evans
by Fife Constabulary and Fife Council

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1. INTRODUCTION

1.1 Colyn Evans was sentenced to life imprisonment on 10 June 2005 for the murder of Karen Dewar, a 16 year old girl living in the same neighbourhood. The crime was committed when Colyn Evans was aged 17. He had been subject to supervision by Fife Council Social Work Service until April 2004, under section 70(3) Children (Scotland) Act 1995 and thereafter to throughcare support under the Support and Assistance of Young People Leaving Care (Scotland) Regulations 2003¹. Following Colyn Evans' arrest, both Fife Constabulary and Fife Council carried out internal reviews and jointly prepared a Serious Incident Report for the Scottish Executive². After he was convicted, they jointly prepared a report on the management arrangements of the case, hereafter referred to as the Fife Joint Report, which was made publicly available. This report was issued on 10 June, following Colyn Evans' sentencing, and gave rise to considerable public and media interest and concern in relation to what it covered. In response to this, Scottish Ministers requested that a review of the management of the case was undertaken jointly by Her Majesty's Inspectorate of Constabulary (HMIC) and the Social Work Inspection Agency (SWIA) with the following remit:

SWIA and HMIC will work together to;

- 1. scrutinise the report of the management arrangements of Colyn Evans;*
- 2. identify any issues not fully covered in the report or which require further examination; and then,*
- 3. work with Fife Council and Fife Police to address any issues that arise and update the report to reflect that work*

Following this, Ministers will meet with the Council Leader, Chief Executive and the Chief Constable to discuss the outcome of this work and any matters which might require further attention.

1.2 In order to address the first two elements of this remit, HMIC and SWIA prepared this report for Fife Council and Fife Constabulary. The Review Team³ were conscious that the remit was not to carry out an 'investigation' into the management of the case and therefore confined their work to an extensive review of all primary documentation, seeking clarification from senior staff where appropriate. The SWIA Team examined all the social work case records and reports in respect of Colyn Evans which were part of the initial review carried out by Fife Council, and had discussions with senior members of staff involved in the process of the review. The HMIC Team examined the relevant police records and reports and interrogated all related police data systems. Working together we were able to piece together a detailed chronology of what is known about Colyn Evans from the time he first became known to agencies in Scotland. This is set out in Appendix 1.

¹ The legislative framework in which the regulations are set are sections 17 and 29 of the Children (Scotland) Act 1995 and section 73 of the Regulation of Care (Scotland) Act 2001.

² Scottish Office Circular No: SWSG 4/99 Serious Incident Reporting advises local authorities of procedures to be followed when notifying the Scottish Executive about an offender or accused person under local authority supervision who is charged with murder or other very serious offences.

³ The joint Review Team consisted of Chief Superintendent John Geates, Inspector Ian McAllan, Detective Constable Andrew McKie, Stuart Bond, Inspector SWIA and Jo Knox, consultant for SWIA.

1.3 In fulfilling the remit, the Review Team considered that they needed to set out a full explanation of their findings, rather than simply address issues not covered in the Fife Joint Report. As a result this report repeats information covered in the Fife Joint Report and supports a number of the earlier findings. We welcome the fact that many areas highlighted by us for action are already being taken forward. We accept that it would not have been possible to predict that the behaviour of Colyn Evans would escalate to the murder of a 16 year old girl. Nevertheless, we are critical of the Fife Joint Report and found considerable shortcomings in the management of this case which we address throughout this report.

1.4 Section 2 of this report provides a summary of the information available about Colyn Evans. Section 3 considers the gaps in relation to the Fife Joint Report. Sections 4 and 5 analyse the issues in relation to this. Although the remit was essentially about the Fife Joint Report, many of the issues it raised were part of an on-going national agenda, therefore in Section 6 we have discussed issues arising from our review in relation to this. Section 7 sets out our conclusions and section 8 provides a summary of the issues we have identified for further work both for Fife Council and Fife Constabulary as well as at a national level. In carrying out our review, we recognised that the task was not to examine the causes of Colyn Evans' offending, but to focus on the agencies' role in his management once he came to their attention and how this was then reflected in their review. The Review Team have worked collaboratively on all aspects of the report and the views expressed are jointly held.

1.5 The Review Team wish to acknowledge that Fife Council and Fife Constabulary have co-operated fully throughout the period of the review.

2. SUMMARY OF KEY EVENTS

Events Leading to First Period of Supervision (November 1999 – December 2001)

2.1 Colyn Evans was born on 17 April, 1987 in South Wales, the third of three children and the records indicate a normal early development. His family moved to Fife when he was 4 years old. He started school at Kennoway Primary School and records indicate early incidents of bullying by his peers. The first reference to his inappropriate sexual behaviour was in 1997 with an alleged indecent exposure to an elderly male. In 1998 he moved on to St Andrews High School and in 1999 was charged with shameless indecency having exposed himself to two adult females. He was referred by the school to Fife Council Social Work Service for difficult behaviour, truancy, and being outwith parental control. A referral was also made to the Reporter to the Children's Panel, however, no further formal action was taken as support was provided at school and by clinical psychology on a voluntary basis. Following an incident in March 2000, in which Colyn Evans attempted to break into a locked car, he received a Reporter's warning. There were two further incidents in March when he went missing and also stole a bike, for which he received a police warning.

2.2 He then transferred to Buckhaven High School where difficulties continued with truancy. Following an incident of truancy in June 2000, Colyn Evans was reportedly assaulted by his father who received a warning from the Child Protection Unit (CPU)⁴. In March 2001, he was again reported missing but returned home of his own accord. In May he was charged with assault, shameless indecency and lewd and libidinous behaviour in relation to inappropriate sexual conduct with two girls under 16 within the school grounds. Following this, in July, he was referred by Fife Council Social Work Service to the Centre for the Vulnerable Child (CVC)⁵, for individual work on his inappropriate sexual behaviour. At this time the Fife Sex Offender Registrar⁶ was notified of concerns about Colyn Evans. In November 2001 the grounds for lewd and libidinous behaviour towards the two girls were established at the Sheriff Court, and Colyn Evans was referred to the Children's Hearing. At a Children's Hearing in December 2001 a home supervision requirement was imposed and he was referred to the CVC for individual work to address problematic sexual behaviour. He was entered on the Sex Offender Nominal Record⁷ held by Fife police and categorised as a Non-registered Sex Offender

⁴ The Child Protection Unit: at the time Fife had two CPUs, staffed with police officers and social workers. Social workers were supervised by a social work Team leader (1 in each CPU). Their remit was effectively limited to joint investigations of child protection referrals that required police involvement because they may have resulted in a prosecution (primarily cases of physical and sexual abuse). They also provided advice and guidance to other staff/referrers on whether situations required a child protection response. These arrangements have been reviewed.

⁵ The Centre for the Vulnerable Child (CVC) is an NHS Fife service providing therapeutic intervention for children who have been the victim of abuse. The service is part funded by the Changing Children's Services Fund. In recognition of the need to provide a similar service to children and young people who are the perpetrators of abuse, CVC now funds a senior practitioner (social work) post in the Child Support Service with whom CVC works closely.

⁶ Sex Offender Registrar: the officer who manages the registration of offenders and monitors those recorded on the database.

⁷ The Sex Offender Nominal Record is a database held by Fife Constabulary (prior to the introduction of VISOR, the Violent Offender & Sex Offender Register database) for recording Registered and Non-Registered Sex Offenders. A 'nominal' is an individual record. This is proactive practice undertaken to provide an overview of individuals identified as potential sex offenders where there are no legal requirements for them to be registered.

Events Leading to Second Period of Supervision (January 2002 –December 2002)

2.3 At various times between October 2001 and May 2002, Colyn Evans was excluded from school. In February 2002, there was a review of his supervision requirement, and a recommendation was made to the forthcoming Children’s Hearing for the supervision requirement to be discharged because it seemed that Colyn Evans and his family were willing to accept services on a voluntary basis. In March, he was reported missing and subsequently found in Leven where he had been for 3 days with an older man; subsequently, in September 2003, he alleged that he had been sexually assaulted by this man. In June 2002, Colyn Evans’ home supervision requirement was terminated by a Children’s Hearing.

2.4 In August 2002, Colyn Evans alleged that he had been threatened by a male and was given advice by the Police. The following month he was charged with shameless indecency involving masturbating in the presence of a 21-year-old female in Kennoway. Although he had an alibi, the matter was referred to the Reporter and subsequently dealt with together with a further sexual offence. This was not recorded on the Sex Offender Nominal Record. Again in September, he was reported for attempting to take an 8 year old boy from school but this was not considered to have sinister intentions. In October there was a complaint to the police of an assault on an 8 year old boy in Kennoway, involving punching and kicking. He was not charged, but a police report was sent to the Reporter because of continuing concerns. In October, he was charged with shameless indecency for masturbating in the presence of a 31-year-old female in Kennoway. Police submitted a report to the Reporter, and this was dealt with in April 2003, together with the earlier offence reported in August 2002, following a proof hearing in January 2003 where the grounds were established. During November and December Colyn Evans made three complaints to the police about being threatened by others. The first AIM⁸ assessment was completed in December which considered him to be a high risk of committing further sexual offences.

Period at Geilsland School (December 2002 – April 2004)

2.5 In December 2002 Colyn Evans became a resident at Geilsland School, initially on a voluntary basis and then subject to place of safety warrants. Geilsland School was chosen specifically because it claimed to be able to provide specialist support for young people with entrenched and concerning sexual behavioural problems. In January 2003 the social work service requested an Initial Risk Assessment⁹ to be carried out jointly by police and social work. At a Children’s Hearing on 30 April 2003, he was made the subject of a supervision requirement to reside at Geilsland School. In June, under the terms of the legislation with regard to preparing young people for ceasing to be looked after, Colyn Evans was referred to the dedicated Throughcare Team in Fife Council Social Work Service to support him practically and financially after discharge from the Looked After and Accommodated system.

⁸ The AIM assessment framework, Assessment, Intervention & Moving on (Print, Morrison and Henniker, 2000) The purpose of the AIM framework is to provide guidelines for practitioners from a wide range of agencies (Youth Offending Teams, police, social services, education, health) in order to give them a common language and a shared approach to tackling sexually harmful behaviour.

⁹ Initial Risk Assessment: this is the first police review of available information about a sex offender or suspect offender. It should be informed by any information held by the local authority Social Work Service and carried out in consultation with them.

2.6 Whilst at Geilsland School, records indicate that Colyn Evans did not initially undertake any programme or intervention to address his sexual behaviour because of his denial of the offences. Subsequently, Geilsland School was not in a position to offer this intervention due to staffing shortages. Groupwork was eventually started towards the end of his time at Geilsland, but this was of a more general nature and no individual specific offence work had started by the time of the Looked After Children (LAC) Review¹⁰ in March 2003. During Colyn Evans time at Geilsland School there were reports of absconding and also of sexual activity with other residents both within and outside the school. In September, there was a meeting between Fife Social Work and Geilsland School where these concerns were raised and there was also a discussion with Fife Child Protection Unit as to whether the sexual activities at Geilsland should be investigated. However, the CPU considered that they did not have a role in this and that no action was required. The matter was not followed up further. Towards the end of 2003, Colyn Evans was permitted more home visits and his behaviour seemed to improve. However, the LAC review in January 2004 considered that he continued to require the structure afforded by placement at Geilsland School. Later in January he was found in possession of small amount of cannabis at Geilsland.

2.7 A further LAC review on 15 March 2004 noted a reduction in absconding and improved contact with his family but continuing concern about the delay in commencing specific work to address sexually inappropriate behaviour. A decision was taken to recommend termination of his supervision requirement and return home, 'because he is now very positive about his future and willing to accept support in the community to help him stop re-offending, including work with the Child Support Service (CSS)¹¹ to address sexually inappropriate behaviour and support from the Throughcare Team'.

2.8 A second AIM assessment was completed by CSS in April 2004 and considered Colyn Evans a continuing high risk of re-offending, but noted positive changes in the last 18 months, including better coping mechanisms and substantial maturation. However, concern remained about him being isolated in the community and in an unstructured environment with little to do. The assessment indicated the need for ongoing offence focussed work if the likelihood of him re-offending in a sexual manner was to be reduced. This report was not forwarded to the Children & Family Team or to the Reporter. At his annual Children's Hearing Review on 14 April, his supervision requirement was terminated and he returned home. On 15 April responsibility for Colyn Evans was transferred from the Children & Families Team to the Throughcare Team.

