DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

Into the death of

Jessica in November 2015

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Preface

The Review Panel members and the Castle Point & Rochford Community Safety Partnership would like to express their sincere condolences to Jessica's parents for the sudden loss of their daughter, and to her child who is now an adult who has lost their mother in such tragic circumstances. Jessica is greatly missed by them and by the many friends she had in her neighbourhood.

The Review Panel chair and members would like to thank Jessica's parents for their assistance with the Review. We appreciate how very difficult this has been for them at times, but thanks to their courage, and their determination to understand how this terrible homicide could have happen, we have been spurred on to try and discover any learning which might prevent other families going through such painful events in future. For the key purpose for undertaking a Domestic Homicide Review (DHR) is to enable lessons to be learnt where there may be links with domestic abuse. In order for these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. We would also like to thank the advocate from the organisation Advocacy After Fatal Domestic Abuse for her support of Jessica's parents and for the Review process.

Statutory Guidance[1] introduced under Section 9 (3)(1) of the Domestic Violence, Crime, and Victims Act 2004, states that there should be a "review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death".

The Home Office defines domestic violence as:

> *Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional.*
>
> *Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim*

During the perpetrator's trial it became clear that although Jessica knew him and may have had brief intimacy with him, it was not a relationship. However, it was felt that, given the perpetrator's previous history of violence to women, there was valuable learning to be gained therefore the Review continued. The term domestic abuse will be used throughout this Review as it reflects the range of behaviours encapsulated within the above definition, and avoids the inclination to view domestic abuse in terms of physical assault only.

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised August 2013) Section 2(5)(1)

DOMESTIC HOMICIDE REVIEW

1. Introduction

1.1 This report of a domestic homicide review examines agency responses and support given to Jessica, a resident of the Castle Point Borough Council area prior to the point of her death in November 2015. The review will consider agencies' contact and involvement with Jessica, and with the perpetrator William Smith from 2012, the year he was released from prison and moved into the Castle Point area.

1.2 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Timescales

1.3 The Castle Point Community Safety Partnership was formally notified 5 days after the homicide that the murder appeared to meet the requirements to hold a Domestic Homicide Review. The chair of the Partnership held a meeting with partners on 2 December 2015 where it was confirmed that a Review would be undertaken. The Home Office was informed of the Partnership's decision on the same day. This was within the required timescales set out in statutory guidance. It was not possible to complete the Review within six months as required by guidance due to the criminal proceedings which concluded in July 2016. The Home Office was informed of this delay on 4 April 2016. The Review and was completed on 9 November 2016.

Confidentiality

1.4 The findings of this review were confidential during the review process. Information was available only to participating officers/professionals and their line managers until the Review was approved by the Home Office Quality Assurance Panel for publication.

1.5 To protect the identity of the victim, perpetrator, and their families the following pseudonyms have been used throughout this report.

The victim: Jessica aged 36 years at the time of her death. Jessica was of white British ethnicity

The perpetrator: William Smith aged 48 years at the time of the offence, is of white British ethnicity

Dissemination

1.6 The following agencies will receive a copy of this review report:

Chair & Members of the Castle Point & Rochford Community Safety Partnership Essex Police & Crime Commissioner
Chief Constable of Essex Constabulary
Chief Officer National Probation Service Essex
Chief Officer South Essex Partnership University NHS Foundation Trust
Chief Officer Castle Point Borough Council
Chief Officer of Family Mosaic
Accountable Officer of Castle Point & Rochford Clinical Commissioning Group
Essex Criminal Justice Board members
Independent Chair Essex Safeguarding Adults Board
Chief Executive, The Parole Board
NHS England Midlands & East – East DCO
National Probation Service
Essex MAPPA Coordinator
Director Probation, National Offender Management Service

Summary

1.7 The perpetrator William Smith was released from prison on life licence in May 2012 after serving 18 years for the murder of his partner and a concurrent sentence for a previous attempted murder. He was briefly managed under MAPPA[2] level 2 arrangements, which changed soon after his release to MAPPA level 1. After leaving Probation approved accommodation he moved into the Castle Point area where his licence conditions were managed by Essex Probation. He was mainly on benefits apart from a short period of employment. During 2013 he was charged with theft from a supermarket on two occasions, but this was not a crime to instigate his licence to be recalled.

1.8 It is not known exactly when Jessica met William Smith, but her family suggest it may have been around July 2014 when she was staying at a friend's flat when her own accommodation was flooded. Someone who had known Jessica for 20 years also thought they met 12 to 18 months prior to the fatal incident. Jessica suffered from mental illness and would sometimes fail to take her medication; she would also have periods where she would misuse drugs and alcohol. She had frequent involvement with mental health services, but during 2015 she disengaged with the Community Mental Health Team and her contact with mental health practitioners was mainly on a crisis basis. It is believed that William Smith lived in the first floor flat above where Jessica was staying temporarily and it is likely that they would have met through a network of friends who used drugs and drank alcohol.

[2] Multi Agency Public Protection Arrangements (MAPPA) Assess and manage the risks posed by sexual and violent offenders. The responsible authorities for MAPPA are Police, Probation and Prisons. Other agencies have a duty to cooperate (e.g. education, employment, housing, social care). Level 1 (ordinary agency management). This involves the sharing of information but does not require multi-agency meetings. Level 2 if an active multi-agency approach is required (MAPP meetings), and at level 3 if senior representatives of the relevant agencies with the authority to commit resources are also needed. (Ministry of Justice & National Offender Management Service. *MAPPA Guidance 2012 Version 4)*

1.9 On the day of the fatal incident Jessica visited a friend with the perpetrator William Smith, however the friend was shut out of his flat by William Smith who then attacked Jessica. The friend called 999, but when the Police arrived William Smith had left the premises. A search for him began and he was arrested in a nearby town the following day and charged with murder.

Terms of reference of the Review

Terms of Reference for the Review : Statutory Guidance (Section 2) states the purpose of the Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

Specific Terms of Reference for this Review:

1) To examine the events leading up to the fatal incident and the decisions made from the date of the decision making process to release the perpetrator from prison in 2012. Agencies with relevant background information about the perpetrator prior to 2012 are to provide a chronology and summary of that information.

2) Information concerning the victim will be examined from June 2015 when it is believed she met the perpetrator. Background information regarding the victim will inform the Review proportionate to its relevance and importance for learning.

3) Was the perpetrator subject to Multi-Agency Public Protection Arrangements (MAPPA)? If so:

    a) what plan was in place and how was it to be managed?
    b) what risk assessment process took place and was it regularly reviewed?
    c) was risk assessment thorough and in line with procedures, and what background history informed the assessment?
    d) was the MAPPA fit for purpose?
    e) was MAPPA fully supported by partner agencies who actively participated in managing offenders?
    f) what flaws if any have been identified in the management of the offender?
    g) is there any good practice relating to such cases that the Review should learn from?

h) did all agencies involved with the perpetrator understand the MARAC process?

4) Was communication and information sharing between agencies or within agencies adequate and timely and in line with policies and procedures?

5) Why did the breach of the perpetrator's 12 month Conditional Discharge in 2013 not result in action by the criminal justice system?

6) Did any agencies or professionals have concerns that they felt were not taken sufficiently seriously?

7) Did any agency have an opportunity to inform the victim of the perpetrator's offending history? If so what risk assessment took place?

8) To examine whether there were any equality and diversity issues or other barriers to the victim seeking help?

9) Are there any systems or ways of operating that can be improved to prevent such loss of life in future, and were there any resource issues which affected agencies ability to provide services in line with procedures and best practice?

10) The chair will be responsible for making contact with family members to invite their contribution to the Review, to keep them informed of progress, and to share the Review's outcome.

Methodology

1.10 After the decision to hold the Review was taken agencies were contacted to establish who had involvement with the victim and perpetrator and to secure their files if this was the case. 8 services confirmed contact, 12 return a nil contact. The first Review Panel meeting took place on 28 January 2016 where the terms of reference were drafted. A total of 4 Panels were held during the Review process.

1.11 7 Individual Management Reviews (IMRs) were provided for the Review by agencies after the trial was completed. The Crown Prosecution Service provided background information on the perpetrator's history of prior convictions. The chair held briefing and debriefing meetings with IMR authors. A Panel meeting was held to quality assure the IMRs after which it was considered necessary to seek further information from a number of authors due to questions arising from their IMR content or for clarifications between agency information.

1.12 With prior contact by the family liaison officer the chair wrote to Jessica's parents asking if they would agree to contribute to the review; the Home Office DHR information leaflet was enclosed for their information. They agreed and a meeting took place where the draft terms of reference were shared and agreed with them. As the criminal proceedings were still to take place the chair arranged to meet the family again when the trial was over. At the next meeting the chair shared the draft chronology with Jessica's parents and they were able to provide additional information which has been incorporated into the Review. Her parents have chosen the pseudonym used for their daughter throughout this Review. Updates took place via telephone, and they were invited to attend the Review Panel at which the draft report was discussed which they accepted. The draft report was shared with Jessica's parents before the Panel to enable any

amendments to be made, and any comments they wished to appear in the report to be included. Jessica's parents were supported in all but the first meeting with the chair by an advocate from specialist voluntary agency Advocacy After Domestic Abuse (AAFDA), who also supported them at the Panel meeting they attended.

1.13 In addition to IMRs the chair wrote to the psychiatrist who undertook an assessment of the perpetrator for his solicitor representing him at his final Parole Board asking for consent to access and cite his report in this Review. The psychiatrist's solicitor responded to this request that the report was the property of the solicitor who had commissioned it, therefore consent would be needed from them. As it would take time to access the files from archives to determine the contact details of the solicitor and to seek their consent, in agreement with Jessica's family it was decided not to proceed with this course of action as it would unduly delay the completion of the Review which the family and the Panel wished to avoid.

1.14 A letter was written to the perpetrator's former employer in the Castle Point area to ascertain his employment history, and the reason why his employment ended, to corroborate information given by him to his offender manager and the Housing Department. No reply was received.

1.15 The chair wrote to a close family member of the perpetrator to invite their contribution, but no response was received. The decision was taken not to contact the perpetrator in this case as was the chair's usual practice. At his trial he had not accepted responsibility for his terrible crime, and for the sake of Jessica's family the chair did not wish to give him a platform to further abrogate responsibility for his actions.

1.16 The Parole Board was emailed on 5 August 2016 requesting a copy of the Parole Board minutes for the perpetrator's last Board before release. No response was received. The chair made numerous phone calls to the Board and emailed the Ministry of Justice all without any reply.

Contributors to the Review

1.17 The following agencies and the nature of their contribution is given below:

- Essex Police - Chronology and Individual Management Review
- National Probation Service Essex - Chronology and IMR
- South Essex Partnership University NHS Foundation Trust (for Mental Health) - Chronology and IMR
- Family Mosaic (Housing Provider & Support) - Chronology and IMR
- Castle Point Borough Council Housing Department - Chronology and IMR
- Crown Prosecution Service - Background Information re: offences
- Castle Point & Rochford Clinical Commissioning Group (for 2 GPs; the victim's and perpetrator's) - Chronology and IMR

Review panel members

- Gaynor Mears, Independent Chair & Report Author
- Melanie Harris, Head of Licensing & Community Safety, Castle Point Borough Council
- Helen Collins, Community Safety Officer, Castle Point Borough Council

- Barbara Horn, Operations Manager & Beena Kahn, Floating Support Services Manager, Family Mosaic, Registered Social Landlord
- Sarah Jane Ward, Deputy Chief Nurse, Castle Point & Rochford Clinical Commission Group.
- Chief Inspector Ian Cummings, Essex Police
- Detective Inspector Caroline Venables, Essex Police (one meeting)
- The Chief Executive, Basildon Women's Aid
- Elaine Taylor, Associate Director Safeguarding, South Essex Partnership University NHS Foundation Trust (Mental Health Service)
- Sam Brenkley, Senior Probation Officer, National Probation Service Essex

Chair & Author of the Domestic Homicide Review

1.18 The chair of this Review and author of this DHR Overview Report is independent DHR chair and consultant Gaynor Mears OBE. The author holds a Masters Degree in Professional Child Care Practice (Child Protection) and an Advanced Award in Social Work in addition to a Diploma in Social Work qualification. The author has extensive experience of working in the domestic abuse field both in practice and strategically, including roles at county and regional levels. Gaynor Mears has experience in undertaking previous Domestic Homicide Reviews, and research and evaluations into domestic abuse services and best practice. She has experience of working in crime reduction with Community Safety Partnerships, and across a wide variety of agencies and partnerships. Gaynor Mears is independent of, and has no connection with, any agencies in the Castle Point Community Safety Partnership area or the county of Essex.

