# SAFER BROMLEY PARTNERSHIP

# DOMESTIC HOMICIDE REVIEW

# OVERVIEW REPORT

# ‘ALICE’ AGED 61

# MURDERED IN JULY 2019 IN BROMLEY


## REVIEW PANEL CHAIR AND AUTHOR
## BILL GRIFFITHS CBE BEM QPM


## 10 FEBRUAY 2021

**Domestic Violence Homicide Review Panel – LB Bromley CSP**
**'Alice' aged 61, murdered in Bromley in July 2019**

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## INTRODUCTION

1. One evening in July 2019, police were called by a concerned friend to a flat in Beckenham, LB Bromley. They forced entry to the flat and discovered that Alice[1] aged 61 had been fatally assaulted in her bedroom. Five days later, a man with whom Alice had been in an intimate relationship since May 2019 was arrested and charged with her murder. He is Kenneth Lannigan aged 52 who was under supervision of the Probation Service while released on Life Licence and residing at Approved Premises, also in Beckenham. In December 2019 at the Central Criminal Court Lannigan pleaded 'guilty' to murder and was sentenced to Life Imprisonment with a minimum of 21.5 years to be served.

2. This report of a domestic homicide review examines agency responses and support given to Alice prior to her murder. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

3. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed because of domestic violence. 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 to reduce the risk of such tragedies happening in the future.

**4.** One of the operating principles for the review has been to be guided by humanity, compassion and empathy, with Alice's 'voice' at the heart of the process. Through the Chair, the Panel have offered Alice's family their heartfelt condolences upon their loss.

## TIMESCALES

5. Upon the report of the homicide the Chair of the Safer Bromley Partnership (SBP) requested partners to secure all records of contact with the parties to support the commissioning of a Domestic Homicide Review (DHR). Following a tendering process and the criminal trial, the review began with a Panel meeting in February 2020 when Terms of Reference (ToR - Appendix 1) were agreed and Chronology reports commissioned from all identifiable public and voluntary bodies that may have had contact with Alice and Kenneth Lannigan to be returned by 17 March. The next meeting was set for 7 April for the purpose of reviewing the chronologies and commissioning of Individual Management Reviews (IMR). This meeting was cancelled due the Covid-19 pandemic and the process placed on hold. In June, it was decided to draft the narrative section based on chronology reports and information from family and friends. It was circulated for feedback and review via a 'Teams' virtual meeting in July. Based on IMRs received, a second version of the overview was debated in September and further enquiries undertaken. A third version including analysis was considered in November and a fourth near-complete version in December. A fifth version was then shared with Alice's family for comment and their views incorporated in this

[1] A pseudonym for this report. Apart from named professionals, all other names used herein are also pseudonyms

sixth version debated by the Panel in January. The seventh and final version was provided to the family.

## CONFIDENTIALITY

6. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.

7. For ease of reference, all terms suitable for acronym will appear once in full and there is also a glossary at the end of the report. Pseudonyms are necessary to anonymise what happened for publication. Alice's husband was invited to choose the false names but he declined saying he would leave it to the Chair. Starting with 'Alice', this has been done alphabetically with the random selections below for family, friends and witness accounts who provide much of the background information available and are also listed for reference in the glossary at the end of the report. As for the perpetrator, Barry was specific that he did not want him to be referred to as if there had been a loving relationship with Alice, hence the common use of Lannigan in the narrative that follows.

| | | | |
|---|---|---|---|
| Alice | Victim | Gwen | Friend of victim |
| Barry | Husband of victim | Helen | Hairdresser to victim |
| Claire | Daughter of victim | Isabel | Acquaintance of victim |
| Darren | Son of victim | Jonathan | Partner of Isabel |
| Eve | Sister of victim | Kenneth Lannigan | Perpetrator |
| Frank | Brother in law of victim | | |

8. The Government Protective Marking Scheme (GPMS) was adopted throughout with a rating of ''Official-Sensitive' for shared material. Either secure networks were in place (gsi, pnn) and adopted (cjsm) or papers shared with password protection. A copy of chronologies and IMRs was provided to all Panel members for review and discussion.

## TERMS OF REFERENCE

9. Following discussion of a draft in the first Panel meeting, the ToR were issued on the same day with a chronology template for completion by agencies reporting contact with those involved. A third version was issued on 8 November 2020. This sets out the methodology for the review, the operating principles and the wider Government definition of domestic abuse, including controlling and coercive behaviour and may be seen in full in appendix 1. The main lines of inquiry were:
    1. Scope of review agreed from March 2019 (when Lannigan was released into the community under supervision of the National Probation Service) to date of homicide with any earlier event of significance to be included
    2. To manage interface with parallel investigations. The Chair attended the sentence hearing in December 2019. There has been a National Probation Service Serious Further Offence (SFO) review which has resulted in a disciplinary investigation.
    3. Identify relevant equality and diversity considerations, including Adult Safeguarding issues (see paragraph 21)

4. Seek any minutes from meetings regarding Lannigan as a MAPPA subject (no meetings held but SFO review has disclosed all relevant entries regarding supervision of Lannigan)
5. Establish whether family, friends or colleagues want to participate in the review. If so, to ascertain whether they were aware of any abusive behaviour to the victim prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware if any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it (see paragraphs 14-16)
6. Take account of previous lessons learned in LB Bromley
7. identify how people in the LB of Bromley gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague

## METHODOLOGY

10. Under s9 Domestic Violence, Crime and Victims Act 2004, a Domestic Homicide Review was commissioned by the Safer Bromley Partnership (SBP) and, in November 2019, Bill Griffiths CBE BEM QPM was appointed Independent Chair of the DVHR Panel and report author. Tony Hester supported him throughout in the role of process manager and Secretary to the Panel.

11. This review was commissioned under Home Office Guidance issued in December 2016. Attention was paid to the cross-government definition of domestic violence and abuse and is included in the Terms of Reference (appendix 1).

12. The following policies and initiatives have also been scrutinised and considered:
    - HM Government strategy for Ending Violence against Women and Girls 2016-2020
    - Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews published by the Home Office December 2016
    - Domestic Homicide Reviews: Key Findings from analysis of domestic homicide reviews published by Home Office December 2016
    - Bromley Council website and related services

13. In addition, a prior DHR report was studied for any parallel lessons or repeat lessons to be learned and none were identified.

## INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

14. On appointment, the Chair met with Barry and the Home Office leaflet for families provided. The advocacy section was highlighted and contact made with an advocate from Victim Support Homicide Service already supporting the family who was then included on the circulation list for the Panel. The opportunity for the family attending the Panel to ask questions was left open. Following a decision at the second Panel meeting, the Chair briefed Barry on the content of the first version of the overview report and they spoke again following the family briefing by a NPS senior manager with the findings of their internal review. He was provided with the fifth version of the overview with an opportunity to

comment and the points he made about Alice's earlier life were incorporated. Barry declined the opportunity to suggest pseudonyms for Alice or family members and was provided with the final version of the overview.

15. The Chair attended, and met other family members, at the sentence hearing at the Central Criminal Court in December. He met separately with Alice's sister and brother in law (Eve and Frank) and conducted telephone interviews with her close friend Gwen and hairdresser, Helen. He sought an additional briefing from the Senior Investigating Officer on what was discovered by the investigation about the day of the homicide.

16. The establishment where Kenneth Lannigan is being held has been identified with a view to inviting his involvement. Visiting has been suspended during the pandemic but the prison probation private CCTV facility was kindly offered and the Chair wrote to Lannigan with a request for an interview by that medium. His response was that he would consult his solicitor but nothing further came of the request, despite a reminder in November.

## CONTRIBUTORS TO THE REVIEW

17. This review report is an anthology of information and facts from the organisations represented on the Panel, some of which were potential support agencies for Alice and Kenneth Lannigan. The Panel were satisfied as to the independence of the Panel members and IMR authors:

The local GP Practice for Alice and Lannigan
Kings College Hospital NHS Foundation Trust (KCH)
Oxleas NHS Foundation Trust*
The Priory Hayes Grove Hospital*
London Borough of Bromley (LBB) Adult Social Care (ASC)
LBB Public Protection Division
LBB Drugs and Alcohol Services (BDAS)*
National Probation Service (NPS)*
Metropolitan Police Service (MPS)*
Bromley and Croydon Women's Aid (specialist adviser)
*Provided an Individual Management Review (IMR), the MPS in the form of a letter.

## THE REVIEW PANEL MEMBERS

18. *Table 1 – Review Panel Members*

| Name | Agency/Role |
|---|---|
| Rob Vale | LB Bromley Head of Service, Public Protection Division |
| Rachael Parkhurst | LB Bromley Domestic Abuse Strategy Coordinator |

| | |
|---|---|
| Dr Tessa Leake | LB Bromley CCG[2] Designated GP Adult Safeguarding |
| Claire Lewin | LB Bromley CCG Designated Nurse Adult Safeguarding |
| Grace John-Baptiste | Head of Social Care Oxleas NHS Foundation Trust |
| Stacey Washington | Trust Lead Safeguarding Adults & Prevent<br>Oxleas NHS Foundation Trust |
| Denise Telford | Hospital Director, The Priory Group |
| Heather Payne | Kings College Hospital NHS Foundation Trust, Head of Adult Safeguarding |
| Lucy Pleass | Director of Operations, Bromley and Croydon Women's Aid |
| Emily Duigan | LB Bromley Drug and Alcohol Service Team Leader |
| Hannah Brice | LB Bromley Drug and Alcohol Service Services Manager |
| Paul O'Brien | LB Bromley Consultant Lead Practitioner, Assessment and Care Manager |
| Helen Rendell | Detective Sergeant, MPS Serious Crime Review Group |
| Katie Nash | Head of Public Protection National Probation Service London |
| Bill Griffiths | Independent Chair and Author of report |
| Tony Hester | Independent Manager and Panel Secretary |

[2] Due to a merger of the six clinical commissioning groups across South East London to form NHS South East London CCG from 01/04/20, any reference to Bromley CCG thereafter refers to NHS South East London CCG

## AUTHOR OF THE OVERVIEW REPORT

19. In November 2019 Bill Griffiths CBE BEM QPM was appointed independent Chair of the DHR Panel and report author. Tony Hester supported him throughout in the role of process manager and Secretary to the Panel. Bill Griffiths is a former police officer who has had no operational involvement in LB Bromley and no involvement in policing following retirement from service in 2010. Since 2013, Bill and Tony have jointly been involved in more than twenty DHRs.

## PARALLEL REVIEWS

20. The Criminal Trial concluded in December 2019. An Inquest was opened by the Coroner and, following the conviction for murder, closed in February 2020. Kenneth Lannigan had been living under supervision of the National Probation Service (NPS) at the time of the homicide. The NPS have conducted a Serious Further Offence (SFO) investigation that informed the IMR provided to the review.

## EQUALITY AND DIVERSITY

21. Consideration has been given to the nine protected characteristics under the Equality Act in evaluating the various services provided:
    Age – Alice was 61 and Lannigan was 52 but the difference between their ages does not appear to have been a relevant factor
    Disability - Alice was diagnosed with Bipolar Disorder and had been addicted for many years to opiate based pain relief drugs and could be considered an adult with care and support needs. This was reviewed by the Panel at the fifth meeting and it was agreed she did not meet the criteria
    Gender reassignment – neither party had been, nor were known to be considering, gender reassignment
    Marriage and civil partnership - Alice had separated from husband Barry in 2016 with an 'amicable' settlement that provided her with independent living but they had not divorced. Lannigan was not known to be married or in a civil partnership
    Pregnancy and maternity – not applicable
    Race – Both are White British
    Sex - Alice is female and Lannigan male. Records show that the majority (74%) of victims of domestic homicide were female and that 80% of that number were killed by a partner or ex-partner[3]
    Religion or belief - is not known but not believed to be actively pursued by either party or is a factor for consideration
    Sexual orientation – the sexual orientation for each is believed to have been heterosexual. There is no evidence of differential service or 'conscious/unconscious bias' from any public body for anyone subject of this report. There is no information available regarding how Alice perceived services.

[3] Office for National Statistics, Homicide in England and Wales - year ending March 2018, www.ons.gov.uk

## DISSEMINATION

**22.** The intended recipients of copies of this report, once approved by the Home Office Quality Assurance Panel, are listed in the table below.