Period Following Termination of Supervision (April 2004 – January 2005)

2.9 Eight days after his return home there was an allegation that Colyn Evans had assaulted a 13-year-old friend, however, this was resolved amicably and no action taken. Early in May 2004, he was reported as missing and later found with a 13 year old girl in a caravan, where they had spent the night. No action was taken, as the girl insisted nothing untoward occurred. In July, Colyn Evans had a first meeting with the Centre for the

¹⁰ Children and young people who are Looked After and Accommodated by the local authority are required to have the circumstances of their case reviewed. Regulation 8, The Arrangements to Look After Children (Scotland) Regulations 1996.

¹¹ Child Support Service: This is a Fife Council Social Work Service which works with young people who may be at risk of sexual offending. It undertakes assessments and provides guidance and support to individuals in an attempt to reduce the risks and manage their behaviour.

Vulnerable Child and CSS but was unwilling to cooperate. Following this, CSS decided that their involvement should end due to his lack of commitment and requested an Initial Risk Assessment from the Sex Offender Registrar. Colyn Evans case was put on a 'review' basis and no further action taken. The Throughcare Team was not informed of this decision. The Initial Risk Assessment was not carried out.

2.10 Following deterioration in his home situation as he was being threatened by local young people, an application was made for temporary accommodation for him. The situation was seen as urgent and on 20 August, Colyn Evans was allocated a single flat in Tayport. The Throughcare Team was aware of the change of address but CSS and the police were not informed. Between 20 August and 19 January 2005, Throughcare and Housing Support made 41 visits to the flat, of which contact was made with Colyn Evans on 20 occasions. On 13 September 2004, he threatened to commit suicide and the police were alerted. He was charged with breach of the peace and later released to the care of his parents. The Sex Offender Registrar was notified but not the local authority. From October onwards, the Throughcare Team found it increasingly difficult to make contact with him. In late October (26.10.04) he went to Wales. Though the Throughcare Team was aware of this they did not inform social work teams or other agencies about this absence. However, when it was made clear to him that if he did not occupy his flat he would lose it, Colyn Evans returned to Fife on 3.11.04.

2.11 In December 2004, Colyn Evans was suspected of breaking into a flat and accessing pornographic sites on the computer. The police made several attempts to locate him but without success. Fife Council staff continued to make efforts to make contact with him up until the murder was committed on 20 January 2005. The last documented contact was a letter dated 19 January arranging to see him on 24 January.

3. THE FIFE JOINT REPORT

3.1 The Review Team found it helpful to find out how the Fife Joint Report was prepared as this is not set out in their report and appears to have had a critical bearing on the contents of the final document. The Fife Joint Report drew on a number of reports that had been prepared in response to the murder. A Serious Incident Review was carried out jointly by Fife Constabulary and Fife Council in accordance with the Scottish Executive guidance, Fife Constabulary undertook an investigation into their handling of the case, Fife Council reviewed the social work and housing involvement in the case. Following Colyn Evans conviction on 24 May the two agencies agreed that a further report should be prepared for public dissemination. This was completed by 10 June when Colyn Evans was sentenced. It is of note that the author of the Fife Joint Report did not directly undertake a review of the case, but was tasked to draw together the various reports prepared by both Fife Council and Fife Constabulary. We accept that the Fife Joint Report was based on considerable discussion with regard to the information available, but it inevitably suffered from the sifting of information at the various stages that the earlier reports were prepared. This meant, therefore, that issues that were not covered fully in these earlier reports were not included in the final report.

3.2 The agencies must be commended in their positive intentions to report jointly on their work in relation to this case. However, our view was that, whilst the Fife Joint Report covered the essential elements of the management of Colyn Evans case, there were key areas which should have been set out in more detail so that the processes and thinking behind decisions were clearer and more transparent. A key issue was that there were gaps in some primary reports on which the Fife Joint Report was based, which meant that the final report was not based on a full review of the information. With regard to the social work process, there were matters that had not been included in the preparatory reports which might, had the author of the final report been made aware of them, have raised issues which might have been investigated further and led to a better understanding of events.

3.3 Key aspects that should have been explored further in the preparatory reports included:

- Details of Colyn Evans time at Geilsland School.
- Details about how the decision to terminate the supervision requirement was reached.
- A fuller explanation of how the property in Tayport was allocated to Colyn Evans.
- A more detailed explanation of decisions made and work undertaken following his return from Geilsland School.
- A fuller explanation as to why the 2 initial risk assessments which Fife Constabulary was asked to complete were not undertaken.
- A series of entries in relation to Colyn Evans activities which should have been recorded on the Sex Offenders Database and, to an extent, the police Scottish Intelligence Database (SID) are absent.
- Any relevant information from the education service, apart from reports prepared for reviews which were contained in the files we saw, who we felt, over the period that Colyn Evans was causing concern, would have had a considerable knowledge of him. We considered that the information available to the education service could have made a greater contribution to understanding his situation. This was also the case for

health documentation, particularly in respect of his involvement with the Centre for the Vulnerable Child.

- Key decisions about Colyn Evans were made by Children's Hearings and a report from the Reporter giving fuller details of the decisions made would also have assisted.
- A better explanation of the Fife protocols governing the management of juvenile offenders such as Colyn Evans and the responsibilities of the various public agencies involved.

This report examines these issues in more detail.

3.4 The principle behind the approach taken to preparing the Fife Joint Report is commendable, however, the timescales involved were tight and ultimately, in our view, led to a report that was in some areas limited and had significant omissions. Nor was it fully representative of the work undertaken by Fife Constabulary and Fife Council both during and after its preparation. The Review Team accept that there cannot be a full enquiry in all cases where there is an unacceptable outcome and public agencies are involved. Nevertheless, a murder must be regarded as the most serious of outcomes, warranting the fullest investigation. This is a substantial task and consideration needs to be given as to how agencies that need to carry out such an investigation can best be supported in this task to ensure that all parties involved feel confident in the outcome.

3.5 Recommendation 6 in *It's everyone's job to make sure I'm alright*¹² sets out that 'The Scottish Executive should consult on how child fatality reviews should be introduced in Scotland. This should include consultation on how they should be conducted, how reviews should be constituted, to whom they would report and what legislative framework is required to ensure their effectiveness.' This work is now being progressed by the Scottish Executive. In addition, in response to the Colyn Evans case, Ministers have instructed that the development of guidelines for local inquiries is also commissioned, to ensure these are carried out on a consistent basis across the country. It is intended that the experience of undertaking this review should contribute to this work. Whilst this is a welcome development, there is a frustration among agencies that guidance has not been available before this.

3.6 The commitment by the Scottish Executive to develop guidance on carrying out local inquiries is welcome and this should be progressed and published as a matter of urgency to ensure consistency of practice throughout the country.

¹² *Its everyone's job to make sure I'm alright* the report of the Child Protection Audit and Review. (2002), Scottish Executive.

4. RISK ASSESSMENT

4.1 Risk assessment at its very best is an imprecise activity, however, it is of no value to undertake risk assessments and use terms such as 'high risk' without developing a management plan to support and, as far as possible, minimise that risk. Whilst there is a developing body of knowledge about sex offending, its very nature means that it takes a long time for follow-up research to come to fruition. We know that sexual offending mostly involves highly secretive activity; that many offences go unreported because of fears about the effects of disclosure; that evidence can be difficult to obtain; that often offenders can have had a life of offending before they are finally caught and that it can be a long time before they are caught again, even if they are continuing to offend.

4.2 Most of the research literature on sex offenders is based on populations of convicted adult offenders and what is known about adolescent offenders is more limited. A recent report *Mapping and Exploring Services for Young People who have Sexually Abused Others*¹³ points to the diversity of this group of young people. The authors describe a continuing debate amongst practitioners about whether young people showing sexually problematic behaviour will grow into adult sex offenders unless treated, or are in fact more similar to other adolescent offenders and will grow out of it. They report the conclusion of many experienced practitioners in the field that the vast majority of young people do not go on to become adult sex offenders, although a small sub-group are at high risk of doing so. There appears to be a high degree of consensus amongst specialists in the field that children and young people who are displaying sexually problematic behaviours or who have abused others are children first and foremost and should be responded to within this underpinning philosophy. It is also known that factors such as experience of sexual abuse and family violence also feature in the backgrounds of young people displaying sexually problematic behaviour.

4.3 In the case of Colyn Evans a number of appropriate risk assessments were undertaken. The Child Support Service (CSS) carried out two AIM assessments which examined a range of relevant factors, identifying both risks and protective factors. Both these assessments drew the conclusion that Colyn Evans was a high risk of re-offending and the second one notes concern about his potential isolation in the community and return to an unstructured environment; it also sets out the view that Colyn Evans had needed some persuasion to agree to further work with the CVC on his inappropriate sexual behaviour and the author thought it unlikely that he would follow-through on this. The summary of the A.S.A.P assessment¹⁴ undertaken by staff at Geilsland School, included with the LAC review documents for March 2003, discussed the results of a number of questionnaires completed by Colyn Evans. These highlighted a range of concerns including: that he was at best confused about his sexual preferences and overly sexually preoccupied; had considerable problems with managing his anger, noting that he would resort to angry responses more readily than his peers and that this has been a major focus of daily care, 'Colyn appears to feel anger as an intense sensation and

¹³ Hackett, S. Masson, H. and Phillips, S. (2003), *Mapping and Exploring Services for Young People who have Sexually Abused Others* Final report on a two year research project funded by Youth Justice Board, NSPCC and the National organisation for the Treatment of Abusers University of Durham, centre for Applied Social and Community Studies and University of Huddersfield, Centre for Applied Childhood Studies.

¹⁴ The A.S.A.P assessment carried out by Geilsland School was based on the findings from completion of questionnaires for the Adolescent Sexual Abusers' Project being carried out by the Probation Studies Unit based at Oxford University.

has a tendency to brood and be suspicious of others.’ Though his scores on the tests indicated he was not overly likely to act impulsively, recent behaviour at the school contradicted this. The report also discussed results of peer aggression scales that indicated that he tended to endorse the use of violence against females and was more likely than average to see violence as a problem solving strategy and was proud of his ability to handle himself. The report suggests that the findings from the questionnaires might inform future work.

4.4 It is notable that whilst these assessments considered many of the key areas known to feature in the lives of young people displaying sexually problematic behaviour, there was little detailed information in the files of the dynamics or history of the family, apart from his mother’s early history. As well as assessing key factors known to be relevant in relation to young people displaying sexually aggressive or problematic behaviour, it is important to carry out a full assessment of need, including a detailed examination of the young person’s early life and family dynamics. The issue of anger and lack of control with regard to this was also indicated in a report from CVC to Geilsland School. Both these seem to have been significant issues for Colyn Evans and are identified in research as being relevant both to inappropriate sexual behaviour and aggressive behaviour. Given the level of offending that had already come to the attention of the authorities and the lack of controls or treatment in place, the chances of Colyn Evans re-offending remained high and there was sufficient known about him to have concern about how this might develop as he matured. However, research seems clear that whilst there is a very small group of young people who pose a great danger to others, tools are not available, and may never be, to identify precisely which young people are in this group¹⁵. It is reasonable, therefore, to assert, as the Fife Joint Report does, that the risk of Colyn Evans committing a murder could not have been predicted.

4.5 It is of concern that the second AIM assessment was not available to the Children’s Hearing on 14 April 2004. The CSS file contains a specific request to them from the Reporter for a report and this is acknowledged in the case note. Whilst we understand that the process is to draw together a composite report, it must be incumbent on those who have been asked to provide a report to ensure that their report is either included or sent directly. The Fife Joint Report notes that although the CSS report was not available to the Hearing, the case was still considered in terms of Colyn Evans being a high risk of re-offending. However, in our view there is considerable material in the second AIM assessment that was lacking in the social worker’s report. Had it been available, the Hearing might have considered the case to be of more concern than it apparently did. In fact the social worker’s report appears to understate any difficulties in relation to Colyn Evans’ sexual behaviour, dysfunctional placement and lack of self-control and highlights the apparent recent improvements in his behaviour. We note that Fife Council has already taken action to ensure that all materials are available to a Children’s Hearing. However, while an adjustment to systems is valuable, this aspect also requires professional staff to recognise their own individual responsibilities in such matters.

¹⁵ Morrison, T. (2003) *Making a real difference or just another child death inquiry? Learning the lessons from ‘Childhood Lost’* in Journal of Sexual Aggression Volume 9 Issue 2 November 2003

1. Fife Council should review its policy and practice in relation to work with young people with sexually problematic or aggressive behaviour to ensure that risk assessments are integral to ongoing care planning rather than a separate activity. It is essential that issues of risk management are taken into account in managing any case where there are potential public protection issues. Regardless of the route of referral, a risk management plan must be agreed with all those involved in the case and implemented. The plan should be regularly updated.