Parallel Reviews

1.19 A Coroner's inquest was opened and adjourned as is the practice when criminal proceedings take place.

1.20 The National Probation Service Essex conducted a Serious Further Offence Review. This has informed their Individual Management Review.

2. The Facts

2.1 At 16:56 hours on a day in November 2015 Essex Police received a 999 call from a man stating that he believed someone had been stabbed in his address and that there was a female on the floor with 'blood everywhere.' He said his friend had come to his address with her boyfriend, the boyfriend had locked him out of his flat and he believed that the male had stabbed and hit her with a hammer.

2.2 The Police attended and found the victim slumped on the floor in a pool of blood. She had a large laceration to her throat and was breathing but not responsive. There was a claw hammer on the bathroom floor next to her. An Ambulance took her to a nearby hospital, from where she was transferred to the Royal London Hospital, but sadly she was pronounced dead at 19:40 hours.

2.3 A post mortem was undertaken by Dr Ben Swift in November 2015 when the cause of death was determined to be blunt force trauma to the head and multiple stab wounds; Jessica had suffered 40 stab wounds.

2.4 The person identified as responsible for the crime had left the scene of the murder and a hunt for him began immediately. Due to his previous history and the Police belief that he posed a risk to the public, a description and photograph was issued. The following day he was identified by an off-duty Police officer in a nearby town and arrested. He was charged with murder and remanded in custody.

2.5 The trial was significantly delayed due to the offender dismissing his legal representative before the date set for the trial to begin. He eventually stood trial in July 2016 where the jury found him guilty of murder. He was given a whole life sentence.

2.6 At the time of the crime the victim Jessica lived alone in her own flat. She had lived there for many years. She has a child who is now an adult who lived with her on occasions and who also lived independently, but who was in touch with Jessica on a regular basis. Her family who also live in the same Local Authority area provided support to her and saw her often.

2.7 Jessica suffered from mental illness and had problems with drugs and alcohol. These conditions made her vulnerable. However, she would not have been considered an 'adult at risk' under the Care Act 2014 which was enacted in April 2015[3].

3. Chronology

Background Information

The Victim

3. 1 Jessica is reported to have been diagnosed with ADHD in her early teens, however, her mother has no knowledge of this therefore the accuracy of this record is questioned. The records from this time are not easily available. Jessica had contact with Mental Health Services from 2004 having attended at her GP practice with symptoms of depression and anxiety following a road traffic accident. It is believed this was compounded by a number of psychosocial issues, which along with her poor coping strategies, contributed to a gradually deterioration in her social and mental wellbeing. This manifested itself in challenging behaviour and Jessica having difficulties in managing various life events which others may not find as problematic. Jessica's condition was exacerbated by the use of alcohol and drugs. During the period of her involvement with Mental Health Services Jessica was also supported by a duel diagnosis worker from Drug & Alcohol Services from 2010, however she had mainly disengaged from Mental Health Service by February 2015 apart from periods of crises in her mental health.

3. 2 Police records show that Jessica reported numerous incidents of domestic abuse involving partners going back to 2005. Jessica was recorded as the victim in 11 incidents, and the perpetrator in 3 incidents.

[3] An 'adult at risk' is considered in need of safeguarding services if she/he: *(a) has needs for care and support (whether or not the authority is meeting any of those needs), (b) is experiencing, or is at risk of, abuse or neglect, and c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*

3. 3 In 2009 Jessica was diagnosed with an Emotionally Unstable Personality Disorder and in 2013 with Bi-Polar Affective Disorder. In 2013 Jessica was detained under Section 2 of the Mental Health Act due to a deterioration in her mental health precipitated by non-compliance with her medication, disengagement with services, and poly-substance misuse.

3. 4 In July 2014 there were significant floods in the area where Jessica lived and she had to be moved to temporary accommodation. In December 2014 she saw her GP with a history of feeling down and depressed due to problems at home and she reported that her home was still gutted. In the Autumn of 2015 her dog died. Both these events, particularly the loss of her dog, had a very upsetting and unsettling effect on Jessica.

3. 5 Jessica appears to have recognised when she needed help for in January 2015 she referred herself for support from Family Mosaic a registered social landlord who also provide floating support services to tenants. In addition to her complex health needs Jessica had a number of significant issues ranging from benefits, debts and financial management, property repairs, and her difficulty in managing and keeping various appointments. After a period of assessments Jessica was allocated a support worker and during 2015 she had the consistent support of the same support worker which began at the end of May 2015. Her support worker was aware of Jessica's mental ill-health and her brief periods of stability when she abstained from drugs and alcohol, and when she relapsed. Contact with Jessica or advocacy with agencies on her behalf was very frequent. Therefore only contacts of significance will be referred to.

3. 6 In April 2015 Jessica reported [to her Duel Diagnosis Worker] that she did not want to abstain from drugs and alcohol and was currently 'living a dangerous life'. Jessica was not taking her medication and staff in the Mental Health Service described her behaviour at this time as potentially violent and aggressive; at risk of harm by others and from herself, and at risk of physical health issues based on her lifestyle. Her dual diagnosis worker with whom Jessica had previously had a good relationship and who knew her well, continued to try and make contact with her despite the Drug and Alcohol Service changing providers. However, no contact had been achieved since February 2015. A professionals meeting on 13 April 2015 reflected the attempts to make contact and the difficulties in engaging Jessica in services; this was made difficult as she did not live in her own flat at the time and she would put the phone down when she realised who was calling.

3. 7 Jessica had gradually disengaged from Mental Health Services. Occasionally she would make contact when she felt she was in crisis, but she did not formally engage with treatment or keep appointments. Jessica's last contact with the service was by phone on 7 April 2015 when she stated that she no longer wanted contact with the Community Mental Health Team. Staff made several attempts to re-engage her, through contact with her mother, her housing support worker at Family Mosaic, and via letters put through the door at her home and her temporary accommodation, however these were unsuccessful.

The Perpetrator

3. 8 William Smith first came to the notice of Police at the age of 17 years when he slashed the face of another youth with a Stanley knife at a club. He was arrested for grievous bodily harm and was subsequently sentenced to a 150 week Community Service Order.

3. 9 At the age of 21 years William Smith was arrested for rape. He invited the victim

back to his flat and approached her for sex. She refused and William Smith assaulted her by grabbing her around the throat and punching her in the face; he then raped her. He was convicted at the Central Criminal Court for a reduced offence of Actual Bodily Harm and sentenced to 2 years imprisonment. He was released from prison on 24 April 1989 and was on licence until 2 December 1989.

3. 10 Just over 3 months later on 8 August 1989 William Smith attempted to murder a 17 year old female victim in the Metropolitan Police area. This followed a very short relationship during which he became very jealous. When the victim refused to have sex with him he strangled her, cut her many times with a carving knife and stamped on her throat. He fled to Ireland after this offence with the assistance of his father. His licence was recalled on 29 August 1989, but he was not apprehended for this offence until he was arrested in 1993.

3. 11 On 1 October 1993 William Smith was arrested for a murder which took place on 28 September 1993 in the Metropolitan Police area. He was sharing a flat with the 30 year old victim at the time, but she had told him to leave; their relationship was over. He then strangled her, removed her jewellery and sold it. It is understood that William Smith believed she was having a relationship with another man. He was sentenced to life imprisonment at the Central Criminal Court in June 1994 for the murder and received a concurrent sentence of five years imprisonment in respect of the 1989 offence of attempted murder. The trial judge commented that he had "an inability to tolerate rejection by women". He was given a minimum tariff of 16 years before he could be considered for release.

3. 12 In 2005 William Smith moved to a lower category C prison, and in 2007 he had his first Parole hearing. He was considered not to be ready for transfer to the more open conditions of a category D establishment, and he would need to complete a Healthy Relationships Programme. His next hearing was set for 2009.

3. 13 William Smith completed the Healthy Relationships Programme in 2009 and the Domestic Abuse Risk and Needs Analysis was undertaken to assess the ongoing risk he might pose to future partners (this is covered in the Analysis of this report in Section 6). As a result of the analysis his move to open conditions was delayed for one-to-one work to take place with a psychologist. On completion of this work in 2010 William Smith was transferred to an open prison where he completed the Integrated Domestic Abuse Programme (IDAP) at a local probation office.

3. 14 William Smith served 18 years in prison and was released on licence on 30 March 2012.

3. 15 William Smith's offending history includes:

5 Offences against the person including:

- Wounding with intent to cause grievous bodily harm - May 1984: Community Service Order 150 weeks
- Assault occasioning bodily harm - October 1988: 2 years imprisonment (offence downgraded from rape charge)
- Murder and wounding - June 1994: Life imprisonment & 5 years (concurrent)

3 Theft and kindred offences
2 Offences relating to Police/Courts and Prisons

Chronology from 2012

3. 16 Prior to William Smith's release from prison an initial Level 1 MAPPA meeting took place on 15 February 2012 where the decision to manage him at Level 1 was ratified. However, the minutes of this meeting record a postscript stating '*Having reviewed information obtained by Essex Police and noted concerns post meeting MAPPA felt it appropriate for the case to be returned for review at Level 2 on 21 March 2012. ViSOR[4] nominal record to be raised by Essex Probation'.*

3. 17 The concerns were raised by a Police officer who was then MAPPA Coordinator; the officer was on leave when the meeting took place, but on reviewing William Smith's criminal record the officer brought her concerns to the attention of her line managers. The officer was concerned that William Smith had not been in the community for any length of time without committing violent attacks on women and considered him to be a serious risk. The officer noted a reference on his criminal record that following the murder offence in 1993 he had been suspected (but never charged or prosecuted) of similar offences. As a consequence William Smith was raised to MAPPA Level 2.

3. 18 On 27 February 2012 Essex Police received notification that William Smith was to be released from prison on 30 March 2012 to Probation Approved accommodation in their area. Licence conditions imposed required him to report any developing relationships. Essex Police recommended that the licence should include a requirement to submit to Police monitoring visits, however, the Parole Board considered this inappropriate[5].

3. 19 Prior to his imprisonment William Smith was under the management of the London Probation Service, his release plan included locating to Essex where he was said to have family support, thus he was transferred to be managed by Essex Probation. The home circumstances were assessed by a probation officer who visited his mother and she confirmed that the family had been supporting him throughout his sentence. In the run up to his release from prison William Smith had successful resettlement leave at Probation Approved Premises; there were no concerns about his behaviour. The Integrated Domestic Abuse Programme which was undertaken in prison by William Smith produced a post programme report indicating that he had made some good progress in understanding the links between negative thoughts and feelings, and the benefits of positive self-talk.