*Table 2 – Distribution List*

| Name | Agency | Position/ Title |
|---|---|---|
| Ade Adetosoye | London Borough of Bromley | Chief Executive |
| Cllr Kate Lymer | LB Bromley | Chair od Safer Bromley Partnership Board |
| Teresa Bell | Independent Chair | Bromley Safeguarding Adults Board |
| Kim Carey | LB Bromley | Director of Adult Services |
| Robert Vale | LB Bromley | LBB Head of Service, Trading Standards and Commercial Regulation |
| Dr Tessa Peake | LB Bromley | SEL CCG Designated GP Adult Safeguarding |
| Claire Lewin | LB Bromley | SEL CCG Designated Nurse Adult Safeguarding |
| Sara Bowrey | LB Bromley | Director of Housing, Planning, Property and Regeneration |
| Heather Payne | Kings College Hospital NHS Trust | Adult Safeguarding |
| Stacey Washington | Oxleas NHS Foundation Trust | Adult Safeguarding |
| Hannah Brice | Bromley Drugs and Alcohol Service | Service Manager |
| Denise Telford | The Priory Group | Chief Executive |
| Lucy Pleass | Bromley, Croydon Women's Aid | Independent Domestic Abuse Advocate |
| Angela Middleton | NHS England | Patient Safety Projects Manager (London Region) |
| David Stringer | Metropolitan Police | South BOCU Commander |
| Helen Rendall | Metropolitan Police | Detective Sergeant Specialist Crime Review Group |
| Bill Griffiths | Independent Chair | Independent Chair/Author of the Domestic Homicide Review |
| Tony Hester | Director Sancus Solutions Ltd | Independent Administrator and Panel Secretary |
| Quality Assurance Panel | Home Office | - |
| Cressida Dick | Metropolitan Police Service | Commissioner |
| Sophie Linden | Mayor's Office for Crime and Policing | Deputy Mayor |
| Baljit Ubhey | Crown Prosecution Service | London Chief Crown Prosecutor |

## BACKGROUND INFORMATION (THE FACTS)

23. Alice and Kenneth Lannigan were in a relationship for about ten weeks before he murdered her in July 2019. Each had a complex life history prior to their meeting and it is felt important to gain an appreciation of these perspectives as a foundation for understanding what happened between them, what was known to agencies in that short period and the lessons for safeguarding. The detail about Alice's various addictions is felt appropriate in order to highlight her vulnerability at the time she encountered Lannigan, a dangerous criminal with a history of abusing and assaulting women. Barry has supported this approach and, in doing so, it came to his mind that Alice had once said to him: "Nothing good in my life lasts".

24. This narrative serves as a timeline and relevant dates are underlined to assist the reader to track the passage of time and also to highlight when significant events occurred..

### Alice[4]

25. Aged 61 at the time of her murder, Alice was born and raised in Bromley from 1958. She attended the local Grammar School but did not excel academically there, being more inclined to sports and was a very good swimmer. She was "sparky", fun to be around and had lots of friends.

26. Their mother had 'signed the pledge' so discouraged alcohol, nonetheless, Alice who described herself as "naughty and disruptive" as a teenager, started drinking aged 14. This was vodka about three times a week and she "didn't know when to stop". By the time she married and when her children were young she had stopped drinking regularly but when she did imbibe, drank too much. She ceased alcohol consumption in 2004.

27. After school Alice gained employment at a bank and then moved to a stockbroking firm in the City of London where she met Barry. They married in 1977 when she was 19 and they had Claire (1980) and Darren (1981) together. When the children were of school age, Alice returned to part-time work as a bank clerk and then with a clothing retailer. She was also a talented seamstress and she initiated her own business making and selling children's accessories such as hair bows. This ended in 2016.

28. In 1998, following a car accident she was given Dihydrocodeine for pain relief which she "loved". She had become depressed around this time and Barry put this down to "empty nest syndrome". Her mother was prescribed the same medication and Alice filched some and became addicted. She continued to abuse opiate-based pain killers, in particular, Co-proxamol which she was using at the rate of 32 tablets daily. In addition, Eve's sons had been prescribed Ritalin and she discovered in 2002/3 that Alice was stealing some of their dosage for herself which caused an argument and rift between them.

[4] Drawn from interviews with Barry, Eve, Gwen and Helen plus Alice's disclosures in clinical notes at The Priory Hospital

29. Alice's GP referred her in 2003 to The Priory Hayes Grove Hospital for private treatment and this carried on until January 2019[5]. During this period she discovered, and became addicted to, cocaine because she had access to someone who smuggled the drug into the hospital. There were three inpatient admissions during 2004, the first following an overdose. From 2005, her attendances for ongoing psychological therapy were as an outpatient, including some with Barry in support. Various drug combinations were tried to treat her depression. Many of her issues arose from the relationships in her life with sister, husband and children.

30. In 2008 she was thought to be hypomanic and diagnosed to have a Bipolar II Affective Disorder: "She could vary between happy and fun to distressed and tearful even within an interview". In 2009 a problem with excessive spending, up to £2k a week on clothing and accessories, was noted. Alice explored working in a nursery school but that did not last. Her mother died and her father, who was ill with cancer, came to live with her and Barry. In 2010, Alice was much happier due to the birth of a granddaughter to Claire which became the dominant theme of her conversations with the therapist. Alice went on to forge strong relationships with her granddaughter[6] and a grandson born later, however, family relationships generally remained strained across the board.

31. Between 2011 and 2015 Alice's addiction to analgesics (up to 30 Tramadol a day, often sourced over the internet) continued, as did the impact on her close relationships to the point where a "post-hypomania depressive phase" was considered. There had been a number of overdose calls and she frequently threatened suicide.

32. In March 2016 a diagnostic review identified possible Bipolar Affective Disorder Type II with mild phases, multiple substance misuse, personality disfunction and multiple difficult family relationships. In September, when the house was being sold for a 'downsizing' move to take place and whilst on holiday together, Alice informed Barry that she wanted to separate. This was her decision and a surprise to Barry. Nonetheless, he felt it led to an amicable separation but this did not develop to the stage of a formal divorce. Subsequently, she took up a flat rental before purchasing from her share of the house sale proceeds the flat in Beckenham that became the scene for the homicide. In November, her GP took over prescribing her medication with daily dispensing from an associated pharmacy. Claire invited Alice to share Christmas with her family.

33. It was on that New Year's Eve 2016[7] when Claire informed police that she had received a text message from her mother stating her intention to take her own life. This was the first time that Alice had come to police notice. She informed officers that she had felt low after a difficult Christmas but did not intend taking her own life. She said she was a recovering alcoholic and had an allocated mental health worker following a previous admission to The Priory. She made a show of disposing of alcohol and pain killers in the drain. Claire was updated from the scene and said she would speak to her mother. Under the Vulnerability Assessment Framework (VAF also known as 'The London Continuum of Need'), the

[5] The Consultant Psychiatrist's summary letter runs to 13 pages
[6] Alice's granddaughter wrote an impact statement for the attention of the Judge at DM's sentencing hearing
[7] Barry recalls that the original upset started on Boxing Day

officers assessed the risk as 'Blue'[8] and completed a MERLIN[9] ACN (Adult Coming to Notice). The officers noted that Alice's flat was 'immaculate'.

34. In January 2017, Claire contacted the therapist to say that, due to Alice's offensive Facebook posts, she intended; "removing myself from the situation". In May, Darren reported to police that he had received threatening messages from his mother via WhatsApp. This was allocated to the Community Support Unit (CSU) who identified the report as a domestic abuse incident. When interviewed, Alice admitted sending the messages and was issued with a First Instance Harassment Warning (FIHW). A MERLIN ACN was created and the risk again assessed within the VAF as 'Blue'. In June, Alice was sent a letter from her GP discharging her if she continued to misuse substances. Although she felt hurt by this, she admitted to taking 40 Dihydrocodeine tablets daily.

35. In early October, Alice called police to report an alleged harassment against her family. A scheduled appointment was made for 15:00 the next day. When officers arrived, they were met by a friend of Alice's who had received a text at 12:00 stating she had taken an overdose. The London Ambulance Service (LAS) had attended, Alice was in bed and alert (15/15 on the Glasgow Coma scale of consciousness), saying she had taken 84 Nitrazepam tablets of 5mg prescribed by her psychiatrist. The LAS crew consulted 'Toxbase' via the clinical hub and calculated Alice was 23 times over the safe dosage.

36. They conveyed her to the Princess Royal Hospital (PRUH) and she was then admitted to Green Parks House[10], part of the Oxleas NHS Trust in the same grounds. Following verbal and physical aggression to staff, damage to property and chaotic behaviour, she was detained for 72 hours under Section 5(2) Mental Health Act. The police VAF assessment was 'Red'[11] and a MERLIN report was sent to Bromley Adult Social Care (ASC).

37. Alice was discharged to the care of the Home Treatment Team (HTT) on in mid-October, to attend drug and alcohol services and to see the private psychiatrist. The next day, Alice declined input from the HTT. She was provided with numbers for benefits claims and the Citizens Advice Bureau. To her therapist, Alice appeared calmer in November but, by December, had financial difficulties looming because she had used up her capital. A supportive letter was provided for Alice to apply for state benefits.

38. In January 2018, Alice appeared to be improved in mental state and not as chaotic, although remaining upset by lack of access to her grandchildren. By April, she was using 40-60 Dihydrocodeine daily and began a community detox in collaboration with a local pharmacist. Alice disclosed seven on-line sources for obtaining the drug and these were contacted to cease trading with her.

[8] The VAF options being Blue (No identified additional need), Red, Amber and Green (BRAG)
[9] The police form for sharing reports with partner agencies
[10] Alice made a complaint about her treatment there, alleging she was assaulted – investigated & found to be due to a fall
[11] VAF Red – Acute needs, requiring statutory, intensive support

39. Sometime between September and November, Alice entered an equity release arrangement on her flat that provided a monthly amount of £3k in cash. Alice was not in receipt of a state pension.

40. In October, Alice was upset that her dog (that had been considered a protective factor) had to be put down and she sought a rescue dog as replacement. Later that month, the LAS were again alerted via a NHS111 transfer call when Alice had again overdosed due to lack of sleep since she had lost her dog and she was taken to the PRUH. Later that day, police were asked to conduct a welfare check at her home because Green Parks Hospital had reported her 'missing' when she left before being examined. She was noted to be 'safe and well'. A follow up offer of support by the HTT was declined but a referral to a COMCAD (Co-occurring Mental Health, Alcohol and Drugs) nurse for weekly support happened within three days October. By late November, the COMHAD nurse recorded that Alice had improved self-management of opiate use and was sticking to her prescription. She did not need any further support and so she was discharged from the service. It was noted that she was looking forward to having a new puppy in early December.

41. By December, the therapist noted Alice was "Happy, but often low" regarding the grandchildren situation and loss of her dog but receiving regular support from Barry. She was not misusing substances and the GP had taken back prescribing the Dihydrocodeine. By her last appointment in January 2019, Alice was engaged with Bromley Drug and Alcohol Service (BDAS), had a good relationship with her GP, had been offered a care worker and a two weekly one hour group.

42. Change Grow Live (CGL) are a charity that have been providing substance misuse services in Bromley since 2012 as part of BDAS. Alice became registered in January 2019 and received her prescriptions from CGL thereafter within a treatment plan that has been seen by the Panel. Alice attended weekly and there were no problems reported.

43. Two younger attendees at CGL, Isabel and Jonathan, happened to know Alice through a neighbour of hers and lived nearby. It is known that they would socialise, including by taking drugs together. Isabel was close to Alice and regarded her as something of a mother figure.

44. 'Gwen' had been Alice's friend for more that 30 years since they met when their children attended the same schools and they would socialise together. When the school encounters ended, Gwen and Alice carried on their friendship which became very close and they would meet up at least three times a week. Gwen describes Alice as warm and generous with "a heart of gold".

45. Gwen knew about Alice's addiction to pain killers and assessed she had an addictive personality. She could be: "addicted to anything going"; Gwen recalls on one occasion it was to grapes. Gwen tried in vain to support her by collecting her prescribed medication and helping her to reduce the amount, however, Alice would always find a way to secure more for herself. Gwen was also aware that she had used cocaine in the past.