Initial Risk Assessments and the Police Involvement

4.6 Evans was a known sex offender. As a juvenile he was referred to the Reporter and dealt with under the Children's Hearing system and could not, therefore, be registered as a sex offender. He was classified as a Non-registered Sex Offender. Scottish Executive guidance¹⁶ in this respect is clear that where the police have concerns about a sex offender not subject to registration requirements (as in Evans case), they may carry out a risk assessment. It also provides that in the most serious cases a Chief Constable can apply for an order to prohibit certain activities in prevention of an offence. From an inter-agency perspective, the Scottish Executive guidance also states that agencies concerned about an individual's propensity to commit crime should report this to the police and if these concerns are not specific, consideration should be given to the need for an inter-agency assessment of risk. (Fife Council and Fife Constabulary have a joint protocol which articulates the 1997 legislation and the accompanying Scottish Executive guidelines.)

4.7 The first AIM assessment that was submitted by Fife Council Social Work Service in 2002 in respect of Colyn Evans identified him as being 'a high risk of re-offending'. This report was a fundamental influence in his subsequent placement in Geilsland School for intervention to address his inappropriate sexual behaviour. As a consequence, in January 2003, Fife Council Social Work Service requested that an Initial Risk Assessment be prepared by Fife Constabulary (normally carried out jointly by police and social work). At this time, there was documentation within Fife Constabulary in the form of a nominal record, crime reports, bullet point reports and other entries on intelligence databases that supported the conclusions of the AIM assessment by Fife Council Social Work Service.

4.8 On 27 December 2002, on referral from the Children's Hearing, Colyn Evans and his family were offered and accepted a residential place at a specialist unit at Geilsland School. His police file at this time was marked as 'historic' and the Initial Risk Assessment was not progressed. There appears to be no obvious explanation in relation to this matter except, as identified by Fife Constabulary, his residential placement. It may be that there had been confusion at this time by comparing Colyn Evans' attendance at a residential school¹⁷ to an

¹⁶ Scottish Executive (2000) The Sex offenders Act 1997: Guidance for Agencies

¹⁷ The current definition of a 'school care accommodation service' is set out in section 2(4) of the Regulation of Care (Scotland) Act 2001: 'A "school care accommodation service" is a service which is provided to a pupil by an education authority or the managers of an independent or grant-aided school, or by any person under arrangements made by any such authority or managers –

(a) for the purpose of the pupil being in attendance at a public, independent or grant-aided school; and

(b) which consists of the provision, in a place in or outwith the school, of residential accommodation, but a service may be excepted from this definition by regulations.'

adult offender who on receiving a custodial sentence is not thereafter risk assessed by the police in relation to registration as a sex offender until released. A residential school is not a secure, closed institution. It usually provides a service for 52 weeks of the year, though young people may also return home on a regular basis.

4.9 The Review Team agree with the subsequent findings of Fife Constabulary that an Initial Risk Assessment should have been completed at this time.

4.10 In preparation for Colyn Evans potential return home to Fife from Geilsland School, on 2nd April 2004, a second AIM assessment was undertaken by Fife Social Work Service. This assessment was presented to the police around the time of his return home (April 2004) but no action was taken with regard to a joint police and social work Initial Risk Assessment. The only apparent reason cited by the police was that the relevant social worker went on extended leave and they did not receive any further updates. The Review Team are of the opinion that there was more than sufficient information already with the police at this time and the matter should have been progressed, as is acknowledged by Fife Constabulary.

4.11 In August 2004 a request was made by Fife Social Work Service to Fife Constabulary to carry out a joint Initial Risk Assessment, however, no assessment took place nor indeed does the case seem to have been actioned. The explanation as detailed in many of the documents reviewed, indicated that the risk assessment did not take place 'because Colyn Evans was in Wales'. This belief was based on a verbal discussion between police and social work. This 'intelligence' appears to have been accepted by the police and not followed through in any way, nor is there any evidence of contact between Fife Constabulary and South Wales Police.

4.12 A further issue of concern is that the request for an Initial Risk Assessment was made in August 2004 (according to files around the 8th). The reason given for not conducting one was due to Colyn Evans being in Wales. Records clearly show that Colyn Evans was believed to be in Wales for approximately a one week period between the end of October and the beginning of November 2004. Whereas there was a gap of around 9 weeks where his file was not progressed. During this period also, Colyn Evans was arrested for breach of the peace when he attempted suicide in Tayport (13 September 2004) and his Sex Offender Nominal Record was updated accordingly.

4.13 There appears to be no valid explanation as to why the police did not progress the Initial Risk Assessment. It should be noted that at this time they were using Tayprep¹⁸ as their assessment tool. Tayprep is not suitable for assessment of those under 18 years of age as the population used as the basis for the research were convicted adult sex offenders. For the same reasons, the tool currently used for assessment purposes, Risk Matrix 2000¹⁹, is also designed for adults. This presents particular difficulties for the assessment of those under this age. However, given the range of information available, the assessment tools available at the time and the structured assessments which had been undertaken beforehand, it is likely that an

¹⁸ Tayprep is a structured tool for evaluation of risk in sexual abusers developed by the Tay Project, part of the Tayside Criminal Justice Social Work Partnership.

¹⁹ Risk Matrix 2000 is a statistically derived and validated risk classification process intended for males aged at least 18 who have been convicted of a sex offence. It uses simple factual information about offenders' past history to divide them into categories that differ substantially in their rates of reconviction for sexual offences. Actual rates of re-offending will exceed the rate of reconviction.

Initial Risk Assessment, had it been undertaken, would have found Colyn Evans to be at high risk of re-offending.

4.14 Given that the second AIM assessment indicated clearly that Colyn Evans did not undertake any of the planned intervention to address his inappropriate sexual behaviour for which he was sent to Geilsland School, that his supervision requirement was discharged with limited evidence of behavioural improvement, and that he was still being assessed as ‘a high risk of re-offending’, a joint Initial Risk Assessment should have been carried out when requested in August 2004.

4.15 There is an issue in relation to use of terminology that can be misleading, particularly to those not actively involved in this specialism. Colyn Evans was described as being at a ‘high risk of reoffending’. This relates to his likelihood to reoffend but does not categorise the degree of potential harm to the public. Police Forces frequently refer to a ‘high risk offender’ which describes someone who is a danger to the public and dictates priority management practices. Based on his offending history, Colyn Evans did not come close to such a management category. We accept that there is a very real element of managing capacity against demand and that prioritisation is the only way that this can be achieved. Colyn Evans had no established record of sexually offending since 2002, though he did of course continue to display difficult behaviours while in residential care. We have noted that the tools available to the police were not entirely suitable for assessing adolescent offenders of this type. Nonetheless, he should have been subject to the risk assessment process as the circumstances indicated sufficient concerns for such an assessment being made.

4.16 It is important to highlight the lack of a case conference in this case. Had a case conference been convened on Colyn Evans’ return to Fife it would have allowed the various agencies with a part to play in his management to come together, share information and agree a way forward. Had the risk assessment been carried out as required a case conference would have been convened on its completion. Such is the importance of this issue, it is highlighted in a separate section under ‘Management and Supervision’, later in this report.

4.17 The Review Team note that the recently published report *Registering the Risk: Review of the Notification Requirements, Risk Assessment and Risk Management of Sex Offenders*²⁰ includes recommendations about risk assessment, although it does not address issues in relation to adolescent sexual offenders.

2. Action should be taken at the national level, as a matter of urgency, to provide public agencies with a framework that can be used consistently across Scotland to assess adolescent sexual offenders.

4.18 Notwithstanding the problems encountered in the Colyn Evans case, there are two areas that the Review Team felt worthy of further comment.

²⁰ Irving, G. (2005) *Registering the Risk: a Review of the Notification Requirements, Risk Assessment and Risk Management of Sex Offenders*, Scottish Executive

Management of Non-registered Sex Offenders

4.19 The Scottish Executive guidance is clear in relation to the management of Registered Sex Offenders, but less detailed in the case of those categorised as non-registered.

4.20 The Review Team acknowledge that Fife Constabulary endeavour to manage Non-registered Sex Offenders and deserve credit for this. However, in relation to the management of low/ medium risk Non-registered Sex Offenders, Fife Constabulary allow some cases of a lesser priority to 'lie dormant' until an issue arises which suggests the need for attention, at which point the dormant categorisation is reassessed. This decision making process is not documented and is a weakness in procedure, which Fife Constabulary have recognised and are already reviewing.

4.21 There is always a risk in relation to the management of sex offenders, registered or non-registered. When for example a risk assessment dictates that a case is less of a priority than others and should, as Fife Constabulary term it, 'lie dormant', then it is important that this process is transparent and well documented.

3. Fife Constabulary should ensure that all decision making procedures and processes are documented and continue to review the manner in which it manages Non-registered Sex Offenders.

4.22 From our research in undertaking this review, it is also apparent that the process of managing Non-registered Sex Offenders varies to different degrees between all Scottish Forces. This disparity reflects the vagueness of the Scottish Executive guidance. This is unhelpful and could usefully be addressed by the Scottish Executive to provide greater clarity and understanding.

4. The Scottish Executive should review the current guidance on the issue of the management of Non-registered Sex Offenders to provide greater clarity and consistency of approach across Scotland.

Resourcing of Sex Offender Management Unit

4.23 If the management issues discussed are to be addressed then the Review Team accept that resourcing requirements within the Fife Sex Offenders Management Unit require to be examined more closely.

4.24 Recent research by the VISOR²¹ National Implementation Team suggests that one police officer can manage approximately 50 offenders. The Review Team thereafter used this guide along with a recently developed formula that measures the ratio of offenders to required police visits and reporting requirements based on levels of risk. This exercise indicates that the appropriate staffing levels for Fife Constabulary at this stage, based on their current register, should be 8 (not including requisite 'back office' staff). This can be compared with the actual Fife resource level i.e., 2 full-time detective constables, a seconded

²¹ VISOR: the Violent Offender & Sex Offender Register is a shared national database to register, risk assess and manage sex offenders, as well as violent offenders and others who may cause serious harm to the public.

full-time detective constable (for a period of 4 months) and a Force Intelligence Bureau sergeant.

4.25 Criminal Justice Social Work Services are subject to 100% funding from the Scottish Executive. The funding is separated into 'core' and 'non-core' services. Fife Council's Community Protection Team is funded as a 'non-core' service to deliver the accredited Community Sex Offender Groupwork Programme for adult offenders. There is no funding allocation, either core or non-core for the joint (police/social work) assessment of registered or non-registered sex offenders living in the community. This joint assessment is a critical part of the monitoring of sex offenders and consideration needs to be given to the funding arrangements for this activity.

4.26 As highlighted in the Fife Joint Report, it is important that risk assessments are carried out timeously so that risk management plans can be put in place to deal with the risk factors identified. Sufficiency of resources obviously has a bearing on the ability to meet these demands.

5. The resourcing of Offender Assessment Units and the contribution made by social work to the joint assessment of sex offenders should be reviewed at a national level, given the findings of this Review, and the recommendations on resourcing contained in Professor Irving's report *Registering the Risk*.

5. MANAGEMENT AND SUPERVISION

Decisions about the Supervision Requirement

5.1 Section 70(3) Children (Scotland) Act provides for young people considered to require compulsory measures of care. These provisions can apply to a young person up to their 18th birthday. Where a child or young person is looked after by a local authority, that authority has a statutory responsibility to safeguard and promote the child's welfare, taking the welfare of the child as their paramount concern. However, Section 16(5) provides for a Children's Hearing, if they consider it necessary in order to protect members of the public from serious harm (whether or not physical harm), to make a decision which would not be consistent with their affording paramountcy to these considerations.

5.2 When a young person has been looked after under this Act, local authorities have a range of responsibilities to support that young person thereafter by preparing them for when they cease being looked after (section 17), providing accommodation (section 25(3)) providing advice, guidance and assistance (section 29). These provisions can last up to a young person's 19th birthday and in some circumstances until their 21st birthday. In reviewing the case for compulsory measures, it is incumbent on a Children's Hearing to be convinced that compulsion is essential to ensure the young person's welfare and safety.

5.3 There is considerable evidence in the files around the time of Colyn Evans' pending move home from Geilsland School to make it reasonable to question the decision taken at the Children's Hearing on 14 April 2004 to discharge his supervision requirement. The draft report provided by the Fife Council Social Work service manager, highlighted the annual LAC review in March 2004, but did not include the review in January 2004. The January report, which was less positive in tone, indicated that Colyn Evans needed the structure provided by Geilsland School for some time yet. It concluded that to aim for a return home in April 2004 (when he was 17) was too soon. Consequently, this change over a period of 2 months to a recommendation for a return home and discharge of the supervision requirement appears very rapid.