3. 20 The following comes directly from the Probation IMR chronology as it clearly explains the process which followed: An Oral Hearing of the Parole Board was held on 2 March 2012 and William Smith's release to Approved Premises in Essex was supported. The Parole Panel expressed some concern that the prison had not arranged a full psychiatric assessment despite the suggestion of the Parole Board in 2007. William Smith's solicitor had commissioned a psychiatric report that concluded that he had made substantial changes to his behaviour and that the risk had "vastly reduced". The Parole Board did express some further concern that an HCR-20 informed by a PCL-R had not been available; Historical

[4] ViSOR is a national IT system for the management of people who pose a serious risk of harm to the public which enables the Police, Probation and Prison Services to access the same IT system to support the work of MAPPA.
[5] MAPPA Minutes 21 March 2012

clinical Risk Management (HCR-20) was developed to help structure decisions about risk of violence. It is often supported by a PCL-R, a diagnostic tool used to rate a person's psychopathic or anti-social tendencies. The psychologist author of the Domestic Abuse Risk and Needs Assessment had suggested these screenings might be useful in further assessing William Smith. However the Parole Panel were satisfied that they had sufficient evidence available to them "which use of these tools would have generated".

3. 21 William Smith was considered to have addressed his risk through offending behaviour programmes in custody, including the Healthy Relationships Programme, Integrated Domestic Abuse Programme and a Cognitive Skills Booster course. The Parole Panel were impressed by the evidence given by William Smith in person. They accepted that he did not pose an imminent risk of serious harm and that there had been no evidence of violence or aggression for many years. It was considered that he could be managed in the community subject to life licence. The licence contained additional conditions for him to reside at Approved Premises and thereafter as directed by his supervising officer; to disclose emerging intimate relationships with women, not to contact directly or indirectly the victim or family [from the previous crimes] and to comply with any requirements specified by his supervising officer to address alcohol misuse, offending behaviour and any medical assessments and treatment (counselling, mental health referrals).

3. 22 A Level 2 MAPPA meeting was held on 21 March 2012 at which the MAPPA coordinator, a Police officer, expressed her concerns about William Smith's violent background towards previous partners and the need for a licence condition in relation to developing relationships[6]. It was confirmed that such a condition was already included. It was also agreed that Police and Probation would undertake a joint visit to interview William Smith at his Approved Accommodation; a police officer from the Public Protection Unit wished to assess whether there were grounds to apply for a Sexual Offences Prevention Order. Grounds were not found as William Smith had not been prosecuted for a sexual offence; the rape in 1988 was prosecuted under a lesser charge.

3. 23 William Smith was released to live in Approved Accommodation on 30 March 2012 on life licence to be managed by probation officer 1 at Essex Probation. He was to be subject to alcohol and drug testing at the Approved Premises (all tests were negative), and the Job Centre had been notified on 30 April 2012 of any restrictions in terms of future employment. At one point William Smith had said he wanted to start a gardening business, but this did not progress. However, this would have been objected to as it would involve him attending private homes.

3. 24 Castle Point Borough Council Housing Department received an enquiry from William Smith on 13 April 2012 requesting housing assistance. He stated that he was in a bail hostel which he needed to leave by mid-May. He disclosed his length of time in prison and that he has having weekly contact with the Probation Service. He reported that he had friends and family who could assist with a deposit. General advice was given regarding rental accommodation/crisis loan.

3. 25 A risk assessment was completed by probation officer 1 on 1 May 2012 and the following day, a further MAPPA meeting was held at which it was reported that the joint visit to interview William Smith had not yet taken place due to the appointment of a new offender manager. The case was reduced to MAPPA Level 1; there were no dissentions recorded in the minutes regarding this decision, and

[6] MAPPA Level 2 minutes 21/3/13

thereafter William Smith was managed by Essex Probation, however the duty of all agencies to share information remained. The joint interview took place on 11 May 2012.

3. 26 On 24 May 2012 an update was provided via email to the South Local Policing Area in which William Smith lived to ensure that any intelligence regarding him was submitted in order that it could be shared with Probation and any other relevant partners.

3. 27 On 1 June 2012 William Smith's probation officer 1 telephoned the Housing Department about his housing application. His housing needs and rent deposit were discussed with him in supervision on 5 June and on 8 June probation officer 1 spoke to a housing officer regarding William Smith's MAPPA status and imminent housing need. On the same day, the 8 June 2012, William Smith made further contact with the Housing Department himself regarding housing. Family were no longer able to assist with a deposit. William Smith claimed to have had no advice or assistance from the Probation Service regarding housing, however the Probation chronology clearly shows he had the support of his probation officer and the probation housing liaison officer and he was being empowered to be proactive himself to arrange his accommodation. He informed the housing officer that he was a MAPPA offender and gave the name of his probation officer. The Council housing officer contacted the Probation Service and expressed concern regarding the lack of communication and difficulties in resolving housing issues, and about arrangements being made at short notice.

3. 28 On 1 July a homelessness application was submitted for William Smith and the case notes recorded that he was MAPPA managed; he was offered temporary accommodation after checks were made with Probation concerning any restriction regarding children or vulnerable adults which might need to be considered. No such restrictions were noted. There was liaison between probation officer 2 and a Local Authority housing officer who was advised that William Smith was being managed under MAPPA level 2, and a joint visit by them with William Smith took place to his planned move-on independent accommodation on 10 July 2012. The joint visit was reported verbally to the Housing Department IMR author; it was not recorded on the Housing Department system. On 13 July 2012 a permanent housing application was submitted for William Smith. There was no mention of MAPPA on this application document.

3. 29 A final MAPPA Level 2 meeting was held on 18 July 2012 where it was recorded in the minutes that an action was allocated to all agencies '*To liaise outside of MAPPA, particularly in relation to developing relationships'.* Any agency could refer back for discussion if required.

3. 30 William Smith signed a secure tenancy agreement which started on 20 August 2012. He was assessed by Probation as adjusting well after release and had the support of his family, although it was noted that he expressed some frustration that he could not find work. On 28 August 2012 Essex Police were informed by Probation of William Smith's new address.

3. 31 During late 2012 - early 2013 William Smith was in contact with the Local Authority relating to rent arrears. On 15 March 2013 Housing Department records show that he attended the office to report that his Job Seekers Allowance had ceased as he was deemed not to be looking for work.

3. 32 On 14 August 2013 William Smith stole a television and food items valued at £160 from a large supermarket. He had left the store making no attempt to pay

for the goods. He was sentenced at South Essex Magistrates Court on 29 August 2013 and received a 12 month Conditional Discharge and a £15 fine. William Smith did not immediately disclose this offence to his offender manager, nor were they informed by the Police of the arrest. The offender manager's senior manager sanctioned the sending of a warning letter to William Smith.[7]

3. 33 William Smith was again arrested for theft from a supermarket on 7 September 2013 when he stole groceries valued at £29.37. He was sentenced at South Essex Magistrates Court on 25 September to one day's detention deemed served after he pleaded guilty. No further action was taken on the breach of the Conditional Discharge which was to continue for the remaining 11 months. The court would have been updated and known about his life licence; the decision to impose a sanction or not for the breach of the Conditional Discharge is at the Court's discretion. On this occasion William Smith was given a final warning on his licence and as part of this he was instructed to attend the Bridge Project which provided a period of intensive community supervision and intervention designed to foster desistence from offenders and improvement in their motivation to lead law abiding lives. William Smith complied with this requirement and was linked with a mentor from a local voluntary agency. When seen in custody for the homicide William Smith told probation officer 3 that he had started gambling.

3. 34 There is a gap in Probation case recording between November 2013 to April 2014. The senior probation officer who managed probation officer 2 at this time considered that William Smith was probably reporting during this period, but that the case record was not updated.

3. 35 In December 2013 William Smith registered with a local GP practice, however, apart from a new patient appointment with a practice nurse there is no contact regarding his health until the GP received a letter from the Mind Counselling Service on 19 September 2014 letting the GP know that William Smith was accessing their Post Traumatic Stress Disorder counselling service. The letter reported that he appeared to be suffering from depression and suggested that if the GP could see him this would help. The GP requested that an appointment be made, however when the receptionist telephoned they were informed that he was no longer at that address. William Smith had been linked to the Mind Counselling Service by his probation officer after he reported struggling with flashbacks in respect of the murder he had committed.

3. 36 In May 2014 William Smith was allocated to probation officer 3. During this period of his supervision the focus was on employment and financial management. He secured work in November 2014 and on the 1 December 2014 William Smith called the Housing Benefit Department to report that he now had full time work and his benefit was reassessed. Following a rent reminder letter on 9 December 2014 he spoke to a Rent Department officer to advise that he was now working and had a Construction Industry Certificate form to complete and his probation officer was visiting him on 15 December to complete the forms with him. A further Housing record shows that William Smith phoned on 13 January 2015 about his rent and reported that "job in November 2014 but not paid for 2 weeks". Advice was given regarding housing benefit and rent payment. It would appear that he did not pay his rent for on 12 February 2015 a Notice of Seeking Possession was served for payment of rent.

[7] The threshold for the recall of a life sentence prisoner is considerably higher than that for a prisoner with a pre-determined set sentence. An immediate risk of serious harm to others needs to be evidenced; the offender was arrested for the non-violent crime of theft therefore he would not have been recalled to prison for this offence.

3. 37 On 17 February 2015 William Smith contacted the Rents Department to advise them that he was now claiming Job Seekers Allowance and he put in a claim for housing benefit. However, his Probation records show that he did not report that he was made redundant in May 2015 to his probation officer until October 2015. Rent Department records suggest that he was already out of work in February 2015 or being untruthful about being in receipt of Job Seekers Allowance to gain housing benefit.

3. 38 Also on 17 February 2015 William Smith made a self-referral to Family Mosaic for support. The referral form stated "no" to does the customer have any known risk issues. His previous offence of murder in 1993 was disclosed; that he had served 18 years and was released in March 2012, and the fact that he was on licence and still on probation. The name of his offender manager was noted. 'Mental Health' was ticked, but no information stated; this was not discussed in assessment and the sections of the assessment on mental health and substance misuse were both recorded as no support needed. Section 4 of the assessment 'Staying Safe - avoid causing harm to others' no support was noted. The risk assessment section mentions 'anger management and alcohol', but this was not discussed at assessment. There was no evidence to suggest that his offender manager was contacted to discuss risk prior to visiting or to request a risk assessment.

3. 39 Jessica's family suggest that she probably met William Smith when she was staying in a ground floor flat with a friend after her own flat was affected by flood water during the floods of July 2014. They believe William Smith was living in the first floor flat, and suspect that Jessica and her friends would have socialised with him through the network of friends who used drugs and drank alcohol together. However the time at which they met cannot be confirmed.

3. 40 William Smith was allocated a male and female support worker by Family Mosaic on 9 July 2015. He missed his first arranged appointment as he said he had a jobcentre appointment. His first appointment with his male support worker was therefore 27 July when it was noted that he now had electricity as he had settled the debt. William Smith advised his support worker that he no longer needed the support as he had been offered a job 40 hours per week and felt he would be able to address his debts with his increased income.

3. 41 Between 6 July and 24 September 2015 Jessica had self referred to the Improving Access to Psychological Therapies Service. In line with the service policy Jessica was assessed by telephone. However, although contact with her was established on two occasions, she declined further services. During her last contact on the 24 September she said that she was going to return to the Community Mental Health Team.

3. 42 Jessica missed an appointment with a Consultant Psychiatrist on 13 July 2015 which resulted in a Multi-Disciplinary Team discussion and due to her continuing non-engagement and what was assessed as static risk, it was decided to discharge Jessica from the service in line with South Essex Partnership University NHS Foundation Trust (SEPT) Discharge and Transfer Clinical Guidelines. Jessica was informed by letter in accordance with SEPT policy.