## Kenneth Lannigan[12]

46. Aged 52 at the time of the murder, Kenneth Lannigan was born and raised in Hackney from 1965. He has a long history of police contact with 44 criminal offences from 22 previous court convictions. His offending history commenced when aged 15 with criminal damage and burglary offences. Sentenced then to an attendance centre, he quickly progressed to a detention centre and a community sentence for having an offensive weapon when aged 18. His first prison sentence was for taking a conveyance and driving offences when aged 22. In 1993 when aged 28 he was handed a 10 year sentence for four counts of robbery and possession of an imitation firearm with intent.

47. In January 2002, Lannigan was arrested for calling on a former partner, shouting abuse and threatening to slit her throat. In March, he approached her in the street, spat in her face and pursued her as she ran into her house and started kicking the door. In June he punched her in the side of the head. None of these incidents resulted in convictions because the former partner withdrew support for prosecution.

48. In October 2002, Lannigan was sentenced to Life Imprisonment[13] for an offence of robbery when he attacked a lone female as she walked through the grounds of Homerton Hospital. He grabbed her bag from her shoulder and when she resisted her pushed her and hit her several times over the head with a seven-inch metal rod taped to a wooden pole with electrical tape. The victim suffered deep lacerations to her scalp and ears that required stitching. He was sentenced to serve a minimum of two years but, in fact, served 13 years in prison until released on Life Licence (from this sentence) in June 2015.

49. Lannigan was recalled to prison in November 2016 following being arrested and charged with a new offence of burglary. In late March 2017, Lannigan was sentenced to 27 months' imprisonment for an offence of domestic burglary committed in Hackney. Substance misuse had been a problem for many years and it had continued even when he was in custody. His appointed Probation Officer (PO3 based in Hackney) considered that his offending history and background posed a high risk of offending after release. Whilst Lannigan had never been formally diagnosed with a personality disorder, he had exhibited thinking and behavioural patterns that indicated an "entrenched personality".

50. Early in March 2019, Lannigan was re-released on Life Licence by the Parole Board to an 'Approved Premises' (AP), providing controlled accommodation for offenders under the supervision of the Probation Service. The Parole Board had stipulated to Lannigan that the normal stay [in an AP] is for a period of three months and that, subject to good behaviour, the period can be extended to linkup with the move to a residential rehabilitation unit.

51. The AP is located in Beckenham, LB Bromley, not an area familiar to Lannigan having lived all his life in LB Hackney. An intelligence report was sent to Bromley police as required under MAPPA[14] (Multi Agency Public Protection Arrangements). In this case the 'lead

[12] Drawn from Prosecuting Counsel remarks at the sentence hearing, MPS letter and NPS IMR
[13] This was at the time of the Government law and order initiative known as: 'three strikes and you're out'
[14] MAPPA is the statutory requirement of agencies to work together to monitor known offenders

agency' was the NPS. Intelligence checks were undertaken and an internal intelligence report was created by South Area[15] Local Intelligence Team (LIT).

52. Lannigan was assigned an Offender Manager (OM), Probation Officer (PO) 3, based in Hackney. PO3 reported to Senior Probation Officer (SPO) 4 also working from Hackney. It is understood that PO3 knew Lannigan having worked with him since May 2018, to prepare for his eventual resettlement and release. He also has specialist experience in managing the Personality Disorder Pathway (PDP). Any unresolvable safeguarding concerns and rehabilitation dilemmas could be raised with an Assistant Chief Officer (in this case ACO1). There was an out of hours contact arrangement in place, managed at ACO level for urgent decisions.

53. Lannigan's Offender Manager (PO3) contacted the drug treatment provider in Hackney to arrange for his placement in rehabilitation following his move on from the AP and secured the support of a drug advocate. Four days after he arrived at the AP, the advocate contacted PO3 advise that Lannigan had been taken to the 'NA' (Narcotics Anonymous) meeting and three days after that was allocated a mentor.

54. By mid-March Lannigan had tested positive for cannabis and opiates. That day, PO3 updated the OASys (Offender Assessment System) with an assessment which is completed by the OM on every offender released on Licence:
*His risk is considered to be high[16] at the current time. There is a direct link between Class A drug use and serious harm. Until he fully addresses the underlying causes i.e. avoidant behaviour, negative attitudes towards support offered, and inability to cope when faced with difficult situations and emotions) that contribute to his choices to use drugs - he will remain assessed as a high ROSH [ 'Risk of Serious Harm'].*
*Also contributing to this assessment is the fact that he continued to use substances in custody which affected his access to treatment and interventions.*
*<u>Internal Controls</u> – [Lannigan] has shown some evidence of improved insight since the last release. He recognises that he often refuses offers of support and can find such offers as intrusive and threatening. He accepts that his thinking can be irrational and that he can project his frustrations with himself onto others.*
*<u>External Controls</u> - Subject to Life Licence and conditions included below. Also, subject to monitoring support and oversight at Beckenham AP - includes regular drug and alcohol testing.*
*<u>Licence conditions</u>[17]*
*1 He shall be of good behaviour and not behave in a way which undermines the purpose of the licence period;*
*2 He shall not commit any offence;*
*3 He shall keep in touch with the supervising officer in accordance with instructions given by the supervising officer;*
*4 He shall receive visits from the supervising officer in accordance with instructions given by the supervising officer;*

[15] One of 12 police operational clusters this, South London Boroughs, including Bromley with the designation 'SN"
[16] NPS definition of 'High risk' on a four-point scale (this being third highest): There are identifiable indicators of serious harm. The potential event could happen at any time and the impact would be serious
[17] Licence conditions 1-7 are generic for all offenders released on Licence and 8-12 are conditions specific to Lannigan

*5 He shall reside permanently at an address approved by the supervising officer and obtain the prior permission of the supervising officer for any stay of one or more nights at a different address;*
*6 He shall not undertake work, or a particular type of work, unless it is approved by the supervising officer and notify the supervising officer in advance of any proposal to undertake work or a particular type of work;*
*7 He shall not travel outside the United Kingdom, the Channel Islands or the Isle of Man except with the prior permission of the supervising officer or for the purposes of immigration deportation or removal;*
*8 He shall confine himself to the address of Beckenham Approved Premises, address XX between the hours of 21.00 and 07.00 daily, unless authorised by the supervising officer. This condition will be reviewed by the supervising officer on a monthly basis and may be amended or removed if it is felt that the level of risk that he present has reduced appropriately;*
*9 He shall comply with any requirement specified by the supervising officer for the purpose of ensuring that he address his drug and offending behaviour problems;*
*10 He shall be assessed for, and if found suitable, participate in suitable interventions as directed by the supervising officer;*
*11 He shall notify the supervising officer of any developing relationships, whether intimate or not, with men or women;*
*12 He shall attend as directed, as reasonably required by the supervising officer, to give a sample of oral fluid/urine in order to test whether he has any specified Class A or Class B drugs in his body, for the purpose of ensuring that he is complying with the condition of his licence requiring him to be of good behaviour.*

55. The IMR author has commented that the risk management plan reflected that Lannigan had been released from custody and the Licence he was subject to. He remained subject to MAPPA level 1 management (led by a single agency – the NPS) which seemed appropriate. The contingency plan was thorough.

56. Two days after the positive drugs test, PO3 followed up with colleagues in the drug treatment agency to request that he be updated on any progress, noting that Lannigan had been referred for assessment for rehabilitation in December 2018 and that the bed space at the AP was only available until early June. He also tested positive for opiates and cannabis that day.

57. Later in March, Lannigan was called to a meeting with PO3 and the Personality Disorder Pathway (PDP) Psychologist to discuss his struggle to manage frustrations and that he projects them onto staff when given the opportunity. He admitted that he had struggled to bring his arousal down on his own and therefore ruminates and sulks in the AP. They also discussed the failed drug test on day of release. He stated that he used cannabis at a 'leaving party' in the prison, and admitted that this was an inappropriate decision. PO3 indicated his concern about this and believed it highlighted his mindset around drug use and the entrenched association of drugs as a reward.

58. In the last week of March, Lannigan had presented under the influence of alcohol, and swore at staff. He was also five minutes late for his curfew. The out of hours SPO (SPO2 also based at Hackney) was contacted and the AP staff were instructed to issue him with a written warning for being under the influence and his late arrival. On two days after that he again tested positive for cannabis and PO3 contacted to consider enforcement.

59. PO3 met Lannigan in early April to discuss the latest failed drugs tests and PO3 referred him to the substance misuse agency near to the AP for an assessment and on-going support. The next day he tested positive for alcohol but was drugs free. A week later PO3 again contacted the drug agency and the substance misuse team at Hackney for an update on the residential rehab proposal. He registered concern that this would impact on the delivery of the risk management plan and the conditions of Lannigan's release by the Parole Board. That day, Lannigan reported to PO4 that he had smoked crack cocaine and heroin the previous day with a previous drug associate in Hackney (confirmed by a test).

60. The next day, a senior Hackney drug service practitioner emailed PO3 to apologise for the delay in direct liaison and the lack of inclusion in emails about Lannigan. She advised PO3 to link Lannigan with the services in the borough where he was being placed.

61. In mid-April, the residential worker at the AP sent a summary of failed alcohol and drugs tests since Lannigan's arrival, including that day's alcohol reading of 16. He queried whether Lannigan had been using Spice, given his presentation and that there had been two positive tests. In early May, Lannigan reported he had been offered a rehab placement in Clapham. He tested positive for cannabis that day, saying he had acquired a small amount "from a friend".

62. When residing in LB Bromley, Lannigan was registered with a local GP. His clinical notes have been reviewed for that period. The only relevant entry was an attendance at the Practice with his 'partner'. He was seen for possible stroke and lung cancer but investigations did not discover anything requiring treatment. The Practice was not involved in his drug screening or treatment.

**Timeline of their relationship together[18]**

63. By March 2019, Alice had taken on a replacement dog. When walking the pet locally in late April or early May she is believed to have met Lannigan who struck up a conversation. It is not known precisely when, but this led to an intimate relationship and shared substance misuse. Alice's family were generally unaware of this relationship; however, Barry does recall that Alice mentioned she had met someone. She said he had a "colourful past" and she related well to him because, in common with her, he had lost access to his grandchildren. It is not known to this review exactly how their subsequent shared substance misuse was funded; however, it is known that by July Alice was withdrawing cash most days up to her limit of £300.

64. PO3 updated the risk assessment in mid-May but the OASys locked it out as 'incomplete' (default) because SPO4 did not countersign within the required timeframe.

[18] Source: MPS letter and NPS IMR, Alice's husband Barry and her friend Gwen

65. The first intimation to the NPS OM of the relationship[19] was three days after that when Lannigan was five minutes late for curfew, which he excused by stating that today was his birthday and that his "girlfriend" had driven him to the AP and this had impacted his arrival. Staff noted that he was very rude using a number of swear words.

66. Lannigan's behaviour continued to be challenging at the AP. He was clearly deteriorating and it was evident he was lapsing to drug use and testing the boundaries in his interactions with staff members and other residents at the AP. The covering AP manager[20] made the decision to request that an ACO warning be issued following his hostile presentation to staff one evening.

67. Later in May, PO3 emailed the drug misuse advocate noting that Lannigan appeared to be pushing away services. The drugs advocate called back and noted that this had been his experience and Lannigan had recently informed the mentor that he no longer required their support. Two days after that, one of the residential workers noted that Lannigan's behaviour had appeared sporadic and he had notable difficulty breathing. He laughed this off stating he was getting old. He added that his girlfriend was waiting outside.

68. Near the end of May, Alice attended CGL regarding a problem with her prescription and, in the course of a welfare conversation, disclosed that she was: "dating someone and he may have lung cancer which was making her anxious". Emotional support was provided and the prescription problem corrected. In a later counselling session in mid-June, she said that things in the relationship were good and she was: "very happy".

69. The next day, PO4 (based at the Bromley office, close to the AP) who was also involved with management of Lannigan noted that his behaviour had been erratic recently and that he had been using substances. He wrote that the recall offence involved the burglary of a female and that they needed to consider disclosure to the new partner. Lannigan had admitted using cocaine with friends leading to a positive test a week earlier but had insisted this was a "blip". Lannigan agreed to attend the local drug service (presumably CGL below) and provided the details of his "partner" Alice who resided in a flat at Beckenham. PO4 noted that Lannigan appeared not happy to provide this information.