5.4 Colyn Evans was at a specialist unit in Geilsland School for 16 months. The expressed purpose of this placement was to provide him with specific intervention to address his inappropriate sexual behaviour. The early reports indicate that although Colyn Evans was willing to go to the unit at Geilsland School, and did so initially on a voluntary basis, he denied the charge of shameless indecency and this required to go to a Sheriff Court for a proof hearing²². Because of his denial of the offence and the delay awaiting the outcome from the Sheriff Court, no work on his offending was commenced. Given his previous history of inappropriate sexual behaviour, including a charge previously established at a Sheriff Court, this decision by Geilsland School is at least open to question. By the time the grounds were subsequently established it appears that Geilsland was no longer in a position to provide the required intervention due to lack of staff.

5.5 The case file makes several references to Colyn Evans absconding on a regular basis whilst at Geilsland School and also to his sexual activity with other boys in his unit, both on

²² A Proof hearing occurs when the ground for the referral to the children's hearing is denied and an application is made to the Sheriff for a finding as to whether the ground for the referral is established.

and off the premises. This included reference to his involvement with a vulnerable young person that could have left him open to prosecution. This activity was acknowledged by the school, one consequence being his referral to the local genito-urinary clinic. A case note on 15 September 2003 records a meeting between Fife Council Social Work Service and Geilsland School where these concerns were discussed. The senior social worker was to write formally to Geilsland School about these matters but we could find no record of the letter on the file. The file also indicates that two planning meetings took place but again there were no records of these meetings on the files we examined. The monthly summary in the Children and Family file records that there was a discussion with the Child Protection Unit (CPU) as to whether there was anything to investigate with regard to the sexual activities at Geilsland School and the fact that Colyn Evans reportedly had sex with a vulnerable young person. The file records that the CPU felt that they did not have a role in this and that no action was required. As a result, no further action appears to have been taken on these matters.

5.6 Although the Fife Joint Report takes up the issue of the lack of specialist provision at Geilsland School and makes recommendation for developing a commissioning strategy, with clear monitoring and evaluation mechanisms, it fails to address the issues of care and protection whilst Colyn Evans was at Geilsland. For the local authority to take no action on this matter raises serious concerns with regard to their duty of care and protection of others. It is of concern that these matters are not raised in the draft report prepared by the relevant service manager. This omission was carried forward into the Fife Joint Report. It appears that staff were prepared to accept at face value the response from the CPU and did not fully consider the serious nature of what appeared to be happening at Geilsland School at that time and possible steps which they could have taken. At the very least the Care Commission should have been alerted to these concerns.

5.7 As a result of the documentary evidence in the files, the Review Team have passed on their concerns to the Care Commission with a request that they follow up and ensure that arrangements for the care and safety of current residents at Geilsland are appropriate. In addition, we have separately reported to Crown Office our concerns regarding potential criminality arising from Colyn Evans' alleged inappropriate sexual behaviour at Geilsland School.

5.8 Towards the end of 2003 there is documentary evidence which suggests that Colyn Evans behaviour was improving and that he was engaging more cooperatively with his care programme at Geilsland. To an extent this seems to have been the result of negotiation between Colyn Evans and his social worker whereby visits home were offered as a reward for more responsible behaviour. By this time he seems to have been eager to return home and clearly was able to demonstrate sufficient progress to achieve the desired visits. In this way he took the 'pole' position in his relationship with his supervising social worker and the record indicates his ability thereafter to 'play the game' to achieve the outcome he wished. Given the speed with which his home situation broke down and his refusal to participate in any intervention programme, it seems reasonable to suppose that the view taken by the social workers involved was overly optimistic.

5.9 This view is supported by evidence from case records which record a phone call on 4 March 2004 from the Children and Families worker to CSS saying that she was 'not going for disposal (of the supervision requirement) as she felt Colyn needed to stay at Geilsland School as his parents will not cope with him full-time at present.' Also a case note from the CSS

worker on 29.3.04 indicates her view that Colyn Evans would not co-operate with any programme of work once the order was terminated. Further, the case records for 22.3.04 and 30.03.04 also indicate that Colyn Evans realised that he needed to say he would co-operate in order to get home and have the supervision requirement terminated.

5.10 The decision for Colyn Evans to leave Geilsland School may have been justified in terms of the uncertainty over whether the school would provide the requisite individual work that was part of his care plan. Indeed, if this was the primary reason for him being there it would have been reasonable to consider removal at a rather earlier stage when the intervention programme did not take place. However, it is quite difficult to fully understand the decision to terminate supervision immediately on his return home. The emphasis in the guidance on the Children's Act (Scotland) is for voluntary measures where this can be reasonably achieved. Although it seemed that Colyn was co-operating to a large extent at this stage, his preparedness to undertake specific offence focussed work on his inappropriate sexual behaviour was untested. There is also an issue in continuing enforced supervision where greater cooperation might be achieved through a voluntary approach, particularly as there are no realistic sanctions to support compulsory measures for a 17 year old²³.

5.11 However, the key to successful throughcare has to be a commitment by the authority to continuing care. Colyn Evans stated at a number of reviews that he would have liked more contact from his social worker. There is also evidence in the file that his relationship with his social worker was not strong. At the very least, maintaining the supervision requirement for a short period after he left Geilsland School would have ensured that there was someone with considerable knowledge of Colyn Evans to maintain initial oversight of his return to the community. Instead this oversight was handed over to different parts of the authority with no one person acting as the 'case manager'. We accept that Fife Council has acknowledged this as a problem and is taking steps to provide more joined up services, particularly when the young person is in transition between services. It should be noted that the decision to terminate the supervision requirement, whilst recommended by the local authority social worker, was taken by the Children's Hearing. The record indicates that the supervision requirement was terminated on the basis of the good progress made by Colyn Evans with two members in favour of disposal and one against.

²³ Supervision requirements made by Children's Hearings may not extend beyond a young person's 18th birthday. Young people aged 16 and 17 who were not subject to a supervision requirement prior to their 16th birthday cannot be referred to a Children's Hearing and therefore cannot be made subject to a supervision requirement. This provision recognises the limitations of the Children's Hearing system for young people over the age of 16. When a young person who is subject to a supervision requirement reaches 16, the requirement may be continued until they reach 18. In practical terms, however, the sanctions that can be applied by a Children's Hearing in respect to 16 and 17 year olds are very limited. Non-compliance with the conditions of a supervision requirement, in practice, will only result in a review of the supervision requirement. The Hearing has little capacity to control a young person's behaviour should s/he chose not to comply with the requirement. Practice tends to reflect the view that a more positive response is likely if young people engage on a voluntary basis with support services offered to them, and very often supervision requirements are terminated by a Hearing when the young person reaches 16. The limitations of this approach are, however, similar to those of the Hearing system in the event of non-compliance.

5.12 The Review Team consider that the decision to recommend the termination of the second supervision requirement was not reviewed by Fife Council with adequate rigour and that this aspect of the management of the case was a key issue that required considerably more examination and explanation in the Fife Joint Report. In reviewing the management arrangements in the case Fife Council should have accessed the records held by education and health and also requested a report from the Reporter with regard to the decisions made over time in relation to Colyn Evans.

Throughcare Arrangements

5.13 Colyn Evans returned home on 14 April 2004. Responsibility for his case was transferred to the Throughcare Team the following day. The Throughcare Team's role with Colyn Evans was essentially to provide practical assistance to help him to live independently. The components of his pathway plan were management of finances, employment and accommodation. There was no apparent assumption of a role in relation to risk management. Indeed, there is a case note made on 18 January 2005 by the CSS worker when she rang the Throughcare worker to check Colyn Evans' change of address, which indicated that the Throughcare worker did not consider him to be a risk. Although the CSS Team had a remit to provide intervention for his sexually inappropriate behaviour, they also did not appear to see themselves as having a responsibility for risk management. Thus, once the supervision requirement was terminated, Colyn Evans seemed to be provided, or at least offered, a range of services, but the key task of ongoing assessment and risk management was not formally assumed by any of the professionals involved. This is clearly demonstrated in that no one thought to inform CSS that the supervision requirement had been terminated and the case passed to the Throughcare Team.

5.14 Twelve days after Colyn Evans' return home, the Throughcare worker reported visiting him at his girlfriend's home as he had fallen out with his parents. Four days later he made a request for temporary accommodation. Following an incident where he was found with a 13 year old girl reported as missing, having stayed overnight with her in a caravan, he returned to his parents home and the situation seemed to tick over for a few weeks. In May he reported being threatened by local young people. Although the reasons for this appear, in the record, to be unknown, the situation was considered of sufficient concern to warrant taking action to find Colyn Evans temporary accommodation elsewhere, and on 20 August 2004 he moved into a property in Tayport.

5.15 In the meantime, the CSS Team had decided, on the basis of receiving a report about the incident concerning the 13 year old missing girl, that they would delay implementation of their planned joint work with CVC because of the police investigation. At the first joint meeting, in July, with CSS and CVC Colyn Evans refused to engage and the view was taken that they could not therefore do any work with him. Following this in August, CSS reviewed the case and decided that an Initial Risk Assessment should be undertaken and a request was put to the Sex Offender Registrar. At the same time the case was put into the 'review' section as it was not anticipated that any further work would be done with him.

5.16 We appreciate that Colyn Evans had a history of poor cooperation with intervention focusing on his problematic sexual behaviour. Nevertheless, it is hard to understand the justification for this decision given the assessment of high risk of re-offending carried out by themselves, at least until the joint risk assessment had been undertaken with the police. Here

was a very young person with a lengthy history of inappropriate sexual behaviour which, although it had not led to further (sexually related) charges whilst he was at Geilsland School, had clearly continued to cause concern. Within 2 weeks of returning home he was purportedly staying the night in a caravan with a 13 year old girl, undoubtedly putting her at risk even if she denied any untoward behaviour. The CSS Team appear not to have seen themselves as having a role in the broader risk management of Colyn Evans, but a specific task to provide him with the opportunity to work on his offending. It is of concern that they made such a hasty decision that he would not work with them.

5.17 These issues inevitably raise questions about the level of skill and experience of the staff in the CSS in working with young sexual abusers. We understand that the CSS Team had been established two years previously, to meet a significant need. Specific offence focussed work is very difficult for most adult sex offenders to undertake, let alone a teenager who appeared to be far from clear about his sexual identity. Staff were coping with a potentially serious offender, but possibly without the level of expertise required.

6. Fife Council should review the training needs of the staff involved in work with young people exhibiting inappropriate sexual and aggressive behaviour. This is a highly specialist area which requires high levels of training and support. Managers providing oversight and support also need to have specialist training and knowledge and if this is not possible then staff must have access to outside expertise for advice.

7. Consideration should be given at a national level to ensuring that those specialist services that are available for young people displaying inappropriate sexual behaviour are delivered to meaningful and rigorous standards and that staff working in the field have access to consistent specialist support and advice.

5.18 There is also a significant cause for concern that CSS has such a limited brief, though we accept that there are capacity issues for them to provide more than this. Nevertheless, they were the only holders of the risk assessment at this time and should, at least, have had a responsibility to ensure that someone, if not themselves, had management oversight of this aspect of the case. As discussed elsewhere in this report, given the assessment that Colyn Evans continued to pose a high risk of re-offending, the most appropriate action would have been to hold a case conference or discussion with all those involved with the case to consider a risk management plan. The terms of section 29(1) of the Children's (Scotland) Act would have allowed for continued oversight where there was real cause for concern, whether or not the young person wished contact.

5.19 The very limited role that the Throughcare Team had is also of considerable concern. We accept that within this limited remit there was an effort to provide a service to Colyn Evans, but it seems to us that the role of the Throughcare worker should have encompassed that of a case manager, assessing all the needs of Colyn Evans at a crucial time of transition from residential care to independent living, coupled with a very real risk of further offending. This issue has been recognised by Fife Council and is addressed in the Fife Joint Report. It is critical that the role of case manager incorporates responsibility for ensuring that all aspects of a young person's needs are being appropriately addressed as well as co-ordination with other agencies and staff. These needs must be assessed in the context of community safety and risk.

8. The decision by Fife Council Social Work Service to establish a case manager for all cases where more than one social work team is involved is appropriate. This role should incorporate overall responsibility for the management of that case, including issues of risk, as well as the need to ensure effective information sharing.

5.20 There are clearly management issues for Fife Council to address. In addition there are issues about the role of supervisors in this case. It is not clear from the records we have seen the extent to which important decisions were made in discussion with supervisors. Fife Council has a detailed supervision policy which sets out the requirement for supervision records to be maintained by the supervisor. We did not examine any of these records in relation to this case. Decisions made as a result of discussion with managers should be recorded in the case file so that their part in the process is explicit.