3. 43 Jessica's Family Mosaic support worker visited on 29 July 2015 to post correspondence, but found the letter box was secured. It is not known or recorded who secured the letter box or why.

3. 44 On 10 August 2015 William Smith contacted Family Mosaic support once more as he still had a few things to be dealt with; he stated that he could not afford white goods and he asked if a charity could be approached. An application to a charity was explored, but when the support worker tried to arrange a visit via text they received no reply. A voicemail was eventually left by William Smith on 21 August to say he no longer required support. Only one visit took place to William Smith; all other contact was via phone or text. Anecdotal evidence from Jessica's family from information in the local community suggests William Smith sold his white goods to pay off gambling debts. He was known to frequent the betting shop and was seen to kick the machines when he did not win. The Review is unable to substantiate this information, however, following his arrest for Jessica's murder it is recorded that William Smith admitted in interview with his probation officer that he had started gambling (paragraph 3.33).

3. 45 On 3 September 2015 Jessica disclosed to her Family Mosaic support worker that she had a cut lip due to getting in a fight. It is not known with whom or who had inflicted the wound as the support worker did not ask.

3. 46 Of significant concern is a record on 10 September 2015 that Jessica alleged to her support worker that she had a gun in her property. She was not asked why she had a gun. The Police confirm that this was reported to the Police by Family Mosaic and it was judged to be properly assessed. There were insufficient grounds to obtain a search warrant and the intelligence was properly recorded and disseminated. The support worker was told by her manager to contact the council to request staff to contact her prior to any further visits.

3. 47 On 29 September 2015 Jessica contacted the Community Mental Health Team in a very agitated state. The call taker found it difficult to understand her reasons for calling as she was speaking loudly to someone else in the background at the same time. Jessica said that she needed admission as she had thoughts of harming others. Support and advice was attempted to be given on how to re-access services through SEPT Rapid Assessment Interface and Discharge Team (Liaison Psychiatry) based at a nearby hospital and the team were informed of Jessica's call as the Duty Worker was unable to ascertain the details.

3. 48 Family Mosaic records dated 1 October 2015 note that following the gun disclosure by Jessica on 10 September her support worker called 101 and spoke to a call taker who said the report was being dealt with as low priority as it was not an emergency.

3. 49 On 14 October 2015 Jessica reported to the Police that someone had tried to set fire to sand bags and damaged her front door causing £500 worth of damage. Police enquiries implicated Jessica as being responsible. On 15 October Jessica's support worker recorded the incident concerning the scorched property and it was also noted that Jessica had spent all her money on drugs and alcohol and lent people she knew money. She did not want the council to know about the 'firebombing', and she wanted to admit herself to the Mental Health Unit as she felt she needed help.

3. 50 Jessica was voluntarily admitted to a Mental Health Assessment Unit via the Emergency Department on 17 October 2015 where she had been taken by her mother suffering from suicidal thoughts. Jessica had stated that she was no longer able to cope with the numerous social issues she faced, in the main the flooding of her home and the recent death of her dog on 12 October 2015.

3. 51 Following a period of psychiatric assessment Jessica improved and her suicidal thoughts reduced. At this point a decision was made that she was fit to be discharged on 21 October 2015. On discharge Jessica was arrested for arson by the Police and bailed until 23 November to enable further enquires to be made.

3. 52 On 22 October 2015 William Smith had a consultation with a GP and he appears to have given his offending history which is recorded as: *"He was in prisons all over UK from 1993 to 2013 because he killed a woman, his girl friend, with his hand. He was released into probation which used to be weekly then fortnightly & has been monthly for the past 8 months or so".* He informed the GP that his crime took place in London, that he was released into a hostel in Basildon and then moved into a council flat. William Smith reported to the GP that he saw a counsellor the previous year, but he did not want to see the counsellor again. He maintained that he was not suicidal. A patient health questionnaire was completed used to assess the level of a patient's depression and he was prescribed Citalopram and asked to return for review in one month.

3. 53 Jessica was referred from the hospital Mental Health Unit to the Crisis Response and Home Treatment Team with a planned re-referral for on-going support and care. The Home Treatment Team was unable to establish contact with Jessica and therefore an incident alert was raised and at 14:26hrs on 30 October 2015. The Police received a call from the Hospital Mental Health Unit to report that Jessica had failed to attend an outpatient's appointment and they were unable to contact her, nor did her mother know her whereabouts. Numerous checks were made at Jessica's home address, but she could not be traced.

3. 54 On 1 November 2015 Jessica arrived at her parent's home. They confirm that she arrived in a car with a new boyfriend saying that she was going to make a new life in Luton. The new boyfriend was not William Smith.

3. 55 Jessica called the Family Mosaic office on 2 November 2015 to let her support worker know that she would be attending an appointment the next day. She stated during the call that she had had to have her dog put down due to smoke inhalation from when the property was petrol bombed. Her dog had actually died of cancer. The following day Jessica told her support worker that she had been set up with reference to the scorched property, and she knew who by. Her support worker did not ask Jessica what she meant by this. Jessica did not attend an appointment arranged at the jobcentre that day. On the 4 November the cessation of support was discussed with Jessica and she agreed to use the local drop-in facilities.

3. 56 William Smith saw his GP on 4 November 2015 requesting sick leave for 3 months for panic attacks and anxiety. Medication was prescribed and a sick note issued. He next saw his GP on 11 November reporting that he had lost his 'fit' certificate. A duplicate was issued.

3. 57 Late one afternoon on a day in November 2015 Essex Police received a 999 call from a friend of Jessica's reporting that she had come to his address with her boyfriend, the man had locked him out of his flat and he believed that the male had stabbed and hit her with a hammer. It was immediately established that the person responsible was William Smith and a hunt began to trace him. He was arrested in a nearby town the following day and charged with murder.

4. Overview: Summary of information known to agencies

4.1. At the start of his release from prison in 2012 the Prison, Probation, and the Police were the agencies most fully informed about William Smith's past offending history. The Police also knew of his reoffending when he stole from a supermarket, and this was eventually known to Probation when he attended court.

4.2. No one appears to have been invited to the level 2 MAPPA meeting from the Castle Point Housing Department. A housing officer was informed by William Smith himself that he was a 'MAPPA offender', and Probation also record that a probation officer informed Housing of his MAPPA status, but the full reasons why he was managed under MAPPA arrangements was not fully known. The Housing Department were aware that William Smith went into rent arrears on occasions, thus indicating that he was in financial difficulties. Family Mosaic Support Services were also aware that he was struggling financially, although they had little interaction to establish the full extent of his problem.

4.3. The Job Centre was notified about any employment restriction which needed to be applied to William Smith. He also told his GP of his past murder of his partner and his prison sentence, and his GP was informed by MIND of his access to their counselling service, but his visits to his GP were minimal.

4.4. The Police, Housing Department, Family Mosaic and Community and Hospital Mental Health knew Jessica and were aware of her mental health, drug and alcohol problems. However, no agencies knew that she and William Smith knew each other.

About the Victim

4.5. Jessica is described by her family as a very feisty young woman who liked to keep fit. She was tall and very attractive with striking blue eyes. Although physically fit Jessica had suffered from mental ill-health since her teens, and she was diagnosed with bipolar disorder. This often resulted in extreme swings in mood and behaviour, and her family have explained that she could move between being a caring daughter who shared family holidays and everyday activities when she visited them, to being unpredictable, argumentative, or aggressive which she would then appear to have no memory of. Jessica is also described as living in her own world on occasions.

4.6. Jessica's family report that she did not take her medication appropriately; she collected her medication weekly, but would frequently take more tablets per day than prescribed and then run out of her medication early; this usually made her sleepy. In recent years Jessica had started supplementing her medication with alcohol and illicit drugs. Her family state that Jessica appeared to need a block. There were occasions when Jessica accessed services to address her alcohol and substance use, but her family report that she found it difficult to sustain the programme she was offered. Jessica's family felt that she would have benefited from a residential placement.

4.7. There is anecdotal evidence that female friends warned Jessica about William Smith days before she was murdered. They thought there was 'something about him'. What was meant by this is not clear, but it is not unusual for women to sometimes have an instinctive feeling of being uncomfortable around someone, or they may have had information that worried them which Jessica did not. Whether Jessica took any notice of this warning is not known; much would have

depended on her state of mind at the time and how well she was. In mid October 2015 when Jessica entered hospital for treatment she reported that she was not in a relationship. If this was how she viewed her standing with William Smith this may also have contributed to how she viewed her friends warning i.e. she was not in a relationship with him, therefore their warnings were irrelevant.

About the Perpetrator

4.8. Little is known about William Smith's early life, his file for the prison panel did not contain a detailed account of his past, however, there is evidence that he witnessed significant domestic violence and it is reported that his father "drank heavily". His parents separated when he was 8 years old and William Smith struggled to accept his stepfather. In May 2012 during supervision with a colleague of his probation officer he talked about the death of his father and the violence he had witnessed as a child. At his final Parole Board Oral Hearing it is noted that he broke down when talking about his troubled past.

4.9. Information provided from an IMR to the Review shows that during his life prison term for the first murder for which he was sentenced William Smith initially struggled to accept full responsibility for the offence for which he had been sentenced, which is reported to be not uncommon for offenders starting a life sentence. He slowly began to accept the concerns of professionals about the number of attacks on women with whom he had formed an intimate relationship. There were mentions of a referral to a psychiatric prison as psychiatric concerns were listed as one of his original risk factors, however it is unclear why this application was not pursued.

4.10. In 2004 during his time in prison William Smith completed CALM, an aggression control programme, and the post programme report identified that further work was needed to address communication skills (interpreting verbal and non-verbal cues) and insight into his emotional self management. He had a number of moves within the prison estate to enable the courses he was assessed as needing to take place, including a move to a lower category C prison in 2005.

4.11. In a Police statement taken from a man who became friends with William Smith during the 3 years they both lived in the same flats, he described him as someone who kept himself to himself. However, he regularly visited the man who made the statement as he said William Smith did not really have any money and he was always visiting him for a cup of tea and food, and hanging around the man's flat. William Smith would also use the man's mobile phone to make calls; on one occasion he used up all the man's phone credit phoning about his benefits. He said William Smith did not work and never really went out, apart from visiting him, which he did every day. This suggests that William Smith was using the good nature of this man to access food and his phone.

4.12. The man was aware that William Smith had spent time in prison, but he was never told why and he never asked. It was only after Jessica's murder that he was told by someone that he had killed his ex-girlfriend. He told the Police that William Smith started seeing Jessica about 12 to 18 months prior to the fatal incident. He described their relationship as very volatile; they would row on a regular basis. The man had known Jessica for 20 years and was aware of her mental ill-health and substance misuse problems, and the erratic behaviour she sometimes exhibited when she was unwell or under the influence of drugs or alcohol. The man stated that Jessica would sometimes come with male friends to the flats and shout up to William Smith's window "Look at me with my new boyfriend". It is extremely unlikely that Jessica would have known the risk of this action given William Smith's previous behaviour when faced with rejection.

5. Analysis

5.1 This analysis will address the terms of reference for the review and is informed by information within the IMRs, Panel deliberations and the author's analysis of the information gathered during the review process.