70. As a result, PO3 sent an email to the Central East Jigsaw[21] Team in Hackney that day with this request:
*Please could I request an address check in the details below. The individual is a new partner of [Lannigan] Cat 2 MAPPA – Lifer. There is some history of offences against females including robbery and burglary and I need to make a decision about disclosure to this individual. Anything of note regarding her address or herself in terms of police contact would be very useful. Perhaps over the last 12 months?.*

[19] See Condition 11 of the OASys assessment review of 13 March, paragraph 54
[20] The Beckenham AP did not have a manager in this period – cover was provided by neighbouring AP managers
[21] MPS Public Protection Unit (PPU), CE being the designation for East London Boroughs, including Hackney

71. The request for information by the Probation Officer was made to inform a decision whether to disclose Lannigan's offences to Alice. The request for information was guided by the Information Sharing Agreement between the Police and Probation (2015) and also justified under MAPPA, Section 325(4) of the Criminal Justice Act 2003, which expressly permits the sharing of information between these agencies for MAPPA purposes. The MAPPA guidance requires the risk assessment of all MAPPA offenders to identify those persons who may be at risk of serious harm from the offender. The risk management plan must identify how these risks will be managed. As part of this process, the Responsible Authority (Probation – lead agency in this case/Police/Prisons) must consider whether disclosure of information about an offender to others should be made to protect victims, potential victims, staff, and other persons in the community.

72. The police response later that day incorrectly indicated that the address was within the boundary of Kent and therefore the Metropolitan Police did not hold any information on it. The day after that, the email request was sent again, this time to the South Jigsaw Team who referred it the Bromley Borough Local Intelligence Team (LIT) for action. This did not happen and it appears that, due to restructuring in the MPS, the mailbox was not being utilised or monitored at that time.

73. In early June, Lannigan put Alice on the telephone to PO3, although he had not asked to speak to her.[22] Alice said that she was aware of Lannigan's criminal history and that she felt safe with him despite this and intended to spend the rest of her life with him. She added that she had no further questions for PO3. Lannigan then told PO3 that he was grateful for the support of Alice and that she had attended the drug treatment agency in Bromley, having become abstinent in the mid 1990s.

74. Friend Gwen knew that Alice had met someone about four or five weeks before the homicide because she had enthused by telephone about meeting Lannigan when walking her dog in Beckenham and they had a coffee together. From that point, Alice stopped calling to see Gwen although they stayed in regular touch by telephone. Gwen had repeatedly told Alice to "be careful".

75. Two days after Alice had spoken to PO3, Alice brought Lannigan to meet Gwen at her home. She has a clear recollection because it was her birthday. Gwen was "shocked" and took an instant dislike to Lannigan, mainly because he was "all over her" [Alice]. As they left, she asked him to "look after Alice" to which Lannigan responded: "I love her and all my brothers love her".

76. Around this time two other close friends, who saw Alice more often as they lived nearby, noticed that she was withdrawing money from the bank more frequently and they suspected she was funding others' drug habit as well as her own.

77. In mid-June, PO3 made a second request to the South Area for the address check on Alice's details:

[22]It is not known to what extent Alice had been coerced into making this call. Her demeanor later that day in the presence of friend Gwen suggests not, however, her saying to PO3 that she had no questions is indicative of a rehearsed/controlled conversation

*Can anyone support with this request – it is very important details around this address and the individuals are checked. Does the individual have a criminal record? Is there anything of concern or police contact in relation to her or her address in the last 12 months? Please can this be expedited as quickly as possible. I have been trying to obtain this information since the [the end of] May.*

78. On that day, Lannigan attended Bromley CGL for a triage assessment having been referred from a similar organisation in Hackney and the drugs worker notified probation of his attendance. This referral did not include a risk assessment based on his profile, nor was one requested from the probation service. A more in-depth assessment was arranged for late June that, following two appointments that he did not attend, eventually appearing in early July. This led to a doctor's assessment being required which was booked for mid-July and that, again, he did not attend.

79. Five days later, Lannigan contacted CGL saying he was Alice's "fiancé" asking if he could collect her prescription and that Alice could not talk due to suffering from laryngitis. This was declined due to absence of consent and her medication dispensing was changed so that she did not have as much in her possession at any one time. Alice collected the prescription two days after that. The keyworker did not note whether Alice was suffering from the signs/symptoms of laryngitis. She said she had been struggling with anxiety recently and a counselling session was arranged for late June. At that session she disclosed the anxiety was caused by separation from her family.

80. Two days after the CGL contact, Lannigan tested positive for cannabis and cocaine. The next day, the social worker reported that a rehab centre had been identified for him. Three days later an AP keyworker raised concerns about Lannigan's behaviour and drug use to PO3. This was picked up by the AP area manager who requested that PO3 keep SPO4 updated on the risk concerns and potential enforcement decisions as she was concerned about the level of drug misuse. SPO4 agreed and made a 'Management Oversight' entry on the log and to record the decision to issue a warning for continued drug use which was done the next day. During a key worker session in late June, it was noted that Lannigan had again tested positive for cannabis and cocaine.

81. Meanwhile, PO3 again contacted the Central East Jigsaw team at Hackney stating that there was Category 2 MAPPA Lifer visiting a female's address in South London and requesting a police check on her address with regards to any call outs or intelligence on the address in the last 12 months. The email confirmed that they are now in a relationship and that he understood that she has previous drug issues. PO3 raised concerns that numerous attempts to obtain this information has not been forthcoming and he had been pursuing this for a month. PO3 requested escalation via the appropriate channels.

82. Hackney Jigsaw checked with PO3 whether Bromley police had responded to his original request and then confirmed that the address is in Beckenham and therefore within the jurisdiction of the Metropolitan Police and he had given the wrong information before. The officer confirmed he had checked and the address is not known to police in the last 12 months. He asked if PO3 had a date of birth for Alice. PO3 did not reply to this email.

83. Having tested positive for cannabis and cocaine again, Lannigan was interviewed by PO3 in early July. PO3 made it very clear to Lannigan that he was very close to recall given the amount of successive positive tests. He admitted to PO3 that he had used drugs in the last few days. Two days after that, PO4 visited the AP and spoke to Lannigan who said that all was well and he felt back on track with his progress after a 'blip' a few weeks ago.

84. That same day the social worker dealing with Lannigan's placement with a drugs treatment agency notified PO3 that they decided that their placement would not be suitable for him particularly as there was the potential for him to have a personality disorder and he needed a more supportive environment. Lannigan again tested positive twice for cannabis and cocaine in the following days. Consequently, PO3 contacted the drug treatment agency in Bromley to request that a schedule of appointments be arranged with their service. The drug worker responded that he had attended a full assessment and now been allocated an opiate worker with a Doctor's appointment arranged for mid-July. PO3 passed this information on to the AP.

85. Alice's sister Eve who dealt with her affairs after the homicide noted that there were multiple cash withdrawals of £250 during July. She found three pawnbroker receipts dated July for items of jewellery with amounts in excess of £500.

86. About a week into July, Alice attended CGL and disclosed that her new partner (Lannigan) can make her feel stressed. The keyworker explained the support available through Bromley and Croydon Women's Aid (BCWA), discussed safety plans and reviewed her options. Alice declined a referral but did retain the contact telephone number for reference. It was about this date that Alice disclosed to Isabel that, although she had loved [Lannigan] at first, she felt lately that she "could not breathe" because he was always there during the day and, when he returned to the hostel in the evening, he would be on the telephone to her for about two hours.

87. The next day, PO3 requested an update from the social worker looking into potential rehab placements, noting the situation was becoming quite urgent. She replied and explained that she was looking at alternative placements which had been difficult given that there was scant availability.

88. The day after that, a four-way meeting was held with PO3, the PDP psychologist, the substance misuse advocate and Lannigan to review his history of drug testing failures. He was reluctant to discuss how much he was using but then admitted he was using cocaine approximately three times a week. It was agreed that the substance misuse advocate and the social worker at Hackney Council would identify a selection of rehabs in and out of London. PO3 noted that he was likely to come to the end of his stay at the AP: "without any move-on and a burgeoning drug habit and he [would] likely be recalled".

89. The next day, Alice texted one of her friends to say she had fallen in the night and hit her head and eye. The friend doubted that those injuries were as the result of an accidental fall. Alice's GP clinical notes have a reference to her not waiting to be seen at an urgent care centre at 17:20 that day which is probably connected. A few days later Alice texted the same friend to say that Lannigan was "getting on her nerves".

90. Three days before the homicide in mid-July, Lannigan tested positive for cocaine. That day the social worker emailed PO3, SPO4, the drug misuse advocate and AP staff to note that Lannigan was not happy to proceed with the referral to an AP in Hull. The social worker added that she had not proceeded with the rehab as she needed his signature on the referral. PO3 responded and noted that Lannigan would have to move out of the AP in two weeks regardless of the positive or negative tests and that if he had nowhere to go, he would be recalled to prison. He noted that they all needed to reiterate to him that only the social worker would be communicating with the rehabs and no one else.

91. PO3 later emailed the social worker that he was fully aware of the situation, they were close to recall at that point and that Lannigan was aware of this. His motivation for rehab was becoming an issue and that he was due to attend a substance misuse appointment that day at 4pm, adding it was very possible that if he failed to attend this appointment, then PO3 would have to recommend recall as the Risk Management Plan was becoming unworkable.

92. At her last visit to CGL on the same day, Alice disclosed that she was upset due to not seeing her grandchildren for a long time.

93. The day before the homicide, an AP staff member emailed PO3 to state that Lannigan had signed the paper work for a drug rehabilitation unit in nearby Lewisham.

94. The key worker also noted on the NPS case management system (known as Delius) that Lannigan's partner was likely to be the one who had ended their relationship as: "he had been taking drugs nearly every day". That evening, Alice called Gwen to say that she had something to tell her and she would pop round the next day. Gwen felt this could be about Lannigan and asked Alice for more information. She replied that: "He's been a bit of a rascal" but would not elaborate further.

**The homicide**

95. At about 05:00 on the day of the homicide, it is known that £300 cash was withdrawn from Alice's account via an ATM. She then sent several texts to Isabel and Jonathan asking them to contact her. They did not respond until about 09:00 when Alice asked that they 'score' some crack cocaine for her. She collected them in her car to visit their dealer. The transaction completed, she drove them back to Beckenham and Alice gave Isabel her bank card to withdraw some more cash at a petrol station ATM, but this was declined by the bank as there was a daily limit on cash withdrawals.

96. Meanwhile, at 07:30, PO4 interviewed Lannigan at the AP. He disclosed that he and Alice had agreed to take a break to enable him to: "sort himself out". He explained that he was honest with her about his substance misuse and she had stated she could not be with someone who took drugs. He left the AP at 08:15.

97. Alice, Isabel and Jonathan returned to her flat at about 09:30. She told Isabel that she wanted to be there before Lannigan arrived but it was raining and he emerged from the flat

with an umbrella for them, at which point, Isabel noticed a marked reluctance on the part of Alice to go with him to the flat. They did go in and Alice called her hairdresser for an appointment. She then went for a shower. Lannigan also went into the bedroom and Isabel has reflected that this was typical behaviour from him – where she went, he followed.

98. Alice left to attend the appointment with Helen, her regular hairdresser, at about 11:10. Alice had enthused to Helen about meeting Lannigan in an earlier appointment, saying he was "a gentleman" and that she met him whilst walking her dog and they had a coffee together. At this latter appointment, she did not seem troubled by anything and did not mention her relationship. She left at about 12:45 and it is known that she visited the pharmacy to collect prescribed drugs on her way home. It is known that Lannigan had called Alice's phone at 12:38.

99. Soon after Alice left the flat, Lannigan and Jonathan had an argument because Jonathan had fallen asleep while smoking a cigarette and had let the ash make a mess of the carpet. They argued and Lannigan accused Jonathan of having a "hidden agenda". Alice and Jonathan left Lannigan at the flat at about 11:45. They visited someone else in the block for a while and were making their way home at about 13:30 when Alice was parking her car at the block. At this point, Jonathan gained the impression also that Alice was reluctant to join Lannigan in the flat.

100. At 13:45, PO3 received a call from Lannigan on Alice's landline who reported that he was at Alice's address: "putting some washing on and then [was] going to the library to read the papers and then go for a walk". He said that Alice was not at home and he was unsure of her whereabouts. He added that they were: "going to have some space so he can focus on his own problems"[23].