9. Fife Council should continue to review its supervision and recording policies and ensure that case records reflect important decisions that are discussed and agreed with supervisors.

Case Conferences

5.21 An important aspect of this case, as previously discussed, was the request for a joint (police and local authority) Initial Risk Assessment, to be carried out by Fife Constabulary. A point of good practice in other areas, in such circumstances, has been the establishment of formal requests for professionals to hold case conferences for the purpose of sharing relevant information, raising concerns and thereafter requesting a risk assessment. The minutes of these meetings reflect any such formal request and are an official record of the proceedings. It is likely that the lack of a case conference in this instance contributed to the communication failures in the interagency management of Colyn Evans. We note that Fife Constabulary is currently working with Fife Council Social Work Service to re-write their working protocols for such circumstances.

5.22 While Colyn Evans was subject to a supervision requirement and was resident at Geilsland School to address his inappropriate sexual behaviour, there is little evidence that any constructive work was completed. The frustration experienced by Fife Social Work Service in this regard is well documented. We consider it would have been helpful to involve the police in on-going case discussions about the management of Colyn Evans. This would have ensured that all the information available was shared by those professionally involved in developing the future management plan. Even more so, when Colyn Evans returned home, at the termination of his supervision requirement, it is of particular concern that a case conference involving all of the appropriate agencies was not initiated.

5.23 We consider that these omissions were important contributory factors to the unsatisfactory management of Colyn Evans on his return to Fife. A more joined up approach could, for example, have meant a different action plan including the possibility of a recommendation to continue the supervision order in some form. Nonetheless, the most critical omission in this area was the failure to convene a case conference on his return from Geilsland School.

10. Fife Constabulary and Fife Council Social Work Service should build on current areas of best practice in relation to case conferences and produce a structured action plan for implementation as part of their Standard Operating Procedures, to ensure such best practice is used in all appropriate circumstances.

Accommodation Issues

5.24 In Fife, homelessness is the responsibility of the Housing Homelessness Service. The Homelessness Service is a specialist service whose task is to receive homeless people, assess their status under the legislation, assess their housing and support needs (not care provision) and place in emergency or supported accommodation. One of their responsibilities is to accommodate care leavers who the authority has a legal responsibility to house. In Fife there is a Care Leavers/ Throughcare partnership with a specialist Homelessness officer working within the social work Throughcare Team, whose task is to undertake an assessment of care leavers needs and provide appropriate support. Anyone over the age of 16 can make an application to be placed on the housing register and as part of Colyn Evans' preparation for ceasing to be looked after he would have been encouraged to complete a normal housing application, which he did.

5.25 The allocation of temporary accommodation is a separate matter and is normally a response to an emergency situation. It is a managed process, which in Colyn Evans case was in response to the harassment he was experiencing in his local area. The Homelessness Service received a request from social work for temporary housing and the Homelessness officer made a referral to a centralised team for temporary housing. In this case the request was for housing away from Kennoway and preferably in East Fife. The initial request was for hostel accommodation of which there are two small 8 bedded units in East Fife. Both of these were considered but rejected: one because of the mixed nature of the resident population and the second because of its proximity to a registered child minder. Other options therefore had to be considered. Fife no longer uses bed and breakfast for temporary accommodation purposes because of its unsuitability for people who may have a range of difficulties at the time of requiring emergency housing. Like most local authorities, Fife Council has a number of properties throughout the three geographically-spread housing networks that are viewed as appropriate for temporary housing purposes. These are referred to as 'scatter flats'. At the time of seeking to allocate temporary housing for Colyn Evans, only one of these properties was available. Consideration was given to its appropriateness given Colyn Evans' history of sexual offending, however, the view was taken that there were no contra-indications to housing Colyn Evans in this property.

5.26 The Housing Support Service meets a range of practical needs to assist an occupier meet the conditions of a normal tenancy. These include keeping the property in a fit state, that the tenant is not a nuisance to others, that the tenant pays their rent and allows appropriate access when required. A range of more general tasks such as assistance with claiming benefit and with shopping and cooking may also be provided. In Colyn Evans' case referral was made to the Home Care Service, but it is not clear from the records we examined whether they fared any better at making contact with Colyn Evans than the other services.

5.27 The housing of Colyn Evans is regarded as a critical issue in this case and should have been set out more explicitly in the Fife Joint Report. This was a significant decision. It would have assisted everyone's understanding of how the property was allocated if a detailed explanation had been given both in the Fife Joint Report and also in the case summary prepared by the Head of Housing.

5.28 From the information that we have obtained, the Review Team believe that the decision to house Colyn Evans in Tayport was a considered and managed process to meet his emergency needs and that there were no evident contra-indications to this placement. The housing service was in possession of the relevant information about Colyn Evans. The property was one of a number that might have been allocated but happened to be the only one available at the time.

Management and Transfer of Police Intelligence

5.29 The need for a single method of management of sex offenders and a standardisation of practice that delivers, in effect, a single system between police forces and other agencies is recognised best practice but has frequently proven difficult to implement fully. It has featured as an issue during this review. The Fife Joint Report highlighted the need for such sound inter-agency policies and practices. However, this is true not only in relation to working practices between agencies but must also include cohesive arrangements between different parts of a single service. This was not achieved in relation to the management and transfer of police intelligence in the Colyn Evans case.

5.30 VISOR now enables the electronic management of sex offenders, both registered and non-registered and has been introduced to police forces throughout the United Kingdom. The Review Team believe that this is a crucial piece of work nationally, that will assist in alleviating a great deal of the ad hoc arrangements that are currently in place throughout Scotland and which could arguably have contributed to some of the gaps in Colyn Evans assessment and management. The issue of VISOR and the management of Registered and Non-registered Sex Offenders is covered in more detail under 'Issues for Future Work'. In the case of Colyn Evans, VISOR was not available to Fife Constabulary at the time. The force did however have other more conventional, routine methods at their disposal that were not fully utilised.

5.31 There are at least two matters which are detailed in social work records but not in police records which pre-date the offences which caused Colyn Evans name to be recorded on the nominal record on the Sexual Offenders Database. In addition the offence of shameless indecency from 1 September 2002 does not appear on the Sexual Offenders Database and is missing from the BPR²⁴ of 20th December 2002.

5.32 In addition, on examination by the Review Team, the Scottish Intelligence Database (SID)²⁵ contained no information about Colyn Evans' sexual offending history. This, despite

²⁴ BPR (Bullet Point Report) is an interim report sent to the relevant police divisional Crime Manager within Fife Constabulary by the Sex Offender Registrar. It summarises a sex offender's previous convictions and activities and seeks the division's opinion on whether the individual should be subjected to further assessment. BPR's apply to non-registered risks exclusively.

²⁵ Scottish Intelligence Database (SID) is the Scottish Intelligence Database – a police system, which allows police officers to share intelligence between forces and across geographies.

Colyn Evans having been charged with sexual crimes and having a history of allegations of a sexual nature as clearly detailed in the chronology at Appendix 1. This is to an extent explained by the fact that Fife Constabulary did not go 'live' with SID until May 2004 (two months after Colyn Evans' return to Fife from Geilsland School). However, at that time, the force restricted its 'back record conversion' onto SID to the details of registered or managed sex offenders, thus excluding all the data held on Colyn Evans from the national database. While Fife Constabulary's back record conversion policy is to an extent understandable, taking into consideration prioritisation, workload and the absence of a national policy, the Review Team believe the circumstances of this case demonstrates the absolute requirement for populating national intelligence databases with as much relevant data as possible.

5.33 Notwithstanding this, no intelligence was transferred from Fife Constabulary to Strathclyde Police when Colyn Evans became resident for a 16-month period at Geilsland School. The need for intelligence is fundamental to the effectiveness of any system to function properly, electronic or otherwise, and it is imperative that such intelligence finds its way into the system.

5.34 During his time at Geilsland School, seven crime reports were submitted that involved Colyn Evans in some capacity, as an accused, a victim and a witness. No SID logs were submitted by Strathclyde Police, albeit two of the crime reports related to Colyn Evans being concerned in the supply of a controlled drug and his involvement in a theft by housebreaking. (Note: the Strathclyde force went 'live' with SID in 2002). The only logs found on the Scottish Intelligence Database by the Review Team related to the murder in Tayport and were dated 24 or 25 January 2005.

5.35 Clearly, the Fife and Strathclyde police forces did not use the processes available to them and this was again repeated by Fife Constabulary in August 2004 when at the time of the submission of the second AIM report, they were told that Colyn Evans was in Wales. Once again, no attempts were made to contact South Wales police or pass information to them through the formal channels in place. This has already been identified by Fife Constabulary as an issue and steps have been taken internally to address such practices. ACPOS²⁶, with the support of funds from the Scottish Executive is progressing the development of interfaces for SID, VISOR and ANPR²⁷ which should greatly enhance the capacity to record, integrate and interrogate data.

11. Fife Constabulary should continue to address the data management issues highlighted in this report.

12. The development of VISOR's interface with SID and ANPR, together with the work currently ongoing in respect of giving other relevant agencies access to the system, should continue to be progressed. (This work should be taken forward in conjunction with *issue number 13*).

²⁶ ACPOS - Association of Chief Police Officers Scotland

²⁷ ANPR is Automatic Number Plate Recognition – Cameras that can scan and record the vehicle registration marks of every passing car. The numbers are then cross-checked against a number of databases, including the Police National Computer and police intelligence records, both locally and regionally, to identify vehicles of interest to officers.

5.36 The Review Team also note that on initially checking Colyn Evans' Scottish Criminal Records Office record (SCRO record) there was no sexual Crime Type Indicator²⁸ (although this has now been resolved). The delay in updating would appear to be due to backlogs relative to Fife and are in keeping with those elsewhere due to the current manual system of information transfer. The Review Team have liaised with the Scottish Criminal Records Office who are endeavouring to address such matters. In future a Crime Type Indicator should be added on disposal of a case as a matter of routine and within a realistic timescale.

Communication and Co-ordination

5.37 The management of Colyn Evans after his supervision requirement was terminated was not co-ordinated by the agencies involved. On 20 August 2004, he was allocated a 'scatter flat' in Tayport. There was no case conference in respect of this decision making process, and there seemed to be limited communication of this decision to relevant teams in social work services or the police. This lack of communication reinforces the need for the establishment of a robust case conference structure.

5.38 On 13 September 2004, Colyn Evans attempted to harm himself and sustained minor injuries. He was subsequently arrested for breach of the peace. He was later released into the care of his parents. On the original incident report, Colyn Evans is listed as a schoolboy attending Geilsland School which should have been an indicator to the officers involved that there were other interested agencies in respect of his circumstances.

5.39 The absence of notifications on the Scottish Intelligence Database, which would have alerted the police officers dealing with the self harm incident to such further interest was an important contributory factor, and indeed SCRO would have revealed nothing more than a "drugs marker" instead of some record indicating sexual risk.

5.40 The following day at a Fife Police briefing, Colyn Evans name was recognised and his sex offender's nominal record was updated. However, as highlighted in the Fife Joint Report there was:

- No circulation of Colyn Evans' change in circumstances, i.e. his new address in Tayport.
- No re-assessment in respect of the outstanding request for an Initial Risk Assessment (raised in August 2004).
- No notification placed on the Scottish Intelligence Database relative to his attempted suicide.
- No contact with the appropriate social work service in relation to what was a fairly significant change in behaviour.

5.41 The Review Team acknowledge that these findings have already been identified in the Fife Constabulary Report and steps are being taken to address them internally.

²⁸ Crime Type Indicator - A marker on an individual SCRO record which highlights, if necessary, the type of crime involved i.e. that it involved a sexual or violent element. Should ideally be generated once a case has been disposed of by the court. The Crime Type Indicator is very useful when undertaking speculative searches of the SCRO system.

5.42 On 29 November 2004, a house in Tayport was the subject of a theft by housebreaking committed by Colyn Evans. Whilst in the house he accessed internet pornography sites. The occupier was known to have allowed youths to access his house and internet and Colyn Evans, it would appear, had taken advantage of this over a period of time which had resulted in large phone bills for the house occupier.

5.43 On being recorded as a suspect, Colyn Evans was listed at the address in Tayport and on this occasion this address was documented on his sex offender's nominal record. However, despite the inclusion of this information on his sex offender's nominal record, and the purpose of the housebreaking, there was still no change in relation to the outstanding request for an Initial Risk Assessment, nor was there any further contact with the appropriate Social Work Service.

5.44 Colyn Evans managed to avoid the police and their attempts to trace him. Records show that the police Divisional Crime Management Unit raised three prompts for the reporting officer to trace Colyn Evans and that the reporting officer made seven such attempts. The Review Team did not explore this issue further.