5.2 ***Term of Reference 1:*** *To examine the events leading up to the fatal incident and the decisions made from the date of the decision making process to release the perpetrator from prison in 2012. Agencies with relevant background information about the perpetrator prior to 2012 are to provide a chronology and summary of that information.*

5.3 ***Term of Reference 2:*** *Information concerning the victim will be examined from June 2015 when it is believed she met the perpetrator. Background information regarding the victim will inform the Review proportionate to its relevance and importance for learning.*

5.4 These terms of reference have been addressed via the background information and the chronology of events known to agencies. It has emerged during the Review that Jessica may have met the offender earlier than first thought in mid 2014. However, this has not affected the outcome of the Review as no agencies were aware that Jessica and the offender knew one another. Analysis of the decision making process will be included within the following specific terms of reference.

5.5 ***Term of Reference 3:*** *Was the perpetrator subject to Multi-Agency Public Protection Arrangements (MAPPA)? If so:*

a) what plan was in place and how was it to be managed?
b) what risk assessment process took place and was it regularly reviewed?
c) was risk assessment thorough and in line with procedures, and what background history informed the assessment?
d) was the MAPPA fit for purpose?
e) was MAPPA fully supported by partner agencies who actively participated in managing offenders?
f) what flaws if any have been identified in the management of the offender?
g) is there any good practice relating to such cases that the Review should learn from?
h) did all agencies involved with the perpetrator understand the MARAC process?

The Plan:

5.6 The perpetrator William Smith was subject to MAPPA level 2 arrangements following a challenge to the initial level 1 decision just prior to his release from serving 18 years for murdering his previous partner. MAPPA Guidance paragraph 7.9 page 7-2 states "The central question in determining the correct MAPPA level is: "What is the lowest level of case management that provides a defensible Risk Management Plan?" The Review is informed that it is not unusual for offenders of serious crime to leave prison at MAPPA level 1 as they would not have been released if their risk to the public was not judged to be low enough to leave detention. Nevertheless, it was justifiable and right that the Police MAPPA coordinator challenged the level 1 decision in light of her concerns about William Smith's very violent past towards women and it was raised to level 2. The Review Panel also shared the officer's concerns on learning of the perpetrator's past offences.

5.7 At MAPPA level 2 the management of the offender is multi-agency. The Police request for the plan to include monitoring visits was rejected by the Parole Board, however, it has not been possible to ascertain the reason for this decision. It was subsequently suggested that monitoring visits might be an objective set by Probation in William Smith's post release sentence plan and an action was set for a joint visit which took place by a detective sergeant and a probation officer on 11 May 2012 at the Approved Accommodation. The Police questioned whether a Sexual Offender Prevention Order was warranted, but William Smith had been assessed in terms of being a sexual risk to women and it was felt that his offending had been triggered by jealousy and sexual rejection, rather than sexual arousal. Also he had not been convicted of a sexual crime, thus the Order would not have been granted.

5.8 Probation confirmed that the plan as part of his license would be for William Smith to:

- Notify his supervising officer of any emerging intimate relationship with women.
- Reside in Approved Premises and thereafter as directed by his supervising officer.
- Comply with any requirements specified by his supervising officer to address alcohol misuse, offending behaviour and any medical assessments and treatment (counselling, mental health assessments)
- He was to be subject to alcohol and drug testing.
- Probation Service to enter his details on the ViSOR data system*.
- Probation to notify the Jobcentre of any restrictions concerning future employment*.
- Support with housing (via the housing liaison officer) and employment (he worked closely with an employment and training advisor)

*These actions are to comply with MAPPA guidance.

5.9 When William Smith moved to MAPPA level 1 he changed to single agency management by Probation. This involves the sharing of information, but does not require multi-agency meetings. It is not uncommon for offenders to be discussed at level 2 before agencies are satisfied that a multi-agency approach is no longer required. A final MAPPA meeting was held on 18 July 2012 where he was seen to be adjusting well. No agencies raised any concerns. He was adjourned from Essex MAPPA in July 2012 with the option that any agency could refer back for discussion if necessary. He was not referred back. His conviction for theft would not have triggered a re-referral.

5.10 The overall purpose of MAPPA was to oversee the release of William Smith into the community and ensure that agencies, notably the Police, were aware of him and that a ViSOR record was created in case he came to notice in the future. Once he was settled into accommodation, was attending probation supervision regularly, and without further cause for concern, adjournment of the MAPPA was appropriate.

5.11 In line with National Standards in 2012 William Smith was seen weekly as part of his licence by probation officer 1. This frequency lessened in 2013 as he appeared stable. Following his arrest for shop thefts contact was appropriately increased, and he was seen under intensive supervision during October 2013. The gap in recording between November 2013 and April 2014 is very disappointing and represents poor practice. Although the senior probation officer managing the probation officer felt William Smith was probably reporting during this time, the records were not updated. This is very unsatisfactory and it is not reassuring to the public that he was not being seen in line with his licence conditions during this time.

Risk Assessment:

5.12 The Parole Board accepted that William Smith did not pose an imminent risk of serious harm and that there had been no evidence of violence or aggression for many years. The Board considered the reports from the various work and groups he had undertaken and the most recent OASys[8] risk assessment which had predicted his static risk of reconviction within 2 years as low, with a medium risk of serious harm to a known adult if in the community. The risk was deemed manageable with appropriate structured and robust supervision.

5.13 The next risk assessment following William Smith's release was a month later. A community based risk management plan had not been in place and the sentence plan had not been revised from the pre-release assessment completed by William Smith's London Probation Trust officer. However, during this time his life licence conditions were discussed with William Smith and there was weekly activity and supervision around accommodation, benefits, and preparing for employment.

5.14 When William Smith was sentenced to life imprisonment for the murder of his former girlfriend the following risk factors were identified:

- attitudes to women- he had been abusive towards his intimate partners.
- possessiveness- he was known to struggle with rejection in relationships.
- aggression- the offences had involved serious violence, notably injuries to and restriction of the airways.
- psychiatric problems- when he was sentenced in 1994, a psychiatric report did not identify any psychosis or mood disorder. He was considered to have a personality disorder. (It should be noted that personality disorders were not well understood at that time).
- relationship problems
- no responsibility/denial- he did not deny that he caused the death of the victim. He did however maintain that the victim had provoked him and he had been unfairly portrayed at his trial

5.15 The Probation IMR found that over the long period of his custodial sentence these risk factors were not always adequately addressed in formal risk assessments. Over the years the factors which were considered critical at the start of his life sentence became diluted and were not given sufficient consideration necessary as his release approached and following his move to living in the community. This issue has been taken forward as early learning both internally with Essex Probation delivery units, and within the South East Essex division as a whole. This clearly highlights an attendant risk when the offence for which an offender is sentenced is many years in the past and risk assessments at the time of sentencing are not revisited effectively or easily visible on file. Such learning as this should perhaps be disseminated nationally and not just in the area relevant to this Review.

[8] OASys is an offender assessment tool providing a consistent framework to assess an offender's risk of serious harm and likelihood of re-offending.

5.16 Whilst William Smith may have attended courses in prison to address these risk factors and his attitude towards women and relationship, the concepts in the courses would have been abstract. He was living in a male environment with no relationship on which to 'try out' any meaningful change in attitude, or for risk assessment to be fully undertaken as to how he would react in reality to challenge or rejection by a woman in real life. The Probation IMR also expressed concern about how William Smith might react when he perceived that his needs were not being met by any future partner.

5.17 Other behaviour raising concern from his previous offence identified in a Domestic Abuse Risk & Needs Analysis by a prison psychologist included:

- alcohol use,
- poor responses to refusal,
- evidence that he might not manage negative emotions and
- behaviour that demonstrates a lack of concern for others.

Protective factors were:

- ongoing support from his family
- not returning to alcohol use.

Warning signs might include:

- lack of engagement with his supervising officer.
- expressions of concern about a partner's behaviour (as opposed to his own).
- establishing more than one intimate relationship.
- increase in alcohol use.

5.18 Whilst in prison it was also noted that there was a clear discrepancy between William Smith's account of his offences and the official version of events. As a result of these factors further work was undertaken in prison even though this took him beyond his sentence tariff. Work included exploring high risk situations in future relationships. The courses he undertook all ended with positive reports. However, the same observation concerning how one can prove a change in attitudes and behaviour in a relationship when the man is in prison still apply. It is also arguable that if release is dependent on positive reports following course attendance, then there is a strong impetus for the offender to 'talk the talk' in order to achieve those positive reports.

5.19 On his move back into the community an OASys risk assessment assessed William Smith as a medium risk of harm to known adults. A medium risk of harm in this context is classified as there being identifiable indicators of risk of serious harm; there is the potential to cause harm, but it is unlikely to occur unless there is change in circumstances.

5.20 When William Smith reoffended by stealing from shops, the Probation IMR found that the reviewed risk assessment contained some helpful comments about finances and an insight into a degree of possible complacency on his part; he had thought he might get away with the theft. Probation officer 1 had concerns that William Smith was not "telling him the full story", and there were "niggling" doubts that there may be more to the offences than he was disclosing. William Smith subsequently told probation officer 2 when he was visited in prison after the homicide that he had started gambling and had stolen the television to sell to

support his gambling problem. He claimed he was struggling financially, but was reluctant to rely too heavily on his family. The intensive supervision coupled with the support of a mentor was judged to be an appropriate disposal for his theft conviction. Essex Probation completed a request for a recall report even though the recommendation to a senior manager was for an alternative action. As previously mentioned this was not a violent crime and would not have caused him to be recalled to prison, and there was nothing to suggest that the risk of harm to others had increased. After the second shop theft a Probation director issued a final warning.

5.21 The Probation IMR is honest and open in its finding that the supervision of William Smith over time tended to focus more on his employability and financial management than the risk posed to known adults, particularly women. The clear risks identified in the prison psychologist's Domestic Abuse, Risk & Needs Analysis were lost sight of over the years, and the probation officer who supervised William Smith between May 2014 and November 2015 was insufficiently reflective beyond the basics. The IMR author points out that William Smith was a man who had been in prison for 18 years for murdering one partner and inflicting serious harm on others. He had broken down at the Parole Board hearing about his troubled past and he mentioned his father's death and witnessing domestic violence as a child which appears not to have been dealt with. He was noted to be cynical about future relationships, and had re-offended for money knowing the potential consequences for a 'lifer', perhaps indicating a lack of protective factors and reintegration not proving as straightforward as first thought. All these factors plus addressing how he would cope without emotional intimacy in the long term were not adequately addressed. Workload may have had a part to play (see Term of Reference 9), but also it is legitimate to ask about management oversight of the case, especially where staff are at capacity.

5.22 The Local Authority Housing IMR confirms that they do not have a separate risk assessment process for offenders, but there is a policy for Potentially Violent Persons Register.

Was MAPPA fit for Purpose:

5.23 The MAPPA appears to have fulfilled its purpose in overseeing the release and resettlement of William Smith into the community. However, the level 2 meetings appear not to have been fully multi-agency; only Police, Prison and Probation who are the Responsible Authorities under MAPPA Guidance are noted to be include in the meetings in their IMRs. The Local Authority was not represented in respect of housing, a key part of any resettlement, and Family Mosaic for tenant support services confirm they were not involved during the MAPPA process. William Smith's offending history required greater consideration and sensitivity concerning where he should be accommodated, bearing in mind his risk to women.

5.24 MAPPA Guidance lists those agencies who are Duty to Cooperate Agencies[9] which includes the Local Housing Authority, Registered social landlords providing or managing residential accommodation in which MAPPA offenders may reside, and Health sector agencies among others. If level 2 management of offenders is to be truly multi-agency and coordinated, then greater consideration is necessary to include relevant agencies when discussing and tailoring the plans to meet the requirements of each offender.

5.25 MAPPA coordination must include a record of changes in an offender's accommodation, and any new area's Housing Department or suitable Local Authority representative should be invited to MAPPA meeting.