101. At about 15:00, a neighbour heard a loud commotion coming from Alice's flat and a male, whom he presumed was [Lannigan], shouting very angrily. He also heard a high pitched scream that sounded like Alice. This was followed by what sounded like punches or thumps, each succeeded by another scream. He had never before heard sounds like that coming from Alice's flat.

102. Another friend, who had not seen Alice for about 18 months, was on her way home from work at about 16:00 and decided on impulse to call on her. She knocked several times as she could hear movement inside. A man whom she did not recognise came to the door. He was covered in blood and said that Alice was not there but he was having a bad day having had a fight with a drug dealer. He left the house saying he was going to get Alice. The friend was sure there was something wrong but decided to give it until the next day to report it to police.

103. At about 17:30, police enquiries established that Lannigan was seen on CCTV at an underground station in Hackney.

104. At 21.23 a management oversight entry was added to the Delius record by the on-call NPS manager, SPO2, noting a call from AP staff at Beckenham about Lannigan's failure to

[23] Given the proximity of timings, it is possible that this call was made before Alice had returned from the hairdresser

return by 19:15 (curfew time with discretionary 15 minutes added) and this was out of character. His room appeared to have been cleared and the key left in the door which was not his usual approach. He did not respond to a telephone call at 20:30. There had been 10 positive cocaine test results. A recall to prison was approved by a Head of Service at 21.30.

105. Following their earlier interactions, Isabel, had called Alice about four to six times but she did not respond which was unusual, so she visited the flat. The curtains were open and she could see that furniture had been moved and at 23:04 she called police and the London Ambulance Service (LAS). Police attended and forced entry to the property. They found Alice's lifeless body in the bedroom. She was beyond saving and paramedics pronounced life extinct at 23:22.

106. Alice had extensive and severe facial and head injuries as well as to her body, 71 in total. She had been strangled and then beaten with a heavy glass lamp holder as well as with fist blows and stamping. There was evidence of defence injuries. Such an attack would meet the definition of 'Overkill' in the latest Femicide Census Organisation 10-year study (2020) which cites an earlier study[24] that identified 'Overkilling' as: *the use of excessive, gratuitous violence beyond that necessary to cause the victim's death*. Over the ten-year study period there was evidence of overkilling in 55% of the femicides analysed.

107. A set of keys to the flat were on the mat as if they had been posted through the letter box. The small safe where Alice kept her jewellery was left open but it is not known if anything had been taken. The pathologist who examined Alice recorded that the cause of death was blunt head and face trauma with features of neck compression.

108. The next day the NPS risk assessment was updated by PO3 and countersigned by SPO4.

109. Lannigan was arrested in North London five days after the murder and denied being responsible for her death, confiding to relatives that he would get off with 'diminished responsibility'. Whilst on remand he dispatched abusive and threatening letters to witnesses. In the event, he pleaded 'guilty' to the murder charge for which he was sentenced to Life Imprisonment with a minimum of 21.5 years to be served.

[24] Mitchell, C., Anglin, A., (2009) *Intimate Partner Violence: A Health-Based Perspective*, p. 325, Oxford University Press

## ANALYSIS

110. Alice was regarded by all who knew her as a kind and warm-hearted person who suffered from an addictive tendency for most of her adult life. This included alcohol but mainly derived from experimenting with opiate-based prescription medication, much of her supply being via the internet. She was also known to lapse into illicit drugs such as cocaine and she received treatment and counselling, privately funded by her husband, over many years.

111. The separation from Barry in 2016 was initiated by her and an amicable settlement provided her with a flat in Beckenham where she settled with her pet dog. Relationships with her children became strained, however, and she became estranged from them and the grandchildren she had doted on.

112. Alice had come to the attention of safeguarding agencies from about this time in connection with talk of suicide associated with separation from her daughter in early 2017, followed by a harassment warning for internet abuse to her son in May and an overdose in October. She was also upset about the death of her dog and a second overdose incident occurred in October 2018. By January 2019, she had a replacement dog that she was happy with, she had concluded her private treatment for drug addiction and had registered with the locally provided CGL addiction service.

113. In April or May 2019, she met Lannigan whilst walking her dog, apparently by chance. He engaged her in conversation, they had a coffee together and soon embarked on an intimate relationship. One problem for Lannigan was that, as a person released from prison on a licence to an Approved Premises nearby in Beckenham, he was subject to a curfew and his nightly unavailability would need explaining.

114. He was open to AP staff about the new relationship when late for the curfew in May (on his birthday) and by early June he had clearly disclosed something of his past to Alice when he put her on the phone to PO3 to say she was happy in the relationship and knew about his conviction history. This may or may not have included his life sentence for violently robbing a lone female using a weapon in 2002, or the reported threats to kill his partner in the same year. They were both drug users and Lannigan tested positively many times for opiates in the following weeks.

115. The drug test results had been similar prior to their meeting and he was open about the fact that he had returned to friends in Hackney to acquire/consume drugs. Once he met Alice there were no further references to visiting Hackney.

116. The relationship lasted about ten weeks in all but latterly Alice was talking of feeling suffocated by Lannigan and she exhibited a demeanour on the day of the homicide that indicated she had enough of the relationship to the point where she was trying to avoid him. Her hairdresser appointment that day was not pre-booked.

117. She was brutally assaulted in a sustained fatal attack upon her return. From about ten days before, she had disclosed her unease with the relationship to a keyworker at CGL and to her friend Alice. The evening before, having ceased her regular visits to Gwen since the relationship with Lannigan began, she told her friend that she would visit her the next day to

tell her something. When asked, she disclosed only that he had been a bit of a rascal. It is highly likely that she was about to end the relationship.

118. There is substantive research[25] available that, frequently, there is a 'journey to homicide' on the part of the perpetrator. Relationship-based homicides are rarely spontaneous and the: 'He just snapped' explanation, which suggests an immediate proximal provocation, is not supported. Schlesinger describes 'catathymic homicides' as occurring when:

> *There is a change in thinking whereby the offender comes to believe that he can resolve his inner conflict by committing an act of extreme violence against someone to whom he feels emotionally bonded*

119. A recent study[26] of Intimate Partner Femicide (IPF) uses Foucauldian analysis to track the eight stages that were present in almost all the relationships' progression to homicide. Evidence gathered from this review will be compared to the research findings:

*Stage one: Pre-relationship history of stalking or abuse by the perpetrator*

It is known that Lannigan was investigated for threats to kill and assaulting his former partner in 2002, a matter that was not prosecuted. Shortly after, he received his life sentence for a violent robbery on a lone female and spent the next 13 years incarcerated so not able to form relationships. Within 18 months of his first release he had been recalled to prison for a burglary offence.

*Stage two: The romance developing quickly into a serious relationship*

Within two months of his second release on licence, Lannigan had apparently struck up a conversation with Alice when she was walking her dog. Lannigan was high on the spectrum of personality disorder with an 'entrenched personality'. These are people with low empathy who can easily appear warm and charming when the occasion suits, perhaps in this case commenting on Alice's pet dog. What started with a conversation over a coffee, rapidly developed into intimacy and a level of trust whereby Lannigan was given keys to Alice's flat.

*Stage three: The relationship becoming dominated by coercive control*

With reference to the types of abuse in the wider definition of coercion and control, the main elements exercised by Lannigan were: <u>psychological</u> – Alice had been diagnosed with Bi-polar Affective Disorder type II and had been sectioned under the Mental Health Act in October 2017, a vulnerability that he exploited and controlled through his constant daily presence, following her from room to room, two hours of telephone conversation every evening, plus exclusion from face to face contact with her best friend; <u>physical</u> – there is a possibility of physical abuse from the injury Alice sustained on 11 July; <u>financial</u> – he drew upon Alice's resources for the supply of cocaine, albeit that she was using it as well, and apparently contributed nothing from his; this probably included the pawning of her jewellery; he had free access to her means of transport and spent his days in her flat, including access via keys when she was not there; <u>emotional</u> – he seized the opportunity to exploit Alice's vulnerability and emotions, for example, by claiming that he also was estranged from grandchildren (when so far as we know he did not have any) and by suggesting he suffered from cancer.

[25] Schauringer 2002, Adams 2007, Monckton Smith 2012
[26] Monckton-Smith 2019

*Stage four: A trigger to threaten the perpetrator's control*
It is generally recognised that intimate partner separation leading to loss of control is a time of heightened risk. There is circumstantial evidence that Alice wanted to end the relationship. Lannigan had been repeatedly warned that he faced recall to prison and this had been made plain to him in a meeting with PO3 on 15 July[27].
*Stage five: Escalation - increase in the intensity or frequency of the partner's control tactics*
Tension in the relationship had increased over the few days prior to the homicide and in the morning it was obvious to Isabel and Jonathan that Alice was seeking to avoid contact with Lannigan if possible. Lannigan's observed behaviour that day was highly controlling.
*Stage six: A change in thinking/decision to act*
Lannigan has not responded to the offer to assist the review so what may or may not happened at this stage is a matter for speculation.
*Stage seven: Planning*
Lannigan had acknowledged to probation staff that he and Alice would be taking a break, yet he still appeared at her flat. He was probably waiting for Alice to arrive with the cocaine she had procured. He monitored her every move on return, including her taking a shower. After she had left for the hairdresser, he picked an argument with Jonathan to ensure he and Isabel left. While waiting for Alice to return from the hairdresser, he placed a call with PO3 to describe his plan for the day with potentially verifiable detail, such as going to the library, while making it clear that she was not at the flat but they would be separating. This was highly likely to be the beginnings of an alibi. The safe may have been left open to suggest an intruder with burglary in mind. Leaving the keys through the letterbox to be found on the mat would have confirmed his earlier story to PO3.
*Stage eight: Homicide*
The research suggests, as is found in this review, it is not unusual for an extreme level of violence to appear to have no direct relation to the absence of reported violence earlier in the relationship. Nonetheless, from the robbery offence he was convicted of in 2002, Lannigan has shown that he is capable of causing serious harm to, and will use a weapon upon, a female.

**The NPS Serious Further Offence review**

120. From the perspective of the family, they believe that this homicide could have been avoided had Lannigan been recalled to prison at an earlier stage. The NPS conducted their Serious Further Offence review in consultation with the family and have informed them of the findings. The key findings from their IMR for this review are summarised here. It should be borne in mind that there are hundreds of entries relating to Lannigan on the Delius case management system.

121. <u>Key findings - assessment</u>
PO3 had correctly completed the risk assessment on Lannigan on the Offender Assessment System (OASys). The expectation that this assessment is then counter-signed by a Senior Probation Officer was not met by SPO4 and as a result the assessment was auto-locked 'incomplete'. In interview, she expressed regret of this omission, and explained that her increased work load had resulted in her struggling to meet the demands

[27] Also a formal Notice to Quit by late July had been issued in mid-July

of the service. She held the position of MAPPA chair, and reported having a high number of newly appointed Probation Service Officers of whom required assessments countersigned. This was a strain on SPO4 completing all the assessments within the specified timeframe and accounted for the delay in this case. She reported that she would rely upon her Offender Managers highlighting particular cases that required prompt countersignature, so that she could prioritise these assessments for review.

122. She could not recall if PO3 had highlighted this case but noted that PO3 was a highly organised member of staff who took pride in his work. She spoke with confidence about PO3's abilities and expertise as a practitioner and noted that she had only issued minor amendments in her feedback to him in May 2019.

123. PO3 was considered proficient in his assessment of Lannigan and the IMR author concurred with his assessment that he posed a high risk of serious harm to others. PO3 referred to both the actuarial data and his clinical judgement to make this assessment, noting the pattern of violent behaviour on his record. He skilfully analysed the risk factors and noted that until Lannigan fully addressed the underlying causes of his behaviour and improved his self-management, the risk would remain high.

124. PO3 did not complete an OASys review when Lannigan disclosed a new relationship with Alice on 12 May or the numerous positive drug tests at the AP. a key work session a month later suggests that this relationship commenced several weeks prior, possibly around mid-April 2019. Given the time span of this relationship, and the emerging lapses to substance misuse, which PO3 appeared to associate with Lannigan's relationship with Alice, PO3 should have completed this review. However, there is evidence of PO3 recording changes in relation to risk of harm in the case management system.