5.45 At the time the police were trying to trace Colyn Evans in relation to this crime, so too were the local authority in relation to his occupancy of the flat. It would appear that Colyn Evans was indeed 'lying low' and doing all he could to avoid any contact with the authorities.

The Murder of Karen Dewar

5.46 The murder of Karen Dewar was examined in some detail by the Review Team. The circumstances of the case are similar to other crimes of this nature which appear to result from spontaneous violence for reasons that are not in any way proportionate to the outcome.

5.47 The focus of this review has been, primarily, on the authorities' management and involvement with Colyn Evans leading up to this crime, rather than the crime itself. The evidence available to us does not provide any clear view of the reasons underlying the murder and it would not be appropriate to make conjectures on this matter. Nevertheless it has been important to consider any possible links, insofar as our remit has allowed, between Colyn Evans' circumstances and the commission of the crime.

5.48 The Review Team concluded from examination of the circumstances presented to them that Karen Dewar's murder at the hands of Colyn Evans could not reasonably have been predicted. A deterioration in Colyn Evans' behaviour and a worsening in his offending is something that might have been anticipated and more credence given to the concerns identified about his capacity to control his anger. However, the escalation in Colyn Evans' behaviour to murder is not something that the Review Team believe could have been anticipated even if none of the shortcomings identified in this report had existed. It is of note that the facts of the case did not lead the Trial Judge to a view that this was a case that required Colyn Evans to register as a sex offender on his eventual release from prison.

6. NATIONAL ISSUES FOR FUTURE WORK

Standardisation of Practice

6.1 The need for standardisation of practice is absolutely critical. There are very able professionals throughout the country who are working effectively to manage the top priority offenders and keep our streets as safe as possible. This is most certainly the case in Fife. There does, however, need to be a general tightening in practice and procedures, particularly in relation to the partnership approach, to ensure that all the good work is fully co-ordinated and therefore optimised. During our research, we found many different practices taking place in almost every local authority and police force area and while we recognise there will always be an element of local variance, there is a significant risk of error if critical aspects of sex offender management are not standardised. This relates not only to individual agencies but also to how they work in partnership.

6.2 One of the particular difficulties that we found was to compare like for like cases in other areas of Scotland and how they are managed. The Review Team do not have evidence to demonstrate that Colyn Evans would have been managed very differently elsewhere in terms of overall outcome although the practice involved would most certainly have varied.

6.3 It is imperative that VISOR is used to maximum effect in relation to the management of Registered and Non-registered Sex Offenders. VISOR is new and provides a potential opportunity to drive forward standardisation of practice. For this to be achieved, there must be a common understanding of its purpose and a standardised approach as to its usage by every Scottish police force. It was clear during the review that there is variance in practice currently between forces. While not extensive, this does create a risk that could be greatly reduced with a more consistent approach. For example, only one Non-registered Sex Offender is currently listed on VISOR who has a vaguely similar profile to Colyn Evans. This in reality is a most unlikely statistic.

6.4 The VISOR system should not be viewed as a panacea for the management of Registered and Non-registered Sex Offenders who move between different local authority or police force areas. It is the proper use and maintenance of the VISOR system which will deliver the necessary improvements.

6.5 The Review Team fully accept that there is an element of ‘infancy’ about the use of VISOR and would see this as a potential opportunity to drive forward the standardisation of practice needed before ‘localised habits’ set in.

13. Work should be progressed nationally through the ACPOS Sex Offenders Working Group and VISOR Implementation Team to consider whether a standardised approach to working with sex offenders throughout the 8 Scottish Forces is achievable and within what timeframes. (This should be progressed in conjunction with *issue number 12*).

Safe Care for Young People Displaying Sexually Problematic or Aggressive Behaviour

6.6 In August 2003, some seven months after Colyn Evans started at the specialist unit at Geilsland School, the Care Commission undertook an unannounced inspection of the school. They found it to be under extremely poor management and failing to meet required

standards²⁹. Of particular concern was the high level of absconding and inadequate management of the care and safety of the young residents, and a lack of change programmes in place. These failings were of sufficient concern for the Care Commission to negotiate a moratorium on further placements on the basis of an action plan by the school to make improvements. As the moratorium was a voluntary agreement rather than statutory enforcement, all local authorities were not notified by the Care Commission about this position or the causes of their concerns. Although the school informed the Care Commission that the relevant local authorities had been contacted regarding the moratorium the evidence we examined does not make clear how much Fife Council knew about the situation at Geilsland School.³⁰

6.7 The Care Commission carried out a joint inspection with Her Majesty's Inspectorate of Education in March 2004 and inspectors considered that in most areas of concern there was improvement, although there was still much to be achieved. The most recent inspection of the school in August 2005, reports further improvements to staffing levels and the supervision of young people but continues to highlight deficiencies in care planning, overall safety issues and the on-going lack of provision of change programmes. The Care Commission will be assessing the extent to which the school has satisfactorily met the requirements and recommendations resulting from this inspection.

6.8 It is clear from our discussions with the Care Commission, that Colyn Evans was placed at Geilsland School when it was going through an extremely poor phase. Our understanding is that Fife Council was not made aware of the situation at Geilsland School, and indeed if they had been, we do not know what action they might have taken. Nevertheless, it is of great concern that a very vulnerable young person was placed in a residential situation that was operating at such a low level and that the weaknesses identified by the inspection at that time were precisely the issues that exacerbated the problematic behaviours displayed by Colyn Evans. It has not been part of our remit to progress this matter further at this stage. However, we feel there are a number of issues arising from this that need to be addressed as a matter of urgency.

6.9 This case has highlighted the difficulties of managing a young person displaying sexually problematic or aggressive behaviour safely in an open residential setting. There is no doubt that at the time Colyn Evans was there, Geilsland School was experiencing serious difficulties. However, we are not convinced that the arrangements now in place at Geilsland are wholly adequate for this group and feel that there is a need for a national forum to consider the difficulties posed in managing young people with the range of difficulties displayed by Colyn Evans.

14. Discussions should take place at the national level, drawing on the experience of the Colyn Evans case, with a view to developing a national strategy for meeting the needs of young people displaying sexually problematic or aggressive behaviour.

²⁹ Scottish Statutory Instruments 2002 No.114 SOCIAL CARE: The Regulation of Care (Requirements as to Care services) (Scotland) Regulations 2002.

³⁰ It is recognised that the Care Commission has no formal role in the assessment of need of any child or young person nor any statutory remit to develop guidance on what might constitute best practice. The Care Commission must therefore rely on the National Care Standards, existing guidance and best practice materials in encouraging service improvement.

6.10 We note the recommendation in the Fife Joint Report for Fife Council to develop a joint education and social work commissioning strategy for the purchase of resources for children and young people. However, there should be stronger arrangements for information sharing between the Care Commission, host authorities and placing authorities to ensure that the needs of young people who are looked after and accommodated are met to the highest possible standards and this is not compromised by broader pragmatic considerations.

15. Consideration should be given at a national level to reviewing the processes currently in place between the Care Commission and purchasers of services to ensure that there are clear lines of responsibility and accountability for sharing information about the quality of arrangements at residential schools and about individual placements. With inspection reports now being publicly available, local authorities should actively seek and consider inspection reports when making, or reviewing, decisions to place a young person in a registered service.

6.11 There is a critical national issue about schools offering specialist services that are only at the development stage. Such programmes need to be of the highest standard and young people cannot be expected to respond effectively to something that has not been fully thought through. This is not to say that robust programmes already in place cannot be developed further. To effect change, programmes must be designed so that they accord with what is known to be effective in producing positive change, with clearly defined objectives and a specified and systematic scheme for delivery. They also need to be delivered to a high standard. These are demanding criteria to meet and also to judge. Specialist programmes designed to be delivered to young people displaying sexually problematic or aggressive behaviour should be subject to robust external quality control measures. We are aware of the demands of delivering robust personal change programmes across Scotland to meet the needs of the wide range of young people caught up in offending. However, the report *Reducing the Risk: improving the response to sex offending*³¹ made a number of recommendations about the needs of children and young people. We note that although the work is being progressed, in our view there is still much to be accomplished and change programmes for young people with sexually problematic or aggressive behaviour must be given a higher priority.

16. Specialist programmes designed to be delivered to young people displaying sexually problematic or aggressive behaviour should be subject to robust external quality control measures which ensure that they are designed and delivered effectively.

Powers of Management of Registered and Non-Registered Sex Offenders

6.13 The Management of Offender's (Scotland) Bill was passed on 3 November 2005 by the Scottish Parliament. It introduces a legislative basis for agencies to work together, not only to assess and manage Registered Sex Offenders but also any other individuals who it is considered pose a danger to the public. As a result it brings certain Non-registered Sex Offenders who may cause serious harm to the public at large, into the new risk assessment and management arrangements. This is a significant development and should extend and enhance arrangements already in place.

³¹ Reducing the Risk: improving the response to sex offending: The Report by the Expert Panel on Sex Offending, (June 2001) Edinburgh: The Stationery Office

6.14 It is of concern, however, that juvenile sex offenders dealt with through the Children's Hearing System remain an unresolved issue. There are a number of young people throughout Scotland who will have similar profiles to Colyn Evans. The management of these young people, who are outside the terms of the legislation, is a matter of judgment and often subject to the interpretation and views of the authorities involved. This was a particular difficulty experienced by the Fife authorities in the management of Colyn Evans and from our discussions, it would appear to be a common problem throughout Scotland in all local authorities.

6.15 In the Colyn Evans case, there was no power to require him to register as a sex offender as he had been dealt with through the Children's Hearing System. While Chief Constables can, on occasions, make application direct to a Sheriff, neither the force nor the social work service could have applied for a Sex Offender Prevention Order in this case, as Colyn Evans had no 'sexual conviction' as such.

6.16 The Review Team accept that simply registering an individual does not prevent them reoffending, nor does it necessarily give the authorities the management control they would wish for. We accept also the circumstances of the Colyn Evans case in this regard, given his history and past offending. However, arrangements should allow, when necessary, non registered juvenile sex offenders to be brought into structured risk assessment and management arrangements, based on their threat to others. This should be without regard to their age or whether the children's hearing or adult system dealt with their offending behaviour.

17. Juvenile sex offenders cannot just be cared for, the risks their behaviour presents must be effectively managed. It is essential that arrangements are put in place to ensure that the future management of juvenile sex offenders is based on their perceived threat to others.

Partnership, Protocols and Information Sharing

6.17 At present ACPOS are leading the implementation of the Information Sharing Steering Group 'Concordat on Sharing Information on Sex Offenders'. This group was led by the Solicitor General and had representatives from all the relevant agencies. The work was completed in March 2005 and in essence represents a commitment to share information about sex offenders within a nationally agreed framework for safeguarding the safety of the public. This is supported by information-sharing protocols between agencies and social work services. These have been circulated to the ACPOS Sex Offenders Working Group to consider how they might be progressed at an operational level. The target is to develop protocols and strategies and implement them. This work is currently ongoing. A key point to note is that the Concordat sets out essentially an administrative approach to the lawful sharing of information between agencies. It allows this to happen but does not in itself create any legal obligation to do so. The Management of Offenders Bill, once enacted, should address this.

6.18 Clear Standard Operating Procedures (SOPs) in relation to partnership working between agencies in the management of sex offenders and information sharing are now necessary. A policy supported by strong Standard Operating Procedures would bring clarity and consistency and would avoid the 'grey areas' and local interpretations that can result from guidelines. Such policy and SOPs would reinforce the work ongoing at ACPOS, would assist

in the enforcement of the Concordat and would help to drive and implement the required standardisation agenda in respect of the management of offenders and partnership working. This would also provide the necessary underpinnings in advance of the forthcoming Act.

18. Consideration should be given to introducing Standard Operating Procedures to replace existing local guidelines in respect of the management of sex offenders, partnership working and information sharing.

Non Registered Sex Offenders

6.19 The Review Team are aware that there are concerns about the definition of a Non-registered Sex Offender and when someone should be placed in this category. The recently published Concordat contains the newest definition and there is work ongoing by ACPOS. The Review Team believe that this is a critical issues that requires urgent resolution.

19. The Review Team stress the importance of the definition of a Non-registered Sex Offender and strongly urge the Scottish Executive, with ACPOS, to pursue a comprehensive and agreed definition that provides clarity.

National ‘Delivery Unit’

6.20 The new arrangements for assessment and management of sex offenders set out in the Management of Offenders (Scotland) Bill will require significant developments in current working practices. There will be a need to ensure that the police service and other relevant agencies are prepared for the new arrangements, through training and provision of the necessary tools and resources. In order to deliver the required degree of multi-agency working and to ensure that the necessary procedures are created and translated into protocols for national dissemination, the Review Team consider it will be essential to provide the necessary underpinnings for a significant cultural change to meet the demands of the forthcoming Act.