Was MAPPA Fully Supported by Partner Agencies:

5.26 For those in attendance in 2012 there is evidence that MAPPA was supported by the Responsible Authority Agencies. Participating partners accepted the concerns of the MAPPA coordinator regarding the initial level 1 decision, and it was amended as a consequence. This demonstrated consideration of others views and a willingness to reconsider a decision based on a partner agency's concerns.

What Flaws were Identified in the Management of the Offender:

5.27 The main flaws were in losing sight of the original risk assessment after the offender's sentence for the murder of his former girlfriend, and the risk factors identified by the prison psychologist through the Domestic Abuse Risk & Needs Analysis.

5.28 Information flow between Housing, Tenant Support, and Probation was not very effective, and the Police did not inform Probation of the offenders arrest for theft in a prompt manner.

5.29 The understanding of MAPPA and what life licence means was not as good as it needed to be in non-criminal justice agencies such as Housing for example. It was noted that GP's have some basic awareness of MAPPA within safeguarding training, but it would not necessarily enable them to discuss relevant risks with a patient, and in this case William Smith's GP had no communication with his probation officer or knew who this was.

5.30 There is further discussion on this aspect of the terms of reference in the conclusions and lessons learnt section.

Any Good Practice the Review should Learn From:

5.31 IMRs were asked to identify good practice in relation to the management of offenders and MAPPA, however none was identified. Agencies are reminded that MAPPA guidance sets out good practice along with the roles of all partner agencies, and it is recommended that agencies refresh their knowledge of this guidance.

Knowledge of MARAC Process:

5.32 All agencies involved with the perpetrator have knowledge of MARAC, however, there was no occasion when agencies were aware of any necessity to refer in this case.

5.33 Section 22 of MAPPA Guidance sets out the link between and cross working between MARAC and MAPPA, but in this case there was no opportunity for this to take place as there were no reported incidents involving William Smith. There is a debate to be had about whether MAPPA offenders who have killed a partner or former partner should be automatically flagged on MARAC and agency systems so that if they come to notice as the partner of a new victim, who may not necessarily be judged high enough risk to be referred to MARAC, a MARAC referral would automatically be triggered in such cases. There is also the view that an agency would already refer to MARAC if a MAPPA offender started a new relationship making an automatic notification unnecessary. The latter point is contingent on individual recognition that a MARAC referral is needed and it is made.

[9]The Duty to Cooperate (DTC) agencies are listed in section 325(6) of the Criminal Justice Act 2003 are listed in MAPPA Guidance Section 3 page paragraph 3.5 page 3-1.

5.34 ***Term of Reference 4:*** *Was communication and information sharing between agencies or within agencies adequate and timely and in line with policies and procedures?*

5.35 Communication at pre-release and immediately after release was between the Prison, Police and Probation instigated through the MAPPA and the post release plan was effective. However, as mentioned previously Housing do not appear to have been invited to the MAPPA 2 meetings. Probation shared information with the Police concerning William Smith's change of address when he moved from Approved Accommodation in August 2012, and this appears to be the last direct contact between these two services. Despite the fact that William Smith was a ViSOR nominal, and the contact details for his Probation office were added to his "intelligence nominal" by the Police if he came to notice, Probation were not informed at the time of his arrest for theft on two occasions. This information came to the probation officer from the court. Whilst the Probation IMR judged that whilst the offence would not have altered the risk management decisions that were taken when he re-offended, discussion could have taken place with him much sooner. It suggests that the relevant database was not checked when he was arrested. Although he was no longer managed under MAPPA at the time of the thefts, his arrest should have been passed more promptly to his probation officer to trigger a timely reassessment in line with expected practice.

5.36 William Smith's probation officer 2 referred him to MIND for counselling, but the Probation IMR judged this to be a missed opportunity to liaise with the counsellor, and in interview the probation officer agreed that gaining consent to contact MIND would have been helpful. Probation officer 2's manager confirmed in interview that the officer was generally good at inter-agency liaison, however, the IMR author felt that at this time the focus was on employability and budgeting and his probation officer was not overly concerned with his emotional wellbeing.

5.37 The Council's Housing Department IMR found the information sharing between the Council and the Probation Service after William Smith made a housing enquiry was appropriate after contact was established with the Team. Probation had their own housing liaison officer whose role was to assist offenders to find accommodation. William Smith's probation officer contacted their housing liaison officer on 4 April 2012 and it is confirmed that the housing liaison officer would have had access to William Smith's risk assessment, it was also confirm that there was liaison between them and a housing officer who was informed that William Smith was a MAPPA level 2 offender. However, the Housing Department felt that given the length of time that William Smith was at the bail hostel information provided to the Council was patchy and was not provided in a coherent form by the Probation Service. The IMR found that the information given did not affect the level of service given to William Smith or the appropriateness of the accommodation which was offered. The risk he posed to women was not considered when allocating housing, however, given the acute shortage of available housing in the area it would have been extremely difficult to house him away from women. Nevertheless, had this risk factor been known local agencies involved in housing and tenancy support may have kept a watching brief on him and his female neighbours.

5.38 An internal gap in information sharing was identified when William Smith was allocated a secure tenancy in the Borough, as the two housing teams he dealt with, one for temporary housing and then moving on to Tenancy Services for secure tenancy accommodation, used different information systems at that time. Details regarding his MAPPA status, and any details or conditions regarding Probation were not passed to Tenancy Services. A single data recording system has now been introduced to facilitate both departments having access to the same information.

5.39 During interviews for the Housing Department IMR the author discerned an attitude by the referral receiving housing officer that William Smith had served his sentence and his MAPPA status did not need to be passed on, as he was making a fresh start. This was a very misguided attitude. The information was important to the department which would be managing his long term tenancy and for understanding the need to liaise with Probation should the need arise; which it did when William Smith went into rent arrears and at one stage was at risk of having his flat repossessed. This information was not passed to Probation; it could have shown that all was not going smoothly in his life as was often thought. The lack of detailed information to Housing staff also mean there could be no risk assessment concerning where he should be accommodated or whether allocating a female housing officer should be avoided.

5.40 Had other agencies, for example Housing and Family Mosaic, had more detail about William Smith's offending history they may have raised concerns about him being accommodated where vulnerable women lived. Although the Review Panel are aware that Castle Point as a local authority has the lowest percentage of social housing of total housing stock[10] and are therefore very limited in where they can place tenants, William Smith had close neighbours who were vulnerable women who could equally have been at risk if he had started a relationship with them.

5.41 When William Smith referred himself to Family Mosaic for support, he informed the staff member taking his referral that he had a probation officer. However, the Family Mosaic IMR author found that the staff member had failed to liaise with Probation. Again the support provided by Family Mosaic would have indicated that he was under financial strain and not managing this aspect of his life. This flaw in Family Mosaic's process was identified as early learning during their IMR and they have since discussed the issues arising in their 'learning circle' meetings. The lack of contact with Probation was found to be an individual failing on the part of the staff member who is no longer in the organisation. Nevertheless, there has been a system change to ensure that Probation are called as routine where relevant in future. Any referral with links to Probation will be further investigated by the Gateway Coordinator prior to assessment for service. Family Mosaic confirm adequate and timely communication took place between themselves and Castle Point Housing Department.

5.42 Some clinical information was shared with William Smith's GP by his MIND counsellor in September 2014, to inform the doctor that he may be suffering from depression and suggesting that an assessment for depression might help. It was at the end of October 2015 that William Smith saw his GP regarding depression, disclosed that he had been in prison for killing his girlfriend, and that he was seeing his probation officer monthly at that time. The GP IMR found that that consultation focussed on his health presentation. A patient Health Questionnaire PHQ-9 was completed; William Smith said he was not suicidal, but no further exploration took place to assess risk to others. This is understandable as the PHQ-9 questionnaire widely used in general practice does not prompt enquiry into risk to others, or indeed ask about domestic abuse. Further exploration of this consultation was not possible as the GP had retired and the practice had closed by the time of the Review. However, the IMR author highlights the fact that there is no template to use, or training in place, that would assist a practitioner to ask more probing questions of a patient who has declared that they have killed a person. Indeed, for most practitioners such a scenario would be a rare clinical experience. The GP had no knowledge of, or contact details for, William Smith's probation officer and would therefore not known who to share any concerns with had that been the case.

[10] ons.gov.uk accessed 9.11.16

5.43 There is evidence of good information sharing by Jessica's care coordinator when she was still with the Community Mental Health Team, but Jessica was not responding to attempts to contact her. Contact was made with Jessica's mother and her Family Mosaic support worker, and her dual diagnosis worker in efforts to contact her to find the best way of providing support and treatment. There was also good liaison and referral between the Mental Health Multi-Disciplinary Team and mental health services in the community. The Crisis and Home Treatment Team acted in line with their policies when they contacted the Police to undertake a welfare check on Jessica when they were concerned about her and unable to achieve contact. Luton's mental health services were also contacted as a precaution when it was thought that Jessica may have relocated there.

5.44 ***Term of Reference 5:*** *Why did the breach of the perpetrator's 12 month Conditional Discharge in 2013 not result in action by the criminal justice system?*

5.45 The Review was advised by National Probation that any action relating to the breach of William Smith's Conditional Discharge in 2013 would be a matter for the court. Where an offender appears in court for an offence which places them in breach of a Conditional Discharge, the court has the discretion to make no separate penalty and this is commonly the case. William Smith was given a final warning and it was an additional condition that required him to attend and receive additional supervision from the Bridge Project following this court appearance in addition to continued supervision by Probation.

5.46 ***Term of Reference 6:*** *Did any agencies or professionals have concerns that they felt were not taken sufficiently seriously?*

5.47 There is no evidence to suggest that professional's concerns about William Smith where they were raised were not taken seriously. The only concerns which appear to have been raised were those by the Police officer when the perpetrator was first assessed as MAPPA level 1 prior to release. The officer appropriately highlighted her legitimate concerns about this level given his offending history, and as a consequence the level was changed to MAPPA level 2, albeit briefly before being moved back to level 1.

5.48 Although not strictly relevant to the DHR the Panel expressed concerns around the issue of Jessica reporting to her Family Mosaic support worker that she had a gun in her flat and the outcome of that report. Equally the support worker was also concerned about the Police response to her call to report the disclosure. The Police report that they get many such calls and have to deal with them according to risk, but reports will inform intelligence. The person that the support worker spoke to said not to tell the Council about the gun as there was no evidence it existed as it had not been seen. Although the gun had not been sighted it was nevertheless decided to tell the Council as Family Mosaic was aware that they may need to visit the property. It was queried why the support worker did not probe Jessica further about the alleged gun. Her support worker was very experienced and knew Jessica well, she could be unpredictable and volatile on occasions depending on her mental state and the support worker judged it was not safe to press Jessica further in case there was a gun and it might be loaded. Therefore, reporting to the Police was the correct step to take. No further information about the existence of the weapon has come to light during the Review.

5.49 ***Term of Reference 7:*** *Did any agency have an opportunity to inform the victim of the perpetrator's offending history? If so what risk assessment took place?*

5.50 Unfortunately, no agency was aware that Jessica knew the perpetrator, therefore there was no opportunity to inform her of his offending history. As a consequence no risk assessment could be undertaken. There is no evidence to suggest that Jessica herself knew of William Smith's background. It is not possible to speculate whether Jessica knew of the Domestic Violence Disclosure Scheme[11] known as Clare's Law whereby she could have requested information from the Police about his previous history of abuse. Jessica had been a victim of domestic abuse in the past and had involved the Police, she could be assertive when necessary, and there is no reason to suppose that had she known of the Disclosure Scheme that she would not have used it. However, it is doubtful that she saw her contact with William Smith as an 'intimate relationship'.