125. Lannigan's threatening behaviour following the end of a relationship in 2001-2002, indicated that he had the capacity to continue domestically abusive behaviour post separation. PO3 was not aware of this information, therefore, Lannigan was not assessed as posing a risk of serious harm to females he was in a relationship with.

126. PO3 had tried on numerous occasions to make enquiries with police regarding Alice's address where Lannigan had been a visitor and, eventually, no concerns were identified[28]. PO3 expressed regret in interview that he did not respond to the police request for Alice's date of birth, further checks suggest that this would not have resulted in additional information to inform the risk assessment. On one occasion PO3 appeared to have contact with Alice by telephone although it is not possible to confirm for certain the identity of the woman he spoke to, given any attempt to verify her identity would have been difficult.

127. There was evidence in the notes that PO3 used the sessions with Lannigan to explore and review his relationships. PO3 reported he undertook regular discussions about the developing relationship with Alice, including the last meeting they had on 10 July during which he disclosed his emotions would fluctuate when he was apart from Alice, resulting in him using substances when he returned to the AP. Lannigan seemed at ease when

[28] Interaction between NPS/MPS explored further in paras 151-153

discussing Alice and in a positive mood when discussing their relationship. PO3 said in interview that the intensity of Lannigan's emotions were expected given his Personality Disorder traits. PO3 recorded that he did not assess this a risk to Alice directly, particularly given he assessed that a relationship breakdown would most likely cause an internal deterioration such as the increased use of substances or absconding.

128. When Lannigan reported the relationship with Alice had ended, initially to his key worker the day before the homicide who recorded it on Delius and, on the morning of the homicide to PO's 3 and 4, there would have been limited time to respond or assess the impact.

129. Key findings – planning

The risk management plan was appropriately updated to indicate that Lannigan had been released from custody and the licence conditions that he was subject to, which were largely the same as the previous release as they remained relevant. He continued to be subject to MAPPA level 1 management which was appropriate. The plan contained details of all the relevant agencies including PO4 who was caretaking the case whilst Lannigan was residing at a Bromley AP. The contingency plan was thorough.

130. Whilst Probation Officers were alert to Lannigan's self-reported abusive behaviour in a relationship during the early years of his sentence, the focus on relationships was mainly in the context of how separation could lead to internal deterioration as opposed to risk to partners. Had PO3 been alert to the incidents from 2001/2002, the Risk Management Plan would have included a requirement to monitor relationships. PO3 did monitor his relationships through regular discussion in supervision.

131. Key findings – implementation and reviewing

Lannigan was familiar with working with PO3 from April 2018 prior to his release by the Parole Board in March 2019 and they appeared to have developed a positive rapport as a result. PO3 ensured that weekly supervision took place throughout, alternating between himself and PO4 based in. It was not easy during both periods of release to sustain engagement given that Lannigan is a challenging individual, owing to his Personality Disorder presentation. He was manipulative and tended to be complimentary to some staff and very difficult with others. This was evident in his interactions with AP staff and his presentation with his Probation Officers.

132. Enforcement decisions were incorrect during this release when Lannigan relapsed into substance misuse. The AP issued a behaviour warning letter at the request of SPO2 on 26 March when Lannigan presented late and under the influence at the AP. PO3 responded to concerns about Lannigan's drug use and challenging behaviour towards staff and other residents at the AP and this led to enforcement action, including a Head of Service warning letter on 20 May and a further licence warning on 25 June. However, as before, the enforcement decisions had little impact on his behaviour when it is known that he produced five further positive drug tests.

133. PO3 and SPO4 both reported in interview that they were waiting on the promise of the rehabilitation placement, which had been provisionally agreed prior to release by the Parole Board. It had been agreed that Lannigan should reside at the AP for three months, before

transitioning to the rehabilitation centre. However, changes in personnel and the requirement for Lannigan to undertake a blood test appeared to delay the process, even after funding was secured.

134. PO3 was explicit in his entries in July, that Lannigan was very close to recall but remained hopeful that a placement would be secured as they were shortlisting Rehabilitation Centres. PO3 reflected that in hindsight it would have been preferable to have secured the exact placement prior to release, given that much of the four-month licence period that had passed was used to progress the referral. On his reflection, the AP Area Manager questioned the validity of waiting for a placement following the positive tests, noting that it was increasingly likely that Lannigan would have required a period of detoxification prior to admission.

135. In evaluating his response to escalating risk, PO3 assessed that it was possible his role as the Personality Disorder (PD) SPOC had led to focusing more significantly upon working with the resistant nature of service users such as Lannigan. SPO4 expressed regret that she had been influenced by PO3's experience in working with Lannigan that recall was not necessary when she agreed to issue the warning letter in late June. She spoke highly of PO3's abilities and competence as a practitioner and had believed at the time it was appropriate to enforce by issuing a warning, rather than proceed to recall.

136. In discussion with ACO1, he noted that SPO4's rehabilitative focus at times overshadowed the need for enforcement decisions proportionate to the risk. He reported that he did not recall being consulted about the risk management concerns relating to this case and that had he been contacted by SPO4 in June he would have supported the recall.

137. Recall should have taken place in April as the threshold for recall had been met. At this stage Lannigan had tested positive for illicit substances on three occasions, had four positive alcohol readings and had admitted that he had met a previous drug using associate in April with whom he had smoked crack cocaine and heroin.

138. The recall policy sets out four criteria which should be met when deciding whether to recall an individual who is subject to an indeterminate sentence. One of these criteria is defined as *'exhibits behaviour similar to behaviour surrounding the circumstances of the index offence'.* This principle had been met, particularly given his emerging pattern of substance misuse was a trigger for offending and these behaviours were present during his index offences, one of which was of a violent nature. ACO1 considers that PO3 and SPO4 should have been clear about when to progress recall.

139. Drug testing did not always take place twice weekly in line with the expectations of the risk management and sentence plans. For instance, no tests took place during the first week in June, and tests were administered only weekly during the second and third weeks of June and early July. In interview with the key worker at the AP, he could not recall the specific reasons for these omissions. There were 28 tests administered overall and the IMR author does not consider the shortfall of five adversely impacted on the management of risk.

140. The internal partnership liaison in this case was extensive and seen as a clear strength. PO3 drew heavily on the support offered through the PD pathway, and his skills as the SPOC for the pathway shone through in his analysis of Lannigan's presentation and engagement. PO3 took Lannigan to the PD Hub at London Bridge on several occasions and utilised the expertise of the PD pathway psychologist and the practitioners. A formulation and Mentalisation Based Therapy assessment had been undertaken during Lannigan's first release and the PD psychologist completed numerous one to one sessions with him.

141. PO3 sought guidance from the PD psychologist to explore any presentation of depression following a significant bereavement. PO3 referred Lannigan for drug treatment sessions and it is noted that PO3 was proactive in liaising with the drug misuse advocate sourced by the solicitor. Despite the challenges of finding the residential Drug Rehabilitation placement, PO3 constantly highlighted the importance of sourcing a placement in line with the risk management plan with Hackney council.

142. The IMR author considers that home visit could have been undertaken at Alice's residence given that Lannigan spent a substantial period of time there when outside of the AP. In his interview PO3 considered that, given the last correspondence from police indicated there were no call outs to Alice's address, that she was willing to talk to PO3 by telephone and knew how to reach him, the fact the fact that Lannigan was subject to curfew and there were no overtly concerning attitudes towards Alice or relationships generally, he felt that the lack of a home visit was fairly proportionate. PO3 also attributed the lack of a domestic abuse history to his decision not to visit Alice. The IMR author has acknowledged that PO3 had been unaware of the 2001/2002 incidents because historical intelligence had not been sought.

143. PO3 made reference to the scale and complexity of the cases he was managing in his capacity as PD SPOC and that decisions had to be made quickly often with little opportunity for reflection. This was raised regularly at the Hackney Office. ACO1 verified this in interview, noting that PO3 had to discontinue an element of the PD Pathway work, specifically his contribution to the delivery of Mentalisation Behavioural Therapy for service users, as his workload became unmanageable. ACO1 confirmed that he continues to keep the workload management of Offender Managers at Hackney under regular review with middle managers including SPO4. He added that his team did their best to: "mitigate the challenges felt day to day". The challenge of managing complex cases in pressured circumstances was recognised by Her Majesty's Inspectorate of Probation in the inspection of NPS London in 2019.

144. The working arrangement between PO3 and 4 was effective whilst Lannigan was resident at the AP and there was evidence of continual communication, particularly in ensuring that they adopted the same approach in addressing his challenging behaviour, and positive drug tests.

145. In interview, the key worker noted the challenge of working with Lannigan when he demonstrated 'self-sabotaging' behaviours. The key worker believed that he did not want

to transfer to a Rehab Unit as he was not ready to address his drug use. The key worker was proactive in relaying this to all relevant parties to aid the risk assessment.

146. Management oversight was evident throughout this case by managers in the AP and field teams. In interview with the covering AP manager and SPO2, both expressed concern about the remote management of the AP from February to August 2019 caused by long term sickness absence. The Area AP manager explained that due to the re-structure within the AP department, there was no formalised arrangement for sickness cover and this led to implementing a rota between AP managers to offer oversight. She reported that, given the evident challenge of remote management, an interim AP manager has now been allocated to the AP since September 2019.

147. The covering AP manager and SPO2 reported that they had the management responsibilities at their respective APs, but attended the Beckenham AP when they were able to ensure some management presence, however, they did not have capacity to offer supervision to staff or hold team meetings. Both noted that staff in the AP raised the concerning behaviour of residents when they arose, although both managers believed that staff only raised the most urgent concerns. Likewise, the AP key worker remarked that Lannigan was but one of a difficult cohort of offenders at the AP and although he noted the challenge of the remote management, he valued the input from both covering managers.

148. The covering AP manager and SPO2 presented as highly competent AP managers, who were experienced and proficient in their roles. The covering AP manager reported how the drug activity at the AP was addressed through her liaison with the local police and through issuing a warning letter to all residents. Room searches were undertaken at her request, although nothing was found. At the start of July, at the suggestion of the covering AP manager, she sought approval from the Head of Service who was covering the Public Protection Lead to implement a rota amongst AP managers to ensure more management presence on site on a regular basis.

149. Specific to Lannigan and following a discussion with PO3 in early July, she issued Lannigan with a Notice to Quit, requiring him to leave the AP by late July. On reflection, she expressed regret that in normal circumstances she would have issued a one-week period for eviction, but had been persuaded by PO3 that a two-week period was necessary given it was unrealistic to resolve the issue of sourcing a residential rehabilitation centre within the shorter time frame.

150. The IMR author does not agree with management decisions during release to delay recall, despite the escalations in risk. It is noted that the Area AP manager explicitly referenced that any such decisions needed to "stand up to scrutiny" and appropriately requested to see evidence of liaison between PO3 and SPO4 in considering the continued positive drug tests and evident link to risk of serious harm and offending.

151. SPO4 has been honest in her reflection on her decision making and her clear regret in not pursuing recall with respect to Lannigan. She accepted her duty to actively challenge the

decision making of Offender Managers, regardless of their experience level and escalate concerns where appropriate to ACO1 for review.

**Communication between NPS and MPS**

152. In support of MAPPA Offender Management, there is an Information Sharing Agreement (ISA) between the MPS and NPS. The purpose of sharing information about individuals is to enable the relevant agencies to work more effectively together in assessing risks and how to manage them. This points to sharing all the available information that is relevant, so that nothing is overlooked and public protection is not compromised. Information that is shared under MAPPA remains the responsibility of the agency that owns it.