6.21 This will involve a significant challenge for all of the agencies involved and could be facilitated by the creation of a multi-agency delivery unit to support the implementation of the new legislation and to ensure standardisation is properly achieved.

6.22 The considerable range of work currently ongoing and the potential scope for change in relation to this particular specialism is substantial, as already outlined. There needs to be a partnership approach to the management and implementation of such change. If this does not happen, the current ad hoc practices and procedures will continue and indeed worsen. The Review Team believe that an appropriately staffed cross agency delivery unit would make real progress nationally in ensuring a standardised and consistent approach.

20. It is strongly suggested that an inter agency delivery unit is created to make the necessary changes happen. The unit would develop and lead training, and create and disseminate the necessary protocols, standard procedures and monitoring mechanisms to improve practice across Scotland.

7 CONCLUSIONS

7.1 The Review Team are mindful of the devastating impact of this tragic case on Karen Dewar's family. We have been at great pains to report our findings openly and without favour. It is undoubtedly the case that when such events occur there is a desire to find a cause, both to satisfy those who have lost loved ones and to ensure as far as possible that such a thing will not happen again. Sadly, there can be little doubt that even on the basis of the detailed information available about Colyn Evans' past offending and his generally unsettled behaviour following his return from Geilsland School, the tragic events that led to the murder of a 16 year old girl could not have been predicted. There are a number of aspects to this case that give rise to serious concerns about how such cases are managed, but the opportunity that hindsight affords to review matters does not provide a direct cause and effect linkage between the shortcomings we have found and the extreme outcome that ensued.

7.2 It is clear that Colyn Evans had difficulties from an early age. Although there are indications of concern in his background there is little to suggest that these problems were of a more serious nature than many other young people who come to the attention of the local authority social work services. Again, whilst there was a persistence to his offending behaviour sufficient to cause realistic concern about his future offending, there were no established episodes of sexual offending in the two years prior to the murder. However, the sexual activity that appears to have occurred at Geilsland School whilst he was there, and which was not followed up, may have masked this, and may have exacerbated his sexually inappropriate behaviour. Although there had been attempts to work with him on his inappropriate sexual behaviour from an early stage through the Centre for the Vulnerable Child, this was limited by his unwillingness to actively participate in any intervention. This is not an unusual effect of adolescence, where a young person experiences all the difficulties of coming to terms with the person they are but lacks the maturity to accept the help to ameliorate them. The opportunity to address this more intensively and perhaps reduce his resistance should have been provided at Geilsland School but was not. The indicators were there that he had difficulties controlling his anger and the Adolescent Sexual Abuser's Project assessment (and other reports from Geilsland) suggest that staff had focused on this in his daily care, though not offered a specific intervention to address this. There is some evidence to support the view that he had learned to some degree how to control his general behaviour better.

7.3 The authorities were therefore faced with a young person for whom they had sought compulsory measures in an attempt to help him change his behaviour, who had been frustrated to some degree both by Colyn Evans himself and, also, crucially by the lack of provision offered by the specialist unit at Geilsland School. They were then faced with the dilemma of a young person well over school leaving age, anxious to return home and who was deriving little apparent benefit for his specific problem. They chose to take a positive view of the progress made, no doubt in an effort to respond positively to the improvements seen in his behaviour. This approach was over-optimistic and can perhaps be explained by a wish on the part of the professionals involved to encourage responsibility from him.

7.4 Once home his situation rapidly broke down and the envisaged plan was not put into place. The fact that Colyn Evans was housed at Tayport is entirely coincidental and a result of it being the only available property at the time. It is clear that he could have been housed in a number of locations, and although he was young to have been living independently this

again is not unusual for young people who have been Looked After in the care system. There is however nothing that has been highlighted that would have meant a significant reassessment of Colyn Evans that would have resulted in him not being housed in Tayport. Despite the gaps identified, Colyn Evans lack of recent (recorded) offending and the dated nature of pertinent intelligence would not have allowed a marked change of management arrangements by the police. Systems were in place to provide support and efforts were made to accomplish this, albeit without success.

7.5 However, this review has highlighted some aspects of police and social work practice that were weak and some aspects of the case that give cause for significant concern. There are also a number of areas where the coordination of working practice could be improved and this has been commented upon throughout. Communication between and within agencies, poor recording, inappropriate response to referrals, inadequacies in supervision, not using the information available to assess risk factors, differences in understandings of risk thresholds, absence of shared decision making and a co-ordinated response and a lack of practice tools are all issues identified as problems in reports on other cases of this nature³². Indeed, these issues are identified in all the major case reviews of the past 20 years and it is important, therefore, to acknowledge that there are no easy solutions. Working with young people displaying sexually problematic or aggressive behaviour is a difficult and demanding activity. Many of the issues resonate with the broader challenges of child welfare practice³³. Whilst this case has highlighted practice weaknesses both for Fife Council and Fife Constabulary to address, it is vital to emphasise the need for the national issues identified in this report to be taken forward.

7.6 This case is by no means unique to Fife nor are the issues highlighted throughout this report. It is vital that we do what we can to prevent any potential for a possible recurrence of a sex offender, registered or not, not being properly managed. The Review Team see the standardised agenda as a way of not only improving current working practice but a means of better protecting the community and ensuring that they may have confidence in the actions of the public agencies.

7.7 The Review Team have welcomed the fullest cooperation both Fife Constabulary and Fife Council have given them during this review. The internal investigations have noted a number of the issues contained in this report and these are already being implemented by the respective agencies. Had the partnership approach to the management of Colyn Evans been better structured and formalised, as it should have been, the Fife Authorities would have been better able to explain their actions and the current perceptions and criticisms could have been answered at an earlier stage.

³² *Learning from past Experience* (2002) Department of Health; and *Childhood Lost: Part 8 Case Review Overview Report*, (2001) Bridge Child Care Development Service, Bridge Publishing, Hay on Wye

³³ Morrison, T. (2003) *Making a real difference or just another child death inquiry? Learning the lessons from 'Childhood Lost'* in *Journal of Sexual Aggression* Volume 9 Issue 2 November 2003.

8. SUMMARY OF ISSUES IDENTIFIED FOR FURTHER ACTION

Many of the issues identified in this case involve more than one agency and are also part of a complex national agenda. In this section we provide a summary of all the matters we have identified for further action. These are grouped under five headings: matters for Fife Council, for Fife Constabulary, for Fife Council and Fife Constabulary, for service providers across Scotland (mainly local authorities and police forces), and for the Scottish Executive. The Review Team welcome the fact that Fife Constabulary and Fife Council are already taking action on many of the areas of concern highlighted in this report. In practice, service providers across the country will wish to consider the implications for them of the recommendations made for the Fife agencies.

Matters for Fife Council

1. Fife Council should review its policy and practice in relation to work with young people with sexually problematic or aggressive behaviour to ensure that risk assessments are integral to ongoing care planning rather than a separate activity. It is essential that issues of risk management are taken into account in managing any case where there are potential public protection issues. Regardless of the route of referral, a risk management plan should be agreed with all those involved in the case and implemented. The plan should be regularly updated. **(Report Issue no.1, see page 13)**

2. Fife Council should review the training needs of the staff involved in work with young people exhibiting inappropriate sexual and aggressive behaviour. This is a highly specialist area which requires high levels of training and support. Managers providing oversight and support also need to have specialist training and knowledge and, if this is not possible, then staff must have access to outside expertise for advice. **(Report Issue no. 6, see page 22)**

3. The decision by Fife Social Work Services to establish a case manager for all cases where more than one social work team is involved is appropriate. This role should incorporate overall responsibility for the management of that case as well as the need to ensure effective information sharing. **(Report Issue no. 8, see page 23)**

4. Fife Council should continue to review its supervision and recording policies and ensure that case records reflect important decisions that are discussed and agreed with supervisors. **(Report Issue no. 9, see page 23)**

Matters for Fife Constabulary

1. Fife Constabulary should ensure that all decision making procedures and processes are documented and continue to review the manner in which it manages Non-registered Sex Offenders. **(Report Issue no. 3, see page 16)**

2. Fife Constabulary should continue to address the data management issues highlighted in this report. **(Report Issue no. 11, see page 26)**

Matters for Fife Constabulary and Fife Council

1. Fife Constabulary and Fife Council Social Work Service and should build on current areas of best practice in relation to case conferences and produce a structured action plan for implementation as part of their Standard Operating Procedures, to ensure such best practice is used in all appropriate circumstances. **(Report Issue no. 10, see page 24)**

Matters for Service Providers in Scotland

1. The development of VISOR's interface with SID and ANPR, together with the work currently ongoing in respect of giving other relevant agencies access to the system, should continue to be progressed. (This work should be taken forward in conjunction with *issue number 13*). **(Report Issue no. 12, see page 26)**

2. Work should be progressed nationally through the ACPOS Sex Offenders Working Group and VISOR Implementation Team to see if standardised working throughout the 8 Scottish Forces is achievable and within what timeframes. (This should be progressed in conjunction with *Report Issue no.12*) **(Report Issue no. 13, see page 30)**

3. Consideration should be given at a national level to reviewing the processes currently in place between the Care Commission and purchasers of services to ensure that there are clear lines of responsibility and accountability for sharing of information about the quality of arrangements at residential schools and about individual placements. With inspection reports now being publicly available, local authorities should actively seek and consider inspection reports when making or reviewing decisions to place a young person in a registered service. **(Report Issue no. 15, see page 32)**

Matters for the Scottish Executive

Adolescent sex offenders

1 Action should be taken at the national level as a matter of urgency, to provide public agencies with a framework to assess adolescent sexual offenders that can be used consistently across Scotland. **(Report Issue no. 2, see page 15)**

2. Consideration should be given at a national level to ensuring that those specialist services that are available for young people displaying inappropriate sexual behaviour are delivered to meaningful and rigorous standards and that staff working in the field have access to consistent specialist support and advice. **(Report Issue no. 7, see page 22)**

3. Discussions should take place at the national level, drawing on the experience of the Colyn Evans case, with a view to developing a national strategy for meeting the needs of young people displaying sexually problematic or aggressive behaviour. **(Report Issue no. 14, see page 31)**

4. Specialist programmes designed to be delivered to young people displaying sexually problematic or aggressive behaviour should be subject to robust external quality control measures which ensure that they are designed and delivered effectively. **(Report Issue no. 16, see page 32)**

5. Juvenile sex offenders cannot just be cared for, the risks their behaviour presents must be effectively managed. It is essential that arrangements are put in place to ensure that the future management of juvenile sex offenders is based on their perceived threat to others. **(Report Issue no. 17 see page 33)**

Information management and sharing

6. The Scottish Executive should review the current guidance on the issue of the management of Non-registered Sex Offenders to provide a greater clarity and consistency of approach across Scotland. **(Report Issue no. 4, see page 16)**

7. The resourcing of Offender Assessment Units and the contribution made by social work to joint assessment of sex offenders should be reviewed at a national level, given the findings of this Review, and the recommendations on resourcing contained in Professor Irving's report *Registering the Risk*. **(Report Issue no. 5, see page 17)**

8. Consideration should be given to introducing Standard Operating Procedures to replace existing local guidelines on the management of sex offenders, partnership working and information sharing. **(Report Issue no. 18, see page 34)**

9. The Review Team stress the importance of the definition of a Non-registered Sex Offender and strongly urge the Scottish Executive, with ACPOS, to pursue a comprehensive and agreed definition that provides clarity. **(Report Issue no. 19, see page 34)**

10. It is strongly suggested that an inter agency delivery unit is created to make the necessary changes happen. The unit would develop and lead training, and create and disseminate the necessary protocols and standard procedures and monitoring mechanisms to improve practice across Scotland. **(Report Issue no. 20, see page 34)**

CASE CHRONOLOGY - COLYN EVANS

Chronology of events drawn from records:

Date	Event	Age at Event
17 April 1987	Born in South Wales, third of three children, normal pregnancy and birth.	0
1987/1991	Normal developmental milestones.	0-4yrs
1991	Family moved to Fife unknown to social work services – police checks negative.	4 yrs
1992/97	Attended Kennoway Primary School. (Reference in later paediatric report to bullying by peer, ‘locked in cupboard’.)	5-10 yrs
1997	Alleged indecent exposure to elderly male.	10 yrs
1998	Attended St Andrews High School.	11 yrs
Nov 1999	Charged with shameless indecency after exposing himself to two adult females.	12 yrs 7 months
Nov 1999	Referred to social work services by St Andrew’s HS, for difficult behaviour, truancy and being outwith parental control. Referred to Reporter, no further action as support at school and clinical psychology.	12 yrs 7 months
15 March 2000	Attempted to break into locked car, resulting in a Reporter’s warning.	12 yrs 10 months
20 March 2000	Mother reported him as missing person. Also stole bike – police warning.	12 yrs 11 months
Summer 2000	Attended Buckhaven High School.	13 yrs
20 June 2000	Truanted, returned to school by police.	13 yrs 2 months
14 March 2001	Mother reported him missing. Returned of own accord.	13 yrs 10 months
April 2001	Centre for Vulnerable Child commenced work with him.	14 yrs
18 May 2001	Charged with lewd & libidinous behaviour, assault and shameless indecency in relation to inappropriate sexual conduct with two girls under 16 on school grounds	14 yrs 1 month
10 July 2001	Referred by Social Work Service to Centre for Vulnerable child; <i>‘would benefit from individual work concentrating on sexuality, appropriate/inappropriate behaviour boundaries and relationships’.</i>	14 yrs 2 months
16 July 2001	Social Work Service notified police Sex Offenders Registrar of concerns about him.	14 yrs 2 months
6 Nov 2001	Grounds for lewd & libidinous behaviour upheld by Sheriff, referred to Children’s Hearing.	14 yrs 6 months
22 Nov 2001	Entry on Sex Offenders Nominal Record	14 yrs 7 months

Oct 2001 to May 2002	Excluded from school. Behaviour at school ranged from good to unacceptable, worsening when truanting. Great concerns at school about his sexually aggressive behaviour and language, for instance on one occasion responded inappropriately to reprimand by staff by shouting in a sexually abusive manner. On another occasion he was suspected of stealing Attendance Officer's mobile phone and making a sexually abusive call during which he appeared to be sexually stimulated and masturbating. His mother concerned that only 3 pieces of work provided for him by Education Link Worker by February 2002.	14 yrs 6 months to 15 yrs and 1 month
5 Dec 2001	Appeared at Children's Hearing, Home Supervision Requirement imposed. Referred to Centre for Vulnerable Child for 1:1 work to address problematic sexualised behaviour.	14 yrs 7 months
13 Feb 2002	Social Work Reviewing Service reviewed his Supervision Requirement, attendance at Centre for Vulnerable Child noted, school placement required, recommendation to forthcoming Children's Hearing that Supervision Requirement discharged because 'he seemed to be willing to accept services on a voluntary basis'. To attend Bridging the Gap (organised community activity) March-April 2002.	14 yrs 9 months
14 Mar 2002	Reported missing by mother, found 16.03.02 at a house in the area; both he and occupier of house interviewed at the time, but denied anything untoward had taken place. However, later (in September 2003) he alleged that he had been raped by the occupier of the house at this time.	14 yrs 10 months
19 June 2002	Appeared at Children's Hearing, Home Supervision Requirement terminated.	15 yrs 2 months
19 Aug 2002	Alleged he had been threatened by a local youth. Police advice given.	15 yrs 4 months
1 Sept 2002	Commits shameless indecency (masturbated in presence of 21-year-old female in Kennoway). Alibi provided by mother. Not charged, but report submitted to Reporter. Not recorded on Sex Offender Register.	15 yrs 4 months
18 Sept 2002	Tried to take 8-year-old boy from school in Kennoway with note allegedly from the boy's parents – not thought to have sinister intentions.	15 yrs 5 months
30 Sept 2002	Sex Offender Nominal Record updated with 18 Sept 2002 incident.	15 yrs 5 months

7 Oct 2002	Complaint of assault on 8 year old boy in Kennoway by punching and kicking. No corroborative evidence, however, Police report submitted to Reporter due to continuing concerns. Victim later same day told mother he told him to pull down trousers. CPU informed and re-interviewed victim and were satisfied there was no sexual motivation.	15 yrs 5 months
8 Oct 2002	CPU database updated re assault case, 7.10.02, notes suggest sexual connotation.	15 yrs 5 months
15 Oct 2002	Shameless indecency, masturbated in presence of 31-year-old female in Kennoway. Police report to Reporter, dealt with 30.04.03.	15 yrs 5 months
6 Nov 2002	He complained to police about fight with his mother at home. Both parties advised regarding future conduct.	15 yrs 6 months
9 Nov 2002 & 17 Nov 2002	He complained to police that being threatened by youth – taken home by Police.	15 yrs 6 months – 15 yrs 7 months
19 Nov 2002	Intelligence that he was involved with other local youths in visiting a dwelling house in Kennoway, possibly for sexual reasons.	15 yrs 7 months
25 Nov 2002	He complained that being threatened by local youth. He refused to make a formal complaint.	15 yrs 7 months
May 2002 to Dec 2002	Attended Sandy Brae Alternative Education Support Centre	15 yrs 1 month to 15 years 8 months
18 Dec 2002	First AIM assessment (Assessment, Intervention & Moving on) completed, “high risk of sexual offending”, submitted to Children’s Hearing	15 yrs 8 months
12 Dec 2002 to Jan 2003	Proof hearing before Sheriff, for shameless indecency, grounds established.	15 yrs 8 months to 15 yrs 9 months
27 Dec 2002 to 14 April 2004	Resident at Geilsland School, Beith, Ayrshire	15 yrs 8 months to 16 yrs 11 months
16 Jan 2003	Appeared at Children’s Hearing with mother. Made subject of place of safety warrant because denying grounds and not safe to return home. Placement at Geilsland School specifically because it claimed to be able to provide specialist support for young people with entrenched and concerning sexual behavioural problems.	15 yrs 8 months
Jan 2003	Social work services requested Initial Risk Assessment by the police	15 yrs 9 months
Feb 2003	Appeared at Children’s Hearing, warrant, Geilsland School	15 yrs 10 months

26 Feb 2003	LAC Review. Settled at Geilsland; bullying by and to him an issue; assessment almost completed; placement at Geilsland to continue with intensive work on difficulties, particularly the sexual component.	15 yrs 10 months
30 April 2003	Appeared at Children's Hearing, Supervision Requirement imposed, placement at Geilsland School.	16 yrs
15 May 2003	LAC Review. Placement to continue; <i>'stated verbally and in writing that he wanted help with his behaviour'</i> ; work to address behaviour to begin now.	16 yrs
9 June 2003	Referred to Throughcare Team to support him practically and financially after discharge from looked after and accommodated system.	16 yrs 1 month
15 Sept 2003	Record of meeting at Leven Social Work Office between social workers and representative from Geilsland. Not doing offence focused work, now absconding and putting others at risk. Meeting discussed child protection concerns to consider what interim measures could be made to ensure his and other young people's safety. Issues to be taken back to Geilsland and follow-up letter outlining concerns sent to Geilsland School.	16 yrs 4 months
Sept 2003	Monthly summary records discussion with CPU regarding activities at Geilsland – notes sexual activity with a vulnerable young person – with regard to whether anything should be investigated, 'CPU felt there was no role'. Child Protection worker's case notes refer to a planning meeting held at Leven with Children and Families Team and Geilsland. Meeting convened to discuss what interim arrangements could be made to ensure his and other young people's safety.	16 yrs 4 months
17 Sept 2003	Alleged being assaulted in 2002 (see entry 14-16 Mar 02).	16 yrs 5 months
7 Oct 2003	LAC Review. Placement at Geilsland to continue provided that he undertakes work with staff to address sexual behaviour issue. Family visits to resume provided he does not abscond. Commence preparation work for return to the community.	16 yrs 6 months
24-26 Dec 2003	Stayed at parent's home over Christmas	16 yrs 8 months
9 Jan 2004	LAC Review. Notes considerable improvement since last review – 10/03 – put down in part to being allowed regular home leave and family contact. (Note agreed plan on family contact to be allowed providing he does not abscond). Reports 1:1 work only just started – group sessions on-going since before the last review. Seen as more relaxed, less argumentative and generally interacting better with staff and other residents. Notes incidents of sexual activity and outstanding charge of smashing window and damaging staff car (entering other's bedroom not noted here). Despite general improvements, notes the ongoing need for structured environment to be safe and	16 yrs 8 months

	undertake work that has been started. Notes his desire to leave Geilsland in April when 17 but indicated view that this is too soon. <i>'He will be 17 years old in April 2004 and had hoped to leave Geilsland at this time. It is felt by staff and social worker that this timescale is too short to progress the work sufficiently for him to leave then and a further residential period will be needed. He appears to accept the reasons put forward for this and is agreeable to staying longer at Geilsland.'</i> Notes limited contact between him and social worker.	
10 Jan 2004	Complained of threats by two fellow residents.	16 yrs 8 months
27 Jan 2004	Found in possession of small amount of cannabis at Geilsland.	16 yrs 9 months
15 Mar 2004	LAC Review; still at Geilsland; Review noted reduction in absconding and improved contact with family but continuing concern regarding delay in commencing 1:1 work to address sexually inappropriate behaviour; decision to recommend termination of Supervision Requirement, and return home <i>'because he is now very positive about his future and willing to accept support in the community to help him stop re-offending'</i> , work with Child Support Services to address sexually inappropriate behaviour and support from Throughcare Team.	16 yrs 10 months
2 April 2004	Second AIM assessment completed, continuing high risk of re-offending, but positive changes in last 18 months, including better coping mechanisms and substantial maturation; concern remained about him being isolated in community and in an unstructured environment with little to do <i>'still high risk of re-offending'</i> . Referral to Centre for Vulnerable Child <i>'he needs to do this work – if the likelihood of him re-offending in a sexual manner [is to] be reduced'</i> . Second AIM report not shared with Children and Families Team or Children's Hearing 14 April 04.	16 yrs 11 months
14 April 2004	Appeared at Annual Children's Hearing Review, Supervision Requirement terminated. Living at parents' home.	16 yrs 11 months
15 April 2004	Responsibility for case transferred from Children and Families Team to Throughcare Team.	17 yrs
22 April 2004	Allegedly assaulted 13-year-old friend. Resolved between friends.	17 yrs
7 May 2004	Reported as missing person by girlfriend, found in caravan with 13-year-old girl, where they had spent the night. Both parties denied any wrong doing and were returned to their respective homes.	17 yrs
Sept 2003 to Aug 2004	Housing applications – Sept 2003, Throughcare Team met with him and Housing Homeless Officer, housing needs assessment commenced; 15 Mar 04 LAC review – agreed Throughcare Team to make housing application for tenancy near parents in Kennoway; 14 April 04 discharged	16 yrs 5 months to 17 yrs 4 months

	to parents' home, fell out, living with girlfriend's family, liaison with Homeless Office; May 04 he withdraws homeless accommodation application; July 04 he takes name off housing list in Kennoway; Aug 04 parents refuse to accommodate, he is referred to Homeless officer; 28 Aug 04 placed in single occupancy 'scatter flat' at Tayport.	
10 May 2004	Mother complains about receiving texts from his former girlfriend alleging he is a "beast".	17 yrs
2 Aug 2004	Change of circumstances notification from Child Support Services (CSS) and request to police for Initial Risk Assessment (IRA). CSS consider him to be high risk of re-offending but changed status to 'review' this status does not allow for chasing up if request not acted upon). CSS terminated work with him 'because of his lack of commitment'. CSS do not inform Throughcare Team of the end of their involvement with him.	17 yrs 3 months
8 Aug 2004	Entry on Sex Offender Register re-request for IRA.	17 yrs 3 months
20 Aug 2004	Allocated flat at Tayport; Throughcare Team aware of change of address but Child Support Service and police not informed. Child Support Services notified police of new address on 18 Jan 05. Police aware of new address from 13 Sept 04 (see below).	17 yrs 4 months
20 Aug 2004 to 19 Jan 2005	Throughcare and Housing Support (aware of concerns re his sexually inappropriate behaviour) made 41 home visits to him, of which 20 were successful. From October onwards Throughcare found it increasingly difficult to contact him. Throughcare do not consider him ' <i>high risk of offending</i> '.	17 yrs 4 months to 17 yrs 9 months
13 Sept 2004	Threatened to commit suicide at Tayport. Charged with breach of the peace and released to care of parents. Notified to Sex Offender Registrar.	17 yrs 4 months
26 Oct 2004 to 3 Nov 2004	In Wales. Throughcare Team informed 'no-one' about this absence.	17 yrs 6 months
29 Nov 2004	Suspected of house breaking onto neighbour's flat and accessing pornographic sites using complainer's computer.	17 yrs 7 months
18 Jan 2005	Change of circumstances notification from Criminal Justice Services re change of address to Tayport.	17 yrs 9 months
20 Jan 2005	Murder committed	17 yrs 9 months
10 June 2005	Sentenced	18 yrs 1 month

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