5.51 The Family Mosaic support worker involved with Jessica during 2015 was experienced and trained in the Protection of Vulnerable Adults and would have been aware of the signs of domestic abuse and the organisation's policy and risk assessment for domestic abuse. Although Jessica had complex needs she was not identified as a victim of domestic abuse, nor did she say anything which would have made her support worker aware that she knew William Smith.

5.52 However, it should be noted that William Smith was supposed to notify his probation officer of any developing relationships as part of his licence supervision. This he failed to do. There also appears to have been no regular discussion about this aspect of his life during his supervision.

5.53 ***Term of Reference 8:*** *To examine whether there were any equality and diversity issues or other barriers to the victim seeking help?*

5.54 Jessica's diagnosis of Bi-polar disorder means she could be identified as having an impairment under the definition of disabled under paragraph A5[12] of the Equality Act 2010 Guidance. However, whether any impairment could be said to have 'adverse effects which are substantial' (see Section B), or the substantial .l adverse effects were long-term (see Section C); and the long-term substantial adverse effects were effects on normal day-to-day activities (see Section D) it is not possible to say. She had been in receipt of support for her mental health condition for some time, and there are no indications that agencies did not take this into account when delivering services to her; all were aware of her vulnerabilities due to her mental illness and substance misuse.

5.55 Jessica had taken action to seek help when she was in a position of mental distress due to her mental illness, and she accepted help from her Family Mosaic support worker and her dual diagnosis support worker for periods of time. This indicates that she could and would accept help at times. Sadly, the main barrier to accepting sustained help and support, despite the best efforts and long term support of her family, appears to have been a combination of her mental illness and periods of substance misuse. These two conditions made Jessica difficult to help and very vulnerable. In addition the fact that Jessica was judged to have mental capacity meant that help and support could not be enforced even when she was at risk.

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[11] The Domestic Violence Disclosure Scheme was implemented on 8 March 2014

[12] Equality Act 2010 Guidance. '*Guidance on matters to be taken into account in determining questions relating to the definition of disability'. Paragraph A5 pages 8/9*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/85038/disability-definition.pdf Accessed 1.10.16

5.56 The GP IMR found that there was one identifiable time during a GP appointment on 1 December 2014 when Jessica could have been offered an opportunity to discuss possible issues of abuse against her as she stated to her GP that “she had problems at home”. Although it is not clear when Jessica met William Smith she may have known him by this time, however Jessica's disclosure did not result in any further exploration of what those 'problems' may have been. GPs are a universal service and they are often the professional a victim of domestic abuse will approach[13], and yet GPs are frequently unsure how to respond. Jessica was a fairly regular attended at her GP practice and had she been asked what her problems at home were she may have explained further. It is recognised that appointments are time limited, but signposting to specialist services is a practical option when accompanied by suitable information.

5.57 As cited in the GP IMR, when Health practitioners are appropriately trained and knowledgeable about domestic abuse they are more proactive in offering effective care and support[14]. The Joint Commissioning Strategy for Domestic Abuse 2015-20 for Essex, Thurrock and Southend page 11 recognises there is a need for domestic abuse awareness prioritising staff that are "most likely to come into contact with victims of domestic abuse". Domestic abuse is currently part of safeguarding training which naturally limits the time and depth of the domestic abuse component. Domestic abuse training is not mandatory, and although some training may contain how to support perpetrators it is not currently routine. A greater understanding of perpetrators and the risks they pose should be addressed if the risk to victims is to be holistically managed.

5.58 It is very doubtful that Jessica would have recognised that she might need to seek help with regards to her relationship with the perpetrator as she probably did not view it as a 'relationship' at all.

5.59 ***Term of Reference 9:*** *Are there any systems or ways of operating that can be improved to prevent such loss of life in future, and were there any resource issues which affected agencies ability to provide services in line with procedures and best practice.*

5.60 Probation relies to a significant extent on offender self-report, particularly in respect of new relationships. The Probation Serious Further Offence review highlighted the need for Probation to have been inquisitive about relationships for offenders, and in the practice of William Smith in particular. The Probation Review noted however, that if an offender is determined to withhold information then the scope for effective intervention is limited. Whilst this is true to an extent, the active liaison and coordination of information from community based organisations and practitioners could be utilised to provide valuable corroboration and intelligence to confirm or contradict self reports to assist the management of risk. To rely on self report from offenders with William Smith's history, especially about any relationships with women, is insupportable.

5.61 Housing received no invitation to the MAPPA level 2 meeting which is meant to be multi-agency. Given the importance of housing and the placing of ex-offenders in the community representation from the Local Authority is key. A different system of operating the Local Authority representation would be more effective if the community safety manager were to attend on their behalf. This role has an holistic overview of issues to be considered, and knowledge of the local area, including of housing needs. The resettlement of MAPPA offenders is a community safety issue and would logically sit with this role which traditionally works on a multi-agency basis.

[13] Domestic violence: a health care issue? British Medical Association 1998

[14] Ramsay, J. (2012) et al Domestic violence: knowledge, attitudes, and clinical practice of selected UK primary healthcare clinicians. British Journal of General Practice. Available through: http://bjgp.org/content/62/602/e647 [Accessed 10 July 2016]

5.62 There were resource issues within Probation during the time under review, notably in the period leading up to the fatal incident. In June 2015 the National Probation Service had split into Probation Trusts and the Community Rehabilitation Company (CRC). Probation officer 1 was reassigned to CRC and probation officer 2 took over the management of William Smith. There were workload issues for probation officer 2 and the local delivery unit in general. The workload measurement tool showed that probation officer 2 was significantly over capacity. Some remedial action was taken with the appointment of temporary staff and report writers. William Smith was presenting as settled and stable, at the time the scope for more reflective inquisitive practice had reduced due to officer's workload. The IMR reports that workload at the Probation office remains high due to staff sickness. The local Senior Probation Officer anticipates that the office will be up to full complement shortly.

5.63 ***Term of Reference 10:*** *The chair will be responsible for making contact with family members to invite their contribution to the Review, to keep them informed of progress, and to share the Review's outcome.*

5.64 The chair has fulfilled this responsibility and would like to express her sincere thanks to Jessica's family for their time and their significant contribution to this Review.

Good Practice Identified

5.65 On checking the MAPPA meeting minutes on returning from leave, the officer who was MAPPA coordinator at the time, judged William Smith's previous offending history and violence towards women to warrant a higher level of management plan. She therefore successfully challenged the initial judgement and the MAPPA level was changed. This was an astute judgement and demonstrated professional confidence to challenge other professionals' decisions.

5.66 The Mental Health Trust liaised with Jessica's mother concerning Jessica's wellbeing. In the author's experience this is not universal practice, and carer's are frequently left uninformed and unsupported. This demonstrates good practice which should be routine with all families.

6. Conclusions

6.1 The Police were right in 2012 to raise concerns about the MAPPA level William Smith was to be subject to on his release from prison. In interview for the Police IMR the officer who challenged the decision said she was concerned that William Smith had never been in the community for any length of time without committing violent attacks on women and considered him a serious risk. This was an astute assessment. As one IMR commented, whilst he may have impressed the Parole Board with his behaviour in prison, and he may not have raised concerns whilst in Approved Accommodation on release, there was no real assessment and monitoring of how he would react when he had a relationship with a woman and whether his previous jealousy and violence would return. It is also worth comment that there is a significant difference between assessing the behaviour of an offender like William Smith in the controlled environment of prison and Approved Accommodation which are male environments, and gaining a meaningful assessment of his interactions with women.

6.2 The Probation supervision lost sight of William Smith's serious past offending history of violence to women, and the nature of that violence. His was a pattern of conduct which escalated over time, triggers for which were clearly identified in the assessment after his sentence for his first murder and by the prison psychologist's assessment. If there has been previous domestic abuse risk rises, as prior domestic abuse is the highest risk behaviour for predicting future homicide[15]. William Smith had already committed a domestic abuse murder thus his risk was undoubtedly higher still; he was also said to be intolerant of rejection by women. Men who are unable to deal with rejection, or who feel powerless without control, have status issues or sociopathic or psychopathic traits, and are more likely to be the most dangerous kind of abusers[16].

6.3 Perhaps the earlier assessments were not readily visible on William Smith's file, but even if this was the case the nature and the specific victims of his previous crimes, and the fact that he had to report relationships with women, should have heightened awareness of risk and a professional curiosity to investigate further. Instead the focus became matters such as employment and finances. In common with a finding by a Joint Inspection by HMI Probation and HMI Prisons there was an insufficient focus on victims' issues[17]. This does not mean that employment and finances are not important, indeed they can be life stressors which can impact on an offender's ability to integrate into a regular law abiding life. Financial difficulties can impact on levels of stress and sometimes control of aggression, as well putting accommodation at risk. Nevertheless, there should have been a greater concentration on recognising his triggers and risk to others as well as challenging and checking his progress and information provided by him in supervision.

6.4 William Smith's history means he should have been more closely supervised and checked up on to corroborate what he was reporting and what he was not. He failed to tell his probation officer about relationships, about his arrests for theft, and that he had been made redundant at the time he lost his job rather than months later. His failure to report the arrests should have been a flag to monitor him more closely. Housing did not appear to have the continuing links with his probation officer following his secure tenancy in order to report his rent arrears and threatened repossession of his flat. This third party information could have been valuable to his probation officer, but it appears that with the end of MAPPA level 2 meaningful inter-agency coordination also ended.

6.5 The agencies working in the community who had contact with William Smith appeared not have full details of the risk he posed to women. This formed a barrier to engendering a sense of professional curiosity about him, the circle of people who lived in the same flats, and those who were known to visit the accommodation. The value of support staff who know the people and the issues in a neighbourhood well is under appreciated and could have been a helpful resource for the Probation service tasked with supervising William Smith.

[15] Monkton Smith J, Williams A, Mullane F (2014) *Domestic Abuse, Homicide and Gender*. Palgrave Macmillian. Hampshire

[16] Websdale 2010, Brown et al 2010 cited in ibid

[17] *A Joint Inspection of Life Sentence Prisoners 2013* paragraph 5.5 page 46. A Joint Inspection by HMI Probation and HMI Prisons

6.6 William Smith consistently maintained that he did not feel able to form an intimate relationship because of his life licence. He did not disclose a relationship with anyone, including Jessica. Is it possible that by explicitly including the notification of emerging relationships into his licence that this acted as a perverse incentive to openness and the ability to bring to supervision any relationships or issues with women he may have had. Could this have created an unintentional barrier which increased risk to women?

6.7 William Smith's previous extremely violent behaviour to women, suggests he not only had an inability to accept when a woman said 'no' or ended the relationship, but that he also wanted to control them. Sadly, Jessica's mental illness and other problems meant that she very vulnerable, and her Bipolar condition meant she could sometimes be disinhibited and unpredictable; she was not a young woman who could be controlled. The fact that she also appears to have publicly rejected William Smith as his neighbour reported by calling out to him that she had a new boyfriend, unwittingly put her at severely high risk which ultimately proved fatal. Jessica would have been totally unaware of this. Had agencies been aware that Jessica was in his social circle and had a very brief relationship with him, then the risk of serious harm to her may have been predicted.