153. There is concern that the communication between PO3 for the NPS and the Jigsaw/Local Intelligence Team for the MPS was not as robust as it could have been and the Chair called for a timeline agreed between the two agencies:
- PO3 is based in Hackney and had a working relationship with the local police Jigsaw Team. His first request with Alice's name and address was sent there by email near the end of May. The enquiry was clear that it related to Lannigan as a 'Lifer' and MAPPA subject with a history of offences against women. It requested 'anything of note – 'perhaps over the last 12 months'. The initial response was that the address was in Kent and enquiries should be addressed there, later corrected
- The next day PO3 sent the same request to the South Jigsaw Team who, in turn referred it to Bromley Local Intelligence Team for action. So far as can be ascertained, the likely reason for this not being picked up for action was that the MPS were in a restructuring phase at that time and the Mailbox where the forwarded message should be identified for action was not being monitored at the time
- In mid-June PO3 sent a reminder to South Jigsaw Team emphasising urgency and that the original request was made in May. For the reasons above, it is likely that this too was not acted upon by the Local Intelligence Team
- In an email to the Hackney Jigsaw Team later in June headed: 'Address check request - fourth request', PO3 asked for escalation of the lack of response from Bromley
- Two days after that in June the Hackney-based recipient of the email conducted a check from their own base and responded that the address: 'Is not known to police in the last 12 months' and added a request for Alice's date of birth[29] in order to conduct further enquiries

154. It is concerning that PO3's request of Bromley Jigsaw Team was not acted upon because the LIT mailbox to which it was forwarded was not being monitored in a period of restructuring; further, that the framing of the question for the time-limited search eventually conducted by Hackney Jigsaw did not reveal relevant information about Alice concerning her vulnerability. Limiting the query to 12 months and not including Alice's date of birth meant that the MPS standard intelligence check of five years across all systems did not happen. Such a check would have revealed the three MERLIN reports and the Harassment Warning related to Alice from 2016/17. A cross-check with the intelligence on Lannigan, the MAPPA subject also mentioned in the NPS email, should have at least

[29] Required to be able to check on a name

promoted consideration of a welfare check on Alice, preferably conducted during Lannigan's curfew time.

## CONCLUSIONS AND LESSONS LEARNED

155. Specific NPS IMR conclusions and lessons learned
The Offender Manager in this case worked tirelessly and relentlessly with Lannigan, who presented as a challenge to all professionals working with him. PO3 had an extensive knowledge of the case and worked in partnership with others with specialist expertise to manage the presenting risks. This included engagement with the AP, the PD pathway, drug treatment and housing.

156. On balance, assessments completed by PO3 leading up to and upon release were of a good quality and identified all the presenting risk factors. Previous police checks did not highlight Lannigan's ability to display threatening behaviour during and following the separation from an intimate relationship. PO3 undertook police intelligence checks at Alice's address, and these did not uncover any concerns in relation to Lannigan nor was there any known evidence of domestic abuse during his first release. PO3 appeared proactive in monitoring relationships through his discussions with Lannigan's during the second release.

157. The over-optimism of PO3 and managers, coupled with a desire to work intensively with a challenging individual to ensure successful rehabilitation, did result in a reduced focus on public protection. Enforcement was ineffective at reducing substance misuse, a key contributor of risk.

158. Recall was delayed during release, despite Lannigan's deterioration and evident relapse to substance misuse. Risk management and implementation were insufficient, notwithstanding the extensive contributions by PO3, a highly regarded practitioner. The enforcement decisions, combined with delays to securing residential rehabilitation during the 2019 release, significantly impacted risk management.

159. The decision not to recall in April 2019 was significant; persistent and increasing indicators of risk were not acted upon. Lannigan continued to remain in the community for a considerable period whilst regularly misusing substances despite the clear understanding that this was linked to risk.

160. Specific Priory IMR conclusions and lessons learned
Timely referral of concerns and strengthened documentation by staff are important for the Priory Group, however, there is no information available to indicate that Priory staff were aware of any risk that Alice was in a domestically abusive relationship or involved with an individual with a recognised risk of violence/abuse toward their partners.

161. Notwithstanding the lack of Priory knowledge of the relationship under review, clinical members of the Panel were concerned to understand the Priory Management Plan regarding Alice's addiction to Dihydrocodeine and the Priory provided a supplementary statement to their IMR prepared by the Psychiatrist that treated her between 2005 and

2018 that clarifies why Dihydrocodeine was prescribed for Alice and what steps had been taken generally to help her with her substance abuse:

> *[Alice] had complex psychiatric problems with a recurrent treatment resistant mood disorder (technically bipolar), dependent use of multiple substances, probable ADHD and a personality disorder. With regard to the latter, she had many difficulties managing her relationships over the years and needed much help negotiating these. In turn, problems with those destabilised her mood and led to self-medication with substances usually bought over the internet for example Dihydrocodeine.*
>
> *There were significant lengths of time without any substance misuse. Whilst [Alice] was under my care she never drank alcohol because it 'made' her self-harm. There were recurring episodes of analgesic misuse with Dihydrocodeine. She would buy this in large amount over the internet. She was often not straightforward about what she was using, but would then declare it. At those points, she would begin a prescription of Dihydrocodeine, which provided a tapered withdrawal. This was combined with psychological help for example from* [A Therapy Services Manager]*. To go too fast with the withdrawal regimen was for her to top up from internet sources. The rate of reduction was a fine judgement.*
>
> *Mostly [Alice] was under some form of addictions therapy. When she was discharged from Priory, it was to BDAS, the Bromley Drug and Alcohol Service.*

162. <u>Specific BDAS IMR conclusions and lessons learned</u>

Based on the analysis of the report, a key piece of information which was missing was Lannigan's risk assessment. This was not shared by probation or requested by BDAS at the time of referral. This may not have prevented future events; however, it could have raised concerns earlier on and more effectively supported Alice. Improved joint working with the MAPPA panel to create more robust management plans for offenders engaging with both substance misuse services and probation would improve communication and the IMR author has that BDAS should conduct more joint work with the MAPPA panel to create more robust management plans for offenders engaging with both substance misuse services and probation.

163. <u>Specific Oxleas IMR conclusions and lessons learned</u>

Contact with Alice was very limited and it was sporadic, often relating to a crisis. She had detailed assessments completed and was offered a crisis admission. Post discharge she was offered crisis services but she declined them and she had capacity when she made these decisions. Her homicide could not have been foreseen at the time she was a patient with Oxleas.

164. <u>Overview</u>

The rationale, supported by her family, for setting out in this review Alice's long addiction history associated with a diagnosis of Bipolar Affective Disorder Type II with mild phases, multiple substance misuse, personality disfunction and multiple difficult family relationships, is to highlight her vulnerability. For a man of Kenneth Lannigan's 'entrenched personality' who was on the NPS Personality Disorder Pathway, Alice would have been easily

enamoured, for example, by his false claim that he too was estranged from grandchildren. Their shared interest in substance abuse and her access to funds and her own flat made her an ideal target for him to charm. He had to disclose something of his past to account for the fact of his curfew. The fact that Alice described him to her husband as having a 'colourful past' and to her friend as 'a bit of a rascal' suggests he was economical with the truth.

165. Alice's family are understandably concerned that Lannigan was assigned to an Approved Premises in a different geographic area, LB Bromley, to the one he was familiar with – Hackney. It is understood that this allocation was based pragmatically on vacancy availability across the London Approved Premises estate and the ability to deliver the risk management plan around the offender. An allocation system based on proximity to pre-sentence orientation would be ideal, but unworkable, as there are not Approved Premises in each London borough. For his Offender Managers (PO3 and SPO4), it was a difficult situation as they were managing a large workload at the time. The communication between LB Hackney and LB Bromley staff worked as is expected to manage cases across boroughs in accordance with the transfer guidelines. Though managing cases across boroughs is not an ideal situation it is common. An additional operational difficulty for the National Probation Service was the absence of an AP manager for the period that Lannigan was resident there

166. While it can be asserted, in all probability, that Alice and Lannigan would not have met without the placement in Bromley, the Panel conclude that this unfortunate coincidence could not have been foreseen. Nonetheless, there are factors related to the Offender Management of Lannigan following his placement in Bromley that have been thoroughly explored.

167. Clearly, the decision making of the National Probation Service with respect to the management and supervision of Kenneth Lannigan, the dangerous offender they were charged with supervising when released on licence in March 2019 to an Approved Premises, is in question, as their own Serious Further Offence Review makes plain. For his failing of drugs tests and general attitude and behaviour in clear breach of his release conditions, Lannigan should have been returned to prison at some point in April and Alice may not have met him.

168. Moreover, the Parole Board release decision provided guidance of three months for the purpose of identifying a residential rehabilitation unit. This period expired on 3 June and the discussion between the OM and the AP manager to extend by what became a further six weeks is not noted in the record, however, it is apparent that strenuous efforts were being made to locate him during this phase. With hindsight, it seems likely that Lannigan was cynically exploiting these efforts in order to extend his time at the AP. The first offer of a placement was at Clapham in April and, by early July, the matter was reported as urgent but that the process required his signature. The day before the homicide, he signed the papers for a placement in Lewisham.

169. While the NPS cannot be held responsible for the apparently random circumstance whereby Lannigan, with relative freedom of movement providing he returned to the AP for his 21:00 curfew, somehow engaged Alice in conversation when she was walking her dog, they did become aware by the end of May of the 'girlfriend' relationship that had developed from that encounter. There was an explicit condition of his release (No.11 of 12) that he should notify his supervising officer of any developing relationships, whether intimate or not, with men or women. PO4 recorded Lannigan's reluctance to provide Alice's name and address, however, he did as requested near the end of May.

170. As a result, police enquiries were initiated and, again, it is an unfortunate circumstance that requests for searches on local police databases were not picked up due to the internal police mailbox not being monitored at the time. When a request eventually came back from Hackney police for a date of birth for Alice that could have enabled the exposure of her history and vulnerability with a possible link to what had already been shared with local police about Lannigan's release, it was not followed up by PO3.

171. Lannigan was a MAPPA subject, albeit at level 1 with a single agency lead, in this case the NPS. There was no requirement to advance him for consideration at the multi-agency meeting set up ensure safeguarding collaboration but, had the proper intelligence links been made, there may well have been a case to do so. At the minimum, there could have been a follow-up enquiry by either PO3 or local police directly with Alice to ensure her well-being and safety.

172. Taking account of all the information discovered in this review, the Panel have identified the strategic learning points:
    1. The main learning point acknowledged in the NPS IMR, debated and supported by the Panel, is that the system for NPS risk management did not function correctly and it is necessary to revise the recall process and the process for Approved Premises staff to escalate concerns about residents.
    2. It is also necessary to address the individual failings by the staff involved in the supervision of Kenneth Lannigan.
    3. It is suggested that the Information Sharing Agreement between MPS and NPS should be reviewed by the strategic leads in London for police and probation to ensure the efficacy of local intelligence checks with respect to any new relationship that is discovered in the course of licence conditions.

## RECOMMENDATIONS

173. IMR authors were invited to make recommendations for internal remedy and also for wider consideration by the Panel. In line with the first strategic learning point, the author of the SFO review recommended a two-part internal action plan addressing processes in NPS London, together with the relevant omissions in practice in this case within a six-month timeframe. The Recall Policy Framework has been updated and re-launched and discussion held with all staff with regard to recall thresholds. There is also a revised escalation process now in place for Approved Premises staff to escalate concerns about residents to Heads of Service.

174. In the second part, an action plan for the Probation staff involved in the supervision of Lannigan has been set out. The themes of the action plan include appropriate responses to escalating risk of harm, consultation with Head of Service with regard to breaches of Licence, reviewing of drug residential rehabilitation placements in Hackney, timely countersignature of risk assessments, risk assessment reviews to be completed when behaviour is escalating and drug testing to take place as stated within the Approved Premises. This action plan is internally monitored to ensure completion and actions are reviewed by the HMPPS (Her Majesty's Prison and Probation Service) and reported to Ministers.

175. With respect to the apparent system failings identified in the SFO review, SPO4 commenced maternity leave in July 2019. Given the perceived omissions in this case, and following her return to work formal proceedings have commenced, an investigation report has been completed. A Hearing date is imminent.

176. For wider consideration the BDAS IMR author identified that partnerships between BDAS and MAPPA would be improved by a joint planning meeting to create an ongoing working arrangement. Such a meeting has been held and an agreement formulated to improve communication and partnership working in LB Bromley. As a result, BDAS will be alerted to new MAPPA subjects and contribute to their risk management plan. The NPS IMR author identified that historic domestic abuse concerns should be highlighted on all NPS intelligence checks with police, with acknowledgement that there may be an impact on police resources.

177. This led to the Panel identifying the third strategic learning point concerning a review of the Information Sharing Agreement between MPS and NPS. This DHR should be used as a Case Study to inform the review and implement the revisions necessary to prevent future shortcomings in the system for information sharing.

178. The following recommendations are set out in the Action Plan in appendix 3:
    1. Revise and re-launch the Recall Policy Framework to reflect the findings from the SFO Review and brief all staff with regard to recall thresholds
    2. Devise and introduce an escalation process for Approved Premises staff to escalate concerns with residents direct to Heads of Service

3. A specific action plan for the Probation staff involved in the supervision of Kenneth Lannigan, with these themes:
   a. The Appropriate responses to escalating risk of harm
   b. Consultation with Head of Service with regard to breaches of Licence Reviewing of drug residential rehabilitation placements in Hackney
   c. Timely countersignature of risk assessments
   d. Risk assessment reviews to be completed when behaviour is escalating
   e. Drug testing to take place as stated within the AP
4. Using the findings from this DHR as a case study, conduct a review of the Information Sharing Agreement between the NPS and MPS and implement revisions necessary to prevent future shortcomings in the system for information sharing.

**Author**

Bill Griffiths CBE BEM QPM

10 February 2021

## Glossary

| | |
|---|---|
| ACN | Adult Coming to Notice |
| ACO | Assistant Chief Officer |
| AP | Approved Premises |
| ASC | Adult Social Care |
| BDAS | Bromley Drug and Alcohol Service |
| CCG | Clinical Commissioning Group |
| CGL | Change Grow Live |
| COMHAD | Co-Occurring Mental Health, Alcohol and Drugs |
| CSU | Community Support Unit |
| DA | Domestic Abuse |
| DHR | Domestic Homicide Review |
| FIHW | First Instance Harassment Warning |
| GP | General Medical Practitioner |
| IMR | Individual Management Review |
| HTT | Home Treatment Team |
| KCH | Kings College Hospital NHS Foundation Trust |
| LAS | London Ambulance Service NHS Foundation Trust |
| LBB | London Borough of Bromley |
| LIT | Local Intelligence Team |
| MAPPA | Multi Agency Public Protection Arrangements |
| MPS | Metropolitan Police Service |
| NA | Narcotics Anonymous |
| NHS | National Health Service |
| NPS | National Probation Service |
| OASys | Offender Assessment System |
| OM | Offender Manager |
| PDP | Personality Disorder Pathway |
| PO | Probation Officer |
| PRUH | Princess Royal University Hospital |
| SBP | Safer Bromley Partnership |
| SPO | Senior Probation Officer |
| ToR | Terms of Reference |
| VAF | Vulnerability Assessment Framework |

## Name references used

| | |
|---|---|
| Alice | Victim |
| Barry | Husband of victim |
| Claire | Daughter of victim |
| Darren | Son of victim |
| Eve | Sister of victim |
| Frank | Brother in law of victim |
| Gwen | Friend of victim |
| Helen | Hairdresser to victim |
| Isabel | Acquaintance of victim |
| Jonathan | Partner of Isabel |
| Kenneth Lannigan | Perpetrator |

**Domestic Violence Homicide Review Panel – LB Bromley CSP**
**'Alice' aged 61, murdered in Bromley in July 2019**

**Appendix 1**

## Context of review[30]

One evening in July 2019, police were called to [**a flat in] Beckenham**. They forced entry to the flat and discovered that **Alice** aged 61 (born in 1958) had been fatally assaulted in her bedroom. Five days later, a man with whom Alice had been in an intimate relationship since April 2019 was arrested and charged with her murder. He is **Kenneth Lannigan** aged 52 (born in 1965) who was under supervision while released on licence and residing at Approved Premises in Penge (address tbc). He formerly lived in LB Hackney. In December 2019 at the Central Criminal Court Lannigan pleaded 'guilty' to murder and was sentenced to Life Imprisonment with a minimum of 21.5 years to be served.

Under s9(1) Domestic Violence, Crime and Victims, Act 2004, the Safer Bromley Partnership have appointed Bill Griffiths CBE BEM QPM as independent chair of a Domestic Homicide Review (DHR), supported by Tony Hester who will manage the process.

## Purpose of review

1. Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.

2. Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence, including its impact on children in the home.

3. Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.

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

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

6. Highlight any fast track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life

[30] V3 issued 08/11/20

**Domestic Violence Homicide Review Panel – LB Bromley CSP**
**'Alice' aged 61, murdered in Bromley in July 2019**

**Terms of Reference for Review**

1. To identify the best method for obtaining and analysing relevant information, and over what period prior to the homicide to understand the most important issues to address in this review and ensure the learning from this specific homicide and surrounding circumstances is understood and systemic changes implemented. Whilst checking records, any other significant events or individuals that may help the review by providing information will be identified [Note: At the first Panel meeting on 04/02/2020, it was established that their relationship commenced at some point in March 2019 (later amended to April). It was agreed that any earlier information of relevance to the review would be included in chronology reports. It was noted that Lannigan was on a life sentence for a robbery committed on a lone female with a weapon in 2002 and was known to the police for domestic abuse against a former partner, also in 2002]

2. To identify the agencies and professionals that should constitute this Panel and those that should submit chronologies and Individual Management Reviews (IMR) and agree a timescale for completion [The current attendees would continue with the exception of the SIO and Adult Safeguarding. It was established that Alice had been treated at 'The Priory' and a chronology from them would be appropriate]

3. To understand and comply with the requirements of the criminal investigation, any misconduct investigation and the Inquest processes and identify any disclosure issues and how they shall be addressed, including arising from the publication of a report from this Panel [Criminal trial concluded in December 2019. There has been a National Probation Service Serious Further Offence (SFO) investigation which may result in a disciplinary investigation. The Coroner has opened an Inquest and is yet to make a decision on closure]

4. To identify any relevant equality and diversity considerations arising from this case and, if so, what specialist advice or assistance may be required [All concerned are White British and Alice is female. Faith is not known but not believed to be actively pursued or a factor for consideration. Alice had separated from husband Barry in 2016 with an 'amicable' settlement that provided her with independent living but they had not divorced. For many years she had been addicted to opiate based pain relief drugs and could be considered an adult with care and support needs. The age difference between victim (61) and perpetrator (52) is not felt to be a significant factor.]

5. To identify whether the victims or perpetrator were subject to a Multi-Agency Risk Assessment Conference (MARAC) and whether perpetrator was subject to Multi-Agency Public Protection Arrangements (MAPPA) or a Domestic Violence Perpetrator Programme (DVPP) and, if so, identify the terms of a Memorandum of Understanding with respect to disclosure of the minutes of meetings [Neither party known to MARAC. Lannigan was on a Life Licence release and a Category 2 MAPPA subject]

6. To determine whether this case meets the criteria for a Serious Case Review, as defined in Working Together to Safeguard the Child 2015, if so, how it could be best managed within this review [No children involved]

7. To determine whether this case meets the criteria for an Adult Case Review, within the provisions of s44 Care Act 2014, if so, how it could be best managed within this review and whether either victim or perpetrator(s) were 'an adult with care and support needs' [Not known to Adult Social Care but see 4 above]

8. To establish whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim or the children she

was looking after, prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware if any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it [The Chair has met with family members in the course of the trial and explained the DHR process. They have voiced concerns about the Offender Management of Lannigan and an internal review by NPS is in progress that may inform the ToR further. The family have an advocate from the Victim Support Homicide Service, with whom contact has been established]

9. To identify how the review should take account of previous lessons learned in the LB Bromley and from relevant agencies and professionals working in other Local Authority areas [Prior reports and other reviews in progress will be researched for parallel or repeat lessons]

10. To identify how people in the LB of Bromley gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague [Research will be undertaken]

11. To keep these terms of reference under review to take advantage of any, as yet unidentified, sources of information or relevant individuals or organisations

**Panel considerations**

1. Could improvement in any of the following have led to a different outcome for Alice, considering:
   a) Communication and information sharing between services with regard to the safeguarding of adults and children
   b) Communication within services
   c) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services

2. Whether the work undertaken by services in this case are consistent with each organisation's:
   a) Professional standards
   b) Domestic abuse policy, procedures and protocols

3. The response of the relevant agencies to any referrals from [insert start date] relating to Alice and Kenneth Lannigan. It will seek to understand what decisions were taken and what actions were or were not carried out, or not, and establish the reasons. In particular, the following areas will be explored:
   a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with Alice and Kenneth Lannigan
   b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
   c) Whether appropriate services were offered/provided, and/or relevant enquiries made in the light of any assessments made.
   d) The quality of any risk assessments undertaken by each agency in respect of Alice and Kenneth Lannigan

4. Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

5. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

6. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

7. Whether any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

8. Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

**Operating Principles**

a. The aim of this review is to identify and learn lessons as well as identify good practice so that future safeguarding services improve their systems and practice for increased safety of potential and actual victims of domestic abuse (as defined by the Government in 2015 – see below)

b. The aim is not to apportion blame to individuals or organisations, rather, it is to use the study of this case to provide a window on the system

c. A forensic and non-judgmental appraisal of the system will aid understanding of what happened, the context and contributory factors and what lessons may be learned

d. The review findings will be independent, objective, insightful and based on evidence while avoiding 'hindsight bias' and 'outcome bias' as influences

e. The review will be guided by humanity, compassion and empathy with Alice's 'voice' at the heart of the process.

f. It will take account of the protected characteristics listed in the Equality Act 2010

g. All material will be handled within Government Security Classifications at 'Official - Sensitive' level

## Definition of Domestic Abuse

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
- 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.

**Appendix 2**

**ACTION PLAN**

| **Learning Point 1:** The system for NPS risk management did not function correctly and it is necessary to revise the recall process and the process for Approved Premises staff to escalate concerns about residents | | | | | | |
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| **Recommendation** | **Scope of recommendation** | **Action to take** | **Lead Agency** | **Key Milestones Achieved in enacting recommendations** | **Target Date** | **Date of completion and outcome** |
| **1** All Offender Managers and Managers in London NPS should ensure they adhere to the Recall Policy Framework in making decisions about enforcement for offenders on Licence | NPS London | **1.1** Revise and re-launch the Recall Policy Framework to reflect the findings from the SFO Review and brief | NPS London | **1.1** Recall Framework updated and reissued nationally 27/01/20<br><br>**1.2** Briefing sessions held for all NPS operational staff by 30/06/20 | 05/09/20 | **Completed 30/06/20** |
| **2** Ensure there is an escalation process for Approved Premises staff to escalate concerns with residents | NPS London | **2.1** AP staff are aware of the escalation process which is via the AP manager who has direct contact with Head of Service. There is an additional option to escalate via AP | NPS London | **2.1** Achieved via contact with AP staff between July and December 2019 | Following SFO Review in June 2020 | **Completed 30/06/20** |

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| | | Directorate Area Manager<br><br>**2.2** Ensure there is AP management availability and contingency to cover sickness | | **2.2** The Approved Premises directorate have a rota to cover absence for long term sickness | Following SFO Review in June 2020 | |
| **Learning Point 2:** It is necessary to address the individual failings by the staff involved in the supervision of Kenneth Lannigan | | | | | | |
| **3** A specific action plan for the Probation staff involved in the supervision of Lannigan, with these themes:<br>a. Appropriate responses to escalating risk of harm<br>b. Consultation with Head of Service with regard to breaches of Licence Reviewing of drug residential rehabilitation placements in Hackney | NPS London | This action plan relates to individual employees and is internally monitored to ensure completion and actions are reviewed by the HMPPS SFO team and reported to Ministers | NPS London | Completion was due 05/09/20.<br><br>This was extended following a change in Senior Management | 05/09/20 Extended to 31/12/20 | **Completed 31/12/20** |

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| c. Timely countersignature of risk assessments<br>d. Risk assessment reviews to be completed when behaviour is escalating<br>e. Drug testing to take place as stated within the AP | | | | | | |
| **Learning Point 3:** the Information Sharing Agreement between MPS and NPS should be reviewed by the strategic leads in London for police and probation to ensure the efficacy of local intelligence checks with respect to any new relationship that is discovered in the course of licence conditions | | | | | | |
| **4** Using the findings from this DHR as a case study, conduct a review of the Information Sharing Agreement between the NPS and MPS and implement revisions necessary to prevent future shortcomings in the system for information sharing | London | **4.1** Set up joint review team<br><br>**4.2** Implement ISA changes necessary to improve system<br><br>**4.3** Conduct testing of revisions to show | Joint work between NPS and MPS strategic leads for London | **4.1** Review team in place working to ToR set by strategic leads<br><br>**4.2** ISA changes implemented<br><br>**4.3** ISA changes tested | April 2021<br><br>July 2021<br><br>September 2021 | September 2021 |

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| | | communication problem eliminated | | | | |