6.8 Whilst research reveals that "The vast majority of life sentence prisoners are successfully integrated back into the community, with only 2.2% of those sentenced to a mandatory life sentence and 4.8% of those serving other life sentences reoffending in any way, compared to 46.9% of the overall prison population"[18], this does not minimise the terrible trauma caused to families such as Jessica's when one of this small cohort does commit a further serious crime. Whether William Smith could have been prevented from murdering again is a difficult judgement. We know from research that those experiencing mental ill-health are particularly vulnerable to domestic abuse, with women at higher risk than men.[19] Jessica's mental ill-health put her at such a heightened risk, but she was not the only vulnerable woman in the vicinity. There were women living in the same block of flats who could also have been at risk if William Smith had started a relationship with them, and at very high risk if they had rejected him. Therefore, one could surmise that it would only have been a matter of time before he injured or killed another woman again. Monitoring arrangements of a man with William Smith's history were wholly inadequate; his violent history towards women seems to have been forgotten over time. Greater attention should have been paid to closely monitoring him, probing his relationships, and using local knowledge and intelligence to enhance risk assessments and to seek corroboration of the self-report information he gave during supervision sessions.

[18] (25 July 2013), Table 19a, 'Adult proven re-offending data, by custodial sentence length, 2000, 2002 to September 2011', Proven re-offending tables- October 2010 to September 2011 , Ministry of Justice, London, https://www.gov.uk/government/publications/proven-re-offending-statistics-october-2010-to September-2011 cited in *A Joint Inspection of Life Sentence Prisoners 2013* page 6 A Joint Inspection by HMI Probation and HMI Prisons http://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2014/04/Life-sentence-prisoners.pdf (accessed 4/11/16)

[19] Trefillion K, Oram S, Feder G, Howard LM (2012) *Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis.(page 9)* PLoS ONE 7(12) :Es1740.doi:10.1371 /journal.pone.0051740 accessed 20.02.2012

Lessons Learnt

Management of the Offender

6.9 The lessons from this Review are primarily to be drawn concerning the management of the perpetrator. The victim Jessica, was a vulnerable young woman who had her challenges due to her mental ill-health. She was truly an innocent victim unaware that her sometimes unpredictable actions, which most reasonable men would ignore, would be lighting the touch paper of William Smith's intolerance of rejection by women and would unleash such terrible violence by a man who took no responsibility for his actions. Even at his trial, in the face of irrefutable evidence he pleaded not guilty and tried to blame an innocent neighbour for the crime. His history of escalating violence from a young age, and the lack of early learning and change from his two previous non-fatal but very violent crimes, continuing until he murdered, not once, but twice, suggests that similar domestic violence offenders need to be managed more thoroughly.

6.10 There is a need to include on file the original risk factors identified after sentencing and any other relevant assessments highlighting risks, triggers, and warning signs as identified in the Domestic Abuse Risk and Needs Assessment carried out in prison. These assessments should be flagged and easily found and read by those supervising an offender.

6.11 Offender records need to be kept up to date and a chronology should be completed on long term prisoners to assist in the holistic understanding of the case and the potential risks. Long term life licence offenders are highly likely to have more than one probation officer and a chronology will greatly assist the effective transfer of cases and ongoing risk assessments.

6.12 There were no Probation home visits recorded to the perpetrator following the joint visit with a housing officer in July 2012 when he moved into independent accommodation. Therefore there was no corroboration of William Smith's reports that he was not in a relationship which an unannounced home visit may have revealed, in addition to other aspects of his life and how he was living.

6.13 There are occasions when a supervising probation officer will be away on leave or due to sickness, and in the management of life licence offenders there will inevitably be a change in supervising officer. This may lead to inconsistencies in management or focus due to unfamiliarity with the offender's case. As this case shows losing sight of original risk factors, or those identified in prison assessments, can significantly impinge on the future effective management of risk. The introduction of a chronology of key events and risk factor assessment history will assist in the visibility of key information to reduce this. However, the chronology must *be* easily visible, and practitioners must access this chronology and record that they have done so.

6.14 A review of the management of life licence offenders "considered that ensuring quality of input by offender managers and maintaining this consistency of approach was far more important than ensuring that the same person maintained the supervisory link with the offender",[20] thus quality of management and consistency of message to any offender by an offender manager about what is required of them, what is acceptable, and what is not, is more important. To successfully achieve this it is incumbent on anyone seeing an offender to read records and be clear what is expected of an offender before supervising them. This requires a whole team system approach, and gives the whole team responsibility for the management of life licence offenders.

[20] *A Joint Inspection of Life Sentence Prisoners 2013* paragraph 5.1 page 45. A Joint Inspection by HMI Probation and HMI Prisons

MAPPA

6.15 MAPPA level 2 meetings need to be truly multi-agency with representation from the local authority and any other Duty to Cooperate Agencies, such as Health who are relevant to the offender's case. A local authority representative such as the community safety manager role would provide information to the MAPPA or relevant department personnel, in addition to bringing an overview of the authority's services and the local community safety issues to consider in the area.

Information Sharing

6.16 There is a need for greater information sharing between Probation and other agencies in the community with regard to those on life licence for serious crime. The Review recognises the resource pressures on Probation staff, therefore closer working with those agencies based in the communities where their offenders live is essential. Outside of MAPPA arrangements agencies can share information in prevention of crime under the Crime and Disorder Act 1998. Service providers outside the statutory sector could have formal information sharing and confidentiality agreements. Information on ViSOR also needs to be accessed promptly to ensure that probation officers are notified of an offender's arrest as soon as possible rather than waiting for a court appearance.

6.17 Any information sharing with the perpetrator's GP was absent. Whilst it will undoubtedly be a rare event in a GPs career to have a life licence offender disclose that they have killed a former girlfriend, the fact that the perpetrator was consulting his GP with a mental health problem could have been disclosed to his probation officer to assist in his supervision had the GP known who to contact. Offenders do sign consent forms for disclosure, thus having such conditions as mental ill-health which may increase risk reported to Probation could strengthen risk assessments.

Housing Location

6.18 Whilst recognising the acute shortage of social housing in the Borough, greater consideration of the risk factors associated with an offender and their licence conditions needs to be taken into account when allocating housing. William Smith was living in flats where women, some of whom were vulnerable, were also living and near neighbours, this heighten risk to them.

Domestic Abuse and Support Awareness

6.19 Jessica was a regular visitor to her GP. She had previously been a victim of domestic abuse, and on her last visit she said she had 'problems at home', and yet no exploration of this statement took place. Health practitioners need a greater understanding of domestic abuse, both in relation to victims and perpetrators. They need to know the services to whom they can be referred, and to refer patients appropriately who are assessed as a risk to others due to their current health presentations, or who have thoughts of violence to others. A greater understanding of domestic abuse and of perpetrators and the risks they may pose to victims, can only increase the confidence of Health professionals when confronted with patients who disclose current or previous domestic abuse, provided they are given the necessary information about resources and agencies to whom they can refer.

6.20 Although there is no way of knowing whether Jessica would have sought information about William Smith's background from the Police using the Domestic Violence Disclosure Scheme known as Clare's Law, the Panel felt greater awareness of this legislation would be helpful. Jessica had had Police support previously concerning domestic abuse incidents, and she did access services when she needed. Had she or her friends who tried to warn her about William Smith known of Clare's Law they may have used this facility.

Recommendations

6.21 The following recommendations have arisen from agency IMRs, Panel discussion, and lessons learnt during the Review. They have also been influenced by discussions with Jessica's family.

County Level:

Multi-Agency Public Protection Arrangements (MAPPA)

Recommendation 1:
MAPPA level 2 meetings should be truly multi-agency with representation from the Local Authority and any other 'Duty to Cooperate Agencies', such as Health and Housing who are relevant to the offender's case and where the offender is to be accommodated after leaving Approved Accommodation.

National Probation National Probation Service Essex

Recommendation 2:
Offender records must be kept up to date and an easily visible chronology on the file should be completed on long term prisoners which includes original risk factors identified after sentencing, any assessments highlighting risks, triggers, and warning signs identified in prison, and any key events, to ensure that those supervising life licence offenders are assisted in the ongoing assessment of risk and the effective transfer of cases between practitioners.

Recommendation 3:
To ensure that regular home visits are undertaken a minimum of six monthly and within two weeks following a move in accommodation and 6 monthly lifer licence reports must include documentation of the home visit.

Recommendation 4:
To ensure that the learning from the Review is disseminated to staff and a process to embed learning concerning the management of life licence offenders in practice and management supervision is achieved.

Recommendation 5:
The Probation Service as a lead agency should ensure that all relevant 'Duty to Cooperate'[21] agencies relevant to the offender's case are invited to MAPPA level 2 and included on the MAPPA referral. This should include relevant agencies from the area to which the offender will move on leaving Approved Accommodation.

[21] Duty to Cooperate Agencies - Youth Offending Teams, Jobcentre Plus, The local education authority, The local housing authority, The Health Authority or Strategic Health Authority, The Primary Care Trust or Local Health Board, The NHS Trust, Electronic Monitoring ("EM") providers, UK Border Agency. *MAPPA Guidance 2012 Version 4*, page 3-3

Local Level:

Castle Point Borough Council Housing Department

Recommendation 6:
Whilst recognising the acute shortage of social housing in the Borough, greater consideration should be given to the risk factors associated with an (ex) offender, and their licence conditions should be taken into account when allocating and managing housing to ensure the safety of existing tenants and any vulnerable adults. *Home Office feedback suggested this recommendation could have national resonance, therefore steps will be taken to disseminate this recommendation and learning nationally.*

Recommendation 7:
Housing Department staff should ensure that, in line the Council's expectations, details regarding a tenant's MAPPA status, licence conditions, and supervising probation officer's details are entered on to the data system to be shared appropriately across relevant Council departments in order to tailor services to the offender and ensure effective liaison with Probation.

Recommendation 8:
It is recommended that the Local Authority review its MAPPA representation and consider making MAPPA attendance part of the community safety manager role with the community safety officer as deputy in their absence.

Recommendation 9:
All relevant staff whose role involves the receipt of housing enquiries, and allocation and management of tenancies, should receive training to understand the implications of MAPPA, life licence supervision, and the importance of liaison with Probation.

Essex Police

Recommendation 10:
There should be a review of the system for alerting the Probation Service of an offender's arrest, including access and use of ViSOR, to ensure that the offender manager is alerted as soon as possible.

Clinical Commissioning Groups

Recommendation 11:
Training programmes for Health practitioners should include awareness and knowledge of domestic abuse and coercive control with the aim of achieving professional confidence to support their care of those experiencing or perpetrating domestic violence or abuse.

Recommendation 12:
Health practitioners should be given information to support their current practice that includes learning from this Review and how to access support and services for their patients that are experiencing or perpetrating domestic violence or abuse.

Southend, Essex and Thurrock Domestic Abuse Board

Recommendation 13:
The existence of the Domestic Violence Disclosure Scheme known as 'Clare's Law' which gives members of the public a ‘right to ask’ the Police for information where they have concerns that their partner may pose a risk to them, or where a member of their family or a friend have such concerns, should be given wider publicity.

Home Office

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Councillor Godfrey Isaacs
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Castle Point Borough Council
Council Offices
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27 July 2017

Dear Councillor Isaacs,

Thank you for submitting the Domestic Homicide Review report for Castle Point and Rochford to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 20 June 2017.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this was a good, sensitively framed, probing review which identifies useful lessons which have been clearly drawn out and evidence based. The Panel particularly commended the chair for fully involving the family in the review from the start and throughout, including inviting them to attend the review panel meeting at which the final draft report was discussed. This is excellent practice and is underlined by the resulting high quality report.

There were, however, some aspects of the report which the Panel felt may benefit from being revised which you will wish to consider:

- It would be helpful if the term "risk rises" in paragraph 6.2 could be clarified;
- You may wish to review the narrative in paragraph 6.7 to satisfy yourselves that it could not be perceived as victim-blaming;

- You may wish to consider whether any of the recommendations have a national resonance, e.g. recommendation 6;

- Please proof read the full report as there are a number of typing errors.

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to your PCC for information.